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Geriatric assessment in Belgian nursing homes: qualitative insights

Julie Merche[1,2*], Thérèse Van Durme[3], François-Xavier Sibille[1,2], Laetitia Buret[4], Didier Schoevaerdts[1,2], Isabelle De Brauwer[2,5] and Marie de Saint-Hubert[1,2]

Abstract

Background Nursing home residents (NHR) have complex health needs due to their multimorbidity and frailty, challenging interorganisational collaboration, particularly between nursing homes (NH) and hospitals. Coronavirus disease pandemic highlighted the need to strengthen the expertise of NHs care teams. Geriatric mobile teams (GMT) exist in several countries and aim to provide interdisciplinary advice to reinforce the primary care expertise. To develop GMTs in Belgium, we chose a participatory and systemic approach. The aim focuses on identifying areas of partnership between hospitals and NHs based on the geriatric needs of residents, from the perspective of the stakeholders involved in their care. Additionally, it examines the essential requirements for fostering collaboration among these stakeholders.

Method Qualitative study using semi-structured interviews of 20 healthcare professionals working in a Belgian academic hospital or within its affiliated NH network. Themes were extracted using thematic analysis, employing simultaneously an inductive approach for the partnership areas and a deductive approach constructed around Karam's framework of interorganizational and interprofessional collaboration.

Results Participants highlighted the increasing complexity of NHRs' healthcare needs and the crucial role of geriatric expertise in managing behavioural and psychological symptoms of dementia, assessing complex medical situations, and advance care planning. While all supported enhanced collaboration, key challenges included formalizing processes and facilitating care integration between providers. Balancing high-level care with the risk of over-medicalization also remains a critical issue. These findings are reflected in three main themes: empowering nursing homes with geriatric expertise; The high importance of integration and formalisation; and balancing tension between a place of residence and high skilled care.

Conclusion This study provides a comprehensive overview of expected collaboration areas and practical strategies to manage constraints. By using a qualitative approach, we integrated the perspectives of all key stakeholders, ensuring that proposed initiatives align with actual needs. Strengthening collaboration between NHs and geriatric services requires formalized frameworks and co-designed protocols with frontline caregivers. Such an initiative has the potential to dismantle compartmentalized care pathways for NHRs.

Keywords Nursing home, Residential facilities, Geriatric assessment, Qualitative research, Mobile health unit

*Correspondence:
Julie Merche
julie.merche@chuuclnamur.uclouvain.be

Full list of author information is available at the end of the article

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Background

It is well known that, similar to the trend of population aging in Europe, Belgium faces a growing proportion of older adults and an increasing demand for nursing home (NH) beds. Between 2020 and 2040, the ageing process will accelerate due to an increase in life expectancy and the effect of the baby boom that occurred in the 1960s. This demographic shift will therefore inevitably impact nursing homes, with a significant rise in the number of residents from 2030 onward and a doubling by 2070 [1]. Belgian projections indicate that an additional 1,800 to 3,000 beds will be needed each year, with an even greater demand anticipated from 2025 onwards [2].

Nursing home residents (NHRs) often have complex care needs, due to the high prevalence of multimorbidity, frailty and dementia among this population [3–6]. The medical aspects are also intertwined with psychological, functional, and social issues [7, 8], requiring coordinated medical support. Moreover, when interprofessional collaboration is insufficient, the management of complex NHRs situations becomes inadequate and leads to a risk of underuse and misuse of medical services [4].

In Belgium, NHRs are afforded the freedom to select their own general practitioner (GP). NHs are required to designate a coordinating physician: a general practitioner responsible for organising continuity of care, formalising policies and coordinating processes that support the quality of NH care, without being directly involved in the treatment of the residents [2]. Coordinating physicians collaborate with a coordinating nurse.

Currently, in Belgium and several other European countries, geriatric expertise requires a visit to the hospital. However, consultations are often challenging to arrange for these NHRs due to transportation difficulties constrained by impaired mobility or the lack of accompanying providers or relatives [9]. NHRs are sometimes admitted to Emergency Departments (ED) because of an acute event that could not be adequately treated within the NH environment. Unfortunately, ED may be an inappropriate care environment for NHRs given their atypical presentation [6–8, 10], and communication barriers. In particular, NHRs may experience difficulties in verbalizing their health concerns due to acute or chronic cognitive impairment [5, 6]. These emergency admissions have an annual incidence of up to 20%, sometimes leading to unplanned hospitalisations [11, 12]. Such hospitalisations are associated with a number of adverse outcomes, including an increased risk of mortality, falls, fractures, pressure wounds, medication errors, delirium and iatrogenic infections [7, 8, 10, 12–15]. Previous studies reported that these unplanned admissions could be avoided in 10–30% of cases, which raises questions about alternative forms of care for this specific population [5, 12, 16]. Some of these admissions could be avoided by anticipating NHR's health deterioration through careful advanced care planning. Conversely, quality of care is jeopardised by the low nurse-to-residents ratios and a high staff turnover, which could lead to undesirable hospital admissions [17]. For all these reasons, providing care for NHRs poses a substantial challenge for primary and in-hospital healthcare professionals (HCPs) while also raising public health concerns related to care planning and costs [13, 18].

Interprofessional collaboration is essential but remains insufficiently structured in primary care settings. Fostering interprofessional and interorganizational collaborative working practices is key to improving the quality of care for NHRs [13]. On-site assessments by a specialist geriatric mobile team (GMT) at NHs could be an appropriate and innovative solution for NHRs. Geriatric assessment, through early and comprehensive evaluation followed by integrated intervention, can prevent and reduce adverse outcomes [8, 19]. In Belgium, a geriatric care program has been implemented which includes in-hospital geriatric mobile teams. The objective of these teams is to provide geriatric expertise to older adults admitted in general medical and surgical wards [19]. However, the recent establishment of a reimbursement code by the National Institute for Health and Disability Insurance encourages the provision of geriatric consultations in nursing homes. Yet, there is currently no structured organisation for geriatric assessment and intervention in primary care settings in Belgium. The role of a GMT in NHs remains unexplored, and the specific needs and collaboration expectations of stakeholders for such an initiative have not been systematically assessed.

This study is crucial as it lays the groundwork for the development of an out-of-hospital geriatric mobile team in Belgium. By identifying stakeholder needs and defining key collaboration areas, it aims to provide essential insights to build the future GMT.

Method

Study design

A qualitative method involving semi-structured interviews was employed, as this is particularly suited to explore the rich perspectives of HCPs about how to improve NHRs' health by the means of a future GMT [20]. The Consolidated criteria for Reporting Qualitative research (COREQ) guidelines for writing qualitative research reports were followed [21] (See Additional file 1). Standards for Reporting Qualitative Research (SRQR) were also used [22] (See Additional file 2).

Sampling strategy

The study took place between May 2021 and November 2022 in a tertiary care hospital, in four NHs, and four general practices. The four NHs have an official agreement

with the included tertiary hospital. A purposive sample was selected by the network used to collaborate with the geriatric team of the hospital to represent the diverse profiles of professions, ages and experiences found in the field (Table 1). They are therefore the ones who are first likely to request and benefit from the GMT intervention. To ensure the collection of highlighted opinions, a minimum of two years' experience was required. Participants were contacted by phone or e-mail and gave their written informed consent after receiving oral and written information. Ten interviews were initially planned, but the sample size was increased to reach code saturation [23].

Data collection

Semi-structured interviews were conducted in the participants' workplace. The interview guide was based on a literature review and the content was discussed during several team meetings between Julie Merche (JM), Marie de Saint-Huber (MSH) and Thérèse Van Durme (TVD) (See Additional file 3). The interview guide was tested with a nurse from the hospital and needed no adjustments. The guide remained adaptable and responsive to emerging ideas. The main author, JM, geriatrician, conducted the interviews, which were audio recorded with the verbal consent of participants. The interviewer took notes in a field report during and after the interview and also used a reflective diary.

Data processing and analysis

All interviews were transcribed verbatim and anonymised. Participants were provided access to the transcripts upon request. Subsequently, all content was entered into NVivo software (version 1.7.1) to facilitate the coding process. The thematic analysis was conducted by JM using a dual approach. The decision to use both an inductive and deductive methodology is linked to the two components of our research project. The initial approach aimed at emphasizing the needs and expectations of collaboration, using a inductive approach, allowing participants to express their views freely without preconceived notions [24]. JM engaged in repeated immersion in the data and established codes that were discussed regularly with a geriatrics expert (MSH) and a senior qualitative researcher involved in primary care projects (TVD). All codes were then organised into themes. As new themes emerged, a targeted review of the literature was conducted in order to clarify any additional questions based on the emerging themes. This approach enabled us to identify emerging themes directly from the data. In contrast, for the determinants of collaboration, we started with a deductive approach, using a conceptual theoretical framework to guide our initial questions and analysis [25]. Based on their relevance for the requested characteristics of the collaboration, five key elements were selected to define pre-established themes: shared objectives, communication, mutual knowledge and power, formalisation, and environment. While some codes were already anticipated, others emerged inductively as we engaged with the data, allowing us to remain open to new insights from the field experience. This combined approach allowed for a flexible yet structured analysis, incorporating both grounded discovery and theoretical validation.

An iterative process of data collection and analysis was used; the data collection process was terminated when no new themes emerged. Descriptive saturation of the data was achieved as the last four interviews did not reveal any new code [23].

Table 1 Summary of participants' characteristics

		Number of women	Age range (years)	Experience (years)	Experience in the care of nursing home residents (years)	Speciality	Initial in the text
Working in hospital (*N*=9)	Doctors (*N*=4)	2	34–53	9–28	6–25	Emergency physicians: 2 Geriatricians: 2	EP Ger
	Nurse (*N*=3)	3	43–54	20–33	7–19	Day hospital: 2 Internal geriatric mobile team: 1	Nurse_H
	Pharmacist (*N*=1)	1	39	16	12	Clinical pharmacist	Phar
	Director (*N*=1)	1	38	15	5	Executive Director: 1	E_Dir_NH
Working in NH (*n*=11)	General practitioner (*N*=5)	2	33–72	8–44	8–44	General practitioner: 3 GP coordinators: 2	GP Coord_GP
	Nurse (*N*=3)	2	42–59	13–23	7–19	NH coordinators: 1 NH nurses: 2	Nurse_C_NH Nurse_NH
	Director (*N*=3)	2	41–50	18–29	2–20	Director: 3	Dir_NH

GP general practitioner, *NH* nursing home

The executive director coordinates the strategic and operational management in the four NHs

The GP coordinator in NH organizes multidisciplinary consultation, implements care policies in the NH and participates in the organisation of continuing education within the NH

Ethical approval

All methods were performed in accordance with relevant guidelines and regulations. The study was approved by the local Ethics Committee of the CHU UCL Namur University Hospital in May 2021 (NUB0392021000022).

Results

Characteristics of participants

Eighteen interviews were conducted, a total of 20 participants were recruited and all agreed to be interviewed and audio recorded. They included two geriatricians, five general practitioners of whom two were coordinating physicians, two emergency physicians, one hospital pharmacist, three geriatric nurses, one nurse coordinating care in NH, two NH nurses, three NHs' directors, and one executive care director. The executive care director, based in the hospital, oversees strategic and operational management across these four affiliated NHs. Among the members of the multidisciplinary geriatric team, we chose to include a pharmacist in our sample due to the well-known issue of polypharmacy in NHs. The interviews lasted between 39 and 96 min, with an average duration of 52 min. Their characteristics are shown in Table 1.

Main findings

Participants acknowledged that NHRs have increasingly complex healthcare needs. The key areas in which specialist expertise is required and currently missing are those in which the expertise of a geriatrician is particularly valuable. The three main concerns were the management of behavioural and psychological symptoms of dementia (BPSD), the ability to provide a different perspective on complex medical situations, and the capacity to engage in discussions about advance care planning. Although all participants are in favour of increased collaboration, two key challenges in the process were highlighted and described as currently lacking: formalising the processes to bring the needed geriatric expertise into the NH and facilitating care integration between providers and institutions. Another important finding was that the challenge of balancing the need to provide care for NHRs within the NH with the risk of over-medicalization remains a key issue, one that is intertwined with the underlying care philosophy, the level of nursing advanced skills, and the logistical considerations.

Accordingly, we have developed three main themes: (1) Empowering nursing homes with geriatric expertise for specific topics; (2) The high importance of integration and formalisation; (3) Balancing tension between a place of residence and high skilled care.

Figure 1 offers a comprehensive overview of the findings.

Empowering nursing homes with geriatric expertise for specific topics

Participants described areas of interest for collaboration, as primary care in these specific topics is sometimes insufficient to meet the needs of NHRs and caregivers.

1. Behavioural and psychological symptoms of dementia

The most prominent difficulty reported by participants working in NH including GPs was the management of BPSD, expressed in the terms of agitation, wandering or aggressive behaviour. BPSD not only disrupt the daily routine of work and required human resources that are already scarce but are also difficult to handle on an emotional level. Finally, despite the willingness expressed by some not to discriminate residents, NH directors confided that this could be a reason for not admitting older people with BPSD, especially when the number of NHRs with BPSD is already high.

> *Here, we have a combination of "ordinary" older people, who show a normal ageing process, and people who belong more to the psychiatric category... we have a wide mix in nursing homes, and it's this mix that sometimes doesn't work out. (Dir_NH-L)*

With the exception of geriatricians, all participants expressed a lack of appropriate training in BPSD management, encompassing both non-pharmacological and pharmacological interventions. Consequently, there is a tendency towards frequent prescription of benzodiazepine and antipsychotics medications, chemical restraint being often favoured over physical restraint. Participants raised concerns about NHs adequate infrastructure for NHRs with BPSD, including issues related to the safety of staircases and open units. Specific units for such NHRs are scarce and cannot accommodate all NHR who would benefit from them. Participants highlighted the absence of support for care, particularly concerning mental health networks. They pointed out a limited access to psychogeriatric units and the absence of available mobile teams providing bedside specialist expertise. Hospitalisation of NHRs with BPSD is sometimes viewed as the sole option to alleviate the burden on NH teams, albeit with limited anticipated benefits while shifting the burden onto other caregivers.

> *They ask for hospitalisation to unburden the team now, are geriatric services the most appropriate when you see that the hospital's teams are already suffering... I don't think so... we've already done it, we'll continue to do it though... we know that these*

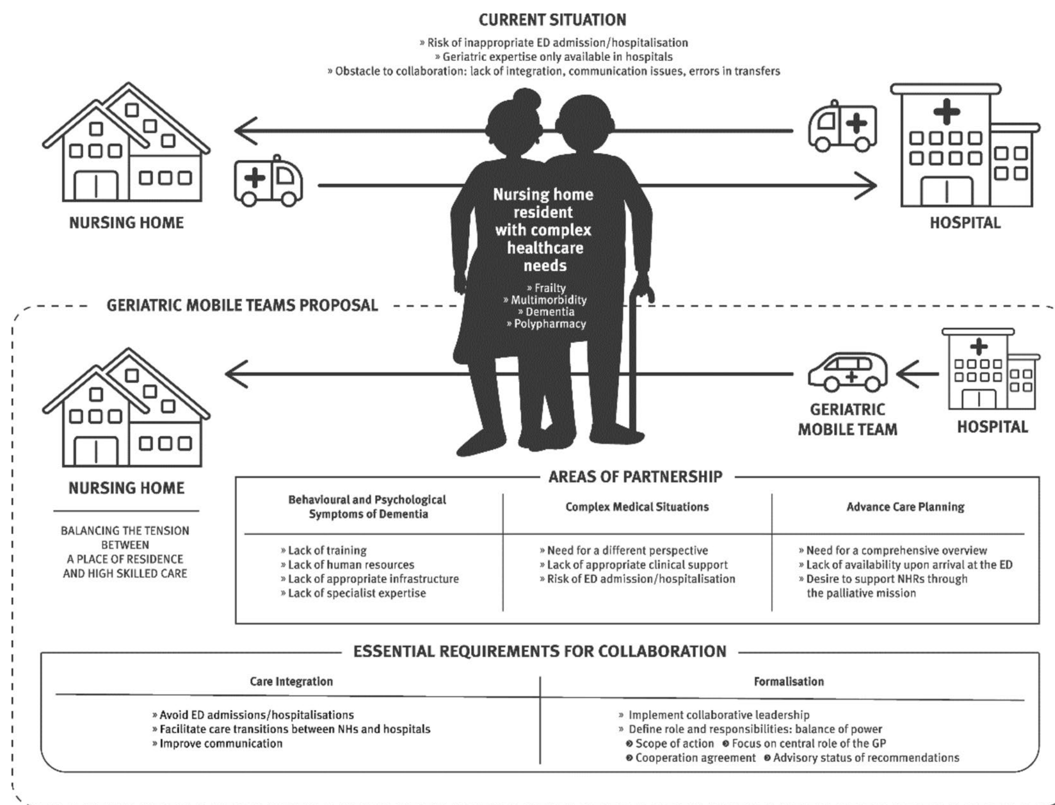

Fig. 1 Comprehensive overview of the findings. ED: emergency department– NH: nursing home– GP: general practitioner

> *patients, taking them out of their environment... it's not going to help... (Ger-G).*

All participants mentioned the potential advantages of mobile specialty team interventions to provide on-site support, with the aim of potentially preventing admissions.

> *It's always an expedition to leave, to be uprooted, to go and see the geriatrician. so, it's true that if a team intervened for this type of dementia, personally I'd find it really interesting. (GP-K)*

2. Complex medical situations

All the GPs interviewed reported the benefit of having "*A different expertise or a different perspective*" (GP-J) when dealing with complex cases, such as those involving polypathology, pain management, or ethical issues. In some instances, hospital admission is viewed as a means of addressing these complexities. However, some NHRs refuse to be admitted to hospital, leaving GPs alone with their questions and a feeling of helplessness. Meanwhile, hospital admission is often an unscheduled referral through the emergency department. Emergency physicians feel that certain scenarios could have been anticipated; they regret what they term an "inappropriate use" of ED, justified by a perceived urgency in the absence of an acute medical condition.

> *What bothers us the most is, well, the assessment of general state deterioration on a Friday at 6pm, all of a sudden there's a notion of urgency. (...) It's situations that have been dragging on for several days and all of a sudden, there's a change of team or the family drops by and someone says, 'that's not possible'. And then, it's all hands-on deck, they send the patient to the emergency department. (ED-Q)*

Specific areas of collaboration highlighted by the participants were related to prevention and management of typical geriatric syndromes, such as falls and polypharmacy.

> *Treatments are a problem in NHs; there are far too many tranquilizers, hypnotics, and whatever else is prescribed, um... it would be worth thinking about it... As a coordinating physician, I have nothing to say! I have to gently suggest and possibly discuss it a little with the colleague. (Coord_GP_I)*

There is an interest in regular interdisciplinary meetings with the NH HCPs, in addition to individual NHRs consultations. The participants postulated that a GMT could prevent hospital admissions by taking preventive

measures. It was evident that geriatric assessment in the place of residence could avoid long, potentially uncomfortable, and costly journeys for NHRs.

3. Advanced care planning

According to participants working in NHs and GPs, the redaction of advanced care planning has become more common since the Coronavirus disease (COVID-19) pandemic. Despite these efforts, participants from hospitals note that such plan are seldom available within the NHRs' files during their transfer to the ED. They believe that the discussion around advanced care planning should take place between the GP and the NHR and/or family, with a particular focus in defining the intensity of the treatments. Yet, the context of the ED is unfavourable to this process. That being said, in the absence of any available information, participants agree that ED staff needs sometimes to initiate palliative care: e.g., in the context of an acute event that could not be anticipated, a lack of medical support (especially during the night and weekend shifts), a disagreement between family and NH teams concerning treatment intensity, or uncontrollable symptoms. The support of a GMT in collaboration with the GP is mentioned by a majority of GPs when they are "*snowed under*" (sic.) and struggle to gain a comprehensive overview of the case, or to make the appropriate decision regarding the initiation of palliative care.

While palliative care is implemented, NHs and GPs can rely on the 'palliative care platform', which employs specialty palliative care providers and could offer support and advice onsite. At the end of life, NHs' HCPs emphasised their desire to support NHRs:

> *Our teams are trained to provide palliative care and are ready and so, the palliative mission, from the moment it's clear, they carry it out and they're not afraid. (Dir_NH-F)*

The high importance of integration and formalisation

Interviews with participants have pointed out several conditions and concerns that should be addressed for a smooth collaboration. These include the appropriate integration of geriatric teams into the NH and the need for collaborative leadership.

1. Care integration

The participants from NHs and hospital emphasised their predominant independence in their work routines and the lack of integrated care: they operate mostly in silos. In instances where the health status of NHRs deteriorates gradually, they often experience a cycle of referrals between specialists or transfers between hospitals and NHs. GPs occasionally encounter challenges in synthesising diverse medical opinions and gaining a comprehensive understanding. Many participants shared their experiences of challenging hospital stays for NHRs, which entail risks such as delirium, falls, and an increased mortality rate. It is imperative to consider the appropriate indications and to conduct only the transfers that align with the specific needs of the NHR "*The right care at the right time*" (Dir_NH-B).

Another advantage of integrating GMT into the NH is the removal of obstacles to the transition between institutions. Communication barriers such as limited time, the challenge of identifying the appropriate contact person, loss of information exchange reports, delays in hospital report transmission, are among the factors that contribute to the complexity of care transitions. The use of onsite/face-to-face, committed, two-way communication is considered as a means of supporting mutual acquaintance, facilitating exchanges, and enabling more realistic expectations of each other.

> *By being on site, we would have had a direct relationship with the nursing home by explaining, by advising them, by saying there's no judgment but we're here maybe to help you give pointers because we have geriatric training with us, the information would perhaps go down better than by saying it over the phone for example. (Nurse_H-C)*

Participants suggest that GMTs could facilitate care transition by screening main problems,

> *We plan examinations in advance, so as to reduce hospitalisation time. (...) Perhaps we can also better target the cases that will go to the outpatient clinic. (Nurse-A)*

thereby avoiding unnecessary visits to the emergency department.

2. Formalisation

Young GPs are more inclined to advocate for collaborative leadership than their older counterparts. The GMT is conceived as working in collaboration with the GP, HCPs in the NH and the NHR. The GMT should at least consist of a geriatrician and a nurse. Other (para)medical staff (psychiatrist, psychologist, pharmacist, etc.) could be involved if necessary. Defining roles and responsibilities is crucial for success. One GP stated: "*I defend the central role of the general practitioner*" (GP_J), expressing concerns about the potentially excessive autonomy of the GMT. As orchestrators of integration, GPs wish to keep their central role in care coordination. This approach

enables consensus by integrating contextual factors, patient history, and geriatric expertise. A cooperation agreement should be drawn up, defining the scope of action, the contact points, the timeframe and the decision-making autonomy of the team.

> *I think we simply need to define the areas of intervention because if there's an overlap between the GP's turf and that team [it will not work]... If territories and competencies are well defined, the whole problem is solved. (Nurse_C_NH_H)*

All GPs must be informed and have given their consent for the GMT consultation. The coordinating physician must agree if it is a general topic. The request could be made by phone. Half of the participants asked for a quick response time, i.e. a visit within 24 h; while the other half suggested a visit within a week, depending on the nature of GMT evaluation. The date of the visit should be communicated. The GP should receive verbal and written feedback as soon as possible. GMT must function as the second line of care, operating in an advisory capacity, and work in partnership by valuing the abilities and autonomy of local teams and strengthening their geriatric skills.

> *You have to trust the people on the front line, in their abilities (...) it's not always the hospital that will bring the best than the other. (Ger-G)*

GMT's recommendations should be advisory, with the ultimate decision resting with the GP, the patient's primary healthcare referent outside the hospital setting.

> *We've done a lot of work on explaining to GPs the reasons for our decision to change a treatment(...), that changes everything for the GP, we work with him, he has the details to decide, I've already had positive feedback. (Pharm-P)*

Circumventing the GP risks undermining their trust and support for the recommendations. Geriatric and NH nurses and geriatricians mentioned the possible utility of GMT in mediating communication in some difficult situations, as a third party. Opinions were divided. This topic perfectly demonstrated the concerns about territorialities. GPs, coordinating physicians, and coordinating nurses, despite expressing interest in seeking an external opinion, emphasised the importance of a diplomatic approach, to avoid disqualification, particularly considering the case of a disagreement with a NHR's family.

Some fears are manifest: hospital/geriatric nurses are reluctant to be accused of making judgments, geriatricians are afraid that GPs will accuse them of stepping on their toes, GPs are suspicious of hospital institutions, and coordinating physicians are afraid of overlapping tasks.

> *It's not easy to set up a team like this because there are basic rivalries between general and specialist medicine. GPs have this fear, the fear of not being appreciated, the fear of being overpowered, the fear of not being recognised, the fear of being rejected. (GP-K)*

The fear of losing control juxtaposes with the sometimes overwhelming demands for availability of GPs, especially for unscheduled care.

> *I have patients there who are in palliative care, who have multiple pathologies, who I should be going to every week... every time it's always a tug-of-war between the nurses who ask, myself who tries to postpone, to procrastinate... I'm overwhelmed (GP-K).*

The commitment of the GP and the GP on duty called by a team in distress varies. Sometimes he does not come to the NH but sends the NHR directly to the ED.

> *So, this is a reality, but it's by no means a generality, it exists, it can happen. We've had situations where the doctor says he's going to come, and he doesn't show up" (Dir_NH-F).*

Some participants criticised the fear of short-circuiting GPs in this context.

> *I don't know if it's a sensitive topic, but they're very susceptible in general practice. They're ambiguous(...) They want their independence, (...) they don't want unscheduled care, but they want to be the referent. (ED-Q)*

The geriatricians warned that the GMT cannot be a substitute for the GPs. They are not staffed and qualified for this role. The position of the GMT needs to be defined in the light of these issues and the potential risk of GPs becoming disengaged.

Balancing tension between a place of residence and high skilled care

The participants have raised the existence of tensions between the NH and hospital environments, that are related to resources and cost constraints, as well as the NHRs' need for skilled care while being in a place of residence.

Indeed, implementing a GMT in a NH requires a comprehensive understanding of the NH environment.

Some participants view the medicalisation of NHs positively, particularly in response to the increasing complexity of care needs, while others are against it "*The nursing home, it must remain a place of life and not be a continuation of the hospital".* (Ger-G).

Moreover, inadequacies in terms of infrastructure, equipment and staff - including the availability of GPs - are often mentioned. Besides functional aspects, participants stressed that normative elements should be integrated in the thinking process: government policies, expected level of technical skills, professional image, ageing perception, etc. The problems encountered by NHs repeatedly extend to the hospital, which at times finds itself overcrowded.

Funding is critical to the quality of care in NHs, raising questions about who will cover the costs of GMT. While GMT is seen as a promising opportunity for cost savings within the health system, through preventing unnecessary admissions and hospitalisations, this is not the case for the hospital who invests in GMT. Participants stressed that there is a need for adequate compensation for geriatricians and their teams when working outside of the hospital setting. There is currently no such plan in Belgium and the current funding framework does not allow for such initiatives.

> *To remunerate expertise, you have to enter into a hyper-rigid framework of consultations, codes, etc.: and I think we're not creative enough with field reality (...), there's still a part of the work that's done over the phone and, well, without being able to put a value on our consultations and without wanting to chase after money, there comes a point when hours are really lost! (Ger-E).*

Discussion

Our findings highlight critical challenges in nursing home care, summarized into our three themes: (1) Empowering nursing homes with geriatric expertise for specific topics, (2) The high importance of integration and formalisation, and (3) Balancing tension between a place of residence and high skilled care. Participants unanimously acknowledged the growing complexity of NHRs' healthcare needs, calling for specialized support in management of behavioural and psychological symptoms of dementia, complex medical cases, and advance care planning. Our study also highlighted key conditions for a smooth and successful collaboration: the needs for care integration and the use of formalisation for balance of power. A deep understanding of structure, resources and processes of each actor, associated to the integration of normative elements, is mandatory for balancing tension between high skilled care without over-medicalisation in a place of residence.

GMTs consulting in NHs have been set up e.g. in France, Switzerland, Italy, Sweden, and the United States of America. Their intervention, aims to provide interdisciplinary expertise to guide the HCPs in establishing a care plan for the resident [26, 27]. The management of *behavioural and psychological symptoms of dementia* emerged in our study as a significant challenge. Our findings are consistent with the literature: BPSD are at the top of the list for the use of existing GMTs, accounting for 75 to 85% of interventions [7, 26–29]. Requests include clinical assessments and therapeutic advice, as well as support for HCPs [28, 29]. It has long been described that understanding the underlying pathology and having a care plan improves the ability to deal with behavioural problems [30]. Intensified on-site care can reduce the severity of BPSD and prevent the necessity of hospitalisation, which is particularly prone to iatrogenicity (restraint, medication errors) [28–31]. This urgent need for psychogeriatrics is linked to the lack of coverage of the mental health network in the NHs [28, 29].

Having a different perspective on complex situations is stated as a need in our study, as in the literature [26, 27]. The multidimensional health aspects of NHRs require a multidisciplinary approach to avoid complications [15, 18]. Integrating health problems reduces medical and medication errors [7, 15]. As in our study, polypharmacy is a major concern in NHs. A Belgian study reported common inappropriate prescribing practices towards NHRs with ten drugs [32]. In Australia, a multidisciplinary case conference and, in Hawaii, a geriatrician review, both advocate to improve prescribing appropriateness [31, 33].

Our study debates the need for external support in the *discussion about advance care planning* or end-of-life support. Improvement is needed in optimizing tools and addressing NH barriers like unclear responsibilities, timing of discussion, and family involvement. The PACE study, which examined the quality of end-of-life care in NHs in six countries, including Belgium, showed suboptimal management, whether in terms of knowledge of uncomfortable symptoms and their treatment, or the risk of hospitalisation [34]. A GMT could focus on these issues. In comparison to community dwelling patients, there is a greater inclination for NHRs to finish their lives in their place of residence [19]. Cardona-Morrell et al.'s systematic review underscores the intricacy of systemic and clinic causes of avoidable admissions at the end of life, emphasising the need for accessible alternative medical advice [35].

Integrating geriatric teams directly into NHs can enhance HCPs knowledge and confidence while supporting continuity of care. The GMT is considered a crucial communication tool during periods when this continuity is most threatened, i.e. *care transitions*. Communication

quality influences care transition in inter-organisational collaboration [25]. Care transitions are complex, involving various aspects: safety, timing, effectiveness, and a goal-oriented care [5]. Considering NHR's wishes and values through shared decision-making is essential [8, 18, 19]. The transmission of information between hospitals and NHs is not optimal and can lead to avoidable admissions and increased mortality [5, 8, 10, 15]. The care pathway for older adults needs to be coordinated [7, 13], with a priority on collaboration between hospital and primary care settings [11, 25]. Lack of coordination and fragmented services harm NHRs with comorbidities [6, 18, 36]. As part of a care pathway approach, by creating a new connection, GMT can bridge the gap between hospital on one side and NH on the other [8, 27, 37]. Existing GMT can assist the GP and help avoid or facilitate hospitalisation [7, 26–28]. However, demonstrating the ability to prevent hospitalisation is challenging. Two systematic reviews have examined interventions aimed at reducing hospitalisations, with contrasting results [14, 38]. This heterogeneity is mainly attributed to the different configurations of the interventions, and of course, to the chosen definition of the 'avoidable' term [14].

In addition to the one-off comprehensive geriatric assessment for diagnostic and therapeutic advice for a specific patient [7, 26], some French GMTs offer multidisciplinary thematic training with topics such as dementia or treatment review. [26]. Regular attendance helps to spread geriatric culture and create informal relationships and can also provide advice in the event of a crisis [3]. Younger GPs valued additional perspectives and expertise in complex cases. The new generation of physicians has received training in geriatrics and palliative care, making them more open to collaborative care models. GP's availability, commitment, and skills in managing older adults vary [3], hindered by time constraints and organisational efficiency concerns. Inconsistent involvement of doctors on duty and unfamiliarity with patients complicate the decision-making process [6]. However, GMT and GP have complementary roles, the GMT will never be a substitute for the coordinating physician or a GP who is absent. While the presence of a geriatrician in the NH has reduced hospital admissions in Switzerland [39], and prevented the risk of functional decline in the SHELTER study [40], its feasibility on a large scale is debated [39]. The number of geriatricians, a speciality in short supply in France and Belgium, does not allow for such an approach [3]. Our study underscored the importance of *defining roles and responsibilities*, establishing communication channels, and fostering *collaborative leadership* to facilitate effective teamwork between different healthcare providers and institutions. The collaborative procedures proposed by the participants are similar to those used by foreign teams: responsiveness through a hotline [7, 26], availability within 48–72 h without an emergency intervention [7, 26, 27], geriatrician-nurse team and multidisciplinary team when necessary [26, 27], communication of intervention times [27, 41], rapid transmission of the report and telephone feedback to the GP [26]. In our study, the need for territorial clarification is strengthened by the GPs' fear of losing their central role. The COME-ON project, which focused on optimising NHRs medication, reported a similar fear among GPs who did not want to lose their freedom to prescribe [42]. In a Swedish GMT, the patient could reach out to the GMT directly, which led to confusion about everyone's role and who to contact in certain situations [37]. To meet this challenge, but also reduce the fear of GPs' disinvestment, our participants suggest positioning the GMT as a second line resource, acting at the request of the GP to support the existing team. In most foreign GMTs, the GP decides on the call and prescribes the recommendations [26, 27]. This partnership increases their satisfaction, reduces opposition and improves adherence to suggestions [3, 26, 27].

Inter-organisational collaboration requires the consideration of the political, social and economic *environment* [25]. Our study reveals a profound tension between the medicalisation of care and the maintenance of a pleasant living environment. Easier access to intravenous treatments, tests and specialist's advice are described as a perspective to reduce emergency admissions [6], but quality of care must be balanced with quality of life [15]. Our findings show a need for better expertise and knowledge in geriatric care and also indicate a keen interest in training and the promotion of geriatric culture. The normative environment within NH allows for a learning culture that is less prominent than which is observed in hospitals [3]. Training initiatives like the IQUARE study in France demonstrate positive impact on emergency admissions and awareness of geriatric syndrome [11]. Catheter-related incidents (intravenous and suprapubic catheters, gastrostomies, etc.) often lead to ED admissions, as NH nurses are often unfamiliar with these devices due to their infrequent use. Access to intravenous treatments or technical care, as seen in the United States of America [5] and Italy [10], can reduce hospital admissions. Implementing mobile radiography services offers timely diagnosis without disruption to NHRs [43].

The lack of recognition of frontline expertise by hospital participants was identified as a major difficulty in this study. NHs' professions are undervalued by HCPs and society [8, 19, 44]. Beyond the profession itself, it is also about the negative image of ageing [7, 19, 44]. This negative representation should be countered by a positive message about the complexity of care in these difficult conditions (absence of a permanent medical practitioner, lack of a technical platform, heavy workload), and in the

daily confrontation with dependency, suffering, illness and death. Both hospital and NHs face similar problems regarding to staffing, training and financial resources, which affect care delivery [3]. Improved understanding of each other's environments and skills between geriatric teams and NHs is beneficial [15], enabling tailored care delivery aligned with available resources and practices [41]. Recognizing the work of each team member is essential; for example, the lack of professional recognition and appreciation for nurses was experienced as a traumatic event during the pandemic [45].

Funding for GMTs needs careful consideration of resources. Fee-for-service systems complicate integrated approaches. Evaluating multifactorial intervention requires a multimodal assessment [11, 14], with qualitative and quantitative analyses covering aspects like the number of interventions, recommendations made and the follow-up, hospitalisations or ED admissions reduction, rehospitalisation and mortality, costs avoided, quality of life, training of HCPs, patient and staff satisfaction, etc. [3, 14, 26]. The indicator "reduction in health care consumption" should be considered cautiously, as a Swedish study showed that a GMT intervening in the home led to an increase in hospital admissions and GP-patient contacts, indicating greater attention to health issues and more appropriate follow-up of problems [13].

By employing semi-structured interviews and a dual analytical framework—combining inductive thematic analysis with a deductive model based on Karam's interorganizational collaboration framework—this research aimed to identify key areas for geriatric expertise and potential barriers to interdisciplinary collaboration.

A significant strength of the methodology was the purposive sampling strategy, which ensured diversity in participant backgrounds, covering various HCPs working in hospitals, NHs, and primary care. This approach facilitated a broad yet detailed understanding of the practical challenges and expectations surrounding GMT implementation. The study adhered to rigorous qualitative research standards, including COREQ and SRQR guidelines, ensuring transparency in participant selection, data collection, and analysis. The study's contextual setting, involving a tertiary care hospital, affiliated NHs, and general practices, reflects the real-world interdependencies between hospital-based geriatric expertise and primary care settings. The inclusion of a wide range of HCPs, from geriatricians to NH directors, enriched the analysis by capturing multiple perspectives on care coordination, expertise dissemination, and potential workflow integration for GMTs. The data collection process was iterative, with interview themes evolving based on emerging insights. This adaptability enhanced the study's credibility and trustworthiness, as it allowed for refinement of the questions to capture nuanced perspectives. The use of NVivo software for coding and triangulation with senior researchers further strengthened the analytical rigor, ensuring that findings were not solely influenced by the lead researcher's background.

However, the study's methodology also presents certain limitations. While efforts were made to ensure sample diversity, participant recruitment relied on professional networks, potentially introducing selection bias. Although saturation was achieved, perspectives from non-affiliated NHs or other healthcare regions in Belgium may differ. Another potential limitation stems from the interviewer's professional background—as a geriatrician, the primary researcher may have unintentionally influenced participants' responses. This was mitigated by cross-validation with qualitative research experts and reflective field notes. Another methodological challenge was the balance between inductive and deductive approaches in data analysis. While the use of Karam's framework provided a structured lens for interorganizational collaboration, the evolving nature of interview data necessitated an openness to new themes. Future studies could benefit from a mixed-methods approach, integrating quantitative measures to assess the direct impact of GMTs on NH care outcomes.

Despite these limitations, the methodological framework successfully captured essential insights into collaboration needs, geriatric expertise gaps, and the operational feasibility of GMTs. The findings provide a solid foundation for the development of structured, evidence-based intervention models, ensuring that the proposed GMT approach aligns with both clinical realities and systemic healthcare constraints.

Future research should explore the long-term impact of GMT implementation, particularly in terms of reducing hospital admissions, improving NH staff training, and enhancing care quality for nursing home residents. Additionally, pilot testing a GMT model in diverse NH settings could provide empirical validation of its feasibility and effectiveness.

Conclusion

This study identifies key areas of collaboration and strategies to overcome constraints in nursing home care. By mapping unmet healthcare needs and stakeholder expectations, our findings underscore the importance of a structured interdisciplinary collaboration program. Such an approach is essential to addressing the increasing complexity of healthcare needs among NHRs through integrated care models. To meet expectations and integrate effectively into the existing system, GMT should adopt a second-line service approach, intervening upon request from general practitioners.

From a research perspective, this is, to our knowledge, the first study to assess the role of GMTs in nursing

homes, beginning with a needs analysis to ensure alignment with real-world challenges. Assessing the benefits and effectiveness of implementing such teams is complex and requires the definition of clear objectives. Our findings highlight the necessity of a participatory approach, where all stakeholders contribute to healthcare solutions addressing systemic barriers. Co-creating sustainable interventions is essential to improving care quality while accommodating operational constraints.

For healthcare organizations, clarifying roles, enhancing team communication, and ensuring professional recognition are key levers for a more effective and sustainable nursing home care model. Several challenges need to be addressed in future research: the negative perception of NHs among HCPs and the general public, under-funding of such initiatives, structural deficiencies, and a lack of mutual understanding. Most of the collaboration shortcomings identified are systemic and structural. Effective communication and formalisation will be essential in overcoming some of these barriers.

The successful implementation of GMTs requires concerted efforts from policymakers, healthcare providers, and stakeholders in the nursing home care sector.

Abbreviations

BPSD	Behavioural and psychological symptoms of dementia
COREQ	Consolidated criteria for Reporting Qualitative research
COVID19	Coronavirus Disease
ED	Emergency departments
GMT	Geriatric mobile team
GP	General practitioner
HCP	Healthcare professionals
NHR	Nursing home resident
NH	Nursing home
SRQR	Standards for Reporting Qualitative Research

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12913-025-12484-4.

Additional file 1. COREQ guidelines. The COREQ guidelines for writing qualitative research reports were followed in our study.

Additional file 2. SRQR guidelines. The Standards for Reporting Qualitative Research (SRQR) were followed in our study.

Additional file 3. Interview guide. We provide the interview guide used to conduct the interviews, based on the literature and constructed by JM, MSH, and TVD.

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Authors' contributions

Conceptualization: JM, MSH et TVD; data collection: JM, statistical analysis: JM, TVD; writing– original draft preparation: JM, MSH, TVD, IDB; writing– review and editing: FXS, LB, DS. All authors have read and agreed to the published version of the manuscript.

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Data availability

Due to the qualitative design and institutional ethics approval granted, the dataset generated and analysed during this study is not publicly available. However, further information can be obtained from the corresponding author upon reasonable request. We can provide the tree maps from NVivo on request.

Declarations

Ethics approval and consent to participate

The study was approved by the local Ethics Committee of the CHU UCL Namur University Hospital in May 2021 (NUB0392021000022). All participants provided both written and oral consent. All methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Author details

[1]Department of Geriatric Medicine, CHU UCL Namur, Yvoir, Belgium
[2]Université catholique de Louvain, Institute of Health and Society, Brussels, Belgium
[3]Université catholique de Louvain, Faculty of Public Health, Institute of Health and Society, Brussels, Belgium
[4]Research Unit of Primary Care and Health, Department of General Medicine, Faculty of Medicine, University of Liège, Liège, Belgium
[5]Department of Geriatric Medicine, Cliniques Universitaires Saint-Luc, Brussels, Belgium

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