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

**Transcript**

**HP09**

INT  
I said just the first question, I'd 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   
Yeah, absolutely. So I have a personalised list of patients in my list size about 1500 patients and so proportion of that will be with patients with dementia and mild cognitive impairment already.

And then we have a annual recall system where those patients are recalled every year with dementia and we go for a care plan together and that if patients are mobile, could come to the practice.

That's done by us as GPs, but if they're housebound, that's done by our frailty nurse.

And if they're in care homes soon, care homes or nursing homes, that is done again by our frailty team.

INT  
Thank you. And can you, can you tell me how much of your workload is this please?

Participant   
So.  
Ohh gosh.

Um, I'd say I probably do.

I'll probably come into contact with the least say three or four patients a week with dementia or mild cognitive impairment, I would say whether that's an as an acute presentation or an chronic issue or a care plan.

INT  
Umm.

Participant   
I am so that would be about 10% probably of my week.

INT  
10%, OK.

Thank you.

And how many of those are taking multiple medications?

Participant   
Most of them.

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

Participant   
So we are we try and review it every opportunistically.

So if they come in, for example, with a yearly tract infection and you think that it's impacting there memory, then you would hopefully try and do a quick review then of what medication already on.

But usually it fall to their annual review.

INT:

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

Participant   
I think it's really important that medications are rationalised and deprescribe where appropriate and just because of the multitude of problems that come with multiple medications, they polypharmacy and I've had at least once a week.

I have a patient who can't cope with their medicines, let alone if they have dementia, so it is important that that is looked at from a safety point of view more than anything else.

INT  
Thank you. And any advantages to deprescribing for those patients and that that population.

Participant   
So there's medication, overburden.

So in its physical form, too many medications can be confusing for patients.

INT  
Umm.

Participant   
So even in a nomad, for example, that can be too much, there can be a burden for patients. So the sheer number, uhm, medication that isn't appropriate. So things like anticholinergic medication we try and deprescribe as much as we can for elderly patients and in particular, but also those with dementia or mild cognitive impairment.

And then you'd be looking at things that so antipsychotics, for example, that some patients can stay on long term that nowadays should be on everyone's radar to to deprescribe where possible.   
So I think it's it's important on all those levels really um in terms of rationalization.

INT  
Thank you and any challenges in deprescribing patients within that population.

Participant   
And the the challenge is if you make a change.

So for example, you uh.

So I had one literally this week patient where I I've stopped there and met and I've stopped there frozen my tablet because they've got heart failure but not as sharing signs of umm oedema. So should they attended? So this was a 91 year old with her with her daughter.

She's got vascular dementia, but she's got a very good family support. So when I say to them, I just need to monitor that in a month's time, but it needs to be a face to face because you to look for overload and you're and and assess for reflux coming back for example.

But if you had a patient that didn't have next of kin or or care regular carers that follow up is really difficult .So when you change and you do need follow up it, it's really uncertain actually.

Will that happen or not?

INT  
That having that regular carer there,

Participant   
Exactly, so that the mean next of kin worth their weight in gold really for that kind of continuity, uh, because often you can say to patients and and and and the problem is even if we set up a recall with our practice.

So even if we said look, because I can send a task to reception and say please call Mrs Blogs next month please and to accelerate your face to face that can some still even not be enough because they might not check their answer machine.

And they might not. They might not just register, they need to call us back. It. Yeah, all sorts of problems.

INT  
Thank you. Any thoughts or reflections about how challenges may be resolved?

Participant   
  
I I think it's really finding out what communication channels work best for the patients, which I don't think we probably spend enough time looking into whether actually umm.

So for example, I saw about socks being manufactured that are sensors for patients that might be in distress of dementia in care homes. I thought it was such a good idea, but what about all those patients that are struggling at home but don't have anyone picking up on those sensors?

If there were, say, for example, a lot of patients might not be able to read as a registered blind or just struggle with a dementia for various reasons, whether I can order tree model of communication with so like a pre recorded message that could be sent to them to remind them until they book an appointment for example. Umm. Because we've got to show 3 modes of communication with patients before we say that we haven't achieved a response.

So there has to be. There can be the written or text or a telephone call, and you and you think an email, even those. Those all count, but with patients with dementia to hit those three, that might still not be enough.

INT  
Hey.

Participant   
Yeah.

INT  
And those those 3 modes of communication is are, are they quite open the forms that they take or they specifically, yeah.

Participant   
See. You see.

So yes, so normally for.

INT  
Umm.

Participant   
So for example, if for a week or so, if if a as a patient is ? by the practice to ask them to book them in for a consultation after they've had a text.

So we try and send a text out first or email.

INT  
Umm.

Participant   
Then we follow up with a phone call and then we run together. So that's usually our protocol with contacting patients.

But for those routine follow-ups often are, we don't have, we don't have capacity to chase patients.

And so it's literally, it's usually just a voicemail message on the phone.

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

Participant   
I think any of them, to be fair. Umm, I think when you if you've been an experienced GP and so for example on a lot of prescribing training with my, with our pharmacy team.

So we've got six and our pharmacy team for our PCR.

And so I've been with them for the last five years.

INT  
Umm.

Participant   
So I think I feel quite confident with most, to be honest, the only ones that I perhaps would be a bit cautious would be perhaps patients with bipolar who might be on lithium long term and might want to just be very careful with that.

Umm. Otherwise, probably yeah, most be fair.

Um, I've got a patient in a minute.

So she's got bipolar, but she's on risperidone and we inherited her from a different out of area practice and she's come to us and somehow she's managed to stay on 6 milligrams of aspirin daily.

INT  
Umm.

Participant   
We just got side effects from it and no formal follow up with the mental health team I refer to as the mental health team and they just said she's too complex for her physical and her mental health needs.

And I thought, well, hang on a minute.

So how am I supposed to deprescribe then? If you're telling me you can't do that, so it just goes to show that actually as a GP, if I feel like I know what I'm doing, just you just get on with it.

Umm. And and as long as you're doing it carefully.

So we say we always say steady and slow.

INT

Participant:

Mm-hmm. Uh. Or start start low, go slow. You're doing it all around.

INT  
Umm.

INT  
thank you. And is there anything either way that would kind of encourage you or support you to reducing or stopping a medication? Is there anything else which would would help? Umm.

Participant   
Umm, I think there's there are frameworks aren't there that that clinicians can work.

So the ‘stomp’ and method there's there are pro formas that we use that look at.

INT  
Umm.

Participant   
So when we do it, for example when we do a dementia care plan and you look at the areas that are problematic for the patient at the time, so whether it's continence issues or whether it's the falls and then would probably sign post to you, right, which medications could be linked to continence issues and making that worse or same with the fools you look at the medicines that might be more ones that you might want to focus on.

INT  
Mm-hmm.

Participant   
Uh, and look at those first rather than doing a huge cleanse of medications.

INT  
Thank you.

And are there any reasons which would kind of for you not to support reducing or stopping make stopping and medication anything that would make you hesitant?

Participant   
Umm. I think if the patient was about to move out of practice area imminently, for example.

So if there are temporary resident or because we get that quite a bit in our on on on the (area) and we get a lot of holiday makers that come into our and patients on respite in the care homes.

So you've got, I think we've got the highest population of patients in the in care homes in the country actually.

Umm, so that would be one of my warning signs. The other one would be if the patient was. Umm, not mine. So if I didn't know them very well, I wouldn't go gun hoe into that situation.

I think I would do it if I knew that I had that consistency with knowing the patient because obviously sometimes what's what's really lovely is when you been in practice for long enough.

INT  
Mm-hmm.

Participant   
So you remember the patients, what they like before dementia and you can rationalize what they need to be on. Umm, so I think perhaps there's probably 2 situations if a patient was completely new to me.

If they I knew they were going out of area shortly, probably.

INT  
Thank you.

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

Participant:  
Time and to do it to do it properly. I mean, I've just done some reviews in in care homes with as part of the pharmacy team training and we spent about an hour per patient and it's just not. It's unfortunately in general practice it's not realistic.

Umm, but that's how long it takes to do it properly, because you've taken into account absolutely everything.

Um, so I think that's the biggest problem because you can only do deprescribing if a patient comes in for their care plan review to do deprescribing. On top of that is asking quite a lot.

Umm, so the reason I could do it this week with that patient that came in, they actually came to me about difficulty breathing, but I knew it wouldn't be anything. I think as I knew it'd be about their dementia more than anything else.

And so I had then that 15 minute appointment to look at their and dementia care plan, which I knew already so I could say I'd reviewed it because I know them so well and and then I could quickly do that deprescribing with the appraisal and freeze ? because I know them that normally that would take long time to achieve and even to do it in a care plan would be difficult.

INT  
OK.  
  
And and then the other things that you think need to be in place were successful deprescribing for someone with dementia, mild cognitive impairment.

Participant:   
I think it's that family support. So for example, the patient this week they had or she already had a nomad tray and we realized it would be too difficult for the for their family to identify the medication.

Sorry, issued a new no mantra to start and but if there wasn't anyone else involved on the scene, that might confuse the patient.

INT  
Umm.

Participant   
So if they've got that reassurance.

I think just that wider practical level support because that you can't do that on the phone. Umm, because it in the patients eyes, they've gone from 4 medications, 2 medications and they'll be thinking, well, where's it gone?

And you might have that conversation frequently because they can't remember what I think.

That's where you can feel quite lonely as a GP because you realize that it's you and only you with these patients sometimes.

INT:  
Umm. OK.. That that you said that practical support, whether it's in the form of family helps.

Participant:  
Yeah, 100%.

INT  
OK. And anything else that you think could be in place for successful deprescribing with patients from that per dementia?

Participant   
Umm.

INT  
Umm.

Participant   
I think that MDT type the model so because the pharmacist would come at an angle differently, perhaps to a GP even, uh, similarly to a nurse.

I think that's something that could work quite well and. I think what might also be good is even like group or carers group consultations with carers even to talk about their medicines generally.

INT  
Umm.

Participant   
How do you take your medications out and and like a deprescribing work group? Really, that might work quite well, umm. And I think that generalized holistic. So for example, if if I am, if we make a change that she has.

I'm if we had to add in say and fruit, if I had to add in fruit in my for example, rather than you, you've got to look at what will they have continence issues.

INT  
Umm.

Participant   
So that follow up and follow up is important because similar if you deprescribe so say for example you deprescribe amitriptyline, will they then get diarrhoea because actually they've been using it and it's been helping there that for just sort of mean you don't know whether it's their bowel habit worse or better because they've been so used to it and all those yeah the side effects basically of deprescribing that might then be revealed if.

You do that and how you monitor that I guess would be important.

INT  
OK. Thank you.   
And and the and the group consultations with carers you mentioned is is that family carers?

Participant:   
Either I think it's something it's there was a dementia cafe that was run locally at a practice near us.

INT  
Umm.

Participant   
It was run and she was a specialist dementia nurse and she faced in primary care. I think she's retired now, actually, but I know that she ran a memory cafe in the practice and she did all the reviews that way.

I'm which I thought was a really lovely model of doing things, and you and you could, I think it would work really well for from a deprescribing perspective really.

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

Participant   
Umm so I will have them frequently, probably at least once a week and it's received well, usually because that medication burden is deemed to be greater than the reason for it being prescribed.

So normally, normally patients, carers, relatives are all quite grateful.

Actually, UM, because I think we lose sight as clinicians. Actually that none of those people might actually know the indication for them being on those medications.

So they just continue? Umm. So, and to be fair, I don't think I've ever encountered a patient relative or carer that's concerned by a suggestion of deprescribing.

INT  
Thank you.

And, umm, in terms of what helps facilitate those conversations and any thoughts about that?

Participant   
And I think it is good to do it in a focused way.

So if it's the reason for a consultation, for example, they, they know they're coming in about that specific purpose, that's makes it a lot easier. Actually, it's much harder to do as a bolt on to anything else.

They come in with umm you just need to be quicker as a GP.

So I think if if they come in their focused or that that is really helped that would be more helpful.

INT  
  
Because they might be helpful if they came to us and said I don't know why I'm taking XY.

Participant

I need to be on these. That's quite a useful. Tool, but they might not realize that.

INT  
Thank you. That's focused conversation you said there.

Participant   
Yeah.

INT  
Yeah, yeah, yeah. And. When and how should such discussions take place?

Participant   
I think you can. You can do search this certainly through emails where you can do polypharmacy searches.

So for example, the structured medication reviews that pharmacists do in in practices, they can set up searches that look at 10 or more medications, or they can look at patients that are on antibiotics and in dementia or think you can set up specific searches that look for medication burden that might be greater than others.

So I think that would be a good way of starting it.

UM, but equally they are the most complex.

INT  
Umm.

Participant:

Because actually like my patient this week, she was only on, I think, 6 medications. I know that's still by definition polypharmacy, but that's quite easy to look at where's when you're looking at 10 or more, it gets harder.

INT  
  
What should happen in these discussions? You mentioned a focus conversation. How would that work?

Participant:

And. So you would talk about their values. So you talk about whether they value umm quality versus quantity of life.

INT  
Umm.

Participant   
And because often, for example statins, there's no evidence based behind them for patients are older than 80, we don't know what their value is.

So then you would talk to patients about you've been on this medication now for 20 years.

We don't know if you need to be on it or not, and having that conversation, it said, well, actually, do you want to come up with it? Do you want? So what do they value? Uh. Then you want to talk about UM.  
Things. The practicalities of medicine, so for example. Capsules versus tablets or dispersible versus those UM and actually like combination drugs. So if you wanted, if a patient was on just basic codeine and paracetamol, then you say well, let's put that on a co-codamol form.

And so you try and combine medicines where you can.

INT  
Thank you.

And who do you think is best place to be involved in deprescribing discussions in primary care for people living with dementia or mild cognitive impairment?

Participant   
  
I enjoy it as part of my job as a GP, I quite enjoy that medical complexity, because I think if it's often I've, I have found that our pharmacists, although there now senior pharmacists, they still don't feel confident with deprescribing.

And then then for example, they're happy with that because you give them a plan and they're follow it.

Whereas if if you give them the patients that are on 10 plus medications and you're saying deprescribe that. That I think they're still, it's all relatively new still to them and carries a lot of responsibility.

So at the minute and I know from say from April, the pharmacy is going to have to do a lot more work on their SMR's generally, but that complex polypharmacy that comes with often patients with dementia I think is still in our certainly our area can only be done by GPs for the time being and without a lot of support and supervision by the pharmacy, our pharmacy team.

But in time, as they get more used to that sort of work, I'm I'm sure it'll be OK, but I don't foresee that changing for the next couple of years.

INT  
Umm OK, thank you. And are there any professional groups who should or should not be involved in those deprescribing discussions and primary care for people living with dementia?

Participant   
I think there's a case of who should or shouldn't?

I think it's working within your capability, so if you've had for example our, our respiratory nurse wouldn't touch diabetes medications with a barge pole. UM, so you wouldn't expect her to deprescribe that because she wouldn't have any knowledge of how to do it.

And so similarly with any any click any clinician whether it's a podiatrist, dietitian and nurse fellow, whoever it is they to work within their competencies and their and their training.

INT  
Could you and who is best placed to lead the discussion?

Participant   
Often patients like it if they've come up with that idea.

INT  
No, that's good.

Participant   
UM and but I think as an opportunistic level GP's probably umm because for example my patient this week, I'm sorry keep referring to them, but they it wasn't typical classical (locality) patient case that she she wouldn't have brought up that can I reduce my medications.

It was me that said, why don't we look at this as part of?

While you're here, OK.

So I think. Patients often just carry on.

INT  
And are there any occasions when it is or or isn't appropriate to involve patients?

Participant   
If they have, so they haven't got capacity, if they've, if they've got a power of attorney in place and then you think about best interest meeting, UM and usually to be fair, often a lot of patients and we encounter particularly in care homes and don't have next of kin.

So the best interest meeting is taking place between the the carer and our team and but I think or if that's the only time that I can foresee, it's not appropriate really.

INT  
Thank you.   
And in terms of informal caregivers, are there any times when it is or isn't appropriate to involve informal caregivers, such as family members?

Participant   
The gray area is around permission to share.

So for example, if patients have got dementia, then they it's too late to then implement the lasting power of attorney and application.

So then you.

But then you don't know the dynamics between next of kin. It is.

INT  
Umm.

Participant   
It it's it's a difficult one and that's when time is quite important. So and local knowledge also in combination with that, UM, so we know we've got a lot of families is quite a strong community where where we work. So we often know and or for example, all of our exceptions live on my living, living on them on our (name of locality), so they know pretty much all the patient families.

INT  
Umm.

Participant   
Personally, as well as through the practice, I think that's that's actually we've utilized that a couple of times that useful knowledge out of patient with dementia who came in, who into the flu clinic and use a little bit wobbly.

UM and I said I need to arrange follow up with this gentleman and and he was just a bit lost in the system known next of kin. And the receptionist went ohh.

INT  
Mm-hmm.

Participant   
He's my neighbour because he wasn't answering our call.

So she brought him back in Umm.

And actually he he somehow been just slipped through the net with all services and so that local knowledge was, I mean that's that's so invaluable to that situation and.

Participant   
So I've gone off on a tangent there, haven't I?  
What was the question?

INT  
So if we're talking about the the local kind of knowledge -

Participant   
So that exception is there became an informal caregiver in, in a sort of emergency setting.

So I think it's only really if they've got anything on their note, the patients notes that says please do not involve so and so with my care and I've only come across that a couple of times...., for example, the two of my patients actually that have got and and relatives that have taken money from them. So we've put warning signs on their notes to say at the patients at the patients request. Do not. For examples, you could be careful in hose scenarios.

INT  
Thank you. And what would assist engagement with health and social care colleagues to support shared decision making?

Participant   
I'm. Like so they're training am they need specific training because what I find is that, UM. Say for example-I can only lead it to examples I know of, but the pharmacy team were particularly used to shared management plans. To form of communication that they're they we've had to develop over the last few years because they've often been along the lines of well that you need this medication.

Please can you start it rather than that shared.

So and that is specific training.

So even something as what you think is simple. Can't be done by everyone.

If they haven't had that training to go alongside it so.

But that's when MDT are really helpful and best interest meetings as well.

INT  
Umm, thank you.

Participant   
So can I just wait? I'm just need to grab my battery.

Do you mind? Just.

INT  
  
Yeah.

Then yeah, yeah.

Participant   
Just it's just go the director. Just.

Sorry about that.

INT  
Oh, no, no, not at all.

Participant   
Sorry, I didn't think about that. There we go. Also.

INT  
No, no, not at all have.

Yeah, the similar question, but 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   
I think a timeline, perhaps and. So for example, if you're, if you're adopting a certain method of doing a deprescribing model, then you want to say, right?

So week one is a discussion about medications.

Currently, a review of care plan review of care needs, advanced care planning, all of that legalities as well.

And then you say week two is the conversation around prioritizing which medications to start deprescribing, and then you'd say then week, so you say week six is your review of that.

Those medication changes week ten, she said.

Me like a timeline.

INT  
Umm.

Participant   
So timeline.

So they're aware of what intervals we're looking at.

Umm, I think the evidence based behind it. So maybe a leaflet on how it's helped other patients, perhaps. UM. And then that could contain a list of charities that support patients UM, local. So for example, we've got like local volunteer services as well.

INT  
And.

Participant   
So you're providing that kind of holistic package really more than just.

But one thing.

INT  
Evening.

OK.

Thank you. And what would facilitate good communication with with patients living with dementia or mild cognitive impairment and all their informal caregivers in deprescribing process?

Participant   
That continuity of care. They get used to the way, for example, like my patients I have of dementia.  
They know. UM, they'll they'll know me, so they'll feel that they can then communicate more openly.

I'll know whether they've got hearing issues or sensory issues, or UM those things because I've known them for so long, so I can adapt. Umm.

So for example, I had a patient in a in a care home who he didn't who didn't, who only had Mark operative impairment, but he had. And very poor hearing. So I still write on a whiteboard for him. UM to communicate, so I think, but I knew him so well. I knew that that was needed. Uh.

INT  
OK. And is there any considerations around language to be used in communicating information about medications with people with dementia or mild cognitive impairment? No formal caregivers.

Participant   
Yeah. No, absolutely.

I think UM patients that it depends on the severity of their dementia. Umm, because if they can't retain, if you've got, not if they haven't got capacity and they can't retain information, then. There's no point. There's no point explaining anything in depth, because that would be cruel and but you could you could have a relevant leaflet to follow on from conversations. They could refer to in the future, but I think, UM, it is. Yeah. As I say, it depends on their level of understanding to begin with.

INT  
OK. And 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   
Yeah, 100% happy. And as I say, patients are usually very receptive to that suggestion.

And it's a lot easier, for example, if they've had recent blood tests and because you know, for example, that you can reduce their ? because they're usually check their renal function or something like that, is it, you've got a reference point. Umm, but I think the the the main reason I feel confident is because I've been at my practice now for long enough to know all my patients with dementia or mild cognitive impairment come to think of it.

INT  
Thank you.

And what would help facilitate their involvement in shared decision making?

Participant   
Umm.

I think if they can identify priorities, so for example, if they struggle with their eye drops and we can, I don't identify that as a priority area.

..  
So if they come, is it again?

It's about ease of administration of medication. So you could you could ask patients to come with ahead of that appointment. Rating each out of 10.

For example, each medication of whether they, for example, they know the indication for it, they don't think they've experienced any side effects with it, ease of use, you could ask them to rank all of them and then that might give you a good starting point and then you've already entered that shared discussion because you've they've patients have already started thinking about it ahead of the meeting.

INT  
Umm.

And what are the barriers to their involvement in shared decision making patients with dementia?

Participant   
I think that capacity issue if if, as I say, they've got, if they got advanced dementia, they don't all they're very cool.

Umm that's difficult.

Because they weren't. Remember that you've had reached a shared decision.

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

Participant   
Yeah, absolutely.

Yeah, fine, .as along as it's not the issues we talked about before.

And then you have no problem at all.

INT  
 and any thoughts around what would help facilitate their involvement in shared decision making?

Participant   
I think if they if they had the information ahead of the appointment like like that, looking at their medications and looking at which ones. Umm, so they could help their relative or or friend fill it in the head of the consultation.

INT  
OK.

Thank you.

And and again any barriers to their involvement in shared decision making.

Participant

And I think if I think things like distance, so you've got relatives that live quite far away. And so they might not actually know if they're relative. UM finds a particular medication of burden or not. Umm, I think the other issue is that you can have that coercion where. So if you have a patient that says, oh, I'm on an aspirin, you should stay on an aspirin. They might come with a preconceived idea that conflicts with our own is clinicians from their experience. So that could be a barrier.

INT  
And what tools or resources are needed to facilitate shared decision making in relation to deprescribing for patients living with dementia?

Participant   
Sorry, sorry to say that, but again.

INT:

What tools or resources are needed to facilitate shared decision making in relation to deprescribing for patients living with dementia? What things might help?

Participant   
I think I think the capacity assessment really, UM. I can't think of anything else specific other than what we've been talking about..

INT  
And how best would patients living with dementia or mild cognitive impairment and their formal care givers be supported during the deepest scribing process?

Participant   
The so what we often say is that and so like for example, this week I said if you if you experience any sort of rebound, gastroesophageal reflux flares as a result of me stopping the ‘omeprazole’, please let us know because we have our pharmacy team in practice that can follow that up with you.

You've got that safety net really.

INT  
OK.

And I'm in terms of follow following up patients as well who who who should be following up patients.

Participant   
Umm, I think it it depends on what level of complexity the patient comes with and. How much relationship you have with them?

So for example, I might have a patient that I know would only really respond best to me. Similarly, I might know they get on well with one particular pharmacist, so I try and make sure I follow.

It was with that. So they they often these patients don't like unfamiliarity. So and and they quite so if you sample, it took us a long time for patients to get used to the idea of pharmacist being in our practice when they were called by a pharmacist. So I think if that's for patients that don't have dementia or cognitive impairment, then for those that do, it must be even more confusing. Uh. So I think that's an important thing to consider. UM, and I think the the the other thing is and the time intervals.

INT  
Umm.   
And how often should net patients medication be reviewed?

Participant   
It's usually every year, unless there's a reason, and so it's an annual review really.

INT  
OK. And what are the potential for senators to integrating shared decision making in relation to deprescribing medication for patients with dementia in into your everyday practice?

Participant   
The facilitators.

INT  
Yeah, things that might help to integrating shared decision making in relation to deprescribing medication for patients with dementia and you're everyday practice.

Participant   
I think sorry. My phones going and I think things like. Sorry, my phone just going and I think.

You could have an embedded tool in EMIS for example, so you could have a a pop up that would maybe activate I I don't know how that would work. Uh. Because the problem we've got is that often these aren't accurate. So so for example, patients have got asthma that actually don't have asthma and it's still flashes up as they pop up. And I said, I don't honestly don't know

INT  
And bedded tool and emus.

Participant   
Maybe a pop up saying we've got things like for anticholinergic burden that comes up as a alert, but I'm just wondering whether something like for example a patient hasn't been requesting the medications properly, whether it comes up as, would this patient be appropriate for deprescribing?

Thank you.

And what are the potential barriers to integrating shared decision making in relation to deprescribing medication for patients with dementia into your everyday practice?

So things that that, that. But then.

Participant   
I think, yeah, I think it will think about. So lack of time. Uh consideration of continuity. I think the problem with the with PCM workings now is that there's. There's too much movement between job roles, so I wouldn't want to. So we had two mental health nurses that worked with us and we gave.

We asked if they could do all of our mental health reviews for patients with severe mental health illness patients got used to them, and now they've both left the PCR.

So that work falls back to GPS.

Who might not know those patients as well?

INT  
Umm.

Participant   
So it's not helpful really for the patients or for GP's.

So I think that's something that can be a barrier.

Because something that's always a something and is undervalued in the NHS is is the value of continuity of care with GP.

So it's all good and well introducing and I'd health professionals enhancing and professional support in, in PC's and practices. But given the way that they leave, that's not helpful for anyone. And so I think that that can definitely be a barrier. Yeah.

INT  
Continuity of care knowing the patient which you've mentioned earlier as well.

Participant   
And.

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?

Participant   
Or you'd hope all GPs could do it. So I think it should be. It's all part of our training, so I don't see why it should be. There shouldn’t be an issue really. I'd be surprised if GPs didn't feel they could do that work.

INT  
And in terms of other colleagues, are there any training needs or educational needs?

Participant   
Yeah, as a as a as I alluded to you before, I think it it takes a long time to train people to do that work.

And because it is difficult, particularly those that are on have got that huge polypharmacy burden as well already. Uh, but if it was something and and as I say, what? What was what?

Well, is if it's a focus deprescribing, so it's a focused pain medication reduction or antipsychotic medication reduction for this a focus deprescribing that's much easier to develop.

INT  
Cheap and is there anything else that you haven't been able to tell me about deprescribing for patients with dementia that you'd like to say?

Participant   
I don't think so.

No, I think that's everything.

INT  
Everything.

Participant   
Yeah. Thanks.

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

So I'll just, I'll just stop this recorders.