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

**Transcript**

**HP16**

INT:. So the first question is just really open question and it's just can you tell me about your involvement in medicine management for older people with dementia or mild cognitive impairment, please?

Participant:  
As a doctor in the memory clinic.

I have two roles in terms of medicine management, people with dementia.

One of the main parts of my job is starting cognitive enhancer medication. So that's something that I prescribe directly. I take I do the prescribing initially before handing over to the GPs ? to that stabilised.

So I initiate that medication on a weekly basis for my patients.

In terms of wider medication initiation, I am likely to advise GPs to initiate antidepressant medication or perhaps sometimes to initiate medication to run alongside cognitive enhancers. For example PPI cover. If a patient was starting Donepezil and had other risks.

On the other hand, I also, although I never directly deprescribe any medication. I do advise GPs quite a lot on reviewing medications that my patients come to me on.

For example, if they were on things had a high anticholinergic burden and we were trying to sort to address that as we thought it might be a factor in their assessment, some of my patients come to me on a huge amount of opioid medication.

And things like that. And I actually have had occasions when I thought that that might be affecting their assessment for dementia and so advised GPs to review that before reassessing them once they're on a more suitable medication regime.

Yep.

INT:  
Great. 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, as I said in my last answer.

One, we need to really thoroughly check the medications that people are on to make sure that they're not actually the cause of any cognitive impairment. Be that you know, transient delirium or a longer-term problem.

It's a key part of the job of the memory service to advise on that.

There's also a really important role which perhaps I do less of because I am involved in the initial diagnosis. So often people come to me at the beginning of of their journey with MCI or dementia and and perhaps still have a longer life expectancy. But my colleagues who work with patients further down the road, we need to then really, seriously, be thinking about the the risks and benefits of all the medications that they're on in terms of their their life expectancy.

INT:  
OK. Thank you.

Participant  
Hmm.

INT:  
And I know you alluded to this as well and in the first question, but how how much are you involved in decisions about deprescribing?

Participant  
N.

Participant  
I.

Advise GPS on deprescribing and.

I have found that they almost uniformly follow our advice.

Participant  
In.

Secondary care where I work, we have the luxury of time. I have a 2 hour appointment slot for my initial assessments. I have time to review the patient's medication as a whole. I have time to use.

Online calculators and things to to facilitate what? What the burden of medication might be.

I have time to educate my patients.

Participant  
And talk them through, you know, perhaps they're on medication for you on your frequency. That could be contributing to levels of confusion. But there's a risk benefit analysis for the individual patient there on whether they want to be getting up in the night to go for or whether they, you know, whether they want to try or time without medication. So I really have that time, which the GPs don't have. So if I advise AGP, they're normally they're normally grateful and normally will.

At least trial my suggestions. However, I'm a psychiatrist. I'm not a general medic anymore.

I don't have the ability to stop people's repeat medications directly.

But so I can't do that and I am grateful for my GP colleagues oversight to check that they haven't missed anything physically, but they do tend to generally follow our advice. And sometimes we've had great success. So yeah.

INT:  
Oh.

Thank you.

Participant  
Hmm.

INT:  
And yeah, if if you could talk a little bit about those advantages you mentioned the the great success or what's what's worked well, that would be really helpful. Thank you.

Participant  
OK, so I think that the main things that we advise GPs to review are.

..  
  
Pain, pain medication, opioid pain medication.

Medications for urinary frequency and medications for sleep, so quite often we have patients on amitriptyline for sleep still.

And sometimes. You know, we'll, we'll put the end to the the calculators and they'll come up with a high score of burden and potential risk of having confusion as a consequence of those physical health medications, and there have been patients.

Who I'm thinking of, particularly of of 1 chap in his 60s, he was a HGV driver. He because of his concerns about his cognition had been stopped from working.

The GP had referred in and after a medication review.

His medication was reduced and his symptoms completely disappeared and he was able to return to work as a HEV driver.

Continued to support his family, and that was something, yeah, that was. And that the advice from that was from the memory clinic to the GP. So I don't want to sort of say that the GPs aren't doing their job because they have 5 minutes and but yeah, given the luxury of time that we have in the memory clinic.

We're able to bring about those changes on occasion, yeah.

INT:  
Thank you. And and on the other hand, any disadvantages around deprescribing of inappropriate medication among people living with dementia, mild cognitive impairment?

Participant  
I haven't come across any disadvantage in terms of actually.

Stopping a medication and that bringing about an issue with a patient. I'm just trying to think if that has happened.

I don't think so. I suppose the disadvantages are I said the advantage in in the fact that my GP colleagues take it, you know, act on. My advice is that that's a second pair of eyes to review my suggestions, however.

It's quite a clunky system. It involves me writing to the GP when I write to AGP. It doesn't go directly to AGP, it goes to AGP admin team who then have to note that I have said action for GP, pass it on to the GP and then the GP to note the action.

That's quite a clunky process. I'm working with people who don't always have the ability to raise those issues themselves with the GP and not all of them have an advocate to act on their behalf to the GP. So sometimes we might make deprescribing recommendations occasionally that don't get acted on for weeks because of the communication mechanisms that we are. Yeah, following through. Yeah.

INT:  
Thank you. And any thoughts around anything that could help those at this point and your reflections or anything that you may help?

Participant  
To communicate with the GPS around that.

I suppose maybe some.

Education of the GPs.

To accept. To understand that we might be suggesting deprescribing. This is something to expect from the memory service.

They're very used to us requesting certain blood tests.

In fact, we require certain blood tests to have been requested before we will accept the referral.

So perhaps something in terms of like a referral questionnaire you know, is your patient taking any of these common medications that can add to confusion?

And and not necessarily to stop them at the point of referral, but that that might bring about a thought in the G PS mind would be quite useful maybe, and it would also highlight it to all the clinicians doing the assessments. Not all of our assessments are done by doctors, some of them are done by our colleagues in psychology. And although they're checked by the doctors, it might not be the psychologist's initial thought to think about deprescribing.

Yeah.

INT:  
Yeah. Thank you.

Thank you. And and any thoughts around the the challenge of the the clunky system as well that you mentioned?

Participant  
Yeah.

Participant  
How would I communicate with AGP in a perfect world?

Maybe I'm not an innovator. I mean it's it's it's, you know, in all the other ways we.

Are communicating via things like teams you know via instant messages. You can see if someone's read your instant message easily, you can act. That's how we communicate within the team.

So maybe something like that would be better rather than what we do, which is formulate something that's meant to look like an old fashioned letter. Send it as basically an attachment to an e-mail.

Fancy a way and then wait for someone to read that at the other end and we never really know if it's been read.

So yeah, maybe something more along the lines of teams, maybe something along the lines of monthly or periodical actual, you know?

Through meetings or teams meetings so that we could talk to AGP from the practise and review the patients that we have together.

And actually kind of bat around ideas. We never get that kind of dialogue with GPS.

Yeah.

INT:  
OK. Thank you. And then and and and anything in terms of 'cause, you also mentioned about the, the, the patient perspective there, is there anything in terms of that communication which which which which could help for for the patients as well?

Participant  
Yeah, I always explain.

You know.

The the rationale behind deepest and deeper scribing to my patients, we ask that our patients come with a relative or carer or a supportive friend.

But it is the nature of our patients and the fact that they have MCI or dementia normally that they can't retain the information.

So they are, they are ill equipped to to act on it themselves.

And it's really noticeable those that have a strong advocate in terms of a partner or a family member to accident for them. So a lot of the time, if someone has that good advocate, it is them that will do the majority of the legwork in terms of making the deeper scribing happen. They will get the-so which they get a copy of and march into the GPs’ and say look it says here. Please don't prescribe this anymore. They will check the repeat prescription to check it's not on there anymore.

They will call us if there's an issue with the GPS. It is that party completely outside of the NHS that does most of the legwork, which is great when that patient has the advocate, then these things run smoothly. When they don't, that there's.

Outside agencies are are not a good substitute for that family friend or partner. That is a really good advocate, yeah.

INT:  
Thank you. Thank you.

And anything in terms of the the form of communication as well in terms of what, what makes it helpful for the for

Participant:

For the for the patient, yeah.

INT:  
Yeah, and and the carer if they have one

Participant  
Definitely a letter, a paper letter landing on their mats in the week after we've had the appointment.

Cognitive impairment or not, especially if it's come on the day of a dementia diagnosis, then some information about deprescribing is quite overwhelming me saying, you know, this drug has a high anticholinergic burden. Look at the, you know, that's a lot of information to take on along with everything else that we're trying to to convey.

Participant  
We have found that our patient group don't really log on to the NHS app. They're not looking at their letters that way. They like a piece of paper to review afterwards, perhaps with some extra guidance on why we might be stopping a certain medication included if needed.

But yes, that is what they tell us that they like. That is what they double check that is going to come and that's what they complain to us about other services not doing.

And that gives them something again.

Normally, the advocate for the patient, but perhaps the patient themselves.

Participant  
Will take a letter into the GP to prompt discussion and they will bring pieces of paper to me from the GP in order to evidence the other side of the story as well they bring in.

Physical green prescriptions to show me what they're taking.

They're still very paper. The majority of the patients that I see over over 75 and they're still very paper based in that kind of thing. So yeah, paper based communication.

Is is well suited to them at the moment I would say.

INT:  
Thank you. And then you think that would be for for the patients as well for for with dementia, more cognitive the?

Yeah. Yeah. I mean, yeah.

I'm I'm just trying to, you know, thinking about.

How patients communicate with me, even with I've I have a patient recently with a moderate dementia who it wasn't actually around. Sort of. The medication being actually inappropriate for health. It wasn't contributing to the confusion. It wasn't inappropriate in terms of

Participant  
That the way that we got to the bottom of that was her bringing in medication and paper to show me the confusion that she was in and the only way that she was able to sort of demonstrate all of the stuff was here's the prescription. Here's the thing. Here's a letter. Here's some medication. And amongst that paperwork was the deeds to her house. But.

It was showing me this is what I have, you know. Yes. The patients even with moderate dementia.

They've got these bits of paper and that's what they that's how they can evidence. And then me, you know, in return, sort of backing up with paper what we've discussed documenting it for them so that they can use it as a communication method. If they can go to the GP and say I'm not sure what it was that we discussed, but I know it's in this, you know, do you understand?

But yeah, they find that useful.

INT:  
Thank you. And and did that, that patient have a a carer or or an advocate with them or?

Participant  
So that patient had a family member who I would unfortunately describe as a a poor advocate wasn't able to support them in which is how they got in such a mess.

That they that that person wasn't equipped to to support them in that way.

Yeah. And what? And hadn't, despite living with them, hadn't sort of got the insight into how much of a mess things were in.

Yeah. Hmm.

INT:  
OK. Thank you. Thank you. That's that's really helpful to know about communication there as well and what what types. I know we we touched upon this a little as well but what types of medications would you feel most comfortable deprescribing for people living with dementia or mild cognitive impairment and why please?

Participant  
So obviously very comfortable with because I'm a psychiatrist with antidepressant medication, which is sometimes prescribed inappropriately in this patient group.

Very comfortable.

In advising on cognitive enhancement medication, when that's no longer safe or appropriate or might be contributing to problems. Again, that's sort of my bread and butter.

And something that I'm I'm really confident in doing.

In terms of moving further out in terms of my level of confidence, I suppose I have a level of expertise in, in drugs with a high anticholinergic burden. And I'm I, you know, I recognise when I see them on a on a drugs list, OK, this could be part of the problem. I've got some insight into possible alternatives.

However, they're normally prescribed for things outside of the the dementia remit that I'm talking to the patient about. So although I might identify that they could be a problem, I perhaps don't have the insight into overactive bladders. That means that I I can highlight them as an issue I can ask for a review, but I wouldn't actually be confident in saying this patient no longer needs this because I might contribute to a physical health problem. So that's when I'm I'm writing to my GP colleagues and saying is this something that we can review?

My colleagues I know go further in terms of wider physical health.

Medications, especially towards the end of life, people with dementia towards the end of life, that's not something that I'm doing really very often in my work and the memory clinic because I'm mainly involved in initial assessment.

So yeah, not doing much of that.

INT:  
OK. Thank you.

And on sorry, just leading on from that is what what would encourage you to support reducing or stopping a medication? Is there anything that would make you, yeah, more, more, more likely if there were things? Yeah.

Participant  
What about you? More likely, I suppose.

Again, I'm in a very privileged service. I've got really good support staff and when we directly initiate or stop cognitive, enhance the medication.

We have weekly contact with our patients and their carers and we'll monitor for side effects and we'll do regular physical observations because they're quite a high risk group of patients.

Themselves on that whiskey, but the patients are.

When we are removed from that process by the step of the GP don't have the same level of confidence that we're monitoring symptoms or any symptoms that might arise that we're supporting patients through that that we, you know it with our cognitive enhancer medication, sometimes my healthcare support workers will go in and physically check that the right number of tablets have gone from the packet.

If we're stopping a medication.

Participant  
I can't always be confident that the patient actually stops the medication unless somebody goes in, takes the medication out and gets it disposed of at a pharmacy because of the level of their cognitive impairment. So what would give me more confidence is.

Having.

That level of support that we can offer with initiation in deprescribing that I could have.

Help the patient dispose of the medication.

Check. You know, say it was a medication for your new frequency. How are you coping without it? Are you getting up in the night? If you're getting up to go in the night to get the loo in the night, is that going to cause you to trip? Have you got the relevant continent? All of those things that that we could do for for initiation that we could do for the prescription because they're risky for patients and and every change in medication that you make if it makes them disorientated. If it makes them lose the loo more.

INT:  
Thank you.

It can easily cause a fall, which can be disastrous in the scoop of patients. Yeah. So more support from my colleagues if they had time to do that, yeah.

HCA Healthcare assistant, yeah, yeah.

INT:  
And that was sorry, just just to pick up the roll, there was hcw you said then HCA Healthcare is, yeah.

INT:  
Thank you.

INT:  
OK. Thank you. And and on the other hand, what medications would you be reluctant to deprescribe and why?

Participant  
Oh, that's a good question.

I would be reluctant to deprescribe

Participant  
Most of the cardiac medications.

Participant  
And.

Anti seizure medications.

I suppose.

If we're looking at.

These patients and their risk of of death and premature death dementia increases, decreases your seizure threshold, so patients might have been on seizure, medic, anti seizure medications for a long time, antiepileptics for a long time. They may not have had a fit for a very long time and these medications, medications can add to confusion.

However. You get that double edged sword with dementia and that it makes them more likely to have a seizure again.

Which could be disastrous. So sometimes we have patients who have been on very old fashioned anti epileptics for a long time and we think, oh gosh, that must have must really be adding to their confusion levels.

But also we can see that that you know on their scans that they're they've got atrophy and it might be decreasing their seizure thresholds. So I'll be very reluctant to touch them. I'm very reluctant to touch the car deck medications, especially if we were starting cognitive enhancers as they.

Can also cause cardiac problems and yeah.

Those are the medications that I'd want to leave well alone, I think.

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

Yeah, yeah.

Participant  
OK, things that needs to be in place are things that we've already touched on a lot, but yeah, really good communication between secondary and tertiary care and the GP.

Do the GPS know what we're advising? Can they clearly see? We can very clearly see what the GPS are doing and can spy on the GPs by looking at GP Connect so I can see what they have prescribed through GP Connect instantly.

Participant  
I can see the patient's current medications when they prescribed them when they were last issued. The GPs rely on the letters coming from us. So very good two way communication on between the GPs secondary and tertiary care.

Good communication between.

Medicine, the NHS and the patient's family, and whoever's or carers, whoever's supporting them.

Quite often.

When I'm trying to work out what's happened with medication, I will say to a family member, oh, it looks like you were taking, you know.

Your mum was taking medication X and it was stopped. Why is it stopped? Oh, I don't know. She went into hospital after a fall. She came out and she wasn't on it anymore. And I don't know why.

So really making sure that those supporting the patients advocates understand the rationale behind why medicines have been stopped.

And can support with that, including disclosing of medication that might still be at home if it's for good reason. And then again, in my ideal world, in this world we sourced memory service we have.

Staff who can go out and do the very practical supporting in initiating medication. And yeah, if if whoever's depositing if they had someone outside of the family or friends or private care as you would go in dispose of medication.

Update medication prompt charts update pill boxes.

And also make sure that nomads double check that a nomad tray had been updated properly. That would be a really big help, but that's that's asking for a lot in in the current NHS.

INT:  
Thank you.

OK. And how much are you involved in or do you support decision making around deprescribing that takes place in primary care? And again we may have touched upon this but.

Participant  
Yeah, I think I think, I think we do, I think.

Sort of.

Giving advice.

For two GPS in the form of letters.

We give, we support it in that way. We support it by taking time with patients and their family to discuss the reasons why we might be considering depositing, so that then they can go to the GP armed with more information and make that decision in a short time.

We support it in terms of advice and guidance requests, so these are requests that GPs put into our service for patients who aren't currently an open referral to us.

But where the GP can put in a short summary of the case and what's going on and, you know, ask for advice, would it now be suitable to to stop this medication?

We support it in that way as well.

Yeah, I think that's how we that's how we support that.

INT:  
Probably care. Thank you and.

Participant  
Hmm.

What? What are the again thinking? Maybe first of the barriers, what are the barriers around supporting decision making in in primary care around deprescribing? Sorry in primary care.

Participant  
Yeah, the the barriers are that we rarely get the opportunity to speak one-on-one with GPs even with an advice and guidance, that's a sort of written.

So that is definitely the barrier. If there's something that we are really concerned about and we have had.

Sort of major concerns and thinking just in the last few months. One example was when I don't really know the discounts deprescribing, but AGP should have stopped a medication and instead they increased the medication and another situation when a patient was on a dangerous dose of antidepressant medication. In those situations we would phone the GP surgery and speak directly to the GP concerned or the duty doctor.

Which overcomes that barrier, but unfortunately we can't be doing that for routine deprescribing. They just don't have the the time to do that.

Yeah. So the Baru, is that lack of regular face to face or online spoken communication.

INT:  
Thank you.

And you mentioned earlier about GP connect that you could use and.

Participant  
Yeah.

INT:  
Do do do you see any role for that in in in other ways or?

Participant  
In terms of yeah, overcoming that that back that, yeah, that might be.

I mean, so really frustrating thing for us in terms of deprescribing and prescribing is patients that are on nomad trays. So these are patient, the GPS prescribe 7 daily courses of all their medications and they are made-up by the pharmacist in the tray and then normally are made-up a month time. So we are communicating with the GP in terms of a letter and.

Then.

That's not getting through, and another four weeks worth of medication is being issued.

Before the GP can see what we've asked for now, if it was a medication error or a major issue then someone could go in and get the tray out. But normally it delays things by a month and we can see it all happening live on GP Kinect, but we have no ability to go in to GP CONNECT and and put an alert on saying don't prescribe this again please or anything like that.

Our communication is completely outside of GP Connect. It's just a tool for us to go in and see. So if we could communicate via, that means perhaps with an alert when the GP next came to issue that medication, that would be amazing.

Because I can't tell you how many times we have in our plans for patients, check again in a month to see if the nomad has been updated, yeah.

INT:  
You and yeah, and. And anything else that might help that that situation around that those those communication.

Participant:  
I suppose also just think I'm just thinking about being able to communicate. I'm talking a lot about GPS, aren't I? And they're so busy and there's less and less of them and or actually, whether there was less or less of them. But from my perspective, it feels like it's less and less of them. And there are other people in that primary care chain.

Delivering that that care to the patient, be that the admin staff in the GP surgery.

If we could, if we could communicate more directly with them, pharmacist based, both in the surgery and in the local pharmacies, could we be communicating better with them?

They do a lot of deeper scribing. I know the pharmacist and the GP surgery do a lot of deprescribing. Yeah, we rarely communicate with them, so maybe that is a field that we could look into in terms of people to talk to and because it is always the GPS that we go to to to sort of.

Get hold of and they are so busy.

INT:  
Thank you and any any reflections on the other hand, so discuss barriers and maybe ways they can be addressed. But things that facilitate or or have helped with that kind of supporting decision making in in deprescribing and primary care?

Participant  
As with so many areas of medicine.

Although you shouldn't be reliant on online calculators or scores or these drugs are read bad and these drugs are yellow, bad actually, when communicating with others, if you can say look, I've been on the online you know anticoagulant calculator and this has come out as high risk that's a really easy way of communicating to AGP.

Processing all sorts of other things in the day. You know how bad is this? How bad? How much of a factor do I think it is? Or actually it's not that bad. This isn't a priority. Having ways of of communicating that, whether it be red, yellow, green, whether it be the score is bad, you know, high, medium or low risk.

Those really help everybody in the situation.

Whether they do it daily or whether it's something that comes up for them once a year, appreciate where we are in the risk level and whether it needs what needs to happen.

INT:  
Thank you.

So although that's not a direct sort of communication means it's a tool that I use a lot in sort of highlighting to the GPS where we are, how bad I think it is, yeah.

And was was that specific anticoagulant calculator?

Of course, yeah, yeah.

Participant  
Yeah. Can I Google it? Well, like just cause to to name drop it. But I always just Google it and then I'm sure what it looks like when it comes up.

INT:  
Yeah, of course. Yeah, yeah.

Soft in the way with these things, isn't it?

Participant  
Yeah. And this is something that I will get out with. It's called the A/C. It's www dot.

Acbcalc.com.

INT:  
Calc.com OK.

Participant  
And that is something that I used to communicate with GPS and I also use it in. I've just let me see your face again. I also use it in clinic some you know, if I have a really interested advocates patient advocates of who really want to get who, you know, whoever they've bought bought better that this is let's put the medications in together and see oh this is this is quite bad isn't it? And then they.

Be the advocate for the patient, and I've even had it that you know, they then themselves or some of those medications and think, oh, maybe that's why I am confused as well. And yeah, they've it's been a really useful way of communicating for me and for patients and families to understand what's going on.

Yeah.

INT:  
Thank you. So so using that tool together with with them, OK.

Participant  
Yeah, yeah, yeah.

INT:  
Thank you and.

INT:  
In terms of.

Participant  
Hmm.

INT:  
Again, is there anything that was assist engagement with primary care colleagues to support kind of shared decision making?

Participant  
Oh, interesting.

Engagement.

I don't know in. In a perfect world, we would have some sort of joint form where we could educate each other.

And talk things through.

We don't have any such form at the moment.

So yeah, and then that's because everybody's busy, not because anyone doesn't care.

So yeah, that that would.

And I suppose sort of being able to in those forums share some of the success stories that we've had.

Of reducing pain meds and and how that's brought about changes in people's lives, that just becomes a flag when they're thinking about patients with new cognitive decline.

INT:  
OK. Thank you. Thank you.

And.

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

Participant  
I love talking to my patients about medication. I love talking to them about the potential benefits of medication. And you know, when they're no longer useful and people tend to be as long as they have still have the cognitive ability.

Participant  
Really engaged in that discussion.

They want to know the side effects, they want to know.

A layman's terms.

Way of of the way that their medications might be affecting their brain, be that on a positive or negative way.

People are really motivated to maintain their independence for as long as possible, and so that is that part of the prescribing at the beginning of dementia I think is is easier.

At the end of life, I haven't done this stuff for a long time.

It can be.

Oh, those. Oh well, probably not with patients don't with dementia, but with their family, engaging them in terms of being realistic about life expectancy and the potential benefits of medications like blood pressure, statins and sort of laying out that the lifespan isn't there for those still to have the benefits can be really difficult and people can be really reticent and want to hold on to those things. I have found in the past.

But yeah, at the beginning of dementia, when the potential benefits are for their brain and maintaining their independence and being more alert, people are really motivated and want to hear about it.

INT:  
Thank you.

And umm.

What are the kind of barriers do you think to involving people with dementia, more cognitive impairment in those shared decision making?

Participant  
I mean the the the I suppose capacity is the number one barrier.

If you have somebody who's no longer capacitors to make that decision, then it that that becomes less of a shared decision and more of a decision made by the doctor and the patient's best interest.

That is a factor where it is where we are.

Some of my patients are lack insight into their condition and because I'm the person that has had to say sorry, I agree with whoever it is that referred you and whoever it is that first succulents, the GP and I think that you have dementia and deliver that bad news. Some of the patients, because of their condition and because of their lack of insight can think that.

You know that my motives might not be.

In their best interest.

And so, sometimes that discussion needs to be with another person who isn't associated with the person. That's that. I have dementia.

Yeah.

INT:  
Thank you. And and on the other hand, any any facilitators around?

Engaging patients with dementia, more cognitive impairment and anything that works works well in those discussions.

Participant  
Written information as you mentioned earlier always works well, but as I said, also engaging patients and family with online calculators to show that they are, you know the risks that that can be involved with their current medication and how reviewing it might be in their benefit. I suppose sometimes we'll have to be careful of is that we don't put too much hope in the in the benefits of deprescribing don't want to be.

Untruthful in the likely benefits.

But yeah, so written information, working things out together with online calculators.

And then always.

Patients seem to to me to love. Sort of.

Diagrams joining clinic about.

The very basic.

Modes of actions of medications and how they might be causing issues.

As well, yeah.

INT:  
OK. Thank you. Sorry if you could just give me an idea of a of a hard to depict a drawing or or what what what what.

Participant  
So for example, if.

When I draw your, are you able to sit on your transcript I talking about so talking about cognitive enhancers, whether we should be stopping them, whether there's any likely benefit. I will always draw a sort of time versus cognitive function diagram. I'll plot out how things will be with the cognitive enhancer and without.

I and then I can clearly show the patient that the endpoint is the same.

And it's very difficult to get that across for me somehow verbally, but sort of being able to show look over time, the endpoint here is the same, so.

If physically, I think this isn't going to be beneficial to you. Cognitive, you know, let's look at what the benefit is and let's see the area so that we can, we can see what's going on here.

I also, in terms of the other kind of diagram I would draw is.

Diagrams with nerve endings in and showing how different things might be increasing or decreasing the amounts of of chemical, and how that could be a negatively or positively affecting depending on what we're talking about things.

Patients. Yeah, it often breaks breaks through to the patient then and they're able to engage in that discussion.

Umm.

Yeah, I mean I I I often say sort of you know, what do you think we should do? You know, thinking often I'd be spoken a lot about going for we in the night, but it's such a big thing to my patients if they've got on a medication that that means they can have a good night's sleep because they're not going up to the loo. They're often reticent to stop it.

But then when they find out that that might be having an effect on their cognition or their confusion levels, then things change. And really.

That is definitely a shared decision. It's definitely based on that patience.

And a thought of also letting people know that it can be. It's a trial we can trial deprescribing something, and if it doesn't work, then if you are up all night going for a wee, if you are in agony. When we reduce this pain medication, it doesn't have to be a forever decision. That is a real yeah.

Way in which she can engage people. Let's do this for a couple of weeks and see what happens.

INT:  
Thank you. And how do you feel about engaging in formal caregivers of patients with dementia or more cognitive impairment, shared decision making as part of deep prescribing?

Participant  
Yeah, they're really interested. They often are the advocates for patients. I suppose the only tricky, and they often often have the, you know, the perhaps more cognitive ability to engage in those discussions when they're when the person they're giving care to might not.

The difficult thing is that.

You can get yourself in a position where.

It becomes unclear who's making the decision if the patients.

Capacity.

But a but a son or daughter or partner is. Come on. Mum, I think you should stop it. I think you should. You know that there can be issues there and there can also be issues if the patient lacks capacity. But the informal caregiver doesn't have any legal footing in terms of, you know what, where they stand in that best interest decision.

That can be tricky as well. So yeah, these are the advocates. These are the people that make things happen.

But you have to be careful that you're then their will is not over overwhelming the will of the patient.

INT:  
OK. Thank you.

Participant  
Hmm.

With.

INT:  
OK. And any on on the reflection, anything, any facilitators, anything that helps with with that revolving caregivers?

Yeah.

Helps with.

Participant  
The same the same things I mentioned before. Understand, you know, understanding via diagrams understanding via online content, the pros and cons of the prescribing.

And what really helps with these the caregivers is that they often have access to more different media so we can phone them and have a chat. We can e-mail them with information which often our patients might struggle to to access.

This group can normally access, hopefully.

INT:  
Thank you. Thank you.

And and now we've we've touched upon this again, but if if you have any other thoughts about any tools or resources to facilitate shared decision making in relation to deprescribing for patients.

Participant  
Yeah, I think, yeah, the same calculators.

For me, the.

The southern. So I work for (name of organisation).

Currently called (name of organisation) for another week.

I, the southern health or the Royal College of Psychiatrists, medication information leaflets are much more accessible than those little bits of paper that come in the boxes with the medication. So printing out those looking together at side effects.

And and intended benefits.

Much more accessible to patients, so having a really ready supply of those to facilitate decisions as well.

INT:  
OK, that's great. Thank you and any any thoughts around those using those, any tools or resources with healthcare colleagues, anything that helps specific ones, mm hmm.

Participant  
Yeah. So yeah, the ACB score calculator as a communication form and I said this engine is going to reflect that maybe we should be communicating it to the pharmacist within practises. But to GPS, they're really useful. GPS will have a score, you know.

The live AQ risk score. They live for these scores, so communicating in that way.

Is really helpful.

Yeah.

INT:  
Yeah. And on the other hand, patients and informal caregivers, any tools or resources around that?

Help. Yeah.

Participant  
That, yeah.

Same things I suppose there must be resources that I'm not using 'cause. I'm not working in the sort of more end of life things, but around thinking about those deeper scribing decisions. Then I if I went back into that area I would need more resources than I currently have and be looking to seek those out. But I don't know what they are.

It's not my current role, yeah.

INT:  
Thank you. And you mentioned about using the kind of the calculator as well, yeah.

Participant  
Yeah. Acb calculator. Yeah.

INT:  
Possibly the person you may see. See with that. OK, thank you and.

Any other thoughts around how to best support patients or caregivers around the deprescribing process?

Participant  
I think that we should be having these discussions early and often and as a routine part of.

.  
Diagnosing memory problems, but also just older person's healthcare.

Patients go from not having any medications to starting to collect them in their 50s and they just keep increasing the load and and nobody says.

There's going to be a point at which we need to reconsider all of these. They just keep, just keep adding them on.

So that needs to be a general part of our discussion and.

I don't know whether I do that when I first diagnose unless I spotted a particular problem.

I don't know whether I have that conversation early. I have a conversation about here's your diagnosis. This is what's going to happen in terms of how it's going to progress. I have a conversation about these are the benefits that you're going to get. Oh, this is the what's going to happen with your driving. But I don't have a conversation about, OK, as this goes on, we're going to need to think about what, what medications you're on. And if these are all still right for you.

And it might not be that they're not white today, but it might be in a few years time at your annual GP review that we start thinking about taking some of these away. So maybe that's something that we need to add into that initial sort of.

INT:  
OK.

Participant  
Script that we do because we we are telling them about how life is going to change over the next few years and we're not unless we've spotted that they're on codeine four times a day and was doing something about it. I'm not giving them that. Heads up. That OK in the future that it might be appropriate to deprescribe. So yeah, maybe that would be a change in practise. We could all do.

Mm.

INT:  
Thank you. And just leading on from that around following up with patients as part of the deprescribing process. Who, who, who should be following up with patients, do you think so particular role or or not?

Participant  
Yeah.

There's a role for that.

We, as I said, when we start something in my service.

We follow up, we check that the OPS are OK. We check that it's working. We check that they can take it safely. We do all of those things.

If, as a person in secondary care, I have made a specific recommendation to deprescribe to AGP.

Would expect that we would do some form of follow up.

..  
Checking in and that could be really formal. That could be. I've noticed this person has a really high anticholinergic burden score and I would like you to stop their amitriptyline and their antihistamine and their whatever it is and I'm going to read see them again in four months and I'm going to redo their cognitive testing and I'm going to redo their OPS? and I'm going to check in for their symptoms. That won't be really formal like that.

But if I.

If it's sort of a less formal situation, I would still if I've made the recommendation, think that they should at least have a phone follow up for me. How has it gone? Have have have have any symptoms come back? Has it been troubling? Have you seen any benefit?

Format. Yeah, it should be me if I've made that recommendation.

INT:  
Thank you.

And I'm following on how how often should that follow up take place?

Participant  
Yeah.

Good question.

I would think that it if you're titrating a dose down, it should happen after each dose titration down and then once the dose is completely stopped, it should happen again. And then I wouldn't routinely do it again after that.

And would just safety net with the person or with the caregivers is appropriate and say if things get worse then please contact us.

INT:  
  
Finally. 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  
Yeah.

Maybe I could do making more specific recommendations. I know how to titrate.

For example, antidepressants down, I said earlier. I'm more confident with those. I wouldn't have a clue how to titrate pain relief down. You know, if someone was on like a buprenorphine patch or something. So my advice to the GP would be, gosh, I'm really worried that this could be contributing. Please, can you stop it?

I'm not able to give any sort of guidance on how that might be and when I'm reviewing with my patients I'm going to struggle to kind of have to ask it from them. OK? What was the titration period? So yes, more training on.

Prescribing those common things that we are concerned about.

Yeah, pain relief.

Being the main one.

That would need to be titrated I think would be useful.

Yeah.

INT:  
OK. Thank you. And any other educational or training needs for you or or your colleagues that you think there's there's gaps work.

Participant:  
In as understanding how the GP practise work, who to communicate to, how to do that in a way that's clear and and seen by them. Yeah, always communication.

INT:  
OK. Thank you.

And is there anything else you want to tell me when you've been taking part or reflecting that you think you wish to add to what you've already said?

Participant  
No, I mean, it's been interesting and the sort of examples have popped into my mind as we've spoken about the successes and the problems.

But yeah, I I think it is quite a big part of what we do.

Participant  
Again, I just really want to emphasise that all of this stuff takes a lot of time and we're only able to do it because we have a lot of time.

So that's a bit of a privilege that I work in, but yeah, if if my patient had turned up to her GP surgery with medications from 10 different years under house deeds and prescriptions and a husband prescriptions, I don't know how they would have had time to kind of work out what was going on. Yeah.

Yeah, yeah.

INT:  
At that time, it's the big, big consideration, yeah.

Participant  
Yeah. And you can't, you know, these patients with cognitive impairment, you can't rush them. You gotta go at their pace. Yeah.

INT:  
Yeah, yeah.

INT:  
I don't know that that that's really helpful and anything else, anything else you want to say or?

Participant  
I don't think so, no.

Don't think so.

Participant:  
Lovely.

OK.

INT:  
We've come to the end of the interview now, so I'll just stop the transcription. Just bear with me.