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

**Transcript**

**HP08**

INT:  
So first question or just like to ask you is can you tell me about the care you provide to people with dementia or mild cognitive impairment, please?

Participant  
OK, so I would have two roles as a GP. A General practitioner in clinic. So when patients come in and have concerns about their memory or our carers for family members who have concerns about the.. I established *diagnosi*s of dementia. We would do assessments for the field and memory service for diagnosis.

We do assessments for health checks and carer checks, so showing their carers have enough support and the patient has enough support for their needs and then the second role would be as General practitioner in a care home.

So I look after half millions of a local care home and I do a weekly care home round and assess those patients. There's approximately 3035? patients on a review for each week with and they are patients with perhaps increased needs needing care home input, as in changing from home to care, home.  
And so I'd be very involved with optimizing their care directly and talking to next of kin, talking to family members, with or without power of attorney, talking to the patients. If they like to talk about the decisions we need to talk about, yeah.

INT:  
OK. Thank you. And for, for, for for that first role you mentioned it's that primarily in primary care for people living in their their own homes, is that right?

Participant  
Yes, exactly. Yeah.

INT:  
OK. Thank you. So just just thinking more in, in, in, in the primary care role that you've mentioned or what what what kind of proportion of your workload is this, what providing care to people with dementia or mild cognitive impairment?  
Participant  
It would be hard to give a percentage, although we are in an area where which the majority are elderly, as in retired, and I probably have at least one consultation a session regarding and regarding dementia or or short term memory loss. And so that's one one per morning, one per afternoon. And I work 12 sessions in a week.

So yeah, I'm not sure I can give a percentage of the population who have dementia, but it's a higher burden here than, uh, middle of?, for example, yeah.

INT:  
OK. Thank you.

INT:  
And and how many of those people are taking multiple medications?

Participant  
I would the vast majority of them, it would be a rare event that a rare enough that on a coffee break we would say oh, I saw a 92 year old and he had no medications were enough for me to mention it.

The vast majority of people would be on multiple more than four or five medications easily. Those in the care home I mentioned would easily be on 9 or 10 medications, yeah. More, yeah.

INT:  
What involvement do you have in their medication management thinking more about the primary care role again?

Participant  
And and so definitely more involved in the primary care lower than the care homes because in the care homes we have a care home pharmacist who does lots of medication reviews. Medical? should be used in the- care role and I think in clinic then as much as all the other GP's are and probably a little bit less compared to the salary GP's because as a partner we get a different variety of patients and so do less medication reviews.

And but again, I'd probably get one or two per session as a medication review as in a year annual review of their medications and and then if people are experiencing problems or they have a new diagnosis and therefore need new medications, we would review the medications. And when we add that extra medication on is that makes sense to the repeat list, yeah.

INT:  
Thank you. And what are your views regarding deprescribing of inappropriate medication among people living with dementia or mild cognitive impairment in in primary care?

Participant  
But personally, the few medications are better is better for everybody, better for the patient, better for the the nursing team, administering any medications or the carers administering medications. And it's better for our prescribing budget. So few medications as possible. Obviously, you can't make unilateral Dr centred decisions about that, and that's new medications as possible if we if certainly. If they're not benefiting or may not benefit from them in the future, like static medications, for example, common moment, we deprescribe yeah.

INT:  
OK.  
Thank you.

INT:  
And and any other benefits or advantages of deprescribing for that population?

Participant  
Well, fewer side effects. Definitely we would give one medication or they have Constipation. With that, we better give another medication to help with that. Yeah. Yeah, and older people would have more at risk of more side effects. I would suggest than the younger people there tend to be more be a bit more sensitive to medications.

INT:  
Oakland on the other hand, any any challenges with that deprescribing for that population?

Participant  
Lots of challenges. Everyone who's older has some much degree of ischemic heart disease. They see a cardiologist and they give them a new medications. I'm exaggerating, but they give a lot of medications.

INT:  
Umm.

Participant  
Even in that they give ... medication and and they say, oh, it's the guidelines. So there's certainly some resistance with some secondary care colleagues just describing as per guidance rather than seeing the patient. And there's also we get paid, we go ohh. We need to offer these patients a statin medication because they are at risk for certain at risk percentage from their huge risk, or so we offer the medication and then an older person would be if they have only mild cognitive impairment, for example, might tell yes, if that would help me, I want to stay on that forever and then she said that they kind of then you ask you later do you want to stop it? And I said, well, no, you said you wanted to give it to me when I was 79. So why when I'm 80, should I stop it?  
So there's there's kind of like paid incentives to keep people on medication sometimes. And and also say that that resistance from secondary care who who just follow a formula rather than look at the patient.

INT:  
OK.Thank you. And and then the other challenges for for deprescribing for that group, people with dementia or mild cognitive impairment.

Participant  
And you might not see the patient as often as other patients. So they just. Oh, I don't want to bother the doctor or we're busy at home looking after the person with dementia. Or we won't bother the doctor and so they get less reviews because they get seen less. So people see their medications less and everything's kind of automated now, so they might just carry on with their static medication and yeah.

INT:  
Thank you. And any thoughts about how some of those challenges may be resolved?

Participant  
Hello. Not an easy answer. OK, given that it's still a problem and I think it's easy to say, it's me if we if we had infinite resources, I mean review the patients more often, we would and I think I I think people will have a quite a good in terms of GP trainees and thinking have quite a good education in terms of the risks of polypharmacy and the risks of. Overprescribing and the benefits of deprescribing that we were talking about at the beginning. But I stayed. Need to remind them of that. You get kind of carried away in all the guideline is to do this.  
  
The guided needs to do that and try and be a bit more holistic, but it takes a bit of time to do that, like longer consultations with older people to have those conversations and say it's not a black and white decision, it's more of a holistic opinion of view rather than balancing risks and benefits rather than a = b. So we'd better.. and yes, a longer time to talk about those changes would be beneficial and more frequent considerations. More frequent reviews would be helpful, but that's easier said than done.

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

Participant  
I mean really varies from the patient. If someone was in their 70 or early 70s and or and on a statin medication for example, and, but they have capacity make decision and they wanted to stay on it, then I wouldn't be pushing for them to not be on it. But certainly statin medication is quite common one with deprescribe because not probably not going to see the benefits of that medication, but it that wouldn't be a black and white decision.

And and then it really varies on how the, how mobile they are, what their frailty is like. Vitamin D and calcium are quite common ones.

Calcium supplements are really difficult to swallow, so I'd be quite comfortable to stop that if they if they're largely bed bound and not risk of falling, then deprescribe that and equally yeah, no.

Yeah.

And then, yeah, be more lenient with blood pressures as they got older. It really varies from patient to patient, but certainly probably the top one. As I mentioned several times throughout, this interview will be a statin medication. I'll be most most comfortable deprescribing if you want to number one spot.

INT:  
OK.

Thank you.

And what would encourage you to support reducing or stopping medications?

Participant  
Certainly, if the patient said I'm having difficulty swallowing any time, I would say well, you know what you could do, cut down any medications that would be 1 or I don't want to take all these tablets or if the next of kin had similar thoughts or.

or any any other Healthcare Commission raised a concern and that will kind of prompt me to have a deeper conversation with next of kin if patients in their capacity, sometimes the next of kin, should just carry on with what we're doing because I don't want to make any decisions because I'm not sure whether mum or dad would have been would have been happy with that.

So I shouldn't rock the boat.

And but if there's more than one clinician kind of putting their heads together and saying, well, actually, I think cutting down would be beneficial, then that adds a bit more and support for you having that conversation with the next of kin to say, actually we've had a discussion and and they we both agree that mum would be better with less medications.

INT:  
Thank you.

INT:  
And what medications would you be reluctant to deprescribe and why?

Participant  
And well, specialist medications definitely.

And so the things I'm thinking really mental health medications, although I do I do try and wean down, wean them down certainly patients who our mental health medications which help with their behaviour.

There's quite a big push back from care home staff, for example, to say, well, if you're stopping this, then what are we going to do?

Cause we want to give the medications to make the behaviour better when actually probably the best decision is not to give them any medication for their behaviour and just have more nursing care.

But as with our time, nursing, nursing care time is also very limited. That's even more so.

So it's easier for them not to have one on one support for their dementia patients and say ohh doctor, would you prescribe some?

No ? to help at night because they're not sleeping, but actually they're not supposed to be sleeping cause they've got sundowning relating to the dementia, which we're never going to help.

And you have to have quite a big no argument, but assertive conversation with some of the care staff to cut that down. And but that is definitely a barrier to say, yeah. I want to cut this medication down and and and then you go.

Ohh.

Well, maybe we'll just reduce the dose. Well, I can just stop it completely and it tends a bit of a bit of a, yeah, a barrier to cutting those kind of medications out, yeah.

INT:  
Thank you.

Are there similar issues in in primary care and people who live at home?

Participant  
Yes, definitely yes. So when I say care stuff, I mean formal care stuff as well as informal.  
Next of Kin.

Yeah, yeah.

INT:  
OK. What are the main things that you think need to be in place for successful deprescribing for someone with dementia or mild cognitive impairment?

Participant  
Uh, I suppose the things we already do definitely need to be in place, so regular medication review time for that medication review, involvement of the patient if they have capacity to do that.

But also next of kin in that medication review, and someone who's doing that medication review, who has an elderly care forward slash, holistic view of the patient and thoughts and just following guidelines and sometimes we have and pharmacists just follow the guidelines and saying of this person should be on this because they're ? is this low and you're like well actually they're bed bound.

They're not going to fall and they can't take their...tube, so.

OK.

Can you still hear me?

Just double checking.

INT:  
  
Yeah, perfectly.

Participant  
Yeah, yeah, my speech.

INT:  
Yeah. Can, can you hear me?

OK.

Participant  
And so, yeah, some some someone doing a medication review, but the right person doing the medication review or at least someone who's educated in it.

INT:  
OK.

Thanks and please describe your experience of having deprescribing discussions with people living with dementia or mild cognitive impairment or their informal caregivers.

Participant  
OK, so I would perhaps start with ohh it.

You're on a lot of medications.

How would you feel about that?

And they might say ohh well if I need to take him, I'll take them.

I'll be like, well, it's not always a black and white decision.

And let's start with the easy ones.

So I'll start with things like statin medication or medications, which you're finding difficult to take and finding alternatives to them if they still want to take them.

And I would say things like, well, the more medications you have, the more likely they are to interact with each other and give you problems or give you side effects and suddenly you can develop side effects as you get older. So the older you get, the more likely you are to have side effects from these medications, so we might benefit from stopping some of them. I mean, if they had very strong opinions like I would say I can see you've had a stroke in the past and you're on these medications, but maybe we could reduce the dose of this or stop this one.

But we would have a like a.

Yeah.

Talk about each individual medication. It's quite common I would do and say, what do you think about this one? If they if they didn't know what it was about, I don't have to explain why they were taking it. And then if the patient couldn't have that conversation would have to have a similar conversation with next of kin and and then I'll give my opinion on. Sometimes I'll be like, well, if I was 92, I wouldn't be taking a statin medication because and then explain why.

And but every patient is different and if they had really strong opinions on taking it, then I wouldn't stop it and say, well, you can't take it, yeah.

INT:  
OK. And in in those conversations, especially in primary care, what what works well, when having those conversations.

Participant  
I think when I say things like, well, if I was 92, I wouldn't want to take so many medications.

What do you think Mum would have thought?

Or how do you think Mum feels when she has to take these tablets?  
Does she have difficulty trying to apply what I'm suggesting to their context?  
So contextualizing would probably be the word is helpful.

INT:  
OK. Thank you.

And, umm, what?  
What challenges have you encountered in those discussions with with people living with dementia and their informal caregivers?

Participant:  
And so I've kind of alluded to them or mentioned about it previously, but people who are reluctant to make decisions on the behalf of their family member. So I don't want to change things just in case I'm doing the wrong thing and I don't want to do the wrong thing, so I'm just going to keep things the same. A bit of well, she's been on this medication for this long while we stopping it now and.

And I'm a bit of, well, I want my mum to live forever. So she should still be getting the same Care now in her 90s that she got in her 60s. So carry on those medications. And so a bit of and so this is from next of kin, a bit of a need to try and explain that and sometimes it's they just refuse to try and take that, that different mindset on board. I not get not have mechanistic view of or maybe these medications are doing something wrong or she's not benefiting from them as much or will not rather than just sticking with well this is what she was like in the 60s.

So carry on with what you're doing, yeah.

INT:  
Thank you. And when and how should those discussions take place?

Participant:  
Again, I've kind of mentioned it previously, but when regularly, when?

And when medications have been added or changed, ideally, but that doesn't always happen when if someone has new symptoms.

Consider medications as a culprit and then rationalization.

After that, every time you look at the medication list, really you should be thinking oh, oh, are all these medications appropriate at this time, and that includes getting older.

Do they need to be on now because they're now 80 or whatever? And, but that's easier said than one with our time constraints and clinical work, there's and. Yes, I was at what does the second part of the question wasn't there?

It was when and how how.

INT:  
Yes, that's right, yeah.

Participant  
Yeah, well, formal medication review and that should be on discharge and at least annually and probably more frequently that with some medications. For mental health medications and and by the paper people, as I said before, so people who are perhaps take a bit more than holistic view. But again, people getting those people to do this medication views is usually more costly than employing someone who hasn't had so much elderly medicine or dementia experience.

INT:  
Q AND who do you think is best placed to be involved in deprescribing discussions in primary care for people living with dementia or mild cognitive impairment?

Participant:  
Well, anyone involved in medications, they should be, but only if they've had the appropriate training and are comfortable with deprescribing.

Because I've lived here before.

That's commonly happened with me.

And. Uh, we. We have clinical pharmacist here in the practice who run surgeries as well within blood pressure medications, etcetera and medication medication review. So it applies equally across GP surgeries as well as care homes that statement. If someone who has, appropriately, who's appropriately trained, it's the short answer, but I think that varies from group to group depending on how much training they have.

INT:  
OK.

Thank you. And is there any professional group who should not be involved?

Participant  
I don't think we can just say one whole group, but we get, we have paramedics, especially trained nurses, were specially trained pharmacists specially trained, obviously GP registrars and GP are trained. Hopefully I don't think we'd exclude a whole group, but exclude those who I haven't had a proper training, yeah.

INT:  
And who is best placed to lead the discussion?

Participant  
As in as a as a practice or as a individual level with each patient.

INT:  
Umm, I think in the discussion in primary care for people living with dementia or mild cognitive impairment.

So there's discussions.

Participant:  
Yeah. Well, it really a meeting. What you mean by lead?

Certainly the person at the center of the consultation should be the patient or the patient's advocate, like the next of kin.

But they might not know about deprescribing and therefore it might be led by the clinician, but should be patient centered, yeah.

INT:  
OK.

And are there any instances when it is or isn't appropriate to involve patients in those discussions?

Participant  
Ohh, but it should.

Participant  
They should be involved all the time and depending on how much capacity they've had, how do they have a for that one decision? So you should really have the patient there, or at least their opinion on things before you have the discussion, or hopefully at the time of this discussion with the next of kin.

So the patients wouldn't have capacity and they would just agree with everything and then have an understanding of that. But that would there be from patient to patient and yeah.

INT:  
And same question for are there any instances when it is or isn't appropriate to involve informal caregivers?

Participant  
And I I think. It's it's it's quite challenging sometimes to decide whether someone has capacity and having as many opinions as, uh, you don't necessarily have to follow that opinion.

As many as opinions as possible that would be helpful.

For example, someone who's responsible for helping with medications might say, well, although she says she's not having any problems with the medications, when I give her the calcium chew, she coughs and chokes every morning. So that would be helpful. And although the patient might have capacities to say that I want to carry on bone protection, because I know that if I stop, it might risk of breaking a bone would be more.

And therefore I want to carry it on. And that said, I I think more information is better, but and yes, does that make sense? Yes.

INT:  
Yes.

INT:  
Thank you. And I know we've alluded to this little bit, but if you could just elaborate internal sort of what would assist engagement with health and social care colleagues to support shared decision making?

Participant:  
What would assist engagement with those colleagues?

Well, communication is always key, isn't it?

And what would assist?

Umm.

Say I I think.

And.

I think this communication from them with us would be helpful as in if they have concerns, talked to us a bit, I think if we're talking about patient, there needs to be some thinking that I might have to talk about the patient on their behalf, have that conversation with the patient to say is it OK to talk to the informal caregivers on their behalf to talk about their confidential medical information?

So have that in place before the medication review, so it makes things more streamlined easier rather than having to talk to the patients that he's OK. Yes.

INT:  
I can't.

Participant:   
And then yeah, that would assist it and yeah, bit of yeah.

Four thought before.

Yeah, before the medication would be would assist it, yeah.

INT:  
So, OK.

And what would assist engagement or involvement of of patients living with dementia, more cognitive event impairment and all their formal caregivers in the deepest scribing process?

So they say that again for me today.

INT:  
I'm sorry, what would assist engagement or involvement of patients living with dementia or mild cognitive impairment and all their informal caregivers in the deprescribing process.

Participant  
What would a system engagement so?

When booking the medication view may be an explanation of what it, what's involved and why might we be adding in medications or taking them out as like a general statement.

They know what they're going to be talking about beforehand, and a bit of explanation of and, as I said, it's an explanation of what you're doing.

There might be some information you could direct them to, like leaflets and things about the dangers or the risks of being multiple medications. And because it sometimes people don't take all that on board when you're trying to talk about it at the time, they can go and think about stopping medication and assistant engagement. Uh.

I think we we routinely send out reminders, they all you need a medication of you, you need a medication review and they give on missing it.

And I think just yeah, stressing the importance of why we do the medication reviews and yeah.

INT:  
And in terms of what would facilitate good communication with patients living with dementia or more cognitive impairment and all their formal caregivers in the deprescribing process, there's anything around good communication that you think could could be helpful.

Participant  
It's it's. Yeah, I think it it is challenging.

I think I personally I don't do these things over the phone if I can help it.

It's really challenging. Most most patients communicate better face to face, especially those with communication differences. So I'll face to face consultation, obviously challenging over the pandemic previously, but I would definitely aim for that rather than a remote consultation, and time again is it something done?

It's going to take a bit of time.

Maybe someone to understand the full this is doing what?

Making those decisions. Do you prescribing and time as in letting them have a think about it before you make a decision and take time and face to face and involving those caregivers or informal caregivers in that consultation so they can help with communication.

Yeah.

INT:  
Thank you and any thoughts around what language should be used in communicating information about medications with people with dementia or mild cognitive impairment and their informal caregivers.

Participant:  
It really varies from patient to patient language, as in I'm assuming you mean like simple or complex rather than Spanish or English I.

INT:  
Yeah, yeah, it could be a consideration.

I mean, yeah.

Participant:  
Yeah, say appropriately appropriate mother language.

Hopefully, if you've got access to that, we can use translators, but simple is always better.

You can always make things more complicated if they're wanting it to be more complicated, but yeah, simple language and you could languages and you could use pictures rather than words.  
So in terms of communicating risk, you could use pictures.

Some people respond to that better than just telling them one out of 10 people that might be helpful, yeah.

INT:  
The pictures as well.  
And would that be printed pictures?

Participant  
Well, if you're there in the consultation room, you could use a screen or you could print it out either.

Again, either long as I can see it, yeah.

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

Participant  
And I know it's going to take more time than someone who hasn't got those challenges.  
So I so I honestly have those reservations that it's going to take more time than other patient and I'm already busy, but also aware that we need to be involved in the patient's, the patients care.

..  
Participant  
Yeah, it's not my care and yeah.

INT:  
And thank you in any anything that would help facilitate the patients involvement in those shared decision making.

Participant  
I think it well, as I said throughout this and she more time. No, I don't know any say the question again, sorry.

INT:  
Yeah, it is. Is there anything or what would help facilitate the patients involvement in those shared decisions?

Participant  
And well, the the clinician using that simple language, you were just talking about the clinician thinking about other communication needs or other communication techniques like diagrams.

INT:  
OK.

Participant  
And and the condition using information leaflets for them to think about the the the patient to think about the problem rather I think about the decision rather than making them one off decision on in that one consultation.

And yeah.

INT:  
Thank you.

And how do you feel about engaging informal caregivers of patients with dementia?

INT:  
Mild cognitive impairment and shared decision making as part of deprescribing.

Participant:  
Yeah, I think kind of the leads it to it.

Before I, I feel confident about it.

I think I do it all the time.

I think it's important to get like another viewpoint because you bring work might not get that viewpoint from the patient themselves or from the clinician and.

And and certainly if the patient hasn't got capacity to make decisions, then you need to.

It's vital and yes.

INT:  
Hi, thank you.

And any.

Any thoughts around what may help facilitate their involvement?

That's the informal caregivers in that shared decision making any things that might help that.

Participant  
And maybe an explanation before they come to the medication review, about what's involved and then they can them be prepared. That would probably be and for them to come along to the to the medication review. I'll be involved in the medication review when it happens.

INT:  
Thank you.

And and on the other hand, are there any barriers to their involvement in shared decision making?

Participant:  
And kind of put related to before in terms of they might not want to change things or they might have not have an understanding of why we might want to change things.

They might not have time to come to the medication reviews because they're busy looking after their patient and medication might not involve them because they've had a medication view whilst they're in hospital and and they've not come to the hospital because the patients being ill and they've been busy with something else and some of the decisions we make with prescribing can be quite regular.

So we wouldn't contact the ? with every decision, but we could make those deprescribing decisions when they're involved, yeah.

INT:  
OK

And what tools are and resources are needed to help facilitate shared decision making in relation to deprescribing for patients living with dementia or mild cognitive impairment?

..  
Participant  
So a tool on our operating system system wide phoenix? called Stop something.

INT:  
Umm.

Participant  
I can't remember what it's called there and and that highlights potential medications you might think about stopping and, but I haven't got access to that system, so I can't talk through it now at the moment.

INT:  
OK.

Participant  
But you could you could use that and do people use it? I don't think they do. And I certainly don't think I have enough experience with talking to people about deprescribing without needing it.

I think if I was challenged to say, oh, are you, what medications do you want to stop?

I could say, oh, there's a tool and we could use it together with the with the informal carer or the patient to say which ones you would want, something that would be a that would be helpful again.

INT:  
Thank you.  
And how best would patients living with dementia or mild cognitive impairment and their informal care that givers be supported during the deprescribing process?

Is there any kind of support that we haven't considered that might help?

Participant:  
And I think safe safety netting as in, we're stopping this medication. Watch out for this and this and this, and be open to being putting the medication back on if they having problems or and having a discussion. So being being available as a clinician, yeah.

INT: OK.

Thank you.

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

Participant  
Uh, that is difficult.

It's lots of resources we're talking about, isn't it?

Uh, I very much doubt every patient who's had deprescribing who's been deprescribed something, would have a follow up consultation to check their own.

Participant  
OK and. I do well.

Ideally you would do that ideally every change, and then you'd follow up to check they're OK, but I suppose just being available because I think honestly that's unrealistic.

And I think how best to support and follow up.

I think just leave it in the patients or caregivers hands to say if you're having concerns that we've stopped this medication, then get back to us and we can talk about it again.

Just being being open minded.

INT:  
Did not think and how often should patients medication be be reviewed?

Participant  
Again, it varies from patient and the type of medication that they're on. I think mental health medication needs to be reviewed more often than a statin medication or something which is less prone to side effects and every time you add in a medication you should probably, but you should look all the other medications every time they have an event like it going into hospital coming out of hospital or they should.

You should look at medications.

Any kind of change you should consider medications, including deprescribing, yeah.

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?

Participant  
Of that, I'm not sure I understand that.

INT:  
Yeah.

Participant  
Could you say say?

INT:  
Yeah, sorry. So what are the potential facilitators or things that help to integrating shared decision making in relation to deprescribing medication for patients with dementia?

Mild cognitive impairment into your everyday practice.

Participant  
Exactly.

INT:  
So what are the things that will help that shared decision making?

Participant  
And yeah, yeah, something to help facilitate shared decision making into my usual practice. I think I'd do it already. I would hope I would hope more time. Yeah, as always, more time to have that conversation with the patient and the informal caregiver at the same time.

Always. Uh. Time, as in don't make that decision all the time, but also at the same time, but also like follow up. So having enough appointments to to say I'll have to think about it, then we'll talk about it again next week. Time, I'm afraid, which is less easy to supply.

INT:  
OK.

Participant  
Yeah, yeah.

INT:  
And and would that also be the case for the barriers to to facilitate in that they're going to be done practice, OK. And are there any other barriers?

Participant  
Uh. Barriers to share decision making?

Uh, I think by the time my on my side, but also time on the the patient and caregivers time side, they're busy with their lives.

They don't want to keep on seeing the GP usually and they want to carry on living their life. So also.

Yeah, not making it too burdensome on burdensome on them.

INT:  
Thank you.

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 or mild cognitive impairment?

Participant  
And so me or my colleagues, and certainly I think those clinicians who aren't traditionally trained, so nurse prescribers and clinical pharmacists, I think umm, lack that holistic view sometimes.

So definitely more than holistic view of medication reviews would be helpful for those that could, yeah.

INT:  
OK. And is there anything else you you want to tell me or anything you wish to add to what you have already said?

Participant  
I don't, I don't think so, no.

INT:  
OK.

Well, we've come to the the end of the interview now.

So thank you very, very much for your time and all your thoughts and contribution.