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Authors	Belec, Dora;Dalton, Kieran;Heinrich, Clara;Ortner Hadžiabdić, Maja;Donovan, Maria
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Tailoring an Implementation Strategy for Deprescribing as Part of a Comprehensive Geriatric Assessment (dCGA) in Long-Term Care Facilities: A Roundtable Discussion

Dora Belec[1] | Kieran Dalton[2] | Clara H. Heinrich[2,3] | Maja Ortner Hadžiabdić[1] | Maria D. Donovan[2]

[1]Faculty of Pharmacy and Biochemistry, Centre of Applied Pharmacy, University of Zagreb, Zagreb, Croatia | [2]Pharmaceutical Care Research Group, School of Pharmacy, University College Cork, Cork, Ireland | [3]Department of Biological and Pharmaceutical Sciences, Munster Technological University, Kerry, Ireland

Correspondence: Kieran Dalton (kieran.dalton@ucc.ie)

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ABSTRACT

Background: Comprehensive geriatric assessments (CGAs), with deprescribing as an integral component, improve outcomes for older adults in long-term care facilities (LTCFs). However, they remain underutilised in Croatia, partly due to systemic and cultural barriers, including limited recognition of pharmacists' roles.

Objective: To tailor an existing deprescribing implementation strategy to support the introduction of deprescribing as part of a CGA (dCGA) in Croatian LTCFs, focusing on healthcare professional (HCP) behaviour change.

Methods: A roundtable was held with Croatian HCPs—general practitioners, pharmacists and a nurse—experienced in LTCF care. Participants first ranked barriers and enablers to dCGA, then engaged in a structured discussion to explore tailored strategies.

Results: Key barriers included limited resources, fragmented data and restrictive policies. Enablers included multidisciplinary collaboration and education. A three-phase strategy (pre-, during, post-MDT) was developed, assigning the head nurse as dCGA lead and positioning pharmacists as deprescribing experts and trainers. Proposed mechanisms targeted priority barriers using Behaviour Change Techniques such as restructuring the social environment, goal setting and feedback loops.

Conclusion: This study co-developed a feasible, context-specific strategy to integrate deprescribing into CGA in Croatian LTCFs. Future steps include pilot testing and evaluation in diverse LTCF settings.

1 | Introduction and Background

Comprehensive geriatric assessments (CGAs) have shown several benefits to older adults residing in long-term care facilities (LTCFs), including reduced falls and improvements in functional status, mental health outcomes and quality of life [1, 2]. Although the components of a CGA may vary depending on individual needs or settings, the domains covered in a CGA are physical, functional, psychological, medication review, social and environmental [3, 4]. Deprescribing can be a component of CGA and refers to the systematic process of discontinuing or reducing the dosage of medications that may be unnecessary, inappropriate or potentially harmful, supervised by a healthcare professional (HCP) with the aim of optimising medication use and improving resident outcomes [5]. Conducting a CGA is a complex process that requires collaboration among various professionals and specialities. In LTCFs, the role of general practitioners (GPs) and nurses in the CGA process is usually well established; however, the contribution of pharmacists to the multidisciplinary team (MDT)

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Plain Language Summary

Older adults residing in long-term care facilities are frequently prescribed medications that may no longer be necessary or beneficial. This study adapted an evidence-based deprescribing implementation strategy originally developed in Ireland to the Croatian context, incorporating local healthcare system characteristics and barriers. A multidisciplinary roundtable involving Croatian general practitioners, pharmacists and a nurse with expertise in long-term care collaboratively co-developed a structured, context-specific approach to safer medication use, integrated within a comprehensive geriatric assessment. The strategy, which designates nurses as care coordinators and pharmacists as deprescribing experts, will be piloted to evaluate its feasibility and effectiveness in practice.

in the LTCF, though documented in the pharmaceutical care research, remains underutilised in daily practice in many countries [6, 7]. Integrating pharmacists into LTCF MDT can optimise therapy, including deprescribing potentially inappropriate medications (PIMs) [8–13]. Pharmacists' involvement enhances the implementation rate of deprescribing recommendations, particularly for medications with safety concerns [8].

When introducing a new service or modifying existing ones in LTCFs, it is highly recommended to incorporate implementation science [9]. By doing so, researchers increase the probability of successful implementation by better understanding the barriers, enablers and stakeholders' insights on strategies for overcoming the barriers and leveraging enablers. Adapting implementation strategies from one setting to another is often complex and remains relatively uncommon in practice. Furthermore, the process of adaptation is not straightforward. It requires careful consideration to maintain the core components of an intervention while modifying aspects to fit new contexts [10]. Research indicates that although adaptation is essential for the success of interventions in diverse settings, it is often underutilised. For instance, a study highlighted that despite the recognition of the value of customising implementation strategies, they are frequently chosen in ways that do not adequately reflect the unique factors of different settings [11].

Barriers and enablers to deprescribing for frail older adults have been explored in both Ireland and Croatia, revealing notable similarities. In both countries, key barriers include insufficient resources, the absence of clear deprescribing guidelines and professional hierarchies in which GPs are viewed as more authoritative than nurses or pharmacists. Conversely, facilitators such as multidisciplinary collaboration and education have been consistently identified as supportive of deprescribing efforts [12–15]. Despite contextual differences, Ireland and Croatia share several structural similarities in their long-term care organisation, such as the coexistence of public and private LTCFs, GPs often covering multiple facilities and the limited integration of pharmacists into on-site care teams [16]. These shared features create opportunities for transferring best practices and adapting successful implementation models across settings. A good example comes from an Irish research group that developed the DEFERAL strategy ('Multidisciplinary Deprescribing Review for Frail Older Adults in Long-term Care'), specifically designed to support HCPs in deprescribing PIMs in LTCFs [13]. The DEFERAL strategy was developed through systematic mapping of identified barriers and enablers to the Theoretical Domains Framework (TDF) and selection of corresponding Behaviour Change Techniques (BCTs), ensuring a theoretically grounded and evidence-informed approach [13]. Its development was further strengthened through national and international stakeholder involvement via Delphi surveys and roundtable discussions, ensuring both consensus and practical relevance. Building upon these international insights, this study aimed to adapt and locally contextualise a similar framework for Croatia. Developing an implementation strategy for deprescribing as part of a CGA (dCGA) would be a milestone for Croatian LTCFs, where CGAs, medication reviews and deprescribing interventions are not yet part of routine practice [16]. The lack of standardised, multidisciplinary approaches to geriatric care and/or medication review within Croatian LTCFs represents a critical gap in care for frail older adults. Previous research conducted among community-dwelling older adults in Croatia highlighted the extent of PIM use [16–22], with over half of the participants identified as candidates for deprescribing [23]. The most frequently identified PIMs were nonsteroidal anti-inflammatory drugs, proton pump inhibitors, opioids and benzodiazepines. Although that study focused on community-dwelling older adults, it underscores the need to develop systematic medication review and deprescribing approaches, particularly in settings such as LTCFs, where polypharmacy and multimorbidity are highly prevalent [23].

1.1 | Aim

The present study aimed to adapt and tailor an existing implementation strategy for deprescribing to support the introduction of the dCGA in Croatian LTCFs, focusing specifically on HCP behaviour change.

2 | Materials and Methods

2.1 | Study Design and Reporting

A roundtable discussion was conducted with HCPs from various disciplines from Croatia who have experience working in LTCFs, ensuring representation from at least one nurse, pharmacist and GP to capture diverse perspectives. This approach was chosen because it allows for interactive dialogue and leads to the development of a consensus-reached implementation strategy. Roundtables unite diverse stakeholders to exchange knowledge, foster collaboration and support developing and implementing evidence-based health literacy practices and policies to improve health and well-being [24]. The roundtable methodology has been successfully utilised in other implementation studies, which have proven to be effective [13, 25, 26].

The Consolidated Criteria for Reporting Qualitative Research checklist was utilised to guide reporting in this study (Table S1) [27].

The study was conducted in accordance with the Basic & Clinical Pharmacology & Toxicology policy for experimental and clinical studies [28].

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2.2 | Identification, Adaptation of Barriers and Enablers and Pre-Roundtable Activities

The roundtable discussion materials were built from the DEFERAL study findings [12]. DEFERAL was developed using the TDF and BCTs to systematically identify barriers and enablers to deprescribing and design corresponding implementation strategies to support HCPs in LTCFs. A summary document was developed for roundtable participants as a pre-reading activity. It included a list of the identified barriers and enablers with definitions, their mapping to relevant TDF domains and the proposed BCTs aligned with each barrier/enabler. This material served to introduce participants to the rationale behind the proposed strategies and familiarised them with the structure and objectives of the forthcoming discussion, ensuring a shared understanding and more efficient strategy co-design [12, 13]. From DEFERAL, five previously validated barriers and enablers (Barriers 1, 5, 6 and Enablers 1, 2) and their corresponding strategies were adopted, as they were considered highly transferable to the Croatian LTCF context. To ensure contextual fit, additional strategies were developed to address barriers specific to Croatian LTCFs. These Croatia-specific barriers were previously identified in research exploring barriers and enablers to deprescribing in Croatian primary healthcare settings [14].

Adaptation involved rewording and refining existing strategies, aligning them with the organisational structure of Croatian LTCFs where GPs, nurses and pharmacists often operate across separate systems, and incorporating new BCTs that promote leadership, communication and interprofessional collaboration. These adaptations were undertaken by the research team, with initial proposals developed by Croatian members based on their contextual knowledge of the national long-term care and healthcare system. The Croatian context and organisational specifics were subsequently discussed in detail with the Irish members of the research team, and the final adaptations were refined and agreed upon through consensus among all researchers. This combined approach provided a structured framework for understanding the underlying factors influencing behaviour change, including psychological, social and environmental determinants of deprescribing practice.

Before the roundtable discussion, participants were asked to rank the barriers and enablers with their corresponding strategies from most to least important. The ranking was conducted using Microsoft Forms, where participants were presented with the barriers and enablers in random order to minimise bias. To maintain anonymity, only participants' occupations were collected. They were also invited to provide direct feedback, comments, or suggestions on the proposed strategies. The final ranking for each barrier or enabler was calculated as an average by dividing the total ranking frequency by the number of participants enrolled in the exercise.

2.3 | Roundtable Discussion Participants

GPs, nurses and pharmacists working in or collaborating with at least one LTCF were eligible for participation; this was necessary so that all participants fully understood the LTCF context. Participants were recruited via the research team's professional network and contacted by e-mail. With this e-mail, they were invited to participate in the roundtable discussion. They were informed in advance about the study objectives, their responsibilities, and the tasks they would be expected to complete. Based on this information, they were able to provide informed consent. The goal was to have two to three representatives from each HCP group, with up to 10 participants.

This study focused on HCP behaviour and implementation strategy development. As such, patient and public involvement (PPI) was not incorporated in this phase, which aligns with findings by Gray-Burrows et al., who note that implementation research 'generally aims to understand and change health professional behaviour' and that PPI in such contexts may risk tokenism if applied without a clear purpose [29].

2.4 | Roundtable Discussion and Data Collection

The roundtable discussion was conducted using Microsoft Teams. It was both video and audio recorded. Two research team members (D.B. and M.O.H., both pharmacists) facilitated the discussion, which was conducted in Croatian. The purpose of the discussion was to explore HCPs' perspectives on the barriers, enablers and whether the implementation strategy would work in their setting in a pre-structured format. They were first introduced to the session's working plan and the results of the ranking activity. Each barrier, enabler and corresponding strategy was briefly described to ensure understanding. Any feedback received from participants was presented to all before the beginning of the discussion on strategies. The HCPs were asked to discuss how the proposed strategy would work in their setting and to discuss each HCP's role in an MDT for the components of the proposed strategy. The strategies were discussed according to the ranking of the identified barriers and enablers, with the most important being discussed first. During the discussion, facilitators made notes that were later used to understand the transcript better. At the end of the roundtable, each participant was asked to choose a barrier or an enabler that was most feasible to implement and explain verbally to all the other participants why.

2.5 | Data Analysis

The discussion was transcribed using Microsoft Teams and proofread by D.B. The transcript was double-checked for verification and thereafter pseudonymised. Researchers read the transcript multiple times to familiarise themselves with the content. Thereafter, a qualitative content analysis was conducted to systematically examine the transcript, which allowed for the identification of recurring themes, patterns and key concepts within the data [30].

2.6 | Ethics Approval

Ethical approval for the roundtable discussion was obtained from the Social Research Ethics Committee at University College Cork (Log Number 2024-034).

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3 | Results

The roundtable discussion lasted 145 min and took place in July 2024. Five of the nine HCPs who were contacted (two general practitioners, two pharmacists and one nurse) participated in this study. These participants had between 4 and 30 years of professional experience caring for older residents (median 10 years, IQR 5–20). The results of the ranking exercise for barriers and enablers are shown in Table 1.

Participants discussed each barrier and enabler during the roundtable, providing specific recommendations for each, as presented in Table 1. These recommendations were analysed, and the final implementation strategy was organised into three phases: pre-MDT meeting, during MDT meeting and post-MDT meeting, based on previous research [13]. Each phase includes several steps with proposed mechanisms and clearly assigned responsibilities for each team member. Table S2 provides a detailed description of each step, as proposed by participants.

A key first step in implementing dCGA in LTCFs is identifying the MDT members—at minimum a GP, nurse and pharmacist—and appointing a dCGA lead. The nurse was seen as the most suitable dCGA lead, given their central role in daily care and frequent residents' contact. The nurse, as the dCGA lead, oversees early stages such as data collection, residents' stratification and prioritisation. The pharmacist supports by providing educational materials and evidence-based deprescribing guidance. In the absence of a standardised prioritisation protocol, resident recruitment strategies vary depending on admission status. During the MDT meeting, the pharmacist will provide and discuss the dCGA plan with other MDT members. After the GP's agreement and the initiation of deprescribing, a nurse needs to monitor for signs of withdrawal from any deprescribed medications (supported by the pharmacist through reviewing documentation in the health record). All changes to the medication plan must be documented appropriately, and data should be accessible to all MDT members.

Finally, roundtable participants recommended that reporting to policymakers and offering evidence of the effectiveness of this additional service in the LTCF would be a valuable component.

During strategy development, BCTs were chosen to address key barriers and enablers identified in the roundtable. These mainly aligned with BCT categories such as goals and planning, feedback and monitoring, social support and environmental restructuring [13, 31].

While the strategy comprehensively addressed the highest-ranked barriers and enablers (Barriers 1–3 and Enablers 1–2), some lower-priority barriers—such as the lack of a standardised protocol (Barrier #4) and hierarchical dynamics (Barrier #6)—were not explicitly addressed in all phases, largely due to feasibility constraints. No formal back-up strategy was developed; however, participants were encouraged to offer feedback and suggest adaptations to the strategy, ensuring flexibility in implementation. A full mapping of barriers, enablers, and their corresponding BCTs is presented in Table 1.

4 | Discussion

Findings from this study's roundtable discussion outlined implementation strategies that overcome barriers and enablers to dCGA in LTCFs and assigned who should be responsible for completing the tasks to facilitate dCGA. Participants identified barriers related to resources, policy and limited accessibility of residents' information as key challenges to implementing dCGA, which have been flagged in previous research [33]. Barriers and enablers to dCGA were mixed across all three phases (pre-, during and post-MDT), which implies that the dCGA process is very complex and that different factors influence each step. This study found that the most significant barriers in participants' daily work are insufficient resources (time, staffing and information technology), lack of complete residents' health record data, absence of standardised criteria for residents' inclusion in dCGA and policy barriers [12, 33]. During this study, participants discussed the burning issue of outdated e-health record systems as part of the resource barrier [34, 35]. In Croatia, HCPs caring for older adults in LTCFs use separate, non-integrated documentation systems. GPs access the national EHR, but not the local nursing system used in LTCFs to record medication lists and daily health notes, which remains inaccessible to other providers. Pharmacists currently lack access to both the national EHR and the nursing home documentation system, leaving them without direct access to individual residents' health data. Participants identified fragmented and incomplete data on medications, health status and other essential information as one of the most critical barriers to performing dCGA. Although policy-related issues, such as the lack of legal frameworks allowing pharmacists to work within LTCFs, were ranked slightly lower, they remain a substantial obstacle to implementation. In contrast to countries like the United States, Canada, the United Kingdom and Australia, where pharmacists are embedded within LTCFs, Croatian legislation does not currently permit their direct employment in these settings. Although current Croatian legislation prevents pharmacists from being directly employed in LTCFs, the proposed strategy remains feasible under the existing framework through collaborative agreements with community or hospital pharmacists. These pharmacists can provide medication reviews, participate in MDT meetings and support deprescribing remotely or through periodic visits, as already practised in some Croatian LTCFs. However, long-term sustainability and optimal integration of pharmacists into deprescribing initiatives will require policy reform to formally recognise and fund their role within LTCFs, similar to models successfully implemented in other countries [36–38]. Addressing both data access and regulatory challenges will be essential for enabling an effective and coordinated deprescribing process.

Previous research has highlighted various types of barriers to deprescribing as the most prominent. Brunner et al. identified uncertainty due to a lack of evidence on deprescribing cardiovascular medications, fear of negative consequences following deprescribing, and social influences as barriers to deprescribing [39]. A study by Okeowo et al. identified key barriers to implementing proactive deprescribing within primary care as negative deprescribing perceptions, limited understanding of HCP roles in deprescribing, as well as a lack of HCP interest

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TABLE 1 | Ranking of the barriers and enablers to dCGA in Croatian LTCFs with mapped strategies and behaviour change techniques.

Barrier/enabler	Example of operationalisation	Rank/Average rank[a]	TDF domain	Intervention type	BCT[b]
Barrier #1: Insufficient resources: time, staffing and IT.	Introduced scheduling tools, streamlined communication processes and clarified roles within the MDT to reduce time/resource burden.	1/2.75	Environmental context and resources	Training Enablement Environmental restructuring	1.1,1.2, 1.3, 1.4, 1.5, 1.7, 2.2, 2.3, 2.7, 3.1,3.2, 4.1, 6.1, 7.1, 8.1, 12.1, 12.5
Barrier #2: Fragmented and/or incomplete data on medications, health status and other essential information about the residents, which leads to insufficient information required to perform the dCGA	Assigned specific MDT roles for data management, implemented standardised consent and ensured shared record access to improve data completeness.	2/3.13	Environmental context and resources	Education Environmental restructuring Modelling	1.1, 1.2, 1.3, 1.4, 1.7, 2.3, 3.1, 3.2, 4.1, 6.1, 7.1
Barrier #3: Policy barriers (i.e., Pharmacist currently not working inside the LTCF [administrative issue], medication reimbursement)	Developed structured reporting to highlight pharmacist contributions, supported regulatory discussions and created external advocacy materials.	3 and 4/3.50	Social influence	Education Persuasion Modelling Enablement	1.2, 1.4, 3.1, 3.2, 7.1, 12.1, 12.2
Barrier #4: No standardised comprehensive protocol exists for identifying and prioritising residents who would benefit from dCGA	Created clear guidance for identifying residents (newly admitted and current residents) using MDT input and clinical judgement.	3 and 4/3.50	Environmental context and resources	Training Enablement Environmental restructuring	1.1, 1.2, 1.4, 2.2, 2.3, 3.1, 7.1, 8.3
Barrier #6: An 'established hierarchy' where GPs are believed to hold a position of superiority compared to pharmacists or nurses.	Assigned leadership roles (e.g., dCGA lead nurse), promoted shared decision-making and reinforced team-based identity.	5/5.63	Social/ professional role and identity	Education Persuasion Modelling	2.2, 2.3, 2.7, 3.1, 3.2, 3.3, 4.1, 5.1, 5.3, 6.1, 7.1, 9.1
Enabler #1: Further education to support the implementation of deprescribing in routine practice.	Provided case-based workshops and evidence summaries from credible sources to build decision-making skills.	6 and 7/5.69	Knowledge	Education	2.2, 2.3, 2.7, 4.1, 5.1, 5.3, 7.1
Barrier #5: Limited practical knowledge and experience in deprescribing	Delivered targeted pharmacist-led training, incorporated clinical examples and practical exercises to build confidence.				
Enabler #2: Multidisciplinary team meetings support deprescribing behaviours and decision-making.	Regular MDT meetings included goal-setting, feedback loops and task prompts to foster collaboration and continuity.	8/6.13	Environmental context and resources	Training Enablement Environmental restructuring	1.1, 1.2, 1.3, 1.4, 1.5, 1.7, 2.2, 2.3, 2.7, 3.1, 3.2, 4.1, 6.1, 7.1, 8.1, 12.1, 12.5

Note: dCGA—deprescribing as part of a Comprehensive Geriatric Assessment; GP—general practitioner; IT—information technology; LTCF—long-term care facility; TDF—Theoretical Domains Framework.
[a]Average rank represents the sum of ranking divided by the number of participants enrolled in the ranking exercise.
[b]BCT—Behaviour Change Technique Taxonomy (Version 1) [31]; TDF—Theoretical Domains Framework [32].

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and confidence in deprescribing [40]. Several other barriers to deprescribing in LTCFs have been identified, including a lack of knowledge and training around the deprescribing process, limited time, breakdowns in communication, concerns about perceived 'abandonment of care', fear of adverse consequences and resistance from residents and/or their caregivers, as highlighted by Robinson et al. [41]. These findings are consistent with the barriers identified in the present study, particularly those related to limited time and staffing, insufficient data and unclear professional roles. Our strategy development process acknowledged these recurring themes and used them to inform the selection of targeted BCTs to overcome these persistent obstacles.

The strategy developed in this study aligns with the 'Four Target Behaviours to Promote a Culture of Deprescribing' in long-term care—that is, relating to having HCPs discuss deprescribing, having shared decision-making with residents and caregivers, careful observation after medication adjustment and documenting information medication use, goals and timelines [42]. Recognising the central role of the MDT in coordinating comprehensive and person-centred care, the strategy produced in this study is structured around the MDT process. It is presented as a three-phase framework—pre-MDT meeting, during MDT meeting and post-MDT meeting—which are discussed in more detail below.

4.1 | Pre-MDT Meeting Phase

An important finding from this study is that different HCPs are needed to form a proactive MDT with each role well described, utilising each one's knowledge and skills to maximise the success of dCGA. The head nurse was deemed in this study to be the MDT member most suitable as the dCGA lead. Nurses play a vital role in daily care and are well-positioned to collect residents' data, provide clinical assessment, monitor residents' responses to medications and therapy changes, identify potential adverse effects, record healthcare utilisation and falls and communicate therapy adjustments to residents, relatives and other staff involved in residents' care. They are in everyday contact with LTCF residents, can observe any slight change in health status and quickly react to residents' symptoms [43–47]. Furthermore, previous research has shown that nurses have led successful deprescribing interventions among LTCF residents [48]. In some contexts, pharmacists or GPs may be better suited to take the lead, especially where they have established relationships with residents and the healthcare team. Therefore, a flexible, context-specific approach to leadership in deprescribing is recommended to ensure the safe and effective reduction of unnecessary medications in older adults [49–52].

4.2 | During MDT Meeting Phase

The main goal of the MDT meeting is to discuss the targeted group of residents and develop a dCGA plan that all MDT members agree on. Among all others, the pharmacist typically has the strongest knowledge of medications, including their harms and benefits, and is recognised as the most competent MDT member to develop the deprescribing plan for individual residents [38, 53, 54]. Within the dCGA strategy, deprescribing is embedded in the medication review component. The medication review represents a structured evaluation of all current therapies in the context of the resident's comorbidities, goals of care and potential adverse effects. When a medication is identified as potentially inappropriate or no longer beneficial, the deprescribing process is initiated as a direct outcome of the CGA. Therefore, deprescribing is not a separate intervention, but an integral part of the CGA aimed at optimising pharmacotherapy and improving clinical outcomes for older adults. The agreed-upon plan must later be discussed with the residents or the residents' relatives to ensure their involvement in shared decision-making [55–58]. The strategic plan proposed in this study emphasises the role of MDT members, which should help overcome the barrier of insufficient time for individuals. BCTs that support this strategy come from three groups: goals and planning, feedback and monitoring and associations [31]. This insight has important implications for designing and implementing future dCGA interventions. Specifically, integrating BCTs from these domains—such as setting shared goals with care teams, providing regular feedback on deprescribing outcomes and using environmental cues to reinforce behaviour—may enhance the acceptability, uptake and sustainability of these interventions in LTCFs. Hansen et al., in their systematic review and meta-analysis of deprescribing interventions for older adults, found that BCTs related to goal setting, monitoring behaviours and providing feedback were among the most effective in reducing inappropriate medication use [59]. Therefore, embedding such behaviour change strategies into future dCGA approaches could improve both clinical outcomes and implementation success.

4.3 | Post-MDT Meeting Phase

The main goal of this phase is to maintain continuous care for older adults and ensure that the MDT decisions are adequately implemented (with residents/caregiver agreement) and monitored. Monitoring for signs of good or poor response to therapy optimisation and deprescribing enables MDT members to track residents' health progress and respond to any alarming signs if the resident is not responding well to medication regimen changes. A pharmacist is recognised as the most suitable for developing a strategy to appropriately respond to clinical symptoms and signs noted by nurses during their daily interaction with residents, since pharmacists' knowledge of medications, side effects and withdrawal symptoms is the broadest of all the MDT members [41]. Additionally, nurses may not have time to develop these strategies, as they have their standard daily tasks, as well as unforeseen situations. It should be noted that pharmacy technicians can play valuable roles in preparing daily unit doses for residents, which may allow more time to facilitate deprescribing [60].

This study's roundtable discussion recognised that a deprescribing report would be an important part of the post-MDT phase for provision to relevant stakeholders and policymakers. All MDT members should contribute to these reports at least annually, and this will allow MDT members to demonstrate their valuable contribution to older adults' health by performing a dCGA. Since this initiative is not financially reimbursed

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in Croatia and surrounding countries, pharmacoeconomic analyses (e.g., cost–benefit) should help LTCFs advocate for introducing dCGA and pharmacy team members in LTCFs. Previous research has already shown positive economic impacts from pharmacist-led deprescribing in several countries [60, 61].

4.4 | Implications for Future Practice, Policy and Research

This study has generated a strategy and recommendations to aid the implementation of dCGA in LTCFs, especially in settings where these practices are at evolving stages.

To successfully optimise and implement dCGA, healthcare stakeholders should consider recognising new roles for pharmacists and pharmacy technicians. Their expertise can reduce the workload of GPs and nurses and improve deprescribing outcomes [62–64].

Outdated EHRs that all HCPs cannot access need to be reviewed and improved. This would facilitate better communication and access to key residents' information, as well as reduce the time required to collect data from different places.

Clinicians and researchers need to advocate for a better working environment and the acceptance of new services (e.g., dCGA) and roles (e.g., pharmacists) within health systems through pharmacoeconomic evidence and evidence on clinical outcomes. These studies can demonstrate the financial benefit of deprescribing, especially if new roles for pharmacists and pharmacy technicians in LTCFs need to be justified.

This study's strategy needs to be tested for feasibility and effectiveness in different LTCFs to ensure that it is transferable across settings based on different LTCF characteristics.

4.5 | Strengths and Limitations

This roundtable discussion study has several strengths. Firstly, it was held between different HCP groups, which ensured diversity in perspectives and facilitated the formulation of a more comprehensive and applicable strategy for deprescribing. Participants discussed the issues according to the ranking of barriers and enablers, allowing more time to discuss in detail the most important issues. Using the roundtable discussion approach facilitated the achievement of a collaborative consensus, which is crucial for developing acceptable and feasible strategies in real-world settings, as it incorporates the insights and experiences of those directly involved in resident care [65].

On the other hand, only a small group of HCPs with varying levels of experience in geriatric care were included in this study. This could affect the dynamic of the discussion by influencing those with less practical knowledge. Pharmacists could only provide theoretical inputs on how the proposed strategies could work since pharmacists are not currently part of the standard care team in LTCFs. Furthermore, the study was conducted in a single country, which may limit the transferability of the findings to healthcare systems with different organisational structures, regulatory frameworks and approaches to geriatric care. However, the strategy could be used as a foundation for other contexts and adapted thereafter, similar to what was done in this study, having used the DEFERAL strategy as a guide. Therefore, while the findings cannot be generalised to all HCPs or healthcare systems, they provide important exploratory insights that may inform future larger-scale studies and guide adaptation of deprescribing strategies in different contexts.

A limitation could be the absence of PPI. However, given the professional focus of this phase, the decision aligns with literature indicating that 'the targeted research users are usually, if not exclusively, health professionals' and that PPI can be difficult to justify meaningfully in this context [29]. Nevertheless, residents' and caregivers' perspectives are essential for deprescribing interventions, as they strongly influence treatment adherence, acceptance of medication changes and the sustainability of deprescribing strategies. Future research should consider including PPI when expanding implementation across broader settings or including resident-facing elements. Their involvement could ensure that proposed interventions are acceptable, feasible and aligned with residents' values. Future research should include resident-relevant outcomes rather than only clinical outcomes, collect residents' feedback following intervention implementation and conduct interviews after testing the strategy to refine and improve it.

5 | Conclusion

This study highlights the complex yet promising process of implementing dCGAs in LTCFs. By developing a structured, three-phase strategy (pre-, during and post-MDT meeting), this research addresses critical barriers and enablers to dCGA implementation. Key recommendations include forming an MDT with clearly defined roles, led by a head nurse due to their frequent residents' contact and ability to oversee initial assessments and resident prioritisation. Integrating pharmacists and pharmacy technicians into the care team is recognised as essential due to their expertise in medication management, particularly in supporting deprescribing efforts and enhancing care efficiency. This structured approach may serve as a practical framework to guide the introduction and optimisation of deprescribing-focused CGAs in LTCFs, particularly in settings where such processes are still in the early stages of development.

Author Contributions

All authors contributed to the study conception and design. Material preparation was performed by Maria D. Donovan, Kieran Dalton, Clara H. Heinrich and Dora Belec. Data collection was carried out by Dora Belec and Maja Ortner Hadžiabdić. Formal analysis was conducted by Dora Belec and Maja Ortner Hadžiabdić. The first draft of the manuscript was written by Dora Belec, and all authors commented on previous versions of the manuscript. Maria D. Donovan, Kieran Dalton, Maja Ortner Hadžiabdić and Clara H. Heinrich contributed to the review and editing of the manuscript. All authors read and approved the final manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Table S1:** Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist. **Table S2:** Proposed strategy for the implementation of the dCGA in LTCFs.

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