**STOP-DEM – Deprescribing for People with   
Cognitive Impairment**

**Transcript**

**HP02**

INT:  
Today is the 7th of July. So first question is just to ask you, can you tell me about the care you provide people with dementia or mild cognitive impairment, please?

HP02:   
Umm, so we, I mean we're quite a big practice and we have quite a big multidisciplinary team.  
So maybe if I just go through each member of the team and how they might impact on a patient with dementia, would that be helpful?

INT:  
However, you want to approach it.

HP02:   
Umm, so I'm obviously we have a lot of diagnosis or made by a GP and so there will be a GP care involved in terms of making that diagnosis, initial investigations blood CT head discussion of treatment versus no treatment risks benefits and then some of those drugs require monitoring like you know post blood pressure once they've started. Umm we have, uh, two care coordinators that we employ at our practice and so they get involved with a wide range of conditions. Umm, but they are really useful to both patients and probably for this group, particularly for carers in terms of signposting.   
Things like a UK certain charities that support people with those conditions. Umm, we also have a social prescriber. In fact, 2 social prescribers that we employ. Umm that again? Are really good at signposting and supporting.

HP02:   
We also have a cafe in our practice and we have certain support cafes, so we will have dementia, cafe Carers Support Cafe where people can meet, you know, have a coffee and meet other people with the same condition or who are supporting people with the same condition. And we also have a team of three pharmacists, so they often get involved with medication reviews.

Often these patients have quite complex polypharmacy, so you know, we have a team of pharmacist that may touch that patient as well. Just I think whether I've missed anyone.

HP02:   
Umm yeah, I think that that would be that would be the main. I think that would cover most people that would be involved in that particular population.

INT:  
Thank you.   
So quite a variety in a lots of lots of people there involved.

nd how much of your workload is involved in in providing care to people with dementia or mild cognitive impairment, please?

HP02:   
Oh gosh, that's really difficult to create as a percentage of that, I would say. It's a, you know, I certainly think every week there would be a consultations where that comes into play and probably if I'm being honest, it comes into play every day.

HP02:   
I think in our working day in some capacity, umm yeah.

HP02:   
It's, umm, I think I'd find it quite difficult to create a percentage or something like that, but it's, but it's certainly it's a common part of our workload and sometimes it can be the primary issue for someone consulting. Sometimes it's just part of a number of medical health conditions, but umm, you know, I definitely think it's something that's become a bigger proportion of our workload.

HP02:   
I think people are more aware of it. I think people are more likely to come forward earlier.

INT:  
Umm.

HP02:   
I feel like we're often seeing people, you know, I think in years gone by, it would have been a much older age population that you might have been making that agnostics and I do feel that I'm.

I'm seeing increasing numbers of people in their 60s undergoing sort of diagnostic processes with it, and whether that's just, I think that there is an increasing awareness or bit and I think perhaps in days gone by, people just accept thought, oh, this is just part of the normal aging process, whereas I think there's probably.

INT:  
Umm.

HPO2:

More awareness of it being something that is, is not just normal aging and that there are things that can be done to support it.

HP02:   
So I think it is probably you know if you were to plot a graph, I think it is in an increasing proportion of our about workload, not necessarily because incidence is increasing. I mean, I generally don't know the answer to that, but I think there is just a more, it's perhaps less taboo, more awareness that we might, you know it might be something to see your GP about.

INT:  
Thank you.

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INT:  
This is really interesting and how many of those people are taking multiple medications?

HP02:   
I would say the vast majority.

INT:  
OK.

INT:  
And what involvement do you have in their medication management?

HP02:   
So it really depends.   
So, umm, you know, if someone's an older patient and it's a fairly clear cut, dementia if they score poorly on a we'd normally do a 30 point MSC? as part of a MSE part of our screening if it's if it's clear cut we would diagnose and we would you know we would offer you know potential dementia drugs if it is a younger person. If there is complex history sometimes with, you know, complex psychiatric history alongside dementia, if it's someone I mean, for example, I had somebody this week who I referred to the memory clinic for diagnosis because she was only 60, very high functioning. I had very clear cuts history of, of memory problems for the last four months and but scored it 29 out of 30 on her school.

HP02:   
But I think that's because in a highly functioning young person that that screening tool is often quite poor. It really picking up the extensive memory difficulty. So sometimes if there's, you know, there are patients, a group of patients who we would refer to the memory clinic where we're fairly sure we know what the diagnosis is. But I think for a variety of reasons, we might want their expertise to, you know, to make that diagnosis and come up with the best. Umm, management.

INT:  
Thank you.

INT:  
And what are your views regarding deprescribing of inappropriate medication among people living with dementia or mild cognitive impairment, please?

HP02:   
Umm, I think it's a really important area.

HP02:   
I think it is absolutely shocking how many pay older patients end up on just the most enormous cacophony of drugs. And I think when they've got complex medical conditions, perhaps under a variety of hospital consultants, not necessarily, I don't think you know, obviously general practitioners are generalist, but consultants are rarely generalists now. And I think it's amazing how these the numbers of drugs can build up and you know, it's having the time to really sit down and rationalize what they're on and think is it? Does this person really need to be on these things anymore?

HP02:   
And I think we're very good at doing it and end of life type patients and just saying, right, that's really not appropriate. But I do umm, I do think there were a lot of people that are on far too many, many medications. I think I think it is a big problem.

INT:  
Thank you. And then any differences there between patients with mild cognitive impairment or dementia?

HP02:   
I don't quite understand the question.

HP02:   
Say sorry.

INT:  
Oh, yes, yes.

INT:  
People with mild cognitive impairment, all those with dementia, specifically diagnosis.

Any difference between kind of your views on deprescribing in those populations?

HP02:   
I guess.   
The biggest issue is that they perhaps might not think to come forward and to have that conversation. They are, since they may be there.

HP02:   
Umm, there's like the less light in someone without memory problems to have that conversation with the healthcare professional, but. I can't think of any other particular difference.

INT:  
And are there any advantages do you think in terms of deprescribing of inappropriate medication among people living with dementia or mild cognitive impairment?

HP02:   
I'm because lots of things and I think just from the basics of struggling to remember to take tablets every day, I think if they're if the more simplified that medication taking is, I think the more likely it is to be concordant and actually taking the right drugs at the right time. I think when people are on 20 drugs taken throughout the day, you know they're realistic, possibility of someone even without dementia.  
Doing that correctly is small.  
I think for somebody doing that. It's probably tiny. That's someone's gonna do that accurately everyday. I also think probably the less drugs, the less monitoring is required. So, you know, lots of drugs require regular blood tests, blood pressure checks, pulse rate checks.

HP02:   
And again, I think that's a challenge for those people to remember. So yeah, I probably those are the biggest things. But yeah, I think yeah, probably moved there in in somebody with dementia.  
I think trying to simplify things to enable them to have the most sort of functional. Existence is probably a good thing.

INT:  
And that that, that helpfully brings on to the next question about how to the challenges could be resolved. So you mentioned about simplifying as well for people with dementia.

INT:  
Is there anything else that could help to resolve those challenges of deprescribing for people with dementia?

HP02:   
I mean it, it's tricky. I think a big part of lots of issues like this comes back to, you know, if you wanna see my opinion is just the total failings and the NHS, there's not enough people, there's not enough staff, there's not enough to GP. You know, we've obviously got 3 pharmacists now because recruiting GP's is really difficult and they and they have a really valuable role and certainly I'll senior pharmacist is I mean gosh, I would go to her for advice. She's so knowledgeable on prescribing. It's, you know, there were great result was but equally they are not the same as GP with 20 years experience and seeing the whole holistic picture and umm, you know I think a lot of the challenges in in, in effective prescribing is these patients getting appointments and having time with doctors.

HP02:   
And I think at the root cause of that is a desperately underfunded NHS. You got 10 minutes with someone you know. They come in about something else, really looking at the complexity of their medication is, you know, is probably gonna be quite far down your priority list. Sometimes it's I think that's probably the biggest the biggest problem. Yeah.

INT:  
And what types of medications would you feel most comfortable deprescribing for people with living with dementia and mild cognitive impairment and why please?

HP02:   
So that's so that's a really good question. Ohh, struggling to answer that, think it's just.

HP02:   
I mean, I guess it's just rationalizing things. So I guess for example, if you had a patient on a load of pain relief and a load of antidepressants, you could think right? And this is not necessarily a great example for somebody older cause I'm amitriptyline has it's you know potential side effects and the older population but a drug like amitriptyline could potentially manage somebody's pain and their depression. And so I guess it's maybe thinking about drugs that have, umm, more than one purpose that may may make things simpler. You know it's, I think managing pain is a really complicated, difficult area, but I think there's a lot of evidence that actually people can be made worse by lots of drugs, fair for pain control. But again, I think that's probably part of a bigger picture in the fact that I think probably a lot of these patients, the biggest benefit they could derive would be having a greater sense of community, social interactions, exercise. There's a lot of things like that that probably if you could improve those, you could reduce antidepressant prescribing pain prescribing. But ..they're not easy fixes.

INT:  
Umm.

HP02:   
Simple consultation. um

HP02:   
Yeah, it's. I think that's just such an individual question. I just it's. I don't feel like there's something that there's, you know, I always do this and I always do that.

You know it's. Yeah, I think that's such a you'd have to take that list of medications as a sort of on an individual basis.

INT:  
Mm-hmm.

HP02:   
Or feel like I'm giving you a very good answer to that question.

INT:  
No, no, that that's no that that's great.

So thank you for that. And is there anything on that individual basis that would help you or encourage you to support reducing or stopping a medication? Is there something that may help with that process?

HP02:   
Umm, I again I can get probably comes down to resource, so I think you know patients might worry if they take something away.

HP02:   
It's gonna flare up a condition, or it's gonna make their depression work. So it's gonna make their pain worse, or it's gonna make their blood pressure worse. You know, whatever it is, you're looking at. I mean, I guess coming back to that last question. It's not uncommon to see people over prescribed blood pressure medicines, and sometimes you do see that actually as people get older blood pressure, can you actually dip again and it can be a big reason for people fooling as postural hypertension. So that's probably a drug that, umm, you know, it's not uncommon to start looking at reducing and stopping, but I guess having enough resource to follow up these patients and for them to feel confident in reducing and stopping things and that they got somebody that they can actually come back to an appointment that they can get if they're wrong and they wanna go back on it um and I guess for someone with dementia having the right support in place you know change can be quite difficult to remember. So I guess the other challenge is for people who live on their own and don't have a family member or someone who doesn't support them to make sure they remembering the changes correctly.

INT:  
Very helpful. Thank you.

INT:  
And in terms of what medications would you be reluctant to deprescribing?

And why?

HP02:   
Oh that's a really good question. I mean, I think my overwhelming view with all of this is just doing things that maintain somebody's quality of life.So yeah, he not gonna want to deprescribe things that mean that they're enjoying it becomes unstable, or that they're depression is uncontrolled. Yeah, I mean, I just again, I just find that a really hard question to answer because I don't think they're there's a specific drug I think, why would never, you know, I guess another common one to maybe you know you'd maybe think about you know, is it really necessary or things like statins but then you know you cut that out and you're potentially increasing someone's risk of stroke.

So I don't have a hard and fast rules with those I think it's I think I would just look at each person as an individual and just think right is this really adding to this person's quality of life and it is you know is this is it other benefits and it's sort of that benefit risk thing that is. You know, based on a lot of just clinical experience, I don't, I don't think I have a specific drug.

INT:  
Mm-hmm.

HP02:   
I would definitely or deprescribe or not deprescribe.

HP02:   
I think it would just, yeah, sorry.

INT:  
No, that that's fine.

INT:  
Like you said, individual and working in terms of their quality of life and decision making.

HP02:   
Yeah.

INT:  
OK, now thanks

INT:  
And in terms of what are the main things that you think need to be in place for successful deprescribing for someone with dementia or mild cognitive impairment?

HP02:   
Umm, I think clinical resource to do that well be that pharmacist, GP and to really be acting in the patient's passengers doesn't and clinical resource to have appropriate follow up when changes are made. And I think support for that person with dementia, be that a family member or somebody else, care coordinator, if someone doesn't have a family member to ensure that you know the changes that you're making are actually what that patient is doing at home.

INT:  
Thank you. And please describe your experience of having deprescribing discussions with people living with dementia or mild cognitive impairment or their informal caregivers.

HP02:   
I'm.

HP02:   
She getting? asking me some difficult questions.

INT:  
I'm sorry.

HP02:   
Yeah. I mean, I think I think for some people, there's probably a great sense of relief if things are more simple.

HP02:   
And I so you know, I think trying to, you know, be the carer for somebody with dementia is, you know, it's a really hard job and I think simplifying medication is provably a helpful thing in, in, in terms of everybody's quality of life there. I umm I'm not quite sure what else I could see to that question. You know, I think broadly speaking, when you do simplify things, it's, you know, it's usually successful.

INT:  
Umm.

HP02:   
It's not. I think the one area where sometimes it is more of a struggle is around. You know chronic pain and you know, I think that nation that also has chronic pain fibromyalgia depression and you. You really want to try and simplify things and decrease. You know that that can be that can be quite challenging persuading people to let go of you know, particularly the sort of code and models.

INT:  
Umm.

HP02:   
Amoles type drugs can be quite difficult and quite time intensive. So yes, that's probably the most challenging area to deprescribe, yeah.

INT:  
The chronic pain mentioned.

INT:  
And the other the other conditions and anything that would help those conversations or discussions, deprescribing discussions with people living with dementia or mild cognitive impairment or their formal caregivers. Anything that you think may help aid those discussions.

HP02:   
I mean, I guess having written information about the benefits of things being simple simplified so that they've got something that you can send. And I mean we use, are you we have something good accuracy where we I mean I send information the whole time and I mean the majority of my consultations I'll send some information sheet about something. So that if they forget everything I've said or just want to look at something, you know, a limit to how much detail you can go into in 10 minutes. So it's quite useful to be able to have written resources.

INT:  
Umm.

HP02:   
I think as well people and obviously if you've got dementia, you're gonna be forgetting things quickly, potentially. So I think having written resources and I think again I think human resources to be able to follow people up properly.

INT:  
Resources.

INT:  
Thank you.

INT:  
And anything else that you think may help that that discussion or conversation around deprescribing?

HP02:   
I mean, I guess it's one of those things that, you know, perhaps just having a greater awareness of the benefits amongst clinicians who stop because, you know, umm, I'm thinking, I mean, I have to say the vast majority of our medication reviews now are done by pharmacy team.

They're not done by GP and I guess that will be some general practices where that's not the case.It is still a GP doing all the medication reviews, but you know, are people really approaching those with the thought of umm, you know, does this patient need to be on all these medicines? And I think honestly, you probably we're not all approaching it with that view. We're probably looking at right are they, are they over requesting?   
Have they had all the right bloods to be safe on those drugs? Is their blood pressure in target? Is their cholesterol in target? You know, honestly, are we always going to medication review thinking right? What could I take off here?

INT:  
Umm.

HP02:   
And I think I don't know how to. Don't think everybody could say that's what they're thinking about every time they do a medication review. So I perhaps a greater awareness amongst clinicians to ask that question. Umm.

INT:  
Thank you. That that, that awareness as well. And when and how do you think such discussion should take place?

HP02:   
I think they're most obvious places.

HP02:   
The annual medication review.

INT:  
OK. And any reasons why?

HP02:   
Because that's the time that is allocated to discuss medications. So it's, you know that one, you know we have a legal obligation at least once a year to review people's medication. That's, you know, that are on repeats. So it just you know, I think that that it would just that would be the obvious time to bring in that kind of conversation to be thinking about that I think.

INT:  
And then you think about what should happen in those discussions part of that.

HP02:   
Uhm, I mean again, I think just having written resource to give people afterwards.

HP02:   
Uh is helpful. I think having somebody without dementia who is supporting that patient present in those conversations is probably helpful.

INT:  
Umm.

HP02:   
Yeah.

HP02:   
I can't really think of anything else.

INT:  
Thank you. And who do you think is best place to be involved in deprescribing discussions in primary care?

INT:  
The people living with dementia or mild cognitive impairment.

HP02:   
I think either the GP or the pharmacy team because they're, you know, they're the people that do the medication reviews.

INT:  
And in terms of is there, are there any professional groups who you think should not be involved?

HP02:   
Umm. Not, you know, not particularly, I mean I think it just needs to be somebody that has the a level of clinical knowledge to know.

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HP02:   
Umm to be able to look at things holistically and understand the purpose of all those drugs and the potential risks of stopping them, as well as continuing them.

HP02:   
So I think it just needs to be people who are. I mean, in some practices they may have a nurse practitioner with a special interest and dementia who may be the most appropriate person. We, we have specialist nurses for diabetes, COPD, asthma.

INT:  
Umm.

HP02:   
So they do, you know they, I mean, they would know far more about prescribing and all those areas than I do because that's all they see. And you know the probably our general practices where there may be somebody that, that that has that interest in dementia. So I don't, I don't have a black and white.

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HP02:   
It has to be GP, pharmacy, nurse like I think it could be any of those people. I just think they have to have the right level of prescribing skill and knowledge to be able to make decisions that are there that are safe.

INT:  
OK. Thank you.

INT:  
And in terms of leading the discussion, but then in those kind of discussions, is there any particular professional group you think we best place to lead the discussion or is it again like you said more in terms of their expertise and knowledge in that area?

HP02:   
Yeah, I change anything like could be. I'm also say I had pharmacist is amazing and I think she'd be brilliant at that. But you know, some people may have not have such an experience from a system. Which case I'd say the GP and some practices may have a really experienced dementia nurse, but they might not know anything about cardiac drugs. So I think it's I think it's just making sure someone's making that decision that just has a broad knowledge base and can really the whole picture holistically.

INT:  
OK.

INT:  
Thank you.

INT:  
And when is it appropriate to involve patients in those discussions?

HP02:   
Uh, I mean, I think as long as the patient has the capacity, they should always be, they should always be involved.

HP02:   
Umm I can't think of, you know, unless someone really has absolutely no capacity and no doesn't understand what I'm talking about. II you when in which case you might speak to whoever they've hopefully previously consented, your discuss your their medical record with or you'll make decisions in their best interest. But I think out with those circumstances, I think the patient should always be involved.

INT:  
Thank you.

INT:  
And when is it appropriate or not appropriate to involve informal caregivers?

HP02:   
Yeah.

HP02:   
I mean, I think informal caregivers are important in terms of concordance with any changes you make, because often those caregivers are the people that remind them to take their drugs or, you know, you know and I think it's umm, I mean, I mean clearly all of that needs to be with patients consent. But I think if you are making changes and somebody's on the more severe end of the dementia spectrum, then then whoever's helping them with their medication needs would need to be involved in those kind of discussions.

INT:  
OK. Thank you. Sorry, what would assist? Engagement with health and social care colleagues to support shared decision making.

HP02:   
Yeah, I don't. I don't particularly see there. So do you mean like a social worker?

INT:  
Umm, it'd be health and social care colleagues, so it could be other health and social care professionals. Umm across primary or secondary care more generally, but if there's anything that could assist engagement to support shared decision making.

HP02:   
Genuinely not sure. Um. No, I mean, I guess the you know really the only person that has that usually that complete overview of everything is the GP, so. Yeah, I'm not sure. Sorry.

INT:  
No, that that's fine.

INT:  
Thank you.

INT:  
And what would facilitate good communication with people with patients are living with dementia or mild cognitive impairment and all their informal caregivers in the deprescribing process.

HP02:   
I think backing up anything you do with written instructions I it's probably the key there because I think you know, even if you don't have dementia, studies show that people kind of they remember the first and last thing you say and don't remember a lot of what you've said in between. So and I think that's gonna be even more profound for people living with dementia. So I think whatever you do, you providing written information is probably the most important thing.

INT:  
Written information. Thank you. And anything else that would assist, engagement or involvement or generally with patients with living with dementia or mild cognitive impairment and then formal caregivers in the deprescribing process.

HP02:   
Yeah. And I think I think it just comes back to when I said that. So just that greater awareness, you know, greater awareness that, you know, perhaps organizations that sort of support patients dementia asked as their profession. Just asking that question, thinking about that sort of polypharmacy question and you know I'm thinking about describe deprescribing as a. It's a bit like, you know that we've got very good at always thinking about. They've got in in in a way that we never did 40 years ago in the same extent. You know, you just, you know, whenever you do a baby check or a postnasal check or a this, you know you're you, you have, you know, both in terms of the templates we used on the computer and just our training. We're constantly thought to think about safeguarding and I guess it's just.

HP02:   
Being taught to think about deprescribing as a priority, and perhaps charities and organizations that support patients with dementia, empowering them to say, you know, have you discussed deprescribing with your GP?

HP02:   
I think that's probably the biggest way to, umm, improve that actually happening.

INT:  
It's that awareness and you mentioned charities there as well in terms of.

HP02:   
Yeah, yeah.

INT:  
Thank you.

INT:  
And how do you feel about engaging patients with dementia or mild cognitive impairment and shared decision making as part of the deprescribing process?

HP02:   
I don't think I have any issue with that. mean I think it's, you know, the vast majority of patients will come with a with a carer and I and I, I would you know I think I would always have that conversation with all of them and I have a total you know there are many times where you think I know this patients are not going to remember any of this but it doesn't mean that they you know they are still the patient and I would still want to have that conversation with them and it in in the room and to engage them as much as I possibly could.

INT:  
Is there any differences there for people you mentioned to you come with an informal carer and those who come on their own, they're in terms of what could help facilitate their involvement?

HP02:   
She has really interesting people rarely come on their own.

INT:  
Umm.

HP02:   
I I've really rarely come on their own. It's not, ah. Yeah, I mean, I mean, maybe just encouraging them to bring a friend or bring somebody that might help them remember. And I guess if they haven't, then they come on their own. I'd probably just go back to that, providing written information. So they've got something to take away and read if they forget everything afterwards. But I'd say yeah, the vast majority people that do come in for consultations that have dementia do tend to come in with somebody else.

INT:  
OK. Thank you. And what are the barriers to that? They're involvement in shared decision making.

HP02:   
OK.

HP02:   
I mean, I think the barriers are then being able to process the information and retain it in order to make that, you know, to, have a informed decision process. I think that I think depending on the level of cognitive impairment, it's just having the ability to make to make those independent decisions.

INT:  
OK. Thank you.

INT:  
And how do you feel about engaging informal caregivers of patients with dementia? Mild cognitive impairment and shared decision making as part of the deprescribing process.

HP02:   
Again, if people have got, you know, carers, you know they will often come with their carers to appointment. So it it's fairly easy to engage those people because they normally they they're normally there anyway. I don't. I don't see that as a particular challenge.  
INT:  
Umm.

HP02:   
I mean, I guess the biggest challenge with carers as often they change, so you know, there's often and particularly if you're using, they're using agencies, they might have a variety of carers and it's everybody aware of the changes. That's probably a challenge, but in terms of engaging carers in a conversation within the general practice, that's I think that's fairly easy. And what we would be doing anyway.

INT:  
OK.

INT:  
Thank you. And anything that would help facilitate their involvement in shared decision making.

HP02:   
You know that I can think of.

INT:  
The OK and in terms of any barriers to their involvement in shared decision making.

HP02:   
Well, I mean I guess they may not feel it's their place to be involved in that. You know, if they're not the patient, they're not a relative, you know. You know, they might not feel that it's their place to be involved in those decisions and I'm not completely sure to the extent of which I think that, I mean I don't really think it is there. I know convinced that they have a huge role to play in in in deprescribing. I think probably the caregivers biggest role is in terms of hope, hopefully making sure whatever changes you make actually happen on the ground, I'm not. Uh, yeah. I think a sort of informal carer that comes in and cooks meals for a patient. I'm not sure they would be the person I would be particularly involving in in decisions as to what we should and shouldn't start. So yeah, I'm not. Yeah, I'm. I'm not convinced I would be seeking a huge amount more to engage that group, other than making sure that that the concordance

INT:  
OK.

INT:  
Thank you. And what tools or resources are needed to facilitate shared decision making in relation to these prescribing for patients living with dementia?

HP02:   
Just probably come back to the written information.

INT:  
Written information.

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INT:  
And how best would patients living with dementia?

INT:  
Mild cognitive impairment and therefore informal caregivers be supported during the deepest scribing process.

INT:  
I know we've touched upon some of those before, but there's anything else that could help support that decision like.

HP02:   
I think just information that's visible for everybody that's involved in the care of that patient.

INT:  
And how best would patients living with dementia or mild cognitive impairment be followed up as part of the deprescribing process.

INT:  
Is there anyone that should be following up the patients for example?

HP02:   
I mean, they're not in our practice. It could be either the GP or the pharmacist that's made those changes and you know, probably making sure that the patient has an appointment before they leave the building for follow up rather than expecting them to remember to ring up and make one.

INT:  
Umm.

HP02:   
You know that can be quite challenging process to get through anyway. So I think making sure the follow up is facilitated for them before they leave and.

INT:  
And how often should patients medication be reviewed?

HP02:   
Ohh I can I think. I mean we as a minimum it would be one year and for most people that's the case.

HP02:   
Uh, you know, in a perfect, ideal NHS it would be great to do it more frequently than that, but there's just not the manpower to do that. So you know and again I think it depends what kind of medications they're on. So yes, but as a minimum, I'd say once a year it in a in a perfect world with a well resourced. NHS then I would, I would say more frequently than that.

INT:  
And what are the potential facilitators to integrating shared decision making in relation to deprescribing medication for patients with dementia or mild cognitive impairment into your everyday practice? Is there anything that you think may help with that?

HP02:   
Not that we've not already discussed.

INT:  
Note that the potential one OK and on the other hand any barriers.

HP02:   
No, not that we've not already discussed anything.

INT:  
And can you identify any training or educational needs for you or your colleagues to enable you to safely stop unnecessary medications for someone with dementia more cognitive impairment?

HP02:   
I don't think. I just. I just think going back to the awareness, I think just you know it's I think even just having this conversation with you today, it's just sort of making me think you know, do I really ask that question every time I look at somebody's medication and the honest answer is no, I probably don't.

INT:  
Umm.

HP02:   
And I'm probably quite an engaged clinician in that kind of thing anyway. So I think just a greater degree of, you know, going back to Med school, Med school, GP training, just thinking and review is all these medicines. Really. Umm. Essential. Yeah.

INT:  
But that that kind of awareness that you mentioned and at that stage of training and any other training or education that you think might be helpful to you your colleagues?

HP02:   
Not that I can think of.

INT:  
Anything else you want to tell me or anything you wish to add to what you've already said, or an important area we haven't covered?

HP02:   
Genuinely not that I can think of.

INT:  
Well, thank you so very much for taking part today.