Received: 31 March 2022 | Revised: 13 September 2022 | Accepted: 17 October 2022

DOI: 10.1111/opn.12511

ORIGINAL ARTICLE

International Journal of Older People Nursing WILEY

Professional home care providers' conceptualisations of frailty in the context of home care: A focus group study

Kristin S. Voie RN, MSc, PhD student[1] | Bodil H. Blix RN, MSc, PhD, Professor[1] | Ann Karin Helgesen RNT, MSc, PhD, Professor[1,2] | Toril Agnete Larsen RN, MSc, Retired Senior Lecturer[1] | Kjersti Sunde Mæhre RN, MSc, PhD, Associate Professor[1]

[1]Department of Health and Care Sciences, Faculty of Health Sciences, UiT The Arctic University of Norway, Tromsø, Norway

[2]Faculty of Health, Welfare and Organisation, Østfold University College, Halden, Norway

Correspondence
Kjersti Sunde Mæhre, Department of Health and Care Sciences, Faculty of Health Sciences, UiT The Arctic University of Norway, 9037 Tromsø, Norway.
Email: kjersti.s.mahre@uit.no

Funding information
UiT The Arctic University of Norway

Abstract

Background: In Norway, as in many other countries, more people receive health and care services in their homes than before. Home care professionals provide care and support to people with a range of health and care needs. Older home care service users are sometimes referred to as 'frail', but the terms 'frail' and 'frailty' have different meanings in different contexts, and little is known about the meaning ascribed to the terms in the context of home care services. Home care services are crucial for many older persons who have health challenges, and how home care professionals conceptualise frailty might shape clinical encounters.

Objectives: The purpose of this study is to explore how home care professionals conceptualised frailty in the context of home care.

Methods: We conducted four focus group discussions with 14 home care professionals who worked in municipal home care in northern Norway and analysed the data using thematic analysis.

Results: Our analysis resulted in five themes: '"Frail" – a term which is too imprecise to be useful', 'Frailty as a consequence of ageing', 'Frailty as lack of engagement and possibilities for engagement', 'Frailty as a contextual phenomenon' and 'Frailty as potentially affected by care'. The home care professionals conceptualised frailty as an individual trait but also as resulting from the interplay between individual and environmental factors. Moreover, their conceptualisations of frailty represented a continuum between frailty as related to prevention and management ('cure') and frailty as related to ageing as natural decline ('care').

Conclusion: The home care professionals conceptualised frailty diversely, as moving along a continuum between cure and care. Diverse conceptualisations of frailty might be necessary if nurses are to meet the changing and varying care needs of older persons who live in their own homes and need health and care services.

KEYWORDS
care, focus group discussions, frailty, home care professionals, home care services, older people

1 | INTRODUCTION

In Norway, as in many other countries, more people receive health and care services in their homes than before (Barry et al., 2018; Fjørtoft, 2016; Kasper et al., 2019). Home care services are provided to people with a range of health and care needs, both short-term and long-term care services (Fjørtoft, 2016; Genet et al., 2011). A recent Norwegian government white paper describes 'frail older people' as a group of patients who need special attention from the health and care services, with cooperation between specialist and primary care services to "prevent progression of diseases and early intervention as well as a better discharge process" (Meld. St. 7, 2019–2020, p. 47). The concept of frailty, which is increasingly used in research and clinical practice (Bergman et al., 2007; Hoogendijk et al., 2019), often refers to a state of increased vulnerability to adverse outcomes (Cesari & Theou, 2017; Clegg et al., 2013; Morley et al., 2013). There is, however, no consensus on a single precise definition (Looman et al., 2018; Sezgin et al., 2019; Waldon, 2018), and little is known about the meanings ascribed to the terms frail and frailty in the specific context of home care services. In this article, we thus explore how home care professionals conceptualise frailty in the context of home care.

1.1 | Background

Although 'frail' and 'frailty' are terms frequently used in the gerontology literature, the terms are used differently in various clinical settings, among different professions (Waldon, 2018), and in everyday language (Thinks, 2015). Scholars have noted that the term frail is used to refer to people of high chronological age (Heath & Phair, 2011), but also to refer to a distinct group of older people who are ill or disabled (Manthorpe et al., 2018). Two well-established medical definitions respectively describe frailty as a clinical syndrome in which three or more pre-defined criteria are present (Fried et al., 2001) and a state of accelerated deficit accumulation (Mitnitski et al., 2001; Rockwood & Howlett, 2019). Furthermore, parts of the research literature use the term frailty as referring to a specific medical diagnosis (Rodríguez-Mañas et al., 2013; Schoenborn et al., 2018), while other researchers discuss frailty as a social construct (Grenier, 2020; Richardson et al., 2011), and some theoretical models consider frailty as multidimensional, resulting from individual, social, and environmental factors (De Witte et al., 2013; Markle-Reid & Browne, 2003).

Home care is provided as health promotion, rehabilitation, medical follow-up, and end-of life care (Fjørtoft, 2016; Genet et al., 2011); thus, it is on a continuum between curative models of care ('cure') and palliative care ('care'). For home care professionals, the identification of frailty might enable interventions to support home care service users (henceforth: service users) in reducing the risk of adverse outcomes (Waldon, 2018; Wallington, 2016), enhance person-centred decisions and care planning (Rolfson et al., 2018), and lead to palliative care for people considered as severely frail (Pal & Manning, 2014; Wallington, 2016). International consensus reports emphasise the prevention and management of frailty (Morley et al., 2013; Rodríguez-Laso et al., 2019), but scholars have also noted that it is more common to become frailer than to improve from frailty (Clegg et al., 2013; Pal & Manning, 2014). How home care professionals conceptualise frailty might shape behaviour and clinical encounters (Markle-Reid & Browne, 2003; Nicholson et al., 2017). If home care professionals, for example, conceptualise frailty predominantly as natural decline, they might prioritise 'doing for' and 'care' rather than activity, prevention, and 'cure'. Conceptualisations

Implications for practice

What does this research add to existing knowledge in gerontology?

- In the context of home care services, conceptualisations of frailty not only relate to prevention and 'cure', as emphasised in much of the literature about frailty but also 'care' and ageing as natural decline.
- Home care professionals consider the term frail as too imprecise to be useful and conceptualise frailty in accordance with how they manoeuvre within the continuum between 'cure' and 'care' in their everyday practice.

What are the implications of this new knowledge for nursing care with older people?

- Home care professionals who provide care to people of advanced age must be aware that characterising older persons as 'frail' does not provide sufficient information about the unique needs of the individual home-dwelling older person in her or his specific context.
- Home care is provided to people as health promotion and prevention of disease, but also as end-of-life care. In the context of home care, it is therefore essential to acknowledge conceptualisations of frailty that allow professionals to move along a continuum between 'cure' and 'care'.

How could the findings be used to influence policy or practice or education?

- Conceptualised as resulting from the interplay between individual and environmental factors, frailty can be addressed with interventions directed towards people's physical and social environment.
- Educators need to initiate discussions about the complexity of the concept of frailty, which includes frailty as a theoretical concept, frailty as a professional term, and the ethical implications of the use of the terms frail and frailty.

predominantly formulated in terms of physical losses might lead to increased fragmentation of care, with a lack of attention to the whole person (Gobbens et al., 2010; Markle-Reid & Browne, 2003). In some countries, access to home care services is based on an assessment of frailty (Grenier, 2020; Manthorpe et al., 2018), and how frailty is conceptualised might impact whether people are granted home care.

Previous studies have shown that healthcare professionals in multi-professional teams (Gustafsson et al., 2012), family doctors (Korenvain et al., 2018) and care professionals with specialised knowledge in geriatric care (Britain Thinks, 2015) have understood frailty as a dynamic and changeable condition. Studies have also shown that primary care professionals perceive physical frailty as an inherent part of the ageing process (Obbia et al., 2020), and care professionals without specialised geriatric knowledge link frailty to end-of-life care (Britain Thinks, 2015). Nevertheless, care professionals do not understand frailty as solely a physical impairment, but rather as including social, psychological, and environmental aspects (Gustafsson et al., 2012; Obbia et al., 2020). In a hospital setting, Cluley et al. (2022) found a discrepancy between healthcare professionals' clinical views of frailty as 'ill-health' and their 'lay' view of a frail person as thin, weak, and old. Older people themselves report having negative associations with the term frail (Britain Thinks, 2015; Schoenborn et al., 2018), and studies indicate that some care professionals rarely use the term in their practice (Britain Thinks, 2015; Manthorpe et al., 2018). These are some of the reasons why the use of frailty as a core concept in care practices has been questioned (Grenier, 2020).

Further research is required to address the continued gaps and inconsistences in knowledge about frailty (Waldon, 2018, p. 491). As more people in need of health and care services, including people living with frailty, receive services in their own homes and communities, more knowledge is needed about how home care professionals understand frailty (Markle-Reid & Browne, 2003; Nicholson et al., 2017). In this article, we aim to explore how home care professionals conceptualise frailty in the context of home care.

2 | METHODS

2.1 | Study design and context

To explore home care professionals' conceptualisations of frailty, we chose a qualitative research design with focus group discussions. Focus group discussions encourage interaction between participants about a given topic and are considered suitable to explore opinions and experiences and different perspectives within a social network (Kitzinger & Barbour, 1999). To gain insight into how home care professionals discuss and understand frailty, we thus considered focus group discussions as well-suited.

We conducted the study in Norway, where a health policy goal is to enable people to age at home (St. Meld. nr. 47, 2008–2009) and home care services are publicly funded. The home care services consist of health care, personal assistance (including domestic care) and support contact (Helse- og omsorgstjenesteloven [Health and Care Services Act], 2011). Norwegian local authorities are obliged to provide their citizens with the necessary primary health and care services, and the provision of home care services is based on an assessment of healthcare needs. In 2020, 30 percent of all Norwegian citizens aged 80 years or older received home care services (Statistics Norway, 2021).

The municipality where this study took place is large by Norwegian standards (Kringlebotten & Langørgen, 2020) and is located in northern Norway. The home care services were organised in units dedicated to specific geographical areas of the municipality. Each unit consisted of several departments, and the units and departments had designated managers. Home care was offered to citizens living in both urban and more rural areas and in different kinds of accommodation, including assisted living facilities. Adult day care centres were also part of the home care services under study.

2.2 | Recruitment and participants

We conducted four focus group discussions with a total of 14 home care professionals who participated in one focus group each. The two inclusion criteria in this study were as follows: (1) Participants were currently working with older service users in home care, and (2) Participants had a minimum of 1 year of experience in the services. We used several strategies to recruit participants. Unit managers in the home care services assisted with the recruitment process and distributed information letters to potential participants. However, we received only a few signed consent forms, and based on this first round of recruitment, we were thus only able to conduct one small focus group with two participants. We arranged a second focus group with six participants in collaboration with a unit manager who recruited participants from this manager's unit and organised the discussion within the participants' working hours. For a third group, we recruited three participants through snowball sampling from the first author's professional network. An acquaintance of the first author presented the study to a home care professional unknown to the first author, who assisted with further recruitment. Because the discussions continued to provide new information about the home care professionals understanding of frailty, we decided to arrange a fourth focus group. This group was also arranged in collaboration with a unit manager. After this group, we assessed the data to be sufficient to answer our research question. This decision was also a pragmatic choice based on available time and resources.

The participants (three men, eleven women) were registered nurses and certified nursing assistants working in home care and care professionals working in day care centres. Most of the participants had worked for more than 15 years in health and care services (range 1–35 years). In two focus groups, the participants worked in the same unit within the same home care department. In two other focus groups, the participants worked within the same home care unit, but in different departments. The participants' prior mutual acquaintance thus varied within and between the groups.

2.3 | Data generation

We conducted all focus group discussions in meeting rooms at the participants' workplaces during the winter of 2019/2020 (prior to the COVID-19 pandemic). We used a thematic interview guide including the themes 'associations with the term frail', 'experiences of frailty' and 'care for persons living with frailty'. After introducing the themes, the moderator (KSV) intervened as little as possible in the discussion. One co-author (KSM) was a co-moderator for three groups, and another co-author (TAL) was a co-moderator for one group. Co-moderators observed, took notes, and asked clarifying questions towards the end of the discussions. Each discussion was audio-recorded and lasted around 90 min.

2.4 | Ethical considerations

The Norwegian Centre for Research Data provided the necessary approval for this study (reference number 428509). In advance of the focus group discussions, the participants had received written and oral information about the study, and they had signed consent forms. In all groups, we emphasised that participation was voluntary, and that the participants could withdraw without explanation until submission for publication. None of the participants chose to withdraw. To safeguard participants' confidentiality, we have not linked information about their professional background or work experience to statements presented in the article. We have also given them non-gendered fictional names.

2.5 | Data management

Signed consent letters including participants' contact information were stored in a locked cabinet in the first author's office. We stored the audio-recordings digitally at Services for Sensitive Data, which is owned by the University of Oslo. Only the first author had access to the recordings. The de-identified transcripts, which were available for the author group, were stored in a two-factor authentication area/share point in Office 365. All de-identified transcripts are available in Norwegian only.

2.6 | Analysis

After the focus group discussions, the first author transcribed and de-identified the audio recordings verbatim and wrote summaries of each transcript. To analyse the data, we used thematic analysis as described by Braun and Clarke (2006, 2013). Thematic analysis provides flexibility as to how theory informs the analysis (Braun & Clarke, 2006), and although our research question was theoretically informed, the coding process was data driven. To gain a first impression of potential patterns, all five authors read the transcripts and the first author's summaries of the transcripts. The first author read and re-read all transcripts and coded meaningful text passages using QSR NVivo software for support. New codes were developed throughout all transcripts in a back-and-forth process. The first author then grouped codes with similar content to form potential themes. Codes such as 'instead of frail, we say', 'we do not use frail', and 'how we could use frail' were grouped in the preliminary theme 'use and non-use of the term frail', which after revision by the authors was further developed into the theme '"frail" – a term which is too imprecise to be useful'. As the authors discussed and revised all preliminary themes and worked to achieve consistency within and between the final themes in parallel with the writing of the article, the final step of the analysis was conducted in English.

To enhance rigour and trustworthiness, we adhered to Braun and Clarke's (2006:96) criteria for thematic analysis. All authors were involved in discussions regarding interpretations, construction of themes, and the selection of quotations. An expert team consisting of representatives from the senior council of the county, and a registered nurse from the municipal home care services, contributed to the analysis by providing 'reflexive elaboration' (Braun & Clarke, 2013, p. 285) of our interpretations. Through this process, we generated the following five themes: '"Frail" – a term which is too imprecise to be useful', 'Frailty as a consequence of ageing', 'Frailty as lack of engagement and possibilities for engagement', 'Frailty as a contextual phenomenon' and 'Frailty as potentially affected by care'. By including substantial quotations in the text, we provide readers with the opportunity to assess our interpretations. The first author translated all quotations selected for presentation from Norwegian to English as literally as possible. All authors discussed the translations of the quotations, both before and after the article was proofread by professional translators. The literal translation of the quotations could have affected the flow of the language, and the authors take full responsibility for the translation of the quotes. To increase readability, we have removed pauses and words without significance for the meaning.

3 | RESULTS

3.1 | 'Frail' – A term which is too imprecise to be useful

In all focus group discussions, participants discussed how they did not actively use the term frail in their everyday practice. In the participants' subsequent dialogues about why they did not use the term frail, the participants presented frail as an imprecise term. Referring to a service user as frail would indicate that the person's general condition and functional level had been reduced. However, the term frail would not provide sufficient information about the service user's individual care needs:

Jo: If someone says: 'This person's got frailer since our last visit', I'm not sure what they mean. Has the nutritional status become worse? Has the person become more unsteady? Has the person

fallen? Has the person contracted another disease? You do not quite know what you are being told.

The participants also discussed frail as a collective term for a reduced functional level, concluding that they would need to ask for additional information if someone used the term frail about a service user.

While some participants stated that as home care professionals they had a shared understanding of the term frail, other participants voiced that frail was a challenging term to explain because people could understand the term in different ways. In two of the groups, participants drew attention to how their workplace and educational background could lead to diverse perceptions of frailty:

Jo: There might be around 2000 definitions of frailty, and you might choose to interpret it based on how it's used at work. What *I* might associate with frailty is people living at home who have difficulty in walking or are malnourished or clinically vulnerable.

The participants furthermore mentioned frail as a term that did not belong in professional terminology. In the dialogue that followed in one of the groups, an exchange occurred in which some group members stated that they had never heard the word frail used in the home care services:

Parker: I do not think it's used in that way. Because you talk a bit more professionally, you maybe describe reduced general condition [...] problems with nutrition and... [...].
Andie: We say it more professionally. Use the professionally correct word.

The participants reported being more familiar with using words that indicated service users' individual needs for care and treatment rather than umbrella terms such as frail. However, some participants reflected on frailty as a potentially useful term in 'theoretical' language, and other participants stated that they might use the word frail to express how they themselves occasionally felt.

3.2 | Frailty as a consequence of ageing

After the groups' initial reflections around frail as a term that they did not actively use in home care, most groups discussed frailty as a physical and visible phenomenon. The participants typically presented physical frailty through depictions of a thin and crooked old person with a reduced functional level. In some groups, participants also discussed how they did not find age-related frailty to be a negative term. However, this might not apply if the word frail was used to refer to a younger person:

Parker: I do not think I would have used 'frail' about a young person. It's more like the definition of an old [person].
Iben: You can be psychologically frail. That's possible.
Parker: Yes. But it sounds really negative if you say that someone aged 20 is frail.

The participants related frailty to old age, as part of a natural ageing process. For some participants, frailty as age-related decline was obvious. Other participants reflected on whether frailty was a process of natural decline:

Cam: I think 'frail' is more long-term. [...] You're thinking in a longer perspective. Do you understand?
Archer: That it's an age decline? In general?
Cam: Yes. Simply that. What you said.
Drew: Frailty, the way I think of it, is not something you recover from. Frail, it is...
Cam: More permanent.

When frailty is perceived as natural decline, being 'a little frail' in old age becomes acceptable:

Parker: If you are 102 years old, then you are a little frail, I assume.
Iben: Yes, you are. Then you are allowed to be a little [frail].
Parker: Perhaps you have too little weight, are thin, and yes, a bit fragile.

While a prominent description of frailty in the focus groups was frailty as a visible sign of physical age decline, some participants also described frailty as being more about dependence on help in everyday activities than about being at an advanced age.

3.3 | Frailty as lack of engagement and possibilities for engagement

Albeit in slightly different ways, all focus groups discussed frailty as involving a lack of interest and motivation. One discussion concerned older persons who were engaged in their everyday life. The participants did not consider older persons who were interested and engaged in their everyday lives as frail. Correspondingly, another discussion concerned associations between loss of interest and frailty:

Kyle: Then it is... frailty as developing over time. When you sort of stop caring and being interested. You're not so interested in the newspaper you have always had delivered. You're not interested in the outside world: 'Day centre? No. What am I going to do there?'

Participants also considered frailty, physical functioning, and lack of engagement to be related. Reduced physical functioning could make it difficult to carry out everyday tasks and participate in social networks. Consequently, physical weakness, boredom and loneliness could lead to poor motivation and engagement:

Taylor: If you stay at home, seven days a week. Who would not have become a bit… Yes, frail. Well, yes, you would.
Iben: A bit depressed, it's the loneliness.
Taylor: Yes! And your body does not function properly. … They do not go out for a run. That's not possible. They sit and watch television. Day out and [day in].

The focus group discussions reflected on perceptions of frailty as originating from a lack of engagement, and frailty as a consequence of lacking possibilities for physical and social activity.

3.4 | Frailty as a contextual phenomenon

In the focus group discussions, frailty was also presented as a contextual phenomenon. The participants discussed examples of how frailty could change if service users moved between different contexts, for example between hospital and home, and talked about how contextual factors could affect frailty:

Kyle: We have seen people who were really depressed, that…
Jordan: …flourished in an institution.
Kyle: And suddenly they become an entirely different person.
Jordan: So, it does have something to do with the circumstances. Definitively.

In the participants' dialogues about frailty as changing with time and place, the importance of service users' opportunities for receiving support in daily life and their social networks was also emphasised. Accordingly, they agreed that they could not describe frailty in the same way for all service users:

Jo: I feel that frailty is something you redefine continuously. There are different reasons for [my] perceptions of frailty. If I visit one person, frailty might be one thing. But if I visit another person, frailty might be something else.

This statement is one example of how participants described frailty as a changing and dynamic phenomenon, affected by contextual factors.

3.5 | Frailty as potentially affected by care

The participants talked about how people who lived with frailty could become less frail if they received the right care and support, and presented frailty as affected by care. They mentioned customised aids, adaptation of a person's home, and assistance from home care services as means to reduce frailty. Prevention of frailty, interventions, and compensation for frailty often coincided, but when the groups discussed frailty prevention, participants frequently mentioned nutrition, and physical and social activity:

Parker: We try really hard to do it, to help a person who's been frail to become less frail, eventually. If we can provide them with support in the right situations. Focus on nutrition, exercise, and social contact, especially.

Most groups highlighted participation in adult day care centres and everyday activity as means to prevent and reduce frailty. According to the participants, everyday activity could maintain and improve service users' functional level, and attending adult day care centres would not only prevent but also reduce frailty:

Jordan: Because there are several [service users] … whom we might have thought of as frail, when we start visiting them, and when they attend a day care centre, their health improves.
Kyle: Yes. Then I think, it might have been psychological.

Furthermore, the participants described how they tried to identify and treat a potential cause, for example, a urinary infection, if a service user's health deteriorated. However, neither intervention nor compensation was always sufficient to reduce frailty:

Kyle: We talk positively about day centres. We would like to try that, to see if they recover. See if something happens. But it does not always work. Some of them just become frailer. More and more frail.

Although the participants worked to improve the service users' health, they did not always succeed. Frailty was often but not always affected by care. In the home care professionals' experience, it could also affect service users' health negatively if the right care, such as a place in a nursing home, was not available at the right time:

Jo: …from the time of the application and until they receive a place, something tends to happen, they become malnourished, or they fall, or… often people get admitted to hospital for some reason.

Thus, the right care to prevent adverse outcomes of frailty could not always be provided.

4 | DISCUSSION

In this study, we inquired into home care professionals' conceptualisations of frailty in the context of home care services. Through a thematic analysis of focus group discussions involving home care professionals, we found that the terms frail and frailty were considered 'too imprecise to be useful' while also being terms to which the home care professionals ascribed several contrasting meanings.

Rather than using the term 'frail', the home care professionals in this study preferred to use terms they considered more 'professional' and specific when addressing service users' care needs. This is in line with what has been reported elsewhere. Manthorpe et al. (2018) found that few social care practitioners working in home care used the term frail. Moreover, Britain Thinks (2015) reported that non-specialist healthcare professionals such as GPs, nurses or ward managers did not view 'frailty' as a useful term. In contrast, healthcare professionals in an emergency department considered frailty as a useful term that provided them with information about their patients' needs (Cluley et al., 2022). In the present study, the participants considered terms other than frail to be more 'useful' in the sense of indicating specific measures. This concurs with the recommendation by Waldon (2018) for person-centred care involving the use of language that suggests practical solutions. That home care professionals consider the term 'frail' as imprecise, while hospital staff considered 'frailty' as a useful term, might be related to the different settings, as well as different conceptualisations of frailty within these two settings.

The home care professionals in this study considered 'frailty' as a natural decline following ageing, in line with what has been reported from previous studies (Britain Thinks, 2015; Obbia et al., 2020). In the home care professionals' view, frailty could be expected in very old age, and very old persons were "allowed to be a little [frail]". Frailty as natural decline corresponds with the description by Murray et al. (2005) of frailty as an illness trajectory of "prolonged dwindling" (p. 1008) but contrasts with other scholars who have argued that frailty is not an inevitable consequence of ageing (Rodríguez-Laso et al., 2019; Wallington, 2016). Implicit in the association between frailty and natural decline is the conceptualisation of frailty as an individual trait. Frailty is perceived as originating from or existing within an individual (Markle-Reid & Browne, 2003). This also applies to the home care professionals' conceptualisation of frailty as a 'lack of engagement'. When frailty is considered an individual trait, interventions to prevent or reduce frailty must be directed towards the person.

Other results from this study indicate that the home care professionals considered frailty not solely as an individual trait, but also as a contextual phenomenon shaped by the interplay between an older service user and this person's social and physical environment. This is evident in the home care professionals' associations between frailty and the lack of opportunities for engagement. This view corresponds with previous research reporting that healthcare professionals associated frailty with having an inadequate social network, being excluded from involvement in everyday life, and not having opportunities to participate in societal development (Gustafsson et al., 2012). Primary care professionals in Italy additionally related older people's financial situation to frailty (Obbia et al., 2020). Similar to these results, studies involving older persons themselves have demonstrated that frailty is shaped by the older adults' homes and access to transportation (Grenier, 2005), a rural place of residence (Bjerkmo et al., 2021), and encounters with care systems (Grenier, 2005, 2020). Although the home care professionals in the present study did not talk about rural locations and access to transportation as directly related to frailty, they emphasised the importance of such factors for all of their older service users'. These perspectives support theoretical models that consider frailty as resulting from individual, social and environmental factors (De Witte et al., 2013; Markle-Reid & Browne, 2003).

Closely associated with the home care professionals' conceptualisations of frailty were their assumptions about care. The participants in this study acknowledged that frailty is 'potentially affected by care'. The participants considered physical activity, nutritional support and social support as means to prevent or reduce frailty, which agrees with suggestions from the literature (Apóstolo et al., 2018; Luger et al., 2016; Puts et al., 2017). Inherent in the assumption about frailty as possible to prevent or reduce is the acknowledgement that frailty is not necessarily, and not always, an irreversible or permanent state of decline. In other words, the participants conceptualised frailty as both a natural age-related decline and a state that can be prevented or reduced. While in previous literature frailty has often been considered either as a state that could be 'cured' or prevented (Gwyther et al., 2018; Rodríguez-Laso et al., 2019) or a state that requires 'care' (Pal & Manning, 2014; Stow et al., 2019), our results demonstrate that home care professionals' conceptualisations of frailty move along the continuum between frailty as possible to prevent and reduce ('cure') and frailty as natural decline requiring care ('care'). The participants thus conceptualised frailty in accordance with the service users' diverse health and care needs, and how they as home care professionals provide services that range from supporting people with minor tasks, such as medication delivery and domestic care, to caring for people with extensive health and care needs.

Several studies have emphasised that care professionals need to focus on early detection and prevention of frailty (Gwyther et al., 2018; Obbia et al., 2020; Shaw et al., 2018). Grenier (2020), who has discussed some of the power relations embedded in "the knowledge and practices surrounding frailty" (p. 2338), argued that the prominent narrative on frailty as a state that should be prevented and treated may imply a reluctance to discuss conditions that cannot be 'cured' (p. 2348). In that regard, conceptualisations of frailty as natural age-related decline may enable discussions about end-of-life care. Others have noted the risk of responding to any challenge experienced by older persons with "it is your age" (Baars & Phillipson, 2013, p. 2), which could result in the neglect and omission of older persons' care needs as well as an 'individualisation' of frailty that overlooks the importance of contextual and structural factors.

Although we do not have data on how home care professionals act in their individual meetings with service users, our results indicate that while home care professionals struggle to conceptualise frailty, they manoeuvre the continuum between cure and care in their everyday practices and in encounters with older persons with complex care needs. While the home care professionals talked about interventions to prevent and reduce frailty, statements such as "But it doesn't always work. Some of them just become frailer" demonstrated that they also recognised the limits of curative models of

care. This study thus suggests that to provide person-centred care, increase the health and wellbeing of home care users, and contribute to sustainable services (United Nations, 2015, p. 16, goal 3.), governments and policymakers need to be aware of the diversity among home-dwelling older persons who receive home care services and are considered frail.

The diversity among older service users living with frailty described by the participants in this study indicates that, in the context of home care, frailty should be understood in relation to the individual older person in need of care, the person's home, and the person's social and physical environment. Diverse conceptualisations of frailty might thus be necessary for the context of home care. How frailty is discussed and understood in other settings, for example in a hospital, cannot be uncritically translated into how frailty is experienced in the context of a person's own home. However, a broad definition of frailty might imply that the terms frail and frailty will continue to be 'too imprecise to be useful'. Cluley et al. (2022) showed that hospital staff perceived frailty as a useful clinical term, but also as a condition that required non-medical solutions outside a hospital setting. In terms of future research, it would be interesting to explore how health and care professionals co-construct frailty across different contexts, with focus group discussions including professionals from a hospital and home care services. Older persons themselves have suggested that care professionals should focus on independence, resilience, and autonomy rather than frailty (Pan et al., 2019). A study exploring how older persons themselves and health and care professionals co-constructed frailty could also be interesting.

4.1 | Strengths and limitations

Although there is a risk that small focus groups may generate less diverse data, our data represented a variety of viewpoints, and we did not assess the data from the smaller focus groups as less rich than the data from the larger groups. The smaller focus groups seemed to enable rich discussions (cf. Braun & Clarke, 2013, p. 115). Some of the focus groups were organised in collaboration with managers, which could have made participants refrain from sharing their views knowing that their managers were aware of their participation in the study. However, the richness and diversity of viewpoints represented in the data do not support this suggestion. The study involved home care professionals in a Nordic setting, and conceptualisations of frailty in other welfare systems and cultures might differ from our results. Our results do, however, corroborate with results from studies in other western countries and might thus be transferable to similar contexts in other western countries. We have sought to enhance transferability (Braun & Clarke, 2013, p. 282) by providing thorough descriptions of the study setting, recruitment of participants, and data generation process. A strength of the study is that all participating home care professionals worked on a daily basis with older persons living in their own homes, in urban and rural environments, and in different care practices. Another strength of the study is the involvement of all authors in the data analysis and the interpretation of the results. Although all authors are nurses, our clinical, theoretical, and methodological expertise is diverse.

5 | CONCLUSION

This study demonstrates how home care professionals conceptualise frailty in the context of home care services, both as an individual trait and as resulting from the interplay between individual and environmental factors. The home care professionals' conceptualisations of frailty moved along a continuum between frailty as possible to prevent and 'cure' and frailty as related to natural decline and, thus, requiring 'care'. Whereas existing literature often emphasises early detection and the prevention of frailty, this study suggests that home care professionals' manoeuvre within the continuum between cure and care in their everyday practices, aiming to prevent frailty, but also recognising that frailty is not always possible to prevent. Practitioners, policymakers, and educators should acknowledge that characterising a home care service user as 'frail' does not provide sufficient information about the service user's individual care needs. However, within the context of home care, frailty is dynamic and contextual and thus needs to be conceptualised in ways that enable professionals to move along the continuum between 'cure' and 'care'.

6 | IMPLICATIONS FOR PRACTICE

- When frailty is conceptualised as resulting from the interplay between individual and environmental factors, home care professionals can adress frailty with interventions directed towards people's physical and social environment.
- Educators need to initate discussions about the complexity of the concept of frailty, which includes frailty as a theoretical concept, frailty as a professional term, and the ethical implications of the use of the terms frail and frailty.

AUTHOR CONTRIBUTIONS

All authors meet each of the following two criteria: (a) substantial contributions to design and data generation, or analysis and interpretation of data, (b) drafting the article or revising it critically for important intellectual content. All authors have approved the submitted version.

ACKNOWLEDGEMENTS

We would like to thank all home care professionals who participated in this study for sharing their experiences and perspectives on frailty. We would also like to thank the participants in our expert team for inspiring discussions and contributions to the analysis, and Mona Pauline Voie and Monika Dybdahl Jakobsen for reading through and providing valuable comments on an earlier draft of this article.

FUNDING INFORMATION

This study was funded by UiT The Arctic University of Norway.

CONFLICT OF INTEREST

None.

DATA AVAILABILITY STATEMENT

The data that support the results of this study are not publicly available.

ORCID

Kristin S. Voie https://orcid.org/0000-0002-8745-5192
Bodil H. Blix https://orcid.org/0000-0002-1049-4636
Ann Karin Helgesen https://orcid.org/0000-0003-4572-9439
Kjersti Sunde Mæhre https://orcid.org/0000-0002-3662-6131

REFERENCES

Apóstolo, J., Cooke, R., Bobrowicz-Campos, E., Santana, S., Marcucci, M., Cano, A., Vollenbroek-Hutten, M., Germini, F., D'Avanzo, B., Gwyther, H., & Holland, C. (2018). Effectiveness of interventions to prevent pre-frailty and frailty progression in older adults: A systematic review. *JBI Database of Systematic Reviews and Implementation Reports*, *16*(1), 140–232. https://doi.org/10.11124/JBISRIR-2017-003382

Baars, J., & Phillipson, C. (2013). Introduction. In J. Baars, J. Dohmen, A. Grenier, & C. Phillipson (Eds.), *Ageing, meaning and social structure: Connecting critical and humanistic gerontology* (pp. 1–10). Policy Press. https://doi.org/10.1332/policypress/9781447300908.001.0001

Barry, A., Heale, R., Pilon, R., & Lavoie, A. M. (2018). The meaning of home for ageing women living alone: An evolutionary concept analysis. *Health and Social Care in the Community*, *26*, 337–344. https://doi.org/10.1111/hsc.12470

Bergman, H., Ferrucci, L., Guralnik, J. M., Hogan, D., Hummel, S., Karunananthan, S., & Wolfson, C. (2007). Frailty: An emerging research and clinical paradigm—Issues and controversies. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *62*(7), 731–737. https://doi.org/10.1093/gerona/62.7.731

Bjerkmo, L., Helgesen, A. K., Larsen, T. A., & Blix, B. H. (2021). "Falling off the wagon": Older adults' experiences of living with frailty in rural arctic communities. *International Journal of Circumpolar Health*, *80*(1), 1–11. https://doi.org/10.1080/22423982.2021.1957569

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research. A practical guide for beginners*. SAGE Publications.

Cesari, M., & Theou, O. (2017). Frailty: The broad view. In H. M. Fillit, K. Rockwood, & J. Young (Eds.), *Brocklehurst's textbook of geriatric medicine and gerontology* (pp. 84–87). Elsevier.

Clegg, A., Young, J., Iliffe, S., Rikkert, M. O., & Rockwood, K. (2013). Frailty in elderly people. *The Lancet*, *381*(9868), 752–762. https://doi.org/10.1016/S0140-6736(12)62167-9

Cluley, V., Martin, G., Radnor, Z., & Banerjee, J. (2022). Talking about frailty: Health professional perspectives and an ideological dilemma. *Ageing and Society*, *42*(1), 204–222. https://doi.org/10.1017/S0144686X20000884

De Witte, N., Donder, L., Dury, S., Buffel, T., Verté, D., & Schols, J. (2013). A theoretical perspective on the conceptualisation and usefulness of frailty and vulnerability measurements in community dwelling older persons. *Aporia: The Nursing Journal*, *5*, 13–31. https://doi.org/10.18192/aporia.v5i1.2894

Fjørtoft, A.-K. (2016). *Hjemmesykepleie: Ansvar, utfordringer og muligheter [Home care nursing: Responsibilities, challenges and opportunities]* (3rd ed.). Fagbokforlaget.

Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener, J., Seeman, T., Tracy, R., Kop, W. J., Burke, G., & McBurnie, M. A. (2001). Frailty in older adults: Evidence for a phenotype. *Journal of Gerontology: Medical Sciences*, *56*(3), M146–M156. https://doi.org/10.1093/gerona/56.3.M146

Genet, N., Boerma, W., Kringos, D., Bouman, A., Francke, A., Fagerström, C., Melchiorre, M., Greco, C., & Devillé, W. (2011). Home care in Europe: A systematic literature review. *BMC Health Services Research*, *11*(207), 1–14. https://doi.org/10.1186/1472-6963-11-207

Gobbens, R., Luijkx, K., Wijnen-Sponselee, M., & Schols, J. (2010). Towards an integral conceptual model of frailty. *The Journal of Nutrition, Health & Aging*, *14*(3), 175–181. https://doi.org/10.1007/s12603-010-0045-6

Grenier, A. M. (2005). The contextual and social locations of older women's experiences of disability and decline. *Journal of Aging Studies*, *19*(2), 131–146. https://doi.org/10.1016/j.jaging.2004.07.003

Grenier, A. M. (2020). The conspicuous absence of the social, emotional and political aspects of frailty: The example of the white book on frailty. *Ageing and Society*, *40*(11), 2338–2354. https://doi.org/10.1017/S0144686X19000631

Gustafsson, S., Edberg, A.-K., & Dahlin-Ivanoff, S. (2012). Swedish health care Professionals' view of frailty in older persons. *Journal of Applied Gerontology*, *31*(5), 622–640. https://doi.org/10.1177/0733464810396874

Gwyther, H., Shaw, R. L., Jaime Dauden, E.-A., D'Avanzo, B., Kurpas, D., Bujnowska-Fedak, M., Kujawa, T., Marcucci, M., Cano, A., & Holland, C. (2018). Understanding frailty: A qualitative study of European healthcare policy-makers' approaches to frailty screening and management. *British Medical Journal Open*, *8*(1), e018653. https://doi.org/10.1136/bmjopen-2017-018653

Heath, H., & Phair, L. (2011). Frailty and its significance in older people's nursing. *International Journal of Older People Nursing*, *4*(2), 120–131. https://doi.org/10.1111/j.1748-3743.2009.00165.x

Helse- og omsorgstjenesteloven [Health and Care Services Act]. (2011). Lov om kommunale helse og omsorgstjenester m.m. [Act Relating to Municipal Health and Care Services] (LOV-2011-06-24-30). https://lovdata.no/dokument/NL/lov/2011-06-24-30

Hoogendijk, E. O., Afilalo, J., Ensrud, K. E., Kowal, P., Onder, G., & Fried, L. P. (2019). Frailty: Implications for clinical practice and public health. *Lancet*, *394*(10206), 1365–1375. https://doi.org/10.1016/S0140-6736(19)31786-6

Kasper, J. D., Wolff, J. L., & Skehan, M. (2019). Care arrangements of older adults: What they prefer, what they have, and implications for quality of life. *Gerontologist*, *59*(5), 845–855. https://doi.org/10.1093/geront/gny127

Kitzinger, J., & Barbour, R. (1999). Introduction: The challenge and promise of focus groups. In R. Barbour & J. Kitzinger (Eds.), *Developing focus group research- politics, theory and practice* (pp. 1–20). SAGE Publications Ltd.. https://doi.org/10.4135/9781849208857

Korenvain, C., Famiyeh, I.-M., Dunn, S., Whitehead, C. R., Rochon, P. A., & McCarthy, L. M. (2018). Identifying frailty in primary care: A qualitative description of family physicians' gestalt impressions of their older adult patients. *BMC Family Practice*, *19*(1), 61. https://doi.org/10.1186/s12875-018-0743-4

Kringlebotten, M., & Langørgen, A. (2020). Gruppering av kommuner etter folkemengde og økonomiske rammebetingelser 2020. [classification of municipalities by population size and economic workload 2020] (2020/48). Statistics Norway. https://www.ssb.no/en/offentlig-sektor/artikler-og-publikasjoner/classification-of-norwegian-municipalities-by-population-size-and-economic-workload-2020

Looman, W., Fabbricotti, I., Blom, J., Jansen, A., Lutomski, J., Metzelthin, S. F., & Huijsman, R. (2018). The frail older person does not exist: Development of frailty profiles with latent class analysis. *BMC Geriatrics*, *18*(1), 84. https://doi.org/10.1186/s12877-018-0776-5

Luger, E., Dorner, T. E., Haider, S., Kapan, A., Lackinger, C., & Schindler, K. (2016). Effects of a home-based and volunteer-administered physical training, nutritional, and social support program on malnutrition and frailty in older persons: A randomized controlled trial. *Journal of the American Medical Directors Association*, *17*(7), 671.e679–671.e616. https://doi.org/10.1016/j.jamda.2016.04.018

Manthorpe, J., Iliffe, S., Harris, J., & Stevens, M. (2018). Frailty and social care: Over- or under-familiar terms? *Social Policy and Society*, *17*(1), 23–33. https://doi.org/10.1017/S1474746416000427

Markle-Reid, M., & Browne, G. (2003). Conceptualizations of frailty in relation to older adults. *Journal of Advanced Nursing*, *44*(1), 58–68. https://doi.org/10.1046/j.1365-2648.2003.02767.x

Meld. St. 7. (2019–2020). Nasjonal helse- og sykehusplan 2020–2023 [White paper No 7 (2019–2020). National health- and hospital plan 2020-2032]. Helse- og omsorgsdepartementet [Norwegian Ministry of Health and Care Services]. https://www.regjeringen.no/no/dokumenter/meld.-st.-7-20192020/id2678667/

Mitnitski, A. B., Mogilner, A. J., & Rockwood, K. (2001). Accumulation of deficits as a proxy measure of aging. *The Scientific World Journal*, *1*, 323–336. https://doi.org/10.1100/tsw.2001.58

Morley, J. E., Vellas, B., Abellan van Kan, G., Anker, S. D., Bauer, J. M., Bernabei, R., Cesari, M., Chumlea, W. C., Doehner, W., Evans, J., Fried, L. P., Guralnik, J. M., Katz, P. R., Malmstrom, T., & Walston, J. (2013). Frailty consensus: A call to action. *Journal of the American Medical Directors Association*, *14*(6), 392–397. https://doi.org/10.1016/j.jamda.2013.03.022

Murray, S. A., Kendall, M., Boyd, K., & Sheikh, A. (2005). Illness trajectories and palliative care. *British Medical Journal*, *330*(7498), 1007–1011.

Nicholson, C., Gordon, A. L., & Tinker, A. (2017). Changing the way "we" view and talk about frailty…. *Age and Ageing*, *46*(3), 349–351. https://doi.org/10.1093/ageing/afw224

Obbia, P., Graham, C., Duffy, F. J. R., & Gobbens, R. (2020). Preventing frailty in older people: An exploration of primary care professionals' experiences. *International Journal of Older People Nursing*, *15*, e12297. https://doi.org/10.1111/opn.12297

Pal, L. M., & Manning, L. (2014). Palliative care for frail older people. *Clinical Medicine*, *14*(3), 292–295. https://doi.org/10.7861/clinmedicine.14-3-292

Pan, E., Bloomfield, K., & Boyd, M. L. (2019). Resilience, not frailty: A qualitative study of the perceptions of older adults towards "frailty". *International Journal of Older People Nursing*, *14*(4), e12261. https://doi.org/10.1111/opn.12261

Puts, M. T. E., Toubasi, S., Andrew, M. K., Ashe, M. C., Ploeg, J., Atkinson, E., Ayala, A. P., Roy, A., Rodríguez Monforte, M., Bergman, H., & McGilton, K. (2017). Interventions to prevent or reduce the level of frailty in community-dwelling older adults: A scoping review of the literature and international policies. *Age and Ageing*, *46*(3), 383–392. https://doi.org/10.1093/ageing/afw247

Richardson, S., Karunananthan, S., & Bergman, H. (2011). I may be frail but i ain't no failure. *Canadian Geriatrics Journal*, *14*(1), 24–28. https://search.proquest.com/docview/1033195218?accountid=17260

Rockwood, K., & Howlett, S. E. (2019). Age-related deficit accumulation and the diseases of ageing. *Mechanisms of Ageing and Development*, *180*, 107–116. https://doi.org/10.1016/j.mad.2019.04.005

Rodríguez-Laso, Á., Mora, M. A. C., Sánchez, I. G., Bouzón, C. A., Mañas, L. R., Bernabei, R., Gabrovec, B., Hendry, A., Liew, A., O'Caoimh, R., Roller-Wirnsberger, R., Antoniadou, E., Carriazo, A. M., Galluzzo, L., Redón, J., & Targowski, T. (2019). Updated state of the art report on the prevention and management of frailty. https://www.advantageja.eu/images/SoAR-AdvantageJA_Fulltext.pdf

Rodríguez-Mañas, L., Féart, C., Mann, G., Viña, J., Chatterji, S., Chodzko-Zajko, W., Gonzalez-Colaço Harmand, M., Bergman, H., Carcaillon, L., Nicholson, C., Scuteri, A., Sinclair, A., Pelaez, M., Van der Cammen, T., Beland, F., Bickenbach, J., Delamarche, P., Ferrucci, L., Fried, L. P., … Vega, E. (2013). Searching for an operational definition of frailty: A Delphi method based consensus statement. The Frailty Operative Definition-Consensus Conference Project. *Journals of Gerontology Series A: Biomedical Sciences and Medical Sciences*, *68*(1), 62–67. https://doi.org/10.1093/gerona/gls119

Rolfson, D., Heckman, G. A., Bagshaw, S. M., Robertson, D., & Hirdes, J. P. (2018). Implementing frailty measures in the Canadian health care system. *The Journal of Frailty and Aging*, *7*(4), 208–216. https://doi.org/10.14283/jfa.2018.29

Schoenborn, N. L., Van Pilsum Rasmussen, S. E., Xue, Q. L., Walston, J., McAdams-Demarco, M. A., Segev, D. L., & Boyd, C. M. (2018). Older adults' perceptions and informational needs regarding frailty. *BMC Geriatrics*, *18*, 1–7. https://doi.org/10.1186/s12877-018-0741-3

Sezgin, D., O'Donovan, M., Cornally, N., Liew, A., O'Caoimh, R., & Sezgin, D. (2019). Defining frailty for healthcare practice and research: A qualitative systematic review with thematic analysis. *International Journal of Nursing Studies*, *92*, 16–26. https://doi.org/10.1016/j.ijnurstu.2018.12.014

Shaw, R. L., Gwyther, H., Holland, C., Bujnowska-Fedak, M., Kurpas, D., Cano, A., Marcucci, M., Riva, S., & D'Avanzo, B. (2018). Understanding frailty: Meanings and beliefs about screening and prevention across key stakeholder groups in Europe. *Ageing & Society*, *38*(6), 1223–1252. https://doi.org/10.1017/S0144686X17000745

St. Meld. Nr. 47. (2008–2009). Samhandlingsreformen. Rett behandling-på rett sted-til rett tid [White paper No. 47 (2008–2009). The coordination reform. Proper treatment, at the right place and right time]. Helse- og omsorgsdepartentet [Norwegian Ministry of Health and Care Services]. https://www.regjeringen.no/no/dokumenter/stmeld-nr-47-2008-2009-/id567201/

Statistics Norway. (2021). Sjukeheimar, heimetenester og andre omsorgstenester [Care services]. https://www.ssb.no/helse/helsetjenester/statistikk/sjukeheimar-heimetenester-og-andre-omsorgstenester

Stow, D., Spiers, G., Matthews, F. E., & Hanratty, B. (2019). What is the evidence that people with frailty have needs for palliative care at the end of life? A systematic review and narrative synthesis. *Palliative Medicine*, *33*(4), 399–414. https://doi.org/10.1177/0269216319828650

Thinks, B. (2015). Frailty: Language and perceptions. A report prepared by Britain Thinks on behalf of AGE UK and the British Geriatrics Society. https://www.ageuk.org.uk/documents/en-gb/for-professionals/policy/health-and-wellbeing/report_bgs_frailty_language_and_perceptions.pdf?dtrk=true

United Nations. (2015). Transforming our world: The 2030 agenda for sustainable development. (a/RES/70/1). https://sdgs.un.org/2030agenda

Waldon, M. (2018). Frailty in older people: A principle-based concept analysis. *British Journal of Community Nursing*, *23*(10), 482–494. https://doi.org/10.12968/bjcn.2018.23.10.482

Wallington, S. L. (2016). Frailty: A term with many meanings and a growing priority for community nurses. *British Journal of Community Nursing*, *21*(8), 385–389. https://doi.org/10.12968/bjcn.2016.21.8.385

How to cite this article: Voie, K. S., Blix, B. H., Helgesen, A. K., Larsen, T. A., & Mæhre, K. S. (2023). Professional home care providers' conceptualisations of frailty in the context of home care: A focus group study. *International Journal of Older People Nursing*, *18*, e12511. https://doi.org/10.1111/opn.12511