

Recovery from disability after geriatric home rehabilitation versus standard of care: pilot study for a randomized controlled trial in older persons with disability at hospital discharge

Authors & affiliations

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Abstract:

Background: One in three older persons is discharged from hospital with new or sustained disability in activities of daily living (ADL). While most older persons are discharged home, evidence for home-based rehabilitation remains uncertain. We conducted a pilot study to assess the feasibility ahead of a full-scale RECOVER@HOME trial, which should evaluate a structured geriatric home rehabilitation program (GAPP@HOME) versus standard of care.

Objectives: The aim was to evaluate the feasibility of recruitment, randomization, blinding, data collection, intervention delivery, and acceptability for participants and staff.

Results: Feasibility differed markedly between two study sites. Recruitment required extensive screening efforts, though retention was high (80%, 12/15 at six weeks). Outcome assessor blinding proved difficult to maintain. Both participants and involved healthcare professionals reported positive experiences regarding acceptability and study burden. Both older adults and study physiotherapists valued the intervention, including the structured physiotherapist training and home-based delivery.

Conclusions: These findings indicate that a full trial is feasible if dedicated study staff can be assured. Additionally, attention to site-specific barriers is vital.

Trial registration: NCT06404138. Registered on 3 May 2024.

To address this gap, we adapted the Geriatric Activation Program Pellenberg (GAPP) (11) for home delivery (GAPP@HOME) and designed a randomized controlled trial to evaluate its effect. The GAPP@home program involves a 6-week physiotherapist-led home-revalidation program for older persons, consisting of 3 weekly 45-minutes session with each session having their own focus. Prior to conducting a full trial however, the feasibility of the rehabilitation intervention in daily practice and the study procedures for its evaluation deserve to be explored

Objective

The overall objective of the RECOVER@HOME pilot study is to investigate the feasibility of recruitment of study participants, all study procedures including randomization, assessments and data collection, as well as the study intervention, as to inform the potential need to adapt the envisioned study protocol prior to the start a full trial.

MATERIALS AND METHODS

For the pilot study, dedicated endpoints were defined. In addition to these endpoints, progression criteria were identified, to determine whether the pilot can move to a full trial, whether the protocol requires adaptation, or whether the full trial should be abandoned. A first try-out before going into the pilot trial confirmed that there were no major obstacles to implement the study procedures. Because the pilot study was conceived as a potential internal pilot (i.e., in case of positive results from the pilot overall, the pilot participants could be included in the actual trial study), we also collected endpoints for the full trial and therefore study methods for the full trial are presented as well (supplementary).

Implementation setting

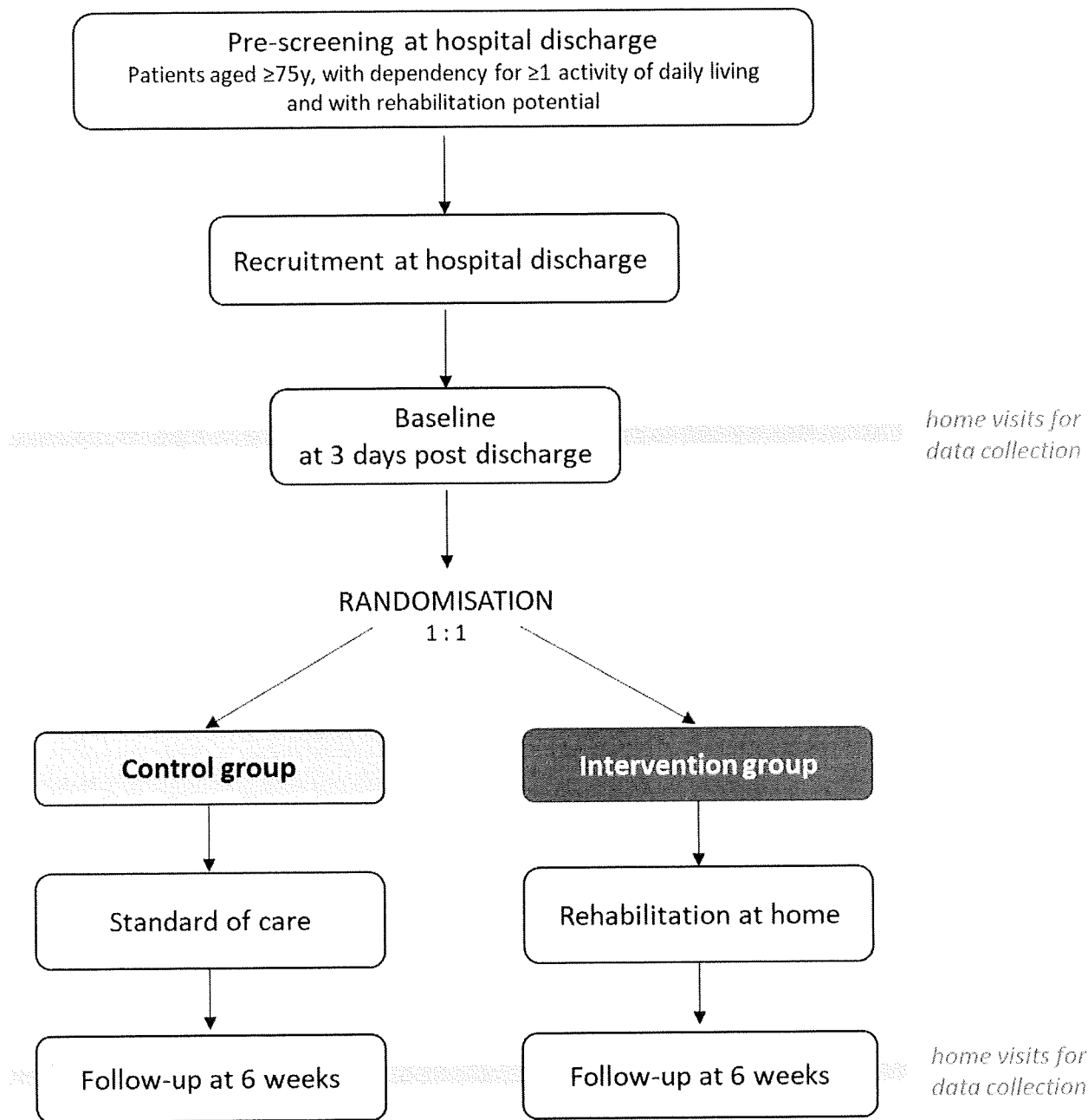


Figure 1: Study flowchart

Profiles of study participants

Baseline demographic and clinical data were collected at enrollment and during the baseline visit using both the electronic patient file and structured forms. These data also included the reason for hospital admission, hospital unit, intensive care unit or surgery exposure, and emergency care use (quantitative). To prove feasibility, participants should be recruited from both acute geriatrics units and other hospital wards, e.g. via an internal geriatric consultation team.

Study Procedures

Time spent on study procedures and assessments

Study nurses and other study staff recorded the time spent on key study tasks (e.g., screening, consent, randomization, visits, administration) using an electronic logbook. Per participant, the time for each activity was recorded in minutes. Data were collected during screening and throughout a 6-week follow-up period (quantitative).

Study burden for participants (older persons)

At the 6-week follow-up, study participants were interviewed using (1) semi-structured qualitative interviews (audio-recorded and transcribed) and (2) a modified version of the Perceived Research Burden Assessment (PRBA), reported descriptively at item level (mixed methods).

Study burden for healthcare professionals

After the recruitment period, structured interviews were conducted with healthcare staff involved in eligibility screening to assess workload disruption and perceived burden. Interviews were audio-recorded and analyzed thematically (qualitative).

Physiotherapists' experiences with the study intervention

Physiotherapists who delivered the intervention were interviewed post-intervention about feasibility, acceptability, barriers, compatibility with their professional role, and perceived patient adherence. Interviews were conducted online and analyzed qualitatively.

Adherence to the study intervention

Session logs were completed by physiotherapists to monitor delivery and any modifications to the intervention protocol. Adherence was further explored in physiotherapist interviews, focusing on reasons for deviations and patient engagement. Data were collected throughout the 6-week intervention period (mixed methods).

226 excluded per reason of ineligibility, for example due to no disability, discharge destination other than home
 227 or geographic location.

228 In total, 15 patients were recruited of which 12 retained after 6 weeks (80%). Recruitment via both acute
 229 geriatrics units and hospital wide via the internal geriatrics consultation team was possible in one of the
 230 two study sites.

231

232 Table 1: Disposition of patients during pilot study

Geriatric Support Team

	Site A			Site B		TOTAL
	Acute geriatrics	GST	Unit 1 and Unit 2*	Acute geriatrics	GST	
Recruitment period	16 Jul 24 - 4 Oct 24	16 Jul 24 - 8 Dec 24	28 Oct 24 - 16 Dec 24	25 Nov 24 - 30 Mar 25	25 Nov 24 - 30 Mar 25	16 Jul 24 - 30 Mar 25
Hospitalized patients ≥75y	933	579	168	no data	(1533) °	3213
Potential candidates #	88	37	20	no data	(171) °	316
Contacted by study team°	18	3	2	no data	14	37
Recruited	10	2	2	0	1	15
Randomized	9	2	2	0	1	14
Retained at 6 weeks	8	1	2	0	1	12

7h.

256 The average screening time needed for one inclusion was 420 minutes. This included time for study nurses
257 to attend the geriatric wards team meetings, going through the hospital admission lists, screening patients'
258 clinical records and contacting the ward nurses or treating physician to discuss potential candidates. The
259 median time necessary for the obtainment of the informed consent (including informing the patient about
260 the study and responding to questions) was 32.5 minutes. Randomization, including additional eligibility
261 check, informing the patient and arranging the first physiotherapy-session in case the patient was
262 randomized into the intervention arm, took 30 minutes per subject. For the baseline visit, a median time
263 of 85 minutes was recorded, whereas for the follow-up at six weeks, this was 67.5 minutes. Additional
264 administrative workload was about 85 minutes per subject for data entry and 20 minutes for
265 communication with the patient to plan the home visits. Additionally, a median travel time of 55 min was
266 necessary to perform the home visits by the study nurse. This time log results in a total time of 13.25 hours
267 necessary per subject that completed the study.

→ bl^o
med

→ Prevalence
have we
to visit
high

→ Random

269 *The study burden for participants (older persons)*

270 Overall, participants experienced the study as positive and low in burden. They appreciated the smooth
271 planning of appointments, the personal connection with therapists, and the attention to their recovery.
272 Study procedures, including home visits, were found acceptable and non-intrusive, with most reporting
273 minimal impact on daily life. The study diary was the least favored element, with many finding it difficult
274 to maintain or irrelevant, suggesting a need for more flexible approaches. Despite minor challenges,
275 participants considered the study relevant, manageable, and expressed support for further research in
276 older populations.

278 *The study burden for healthcare professionals*

Blinding of outcome assessors

Blinding data were only available from one site (table 2); no data on outcome assessor blinding were collected or reported from the other site. Results show that blinding of outcome assessors was not achieved for any of the participants. In all cases (13/13; 100%), either study nurse 1 or Study nurse 2 was aware of the participant's treatment allocation. Unblinding most frequently occurred during the second home visit, corresponding to the 6-week follow-up assessment.

Table 2: Blinding of outcome assessors.

	Study nurse 1	Study nurse 2
Correct on group allocation	10/13 (767%)	6/13 (46%)
Incorrect	0/13 (0%)	1/13 (8%)
Had no idea	3/13 (23%)	6/13 (46%)

Feasibility of the study procedures, assessments and data collection

The screening and recruitment process was generally well-organized and collaborative, though subjective assessments like cognitive status sometimes caused inconsistencies. Informal caregivers often facilitated recruitment but were not consistently involved or available. Geographic barriers, especially in rural areas, and patient reluctance posed challenges. Administrative tasks and time tracking were perceived as burdensome because of complex coordination and communication issues, causing delays and additional pressure. Nonetheless, data entry in the REDCap platform was reported as user-friendly. Recommendations included expanding the geographic coverage and involving more physiotherapists with dedicated availability, establishing clear inclusion criteria with a designated decision-maker in case of doubt, implementing more systematic cognitive screening, involving caregivers earlier in the process, and improving communication around randomization and follow-up, potentially using video or in-person meetings instead of phone calls.

commitment. While the intervention was generally feasible and manageable, some challenges arose, such as scheduling three weekly sessions, especially with home visits, and occasional communication issues due to study blinding and patient transfers. Managing multiple intervention patients simultaneously was often too demanding, sometimes leading to early termination of treatments.

Adherence to the protocol was reported as high, with physiotherapists making flexible adjustments based on patient condition while maintaining the intervention's core goals. For broader implementation, they recommended increasing reimbursement rates and expanding geriatric training within physiotherapy curricula. Screening for cognitive function before inclusion was advised to ensure patient suitability.

Harms/other unintended effects

No intervention-related adverse events occurred. During the pilot phase of the study, two adverse events were reported. One patient felt unwell during the intervention period, resulting in one shortened physiotherapy session and one cancelled session. The participant fully recovered and could proceed with the sessions afterwards. Another patient (control group) fell at home, resulting in a fractured femur necessitating surgery.

Falls related to intervention delivery were predefined as AEs of special interest. No fall incidents during intervention delivery were reported during the pilot stage of the study.

the two sites highlight the influence of local organizational factors, but they do not allow for broader conclusions. Third, the number of patients who actually received the complete intervention was relatively small, which limits the robustness of qualitative insights regarding the acceptability and perceived benefits. While the participant feedback was encouraging, the findings should be interpreted with caution until confirmed in a larger sample.

Some operational challenges emerged, including geographic constraints which also acted as a de facto exclusion criterion, as only patients living within the predefined coverage areas of participating physiotherapists could be included. Additionally, the availability of physiotherapists was constrained, leading to two instances where treatment was discontinued. Third, the unpredictability of discharge planning, particularly late decisions regarding discharge destination and timing, resulted in the inadvertent exclusion of eligible patients.

→ *Remarque: pour avoir contact par téléphone pour discuter de sortie*

Missing data was higher than expected for some key outcomes, particularly at follow-up, due to participant burden and logistical challenges in data collection (e.g. cumbersome healthcare diaries). Although baseline data completeness was satisfactory, the follow-up data (6–15% missing) indicated the need to optimize data collection strategies.

par mail
↓

Modèle AS ?

Generalizability

Given the limited number of sites and the variability in between, extrapolation to other settings remain uncertain. As a pilot study, this trial was not designed to assess treatment effects or draw conclusions about clinical outcomes. Nonetheless, the feasibility outcomes and qualitative findings at site A suggest that the intervention and associated procedures are applicable in similar tertiary care settings with adequate staffing and integrated discharge planning. However, results from site B demonstrate that findings are less transferable to contexts where such enabling conditions are not met. Therefore, while the

434 However, the pilot also identified critical operational issues, including high administrative burden,
435 insufficient availability of physiotherapists in certain regions, and logistical challenges tied to hospital
436 workflows. These findings should be considered in the design of a definitive trial, which must include
437 tailored site-level implementation strategies.

↳ *volunteer*.

439 **CONCLUSION**

440 This pilot study demonstrates that home-based rehabilitation is feasible and acceptable under appropriate
441 conditions but requires structural adaptations for broader implementation. Key lessons include the need
442 for stable staffing, integration into discharge planning, and improved internal communication. Optimizing
443 study procedures, such as simplifying patient diaries, will help reduce data loss. The positive experience
444 at Site A provides a strong foundation for scaling up to a multicenter randomized controlled trial, with
445 tailored operational strategies for each participating site.

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518 3. GAPP@HOME outline

519 4. CONSORT Checklist

542

543 *Older persons*

544 Eligible patients were minimum aged 75 years or over, with a disability (i.e., dependent in one or more
545 activities of daily living) at hospital discharge, rehabilitation potential (as assessed by the multidisciplinary
546 team) and who gave their consent. Exclusion criteria were patients discharged to a rehabilitation center
547 or nursing home, receiving palliative care or being enrolled in a specialized rehabilitation program, such
548 as for example cardiac, stroke or oncology rehabilitation. Additionally, other patients that were already in
549 active follow-up with a physiotherapist for other indications, and for whom participation in the
550 intervention would be too demanding or would compromise the integrity of the therapy and its
551 anticipated outcomes, were excluded.

552 Recruitment of older persons involved selecting patients who were hospitalized at the geriatrics ward or
553 hospital wide if a consultation has been requested for the internal geriatric consultation team at the two
554 study sites. Patients were invited to participate after prescreening by the investigators. All participants
555 signed a written informed consent.

556

557 *Informal caregivers*

558 Alongside the participating older persons, informal caregivers were recruited if available, in order to
559 estimate the feasibility of collecting data for economic evaluation, which will be embedded in the full trial.
560 Informal caregivers were defined as non-professional individuals, e.g. family members or friends who
561 provide (often unpaid) support.

562

563 *Physiotherapists*

564 Physiotherapists who delivered the intervention were recruited and trained before the start of participant
565 recruitment. Recruitment criteria were (1) being licensed for practicing in Belgium; (2) work experience as

GAPP@HOME is a structured six-week rehabilitation program consisting of exercise sessions three times per week, each lasting 45 minutes. Each of the sessions are individually delivered at the older person's home. The sessions were organized as follows:

- **Day 1:** Strength and power exercises
- **Day 2:** Balance exercises
- **Day 3:** Speed, endurance, and coordination exercises

Each session started with 10 minutes of gait training, followed by the main exercises for the day. A set of prescribed exercises was available for each of the three exercise days in a booklet provided to the physiotherapists during the training. The physiotherapist delivering the intervention selected exercises based on the individual's abilities and needs. The protocol was flexible and could be adjusted daily to reflect improvements in the participant's capacity. Hands-on guidance was encouraged to ensure the proper execution of exercises.

The program started with goal setting, where the physiotherapist and participant collaboratively identified personal goals related to daily functioning in the home environment. These goals were tailored to the participant's preferences, such as improving the ability to climb stairs, engage in outdoor activities, or perform household tasks like hanging laundry. Exercises targeting strength and balance were specifically selected to align with these individualized objectives (Appendix 2). During the initial session, the goals were documented, and progress was assessed at the end of the therapy sessions. In order to assess protocol adherence and feasibility, the number of sessions, duration and content were logged by the physiotherapists. Additionally, as part of a qualitative analysis, physiotherapists and older persons were interviewed about the value, feasibility and adherence of the intervention. Physiotherapists were also asked about their experiences with the training they received to deliver the intervention.

636 *Sequence generation*

637 A randomization sequence was generated by a researcher not affiliated with the study team (i.e. not
638 involved in recruitment, data collection or any other study procedure).

639

640 *Allocation concealment mechanism*

641 The randomization sequence was securely stored in REDCap and configured so that group allocation was
642 concealed from investigators until the point of randomization. Access was restricted to authorized users
643 not involved in recruitment or outcome assessment.

644

645 *Implementation*

646 Eligible participants were enrolled by study team members at the participating centers. Upon enrollment,
647 group allocation was automatically assigned through REDCap based on the pre-generated randomization
648 sequence. Patient allocation was done individually and by designated study personnel, not involved in data
649 collection, after ensuring patient's suitability for randomization. The allocated treatment arm was
650 communicated to the treating geriatrician in order to provide the correct prescription (standard-of-care or
651 GAPP@HOME), the patient was informed of the allocated arm and in case of intervention, a trained
652 physiotherapist was contacted to start up the intervention delivery.

653

654 *Blinding*

655 The study nurses (outcome assessors) performing baseline and follow-up assessment were blinded for
656 treatment arm. The success of blinding of the study nurses was evaluated at the end of the pilot using a
657 structured interview conducted by the sponsor team (KU Leuven). Nurses indicated whether they knew,
658 suspected, or did not know each participant's group allocation, and how this information was obtained, if
659 applicable. Responses were compared to actual allocations, as to calculate a Blinding Index. If systematic

content of the diary to confirm completeness, and occurrence of any adverse event since hospital discharge.

Qualitative data collection

Interviews were performed with participants, physiotherapists, healthcare professionals and members of the study team. A rapid qualitative evaluation was conducted, following the guidance of the Rapid Research Evaluation and Appraisal Lab (RREAL). The aim was to identify actionable insights relevant to the feasibility of the pilot study.

Data analysis and statistical methods

The analysis plan combined analyses of quantitative and qualitative data.

Analysis of quantitative data

For quantitative endpoints of the pilot study, as well as the progression criteria for proceeding to the full trial, simple descriptive statistics (frequencies, proportions, median or mean scores) were used to see if endpoints were reached and criteria were met. Recruitment of study participants was documented in a logbook. This information was used to produce a consort flow diagram.

The following variables were assessed at baseline and were used to assess the characteristics of the sample: Study site, reported as proportions; Recruitment pathway (acute geriatrics ward versus hospital-wide via the GST), reported as proportion; Hospital ward, reported as proportions; Age: continuous, reported as mean with standard deviation; Sex: categorical, reported as proportions; Country of birth for participants and their parents, reported as proportions; Educational level: categorical, reported as proportions; Monthly household net income: categorical, reported as proportions; Current living situation: categorical, reported as proportions; Recruitment of an informal caregiver, and relationship (partner, child,

730 themes from the interviews. A summary was drafted identifying factors related to the feasibility of
731 intervention delivery as well as delivering the full trial, and opportunities on how to improve the feasibility.

732
733 Nine participants, all from UZ Leuven, were interviewed about the study burden, with 4 of these
734 randomised in the intervention group that were additionally interviewed about their experiences with the
735 intervention. Four trained physiotherapists took part in the interviews, with three located around UZ
736 Leuven (interview about physiotherapist training and intervention delivery), and one located around CHU
737 UCL Namur Mont-Godinne. As there was no intervention delivered, the latter physiotherapist did not
738 participate in the intervention delivery interview.

739
740 The feasibility of study procedures, assessments and data collection was discussed in interviews with the
741 two principal investigators, three study nurses and two persons involved in randomisation from both study
742 sites.

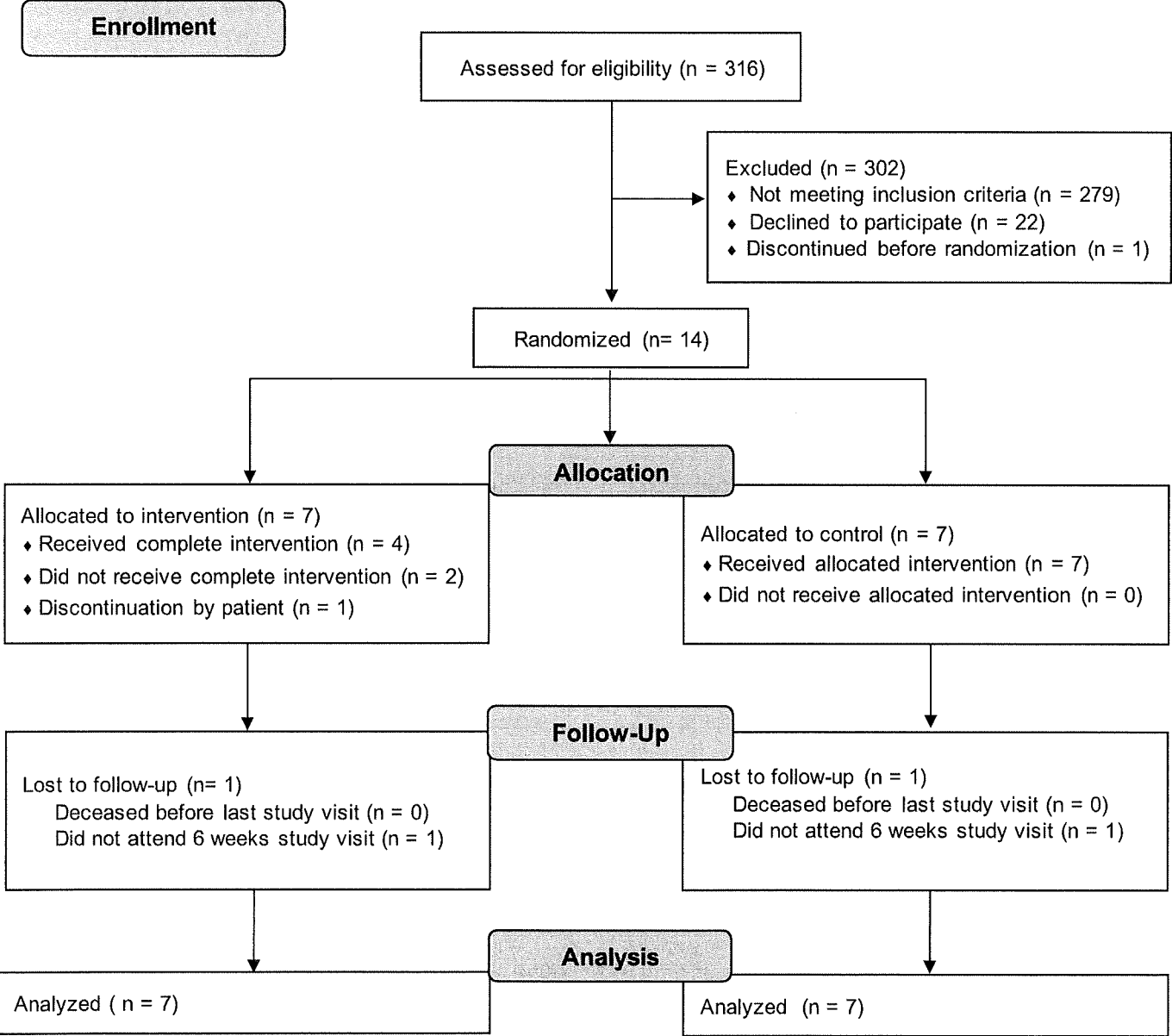
743
744 At the end of the pilot phase, healthcare professionals involved in the care for our target population,
745 were contacted to discuss the study burden and consequences for their daily practice. In total, 19
746 healthcare professionals took part in the interviews. Based on the participants' preferences, interviews
747 were conducted one-on-one or in small groups per department or specialisation, i.e. the geriatric
748 consultation team of UZ Leuven comprising 5 nurses, a specialized nurse, the head nurse and two
749 occupational therapists or the physiotherapist team on the geriatrics ward, including 3 physiotherapists
750 and an occupational therapist. Six group interviews were performed for healthcare professionals in UZ
751 Leuven and three for staff in CHU UCL Namur Mont-Godinne.

760

761 **CONSORT 2010 Flow Diagram**

762

763



Primary education	4	3	1
Secondary education	6	2	4
Higher education	2	1	1
University degree	2	1	1
Social situation			
Living alone	5	2	3
Living with partner	9	5	4
Net family income (€)			
1500 to 1999	2	1	1
2000 to 2499	2	0	2
2500 to 2999	1	1	0
3000 to 3499	5	3	2
3500 to 3999	1	1	0
4000 to 4499	1	0	1
4500 to 4999	1	1	0
Missing	1	0	1
Reason for hospitalization			
Fall	7	2	5
Pneumonia	2	1	1
Mobility/physical dysfunction	3	2	1
Heart/kidney failure	1	1	0
Cognitive dysfunction	1	1	0
Hospital unit of recruitment			
Acute geriatrics	11	5	6
Cardiology	1	1	0
Traumatology	1	1	0
Thoracal surgery	1	0	1
Healthcare use during hospitalization			
Emergency service	13	6	7
Surgery	2	1	1
Intensive care unit	1	0	1
Mini cog, <i>median (IQR)</i>	2.5 (2) ¹	2 (1.5)	3 (1.5)
Charlson Comorbidity scale, <i>median (IQR)</i>	5 (1) ¹	5 (1)	5 (1)
Geriatric depression scale, <i>median (IQR)</i>	3 (2) ²	3 (2)	2.5 (2)
Tilburg Frailty Index, <i>median (IQR)</i>	5 (3) ¹	7 (4.5)	5 (2)
Groningen Activity Restriction Scale, <i>median (IQR)</i>	44 (25.25) ¹	54 (22)	36 (14.5)
Short Physical Performance Battery <i>median (IQR)</i>	5 (5) ³	6.5 (3.5)	5 (4.5)
EQ-5D-5L – VAS <i>median (IQR)</i>	60 (20) ²	60 (12.5)	60 (15)
Multidimensional Fatigue Inventory <i>median (IQR)</i>	60 (13) ¹	60 (11)	60 (10.5)

Feasibility of recruitment and training of therapists

At UZ Leuven, three physiotherapists were successfully recruited and trained within the two-month timeframe. One physiotherapist discontinued participation in October 2024. At the CHU UCL Namur Mont-Godinne site, two physiotherapists were recruited and trained within the two-month timeframe. One physiotherapist dropped out in December 2024. A replacement was recruited in January 2025 and trained on 24 February 2025.

Feasibility of participant recruitment

To assess recruitment feasibility, a key START-STOP criterion was the ability to recruit 24 older participants within six months across sites. In Leuven, 14 participants gave informed consent and were thus recruited over a four-month period (August–November 2024). In CHU UCL Namur Mont-Godinne, one participant was recruited between December 2024 and March 2025 (consent signed on 10 December 2024). In total, 15 participants were recruited across both sites within the six-month timeframe. Although the target of 24 participants was not reached, recruitment at UZ Leuven progressed steadily, while lacking recruitment at CHU UCL Namur Mont-Godinne was primarily due to slower site activation and a lack of staff availability. These findings indicate partial feasibility of the recruitment.

To evaluate the feasibility of recruiting from both geriatric hospital wards and other wards via internal geriatric consultation teams, recruitment sources were tracked during the pilot phase. In UZ Leuven, 10 participants were recruited at a geriatric ward, while 4 were enrolled via the internal geriatric consultation team and at non-geriatric wards. In CHU UCL Namur Mont-Godinne, the single participant was recruited through the liaison (consultation) team. These findings confirm that recruitment is feasible for both pathways at UZ Leuven, with the majority of participants in this pilot recruited from dedicated geriatric

withdrew (1 patient before the baseline visit, 3 patients before the 6-week follow-up visit) were excluded from this analysis (displayed as “without dropouts” in table S3), ensuring that only sporadic missing data were considered. Missing data rates ranged from 6% to 15% across the primary and two key secondary outcomes among participants completing the 6-week follow-up, meeting the “proceed with changes” criterion for the full trial.

Table S3: Missing data for items of the primary and key secondary outcomes

	Missing data (%)			
	Baseline		6 weeks follow-up	
	Missing data for all participants (= including dropout) <i>15 subjects</i>	Individual items left blank (= missing without dropouts) <i>14 subjects</i>	Missing data for all participants (= including dropout) <i>15 subjects</i>	Individual items left blank (= missing without dropouts) <i>12 subjects</i>
GARS (18 items)	18/270 (7%)	0/252 (0%)	72/270 (27%)	18/216 (8%)
SPPB (5 items)	13/75 (17%)	8/70 (11%)	22/75 (29%)	7/60 (12%)
EQ-5D (7 items)	8/105 (8%)	1/98 (1%)	28/105 (27%)	7/84 (8%)
Total	39/450 (9%)	9/420 (2%)	122/450 (27%)	32/360 (9%)

Feasibility of intervention implementation

Interviews with physiotherapists in Leuven indicated that delivering the intervention is feasible within routine practice. However, a major challenge identified was the limited geographic coverage of the physiotherapists’ catchment areas, which significantly restricted the pool of eligible patients for recruitment. This finding highlights a potential barrier to scaling intervention delivery that will need to be addressed in the full trial.

Table S2: Progression criteria summary

#	Criteria	Target for GO	Pilot result	Assessment	Comment
1	Site start-up	≥2 participants recruited per site in <2 months	UZ Leuven: 3 recruited Namur: 2 recruited	Proceed with changes	Site start-up was successful in UZ Leuven. No recruitment of 2 run-in patients within 2 months in CHU UCL Namur Mont-Godinne because of unavailability of the Study nurse between 31/07/2024 and 26/8/2024
2	Recruitment and training of therapists	≥2 therapists trained per site in 2 months	Leuven: 3 trained Namur: 3 trained	Go	Target reached in both sites. Training package (e-learning + practical) well received. One therapist dropped out, and a new therapist could be trained.
3a	Participant recruitment: total number	≥24 participants in <6 months	15 participants recruited (14 Leuven, 1 Namur)	Proceed with changes	Recruitment fell short of target. In Namur, study staff turnover, limited staff availability and prolonged sick leave in the geriatrics team delayed internal coordination and recruitment activities.
3b	Participant recruitment: via two pathways	≥4 via geriatric wards and ≥4 via consult team (if <24 participants)	Achieved: ≥4 via both pathways	Go*	Both recruitment streams were utilized adequately at UZ Leuven.
4	Participant retention	≥75% retained at 6 weeks	12/15 (80%) retained	Go	Retention above threshold despite small sample. Interviews with participant demonstrate high acceptability of study.
5	Feasibility of the intervention	Qualitative data support feasibility	Most participants completed and valued the intervention; some found it intense but manageable	Go*	Intervention acceptable; minor adjustments to intensity or flexibility may further improve feasibility.
6	Feasibility of data collection	<5% missing on primary and key secondary endpoints	6–15% missing data (depending on outcome)	Proceed with changes	2% missing data (individual items without drop-outs) at baseline, 9% missing data at 6 weeks follow-up.
7	Feasibility of intervention implementation	PT interviews support feasibility	Feasible in Leuven; challenges with home visit reimbursement and coordination	Proceed with changes*	Delivery is feasible but depends on improving therapist coverage, workload planning, and remuneration models.

868 *: data only available from UZ Leuven