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Preventing frailty in older people: An exploration of primary care professionals' experiences

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Abstract

Background: An increasing number of the ageing population worldwide is at risk of becoming frail and incapacitated. This has the potential to impact not only on the well-being of individuals but also on the sustainability of healthcare systems.

Objective: The aim of this study was to explore the views and experiences of frailty from the perspective of primary care professionals, including nurses, who work directly with older people within the community.

Methods: A qualitative approach with a descriptive phenomenological methodology was used, which focused on exploration of primary care professionals' current experiences of early detection and prevention of the onset of frailty. Four multiprofessional focus groups were held with a total of thirty-three primary care professionals who worked with older people as part of their daily role. Participants included district nurses, general practitioners, home care workers, physiotherapists and social workers.

Results: Professional views encompassed typical patterns of ageing, loneliness, presence of comorbidity, disability and end of life, with social conditions prevalent in most frailty they encountered. Three main themes emerged: the psychosocial nature of frailty, late detection of frailty and barriers to the feasibility of prevention. Physical frailty was considered a constituent part of ageing, which recognised the presence of a skills gap related to the detection of the early signs of frailty. Present health and social care systems are not designed to prevent frailty, and the competencies required by health and social care professionals are not usually included as part of their training curricula. This may hinder opportunities to intervene to prevent associated decline in ability of older adults.

Conclusions: To enhance the early assessment of frailty and the planning of preventive multi-factorial interventions in primary care and community settings, training and effective detection strategies should be incorporated into the role and daily care activities of primary care professionals.

Implications for practice: Using a multidimensional assessment instrument can help primary care professionals to identify older people who are frail or may become frail.

In order to be able to carry out this properly strong inter-professional collaboration is needed. In addition, interventions aimed at preventing frailty or adverse outcomes of frailty should be tailor-made and thus should meet the needs and wishes of an older person.

KEYWORDS

frailty, older people, prevention, primary health care, professionals' experiences, qualitative methods

1 | INTRODUCTION

Frailty is a relatively new construct, which is often poorly understood, unclear and at times controversial (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004). It is used as an umbrella term that covers ageing decline, disability, multi-morbidity, cognitive and social problems and those approaching the end of life with a long-term condition (Cesari et al., 2016). According to Lacas and Rockwood (2012), frailty is considered by older people specialists as variable vulnerability, which leads to adverse health outcomes among older adults. Fried et al. (2004) defined frailty as the presence of general weakness, poor endurance, weight loss and/or undernourishment, low activity and unsteady gait. Frailty status can be a predictor of risks such as falls, disability (Gobbens, van Assen, Luijkx, & Schols, 2012; Puts, Lips, & Deeg, 2005), hospitalisation (Fried et al., 2001), institutionalisation (Rockwood et al., 2005) and death (Fried et al., 2001). Additionally, frailty is related to a lower quality of life in older adults (Bilotta et al., 2010; Gobbens & van Assen, 2014).

There is an ongoing debate around distinguishing between frail and non-frail older people and whether there are precursors to frailty and prefrailty conditions that are included in the phenotype of frailty (Fried et al., 2001). There is a belief that frailty could be reversed if there was a process for early screening followed by appropriate interventions (Cesari et al., 2016). Interventions require to be multi-factorial and include physical exercise, adequate intake of calories, protein, vitamin D supplementation and increased social support to be most effective (Luger et al., 2016; Zuliani et al., 2015). A recent systematic review showed that a combination of muscle strength training and protein supplementation was the most effective intervention to delay or reverse frailty in older people and additionally the easiest to implement in primary care (Travers, Romero-Ortuno, Bailey, & Cooney, 2019). The World Health Organization (2017) also raises concern that the majority of healthcare professionals may not have the required knowledge and skills to intervene in ways which promote health and prevent disease in older people (Bardach & Rowles, 2012; Knight, Oliver, Wyrko, Gordon, & Turner, 2014). A "knowledge gap" and a lack of understanding of the nature of frailty and its reversibility were further identified by Gwyther et al. (2018) in their qualitative study that examined policymakers' views regarding frailty screening and management. In addition, ageist stereotypes may also affect the assessment of the frail condition, if treatable disorders are dismissed as being normal aspects of ageing (Center for Policy on Ageing, 2009; Levy, 2001).

What does this research add to existing knowledge in gerontology?

- A rich understanding of primary care professionals' views and experiences of the detection and treatment of frailty in older people.
- Understanding of the complexity of frailty in community-dwelling older people and effective interventions considered to support frailty.
- Recognition of the physical signs of frailty that are often considered as a decline within normal ageing.

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

- An opportunity to improve knowledge, understanding and detection of frailty by professionals, including nurses, working in the front line with older people in primary care settings.
- The findings advocate a shift from the current approach of providing interventions and advice towards a collaborative consultative approach. Nurses are core to this shift.
- An opportunity to enhance the early assessment of frailty and plan preventive multi-factorial interventions and effective detection strategies. These should be incorporated into the daily care activities of nurses and other primary care professionals.

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

- The findings highlight the need for improved multi-professional training to enhance the knowledge of frailty in older people and to disentangle frailty from disability and multi-morbidity in a collaborative context.
- The findings indicate a need to inform policy and practice in relation to frailty in older adults.

The potential benefits of proactive early assessment of frailty and age-related chronic illness by primary care professionals require a clear understanding of the importance of frailty (Fairhall et al., 2011). It also requires having a coherent means of identifying when it is occurring and agreed ways of dealing with it if when suspected. Many factors influence health and social care professionals' decision-making processes (Clemens & Hayes, 1997; Craig & Smyth, 2007; Gabbay & le May, 2004), including their personal attitudes, knowledge and experience, as well as the organisational cultures and the structures in which they work. In the study conducted by Shaw et al. (2017), which examined the views of professionals and stakeholder in three European countries, it was identified that consideration of professionals' beliefs in relation to the effectiveness of screening and the feasibility of intervention was notable factors, which could impede instigating screening. Professionals need to believe that screening and interventions work for these to be instigated.

While it is recognised that professional beliefs have an impact on screening and intervention, few studies have focused on the views, experiences and professional understanding of the concept of frailty in older adults (Fried et al., 2004; Gustafsson, Edberg, & Dahlin-Ivanoff, 2012; Herrmann, Osiek, Cos, Michel, & Robine, 2005; Kaethler, Molnar, Mitchell, Soucie, & Man-Son-Hing, 2003; Roland, Theou, Jakobi, Swan, & Jones, 2011, 2014).

1.1 | Aim

The aim of this study was to explore the views and experiences of primary care professionals working with older people on of the concept of frailty.

The research questions addressed in the study were as follows:

- What are the views held by primary care professionals regarding frailty in older people?
- What are their experiences regarding the early detection of frailty among their older clients?
- What are their experiences of introducing preventive interventions in practice with older people showing signs of frailty?

2 | DESIGN AND METHODS

2.1 | Design

A qualitative approach with a descriptive phenomenological methodology was used. Focus group interviews were considered the best approach to gain an understanding of the experiences and views of professionals in the field. By determining the here and now, questions relevant to practitioners and policymakers would be explored (Sandelowski, 2000), in order to reveal any changes that could be made to improve care (Holloway & Wheeler, 2010).

2.2 | Participants

The population under study was primary care professionals. The sample was homogeneous, because the inclusion criteria required that participants were primary care professionals dealing with older people as part of their daily activities who had comparable working experiences. The sample was made heterogeneous owing to the presence of different professionals including general practitioners, district nurses, home care workers, physiotherapists and social workers. Four different Local Health Agencies in Piedmont, Italy, were chosen in order to represent the locality in which the research was taking place: one was in a middle-sized town (Focus Group A), one in a rural area (Focus Group B), one in an affluent urban area (Focus Group C) and one in a deprived urban area (Focus Group D). The desired recruitment number for each focus group was eight since this is considered the ideal number of participants for this type of data collection (Morgan, 1988). Table 1 presents a description of the study participants' characteristics from the four focus groups.

2.3 | Data collection

Focus groups were considered to be the most effective way to gather the views and experiences of participants as they offer the opportunity of obtaining information about participants' views, emotional reactions, feelings and values that may not be so evident from individual interviews (Lutenbacher, Cooper, & Faccia, 2002). Morgan (1988) suggests that group discussions are more productive than individual interviews because these enable people not only to reveal what they think, but also challenge them to reveal why they think in that particular way. Furthermore, focus groups stimulate discussion and insightful thoughts among participants about their practice. The research questions were framed in an iterative manner, based on discussion among the research team, in order to offer open-ended questions that were broad enough to address the objectives of the study without overwhelming the participants. The questions so framed were then tested in two pilot focus groups. This final iteration led to minor revisions for the final set of questions as shown in Appendix 1.

The focus group discussions were conducted over one and a half hours and were audio-recorded and transcribed verbatim. Each focus group was conducted by a facilitator (the principal researcher), accompanied by an observer who was a skilled psychologist. The observer was assigned with keeping the group's focus upon the central topic and observing the non-verbal aspects of the group participant.

2.4 | Ethical considerations

The research design was approved by the Ethical Committees of the University supervising the study, and the permission to conduct the study was granted following further consultation with the four participating Local Health Agencies. The data of participants were held confidentially in line with Italian national data legislation (Italian Data

TABLE 1 Description of the participants' characteristics in the focus groups

	Code	♀	♂	Age	Mean number of years' working experience in primary care
Focus group A					
District nurse	A1 Nurse	1		42	18
District nurse	A6 Nurse	1		55	20
District nurse	A7 Nurse	1		40	12
General practitioner	A4 GP		1	67	40
Home care worker	A2 Home care worker	1		48	25
Physiotherapist	A8 Physiotherapist	1		45	12
Social worker	A3 Social worker	1		45	23
Social worker	A5 Social worker	1		50	25
Focus group B					
District nurse	B1 Nurse	1		45	20
District nurse	B3 Nurse	1		46	18
District nurse	B7 Nurse	1		44	18
General practitioner	B4 GP		1	53	27
Home care worker	B5 Home care worker	1		44	20
Home care worker	B6 Home care worker	1		50	24
Physiotherapist	B2 Physiotherapist	1		48	15
Social worker	B8 Social worker	1		45	18
Social worker	B9 Social worker	1		44	17
Focus group C					
District nurse	C2 Nurse	1		38	12
District nurse	C4 Nurse	1		34	12
District nurse	C9 Nurse	1		40	11
General practitioner	C1 GP	1		56	28
Home care worker	C3 Home care worker	1		48	20
Home care worker	C6 Home care worker	1		50	25
Physiotherapist	C7 Physiotherapist	1		42	12
Social worker	C8 Social worker	1		55	30
Focus group D					
District nurse	D2 Nurse	1		36	10
District nurse	D5 Nurse	1		44	16
General practitioner	D7 GP		1	62	35
Home care worker	D3 Home care worker		1	45	13
Home care worker	D6 Home care worker	1		50	20
Physiotherapist	D1 Physiotherapist	1		43	10
Social worker	D4 Social worker	1		52	27
TOTAL		29	4		

Protection Act D. Lgs. 196/2003) and the University's requirements for data protection.

2.5 | Data analysis

To ensure rigour and transparency in data analysis, the principal researcher followed Colaizzi's (1978) seven-step method of phenomenological analysis. This involves becoming fully familiar with the focus group data, identifying significant statements, formulating meanings, clustering themes, developing an exhaustive description of the phenomenon incorporating all the themes and their relationships, producing the fundamental structure of the phenomenon and finally seeking confirmation of the findings with the participants (Shosha, 2012). While the principal researcher focused on coding and managing the primary data, the other members of the

team undertook observational roles and had oversight of the process. Peer checking of intercoder reliability was not undertaken, as there is scepticism about the value of such testing. Loffe and Yardley (2004) and Vaismoradi, Turunen, and Bondas (2013) suggest that such checks do not establish that codes are objective, merely that two people can apply the same subjective perspective to the text. Intercoder reliability as a consequence may merely be training one researcher to think like another, when looking at fragments of text. The team took an approach that challenged the principal researcher to be reflective and to frequently review the data from different perspectives during each stage of data analysis, adding memos and insights as analysis progressed (DeSantis & Ugarriza, 2000; Graneheim & Lundman, 2004).

The initial analysis was carried out using the verbatim transcriptions in Italian. Translation from Italian to English was performed later by a professional translator, expert in health matters. A secondary examination of the English language transcriptions was undertaken by another researcher in The University of Turin.

2.6 | Rigour

The observer, a skilled psychologist, helped verify the accuracy of the original thematic analysis recounting, her observations of the non-verbal behaviour exhibited during the focus groups and how these may have impacted the discussion. She also confirmed the cogency of the emergent themes. The observer ensured the rigour of the study by confirming that the transcripts accurately reflected the content of the focussed discussions.

Member checking (Birt, Scott, Cavers, Campbell, & Walter, 2016) was carried out through email at the end of data analysis to allow participants' to validate the themes that had emerged. This reinforced the confirmability of the findings and provided further internal validity (Polit & Beck, 2012). An additional step to ensuring rigour was to present the results to a group of European experts in the field of care for older people and in particular frailty during a meeting of the SUNFRAIL project (https://www.sunfrail.eu), where we asked them to provide their feedback on the emerging themes. These experts, including geriatricians, nurses and sociologists, confirmed that the interpretations were grounded in the data and consistent with what they experience day to day.

3 | RESULTS

3.1 | Characteristics of participants

The participating professionals were not new to the primary care setting, the length of time that they had been present in this field of work ranged between 10 and 35 years. The mean age of participants was 48 years. Thirty-three practitioners participated: eleven district nurses, four general practitioners (GPs), eight home care workers, four physiotherapists and six social workers. Twenty-nine were female and four were male. Three main themes related to the three principal research questions emerged through analysis: the psychosocial nature of frailty, late detection and the enablers/barriers to preventive interventions. The themes are presented below.

3.2 | The psychosocial nature of frailty

The first research question was "What are the views held by primary care professionals regarding frailty in older people?" In response, the participants revealed that their concept of frailty among older adults was linked to multiple pathologies and to a wide framework of social, relational, psychological and, most important, economic problems. They described a "psychosocial nature" of frailty, where multiple factors could put the older persons at risk of adverse outcomes if a trigger event, such as a fall or a bereavement, altered the fine balance of their lives.

> *As Anna (A4 Home care worker) has just said, I also think that frailty is a risk situation, maybe one which has not already appeared, but can blow up at any moment.*
>
> *(A2 Nurse)*

Social factors, such as having family members, neighbours or informal caregivers, were considered core to coping with disease or recovering from an acute episode of illness. Within this overarching theme, a number of the psychosocial dimensions of frailty in older adults emerged as significant subthemes: loneliness, financial issues, family and community networks, psychological distress, hidden cognitive problems and the loss of independence in their activities of daily living.

3.2.1 | Loneliness

Loneliness was perceived as a common condition faced by many ageing citizens and as a common trait affecting frail older people.

> *(…) sometimes the diseases aren't so big an issue, but actually the old person is alone without a relative or with a spouse, who now is old too.*
>
> *(B3 Nurse)*

> *(…) the frailty I see it is more like the older person perhaps alone, without a support network.*
>
> *(A1 Social worker)*

The participants linked the loneliness to environmental isolation and lack of public transport in rural areas, while in urban areas, it was described as the absence or lack of social interactions. They also

recognised demographic and geographic transitions as a contributor to loneliness. When family members or friends have died or moved away, the isolation is exacerbated. Consequently, lonely older people are more at risk of frailty and, if already frail or ill, their health conditions could worsen rapidly.

3.2.2 | Financial issues

In the professionals' views, monetary issues were considered to be the core contributing factor inducing frailty in older people. This was related both to the individuals' conditions and to the availability of resources and public services in the community.

> *In the establishment of the mechanism of frailty, there is a huge obvious base element which touches all, that is the underlying economic frailty that affects the structure and resources that the individual has…*
>
> *(A4 GP)*

They recognised that this lack of resources impacts multiple health-determining factors such as the ability to self-care, the adequacy and suitability of housing and access to adequate health care. Moreover, they noted that unforeseen changes, such as those mentioned above: a bereavement or the relocation of children elsewhere, could further deteriorate the economic conditions.

> *She didn't have enough money to live, she would have had problems attempting to move, didn't have food and had lost 5 kilos in a short time and hadn't bought the medicines that the doctor had prescribed her. So I think that frailty can also be an economical frailty and without a social network life can quickly change.*
>
> *(D4 Social worker)*

In addition, health and social services were facing funding cuts, which further depleted the chances of providing community care. In the professionals' experience, helpful services formerly provided have been very limited and are not available anymore.

3.2.3 | Family and community networks

The participants noted that the family and social networking are no longer considered the bedrock of community living for older people they have met. They reported from their experience, that, even if present, the family could itself be vulnerable or have poor or strained interpersonal relationships. Therefore, the lack of support from family members was viewed as a common condition in frail older people. The professionals also perceived a paucity of community network, especially in the urban area. This is made clear from the following quotes.

> *When we enter into the life of a patient, we know that this is a frail person, maybe because they do not have a family who can support them, or they just has some cousins or distant relatives.*
>
> *(A8 Physiotherapist)*

> *…this person cannot manage anymore himself or his daily routine; he doesn't have any family, friends or neighbours that can help him.*
>
> *(C3 Nurse)*

This low level of social inclusion results in the loss of natural support often provided within local communities where social cohesion was previously higher. In town buildings, even if older people live surrounded by other people, it is often the apartments' manager who reports their conditions to health or social services, due to unavailability of family members or a friend to contact.

3.2.4 | Psychological distress

Apparent to the professionals in the study was also a state of psychological distress in the older patients they saw. This was associated with ageing and family issues, coupled with social, health and economic concerns.

> *… one thing I've noticed a lot in seniors,……even in older people who have not got a disease, is anxiety…… they realize that they are getting older, no longer at 100 % and they need help, and I do not always know why, it's a fact that I note a lot in many older people.*
>
> *(B7 Nurse)*

They also identified the fear of being alone as a common cause of anxiety and confusion.

3.2.5 | Hidden cognitive problems

Early cognitive symptoms are difficult to detect. Older people and their relatives usually considered cognitive decline as a part of the normal ageing process. Moreover, older people often try to cope with memory loss and to mask or deny their cognitive impairment, fearing potential loss of their independence.

> *Sometimes they are healthy people; however, they have different difficulties or show the first signs of a dementia that is not yet evident. These are the most difficult situations we have to manage, because they are people who start to lose their memory but are still very capable and so they do not recognize their difficulties.*
>
> *(D4 Social worker)*

Home visiting and the development of long-standing client/professional relationships in the primary care setting were considered enablers to detecting cognitive problems. This quote from a GP is revealing.

> *She is an educated person who speaks with a refined language …, she is smart but evidently a part of her brain has been damaged, then it jumps out… when we went to see her house everything wrong just jumped out…*
>
> *(B4 GP).*

This hidden cognitive problems' dimension makes it particularly difficult to assess the person properly and to plan shared interventions. Furthermore, even the relatives are often in denial and are not keen to face the problem.

3.2.6 | Loss of independence

The participants identified the loss of independence in performing their activities of daily living is a prominent aspect of frailty for a person, which leads them to request help from health and social care services. This is generally more in case of disability than frailty. However, practitioners were unable to chart a clear distinction between the two conditions. The overlap and confusion is clear in this quote.

> *Frailty for me is the permanent or total or partial loss of physical activities. However, these can be physical, but also cognitive or relational or sensory and these definitely bring a loss of capacity to complete life activities every day.*
>
> *(B3 Nurse)*

The observer noted that the professionals appeared uncomfortable discussing these subthemes related to the psychosocial dimension of frailty in older adults, as this was something which was out or their ability to control or to help with.

3.3 | Late detection

The second research question looked at capturing healthcare professionals' experiences in relation to the early detection of frailty among the older people they came across. The most common finding was late detection, which occurred since the participants came in contact with frail people only when adverse events had occurred.

> *The frailty, that was the question, we get it almost always late.*
>
> *(A4 GP)*

> *Of course, when we are asked to intervene there's already a situation of frailty, otherwise we would not have been contacted.*
>
> *(C2 Nurse)*

> *There are few prevention experiences… We are interventionist, because we are called by the hospital or by the family doctor and so we intervene where a problem already exists.*
>
> *(D5 Nurse)*

They recognised that, at present, the health and social services are structured only to respond in crisis and a lack of resources inhibits proactive interventions. The professionals reported that sometimes, even when a problem is detected, the person or family members fail to recognise it or are not keen to remediate concerns. This was linked to all the domains of the psychosocial nature of frailty in older adults.

3.4 | The enablers/barriers to preventive interventions

The third question this research asked was "Do you consider preventive interventions feasible when you meet with older people showing signs of frailty?" The respondents believed that prevention is complex but entirely feasible to initiate. However, they recognised that, presently, the prevention of frailty is not routinely considered within the daily activities. The subthemes related to enablers and barriers to preventive interventions identified within the participant discussions were support and related outcomes, lack of awareness and fear of being labelled, the wall of bureaucracy, access to the care network and integrated care.

3.4.1 | Support and related outcomes

The primary care professionals were confident that appropriate interventions could mitigate or even reverse the progression of a frail condition advancing towards disability. They could see the influence that their work with individuals and families could have towards improving the health conditions and the quality of life of older people.

> *… at the end of that period where they are supported, there are cases where the frailty condition decreases… the frail must always be supported.*
>
> *(A2 Home care worker)*

> *… persons, who even though they had lived in isolation or whose disease had been getting worse, would live in a respectable way. Of course, they are old people and so we cannot completely restore their condition, but we can help them not to worsen and to not get sick or dependent on others.*
>
> *(D6 Home care worker)*

The practitioners shared their experiences of the reversibility of frailty when support had been made available, and their view was captured in the quote below.

> *This is absolutely connected to our intervention, because we can stimulate something that seems to be lost, but actually could still be recovered. Sometimes we stopped the situation from getting worse or the person from falling into depression.*
>
> *(D6 Home care worker)*

The psychological relief experienced by the older person in receiving some help, in being cared for or in simply being given more information and counselling was considered by the participants, as both encouraging and supportive towards enabling people to cope with their conditions.

3.4.2 | Lack of awareness and fear of being labelled

The professionals in the study felt that the major barrier in early assessment among older people was denial and a fear of being labelled as someone in need.

> *They have never recognised their problem. (A7 Nurse)*

> *"…people will stigmatise me as one being followed by social services".*
>
> *(B5 Home care worker)*

The need to maintain personal dignity was of particular concern within small communities where sometimes professionals were even asked not to park their service vehicles close to the house, for fear of disclosure.

3.4.3 | The wall of bureaucracy

The participants were also concerned about the difficulties that "the wall of bureaucracy" poses to individuals and their families when they have to seek help. Procedures are seen as complex and time-consuming, and can prove burdensome to both the older person and their caregivers. Health care is not always easy to access. Moreover, for requesting financial assistance and home care, provided by the allied health professionals, older people have to present a certification from their GP and a number of related papers.

> *People are not aware of what could have… they don't know if they can contact the social service, they don't know if…*
>
> *(A1 Nurse)*

> *They have to pay for a certificate and then they don't obtain anything because they don't reach the required score to get help…and the family get angry…*
>
> *(A3 Nurse)*

> *…now the bureaucracy is an end in itself, it is a monster which feeds itself, this is the problem …*
>
> *(C3 Home care worker)*

Based on their empirical experience, the professionals argued that an assessment based only on medical records and financial data is not adequate to have an accurate picture of the dynamic problems of older people. They also reported that sometimes individuals in need and their families feel they have to fight against the very system that should in fact support them. In most of the cases, if the financial contribution or the eligibility for help from public services is refused or delayed, more distress arises, affecting their faith in the social and health system.

3.4.4 | Access to the care network

To improve preventive interventions, professionals proposed less formal routes to access the care network. At present, in the health service within which they are working, a GP request is needed to access the nurses', or the physiotherapists' or the social and home workers' care. They considered the nurse clinic as a place where older people should have free access to consultations.

> *… so it would be very important that nurses also have their own open access clinics.*
>
> *(B3 Nurse)*

> *…it is easier to go to the nurse, even more so than to the social worker … they think …if I go to the social worker then they will control me, I will just be labelled.*
>
> *(B5 Home care worker)*

> *…in recent years, we have seen increases in the number of patients in the clinic… 10 years ago you saw 4 or 5 older people a day, now, with the same overall number of patients, our clinic is always filled.*
>
> *(B4 GP)*

In the practitioner's experience, people tend to visit their GPs only when a health problem had already progressed. They also noted that older people could be ashamed of being labelled if they visit the social worker and also stated that, for older people, it would be easier to visit a nurse than other professionals for minor problems. This would also improve opportunities for counselling and health education, empowering

citizens to address their condition while feeling supported through the process.

3.5 | Integration of care

During the focus groups, the participants tended to socialise within their professions. They drew attention to the need for better integration among professionals and services. They saw effective communication among professionals, as a critical aspect in improving prevention and care delivery.

> *The main problem is that there is not a network to connect different services and so often we don't know who is working within the territory.*
>
> *(A3 Nurse)*

They perceived the integration of care was based more on the goodwill of individuals, rather than upon a structured formal integrated system. This issue was considered relevant among primary care professionals and also when older people try to access the different levels of care services. The professionals working in rural areas where social care workers and home care workers' offices are located in the same buildings with district nurses and GPs clinics noted that this co-location facilitates collaborative efforts towards more integrated care. This group of professionals also observed that working in a team and giving all the same advice to the patients should improve the desired outcomes. They noticed that a message, reinforced by all the different professionals visiting the house, for different reasons and in different moments, leads to more compliance. The participants in the study remarked the importance of scheduling meeting for sharing their opinions with other professionals involved, and to discuss the needs of their patients. In addition, more integration with the resources of the community was noted as a feasible way to help older people in order for them to stay in their homes for as long as possible.

4 | DISCUSSION AND IMPLICATIONS

This study explored the awareness and attitudes of key primary care professionals including district nurses, general practitioners, home care workers, physiotherapists and social workers, regarding frailty in older people. From the focus groups, three main themes emerged: the psychosocial nature of frailty, late detection of frailty and barriers to the feasibility in prevention. We will discuss these three themes one by one.

With regard to the first theme, the psychosocial nature of frailty, professionals are well aware of the psychosocial dimensional aspects of frailty: one that is consistent with a bio-psycho-social paradigm (Gobbens, Luijkx, Wijnen-Sponselee, & Schols, 2010) and with the effects of the social determinants of health (Marmot & Wilkinson, 2006). The frailty phenotype as a status with five or more components, however, was never mentioned during the interviews (Fried et al., 2001). This lack of awareness towards the importance of early physical signs of frailty appears to be common in health and social care professionals and the wider populace because the decline into frailty is simply considered to be normal ageing (WHO, 2017). This leads to inadequate management and delay in delivering preventative interventions, whereas early identification should be a priority among community-dwelling people interfacing with primary care networks (Apostolo et al., 2017; Gwyther et al., 2018). Moreover, the professionals interviewed in this study made no clear distinction between frailty, multi-morbidity and/or disability. In geriatric medicine, there is a common consensus that the awareness of the difference between frailty and disability can lead to improved strategies for detection and care (Fried et al., 2004; Wong et al., 2010).

Loneliness was perceived as the most apparent catalyst for manifestation of frailty in older people, by healthcare and social care professionals. Social components such as loneliness and social isolation have often been neglected in definitions of frailty (Gobbens, Luijkx, et al., 2010; Markle-Reid & Browne, 2003). They have subsequently proven to be relevant factors when considering the future likelihood of frailty in older adults (Luo, Hawkley, Waite, & Cacioppo, 2012; Perissinotto, Stijacic Cenzer, & Covinsky, 2012). Even without considering frailty, isolation and loneliness are known to affect the quality of life in older people negatively (Luo et al., 2012), even impacting their physical status (Shankar, McMunn, Demakakos, Hamer, & Steptoe, 2017). Moreover, lack of or reduced social relationships are considered as great a mortality risk as smoking and alcohol consumption, and exceed the mortality risk posed by physical inactivity and obesity (Holt-Lunstad, Smith, & Layton, 2010). One factor that has created more social isolation is the societal drift towards nuclear families. Not only does this limit social contact, but also it is increasingly noticeable that care from spouses and/or children is becoming less common (Pickard, 2015).

Financial issues are also considered by the professionals to be a main cause of frailty. In fact, a strong relationship exists between national economic indicators and the number of frail older people (Theou et al., 2013). A growing number of studies highlight that poorer and less educated older adults are more likely to confront health deprivation and less likely to experience health improvements (Lang et al., 2009; Romero-Ortuno, 2014; Stolz, Mayerl, Waxenegger, & Freidl, 2017; Szanton, Seplaki, Thorpe, Allen, & Fried, 2010). The effects of the economic crisis of 2008 have exacerbated poverty across Europe, reducing income security and social protection (Prince et al., 2015). According to Stolz et al. (2017), this needs to be addressed with existing social programmes. These programmes need to work towards benefitting dependent older adults, particularly those identified as prefrail, in an attempt to reduce the onset of dependency and disability (Frost et al., 2017).

Concerning the second theme (late detection of frailty), this research revealed that health and welfare professionals were only in contact with frail older people when adverse outcomes occurred, such as hospitalisation and falls. The use of a multidimensional assessment instrument, such as the Tilburg Frailty Indicator (TFI) (Gobbens, van Assen, Luijkx, Wijnen-Sponselee, & Schols, 2010) or

the Gérontopôle Frailty Screening Tool (GFSC) (Vellas et al., 2013), could help professionals in the early detection of potential frailty and allow them to initiate proactive, holistic and person-centred interventions.

There were several barriers reported by participants in carrying out preventive interventions (theme 3). Early detection and effective preventive interventions were considered complex but feasible by participants. However, this may require a systematic restructuring of primary care organisations (Berrut et al., 2013) and the development of more integrated and accessible health and social care systems (Beland & Hollander, 2011). It appears that a lack of community and personal resources affects the adoption of proactive interventions, thereby producing ethical and deontological conflicts between the response required to address the needs of the individual and what is actually available from health and social care organisations (Fairhall et al., 2015).

The role of GPs as principal gatekeepers is recognised, but strong interprofessional collaboration is needed to roll out the assessment of frailty in practice. This is a means of building tailor-made preventive interventions that draw on the available resources of older people, their families and their communities (Vellas et al., 2013). According to Prince et al. (2015), at present, effective preventive interventions for older people are also hindered by ageist stereotypes and a lack of age-appropriate trained professionals. The concept of frailty can contribute to ageism. Professionals should be aware that not all older people are frail. A "knowledge gap" and lack of understanding of the nature of frailty and its reversibility are not only highlighted in this study, but was also recognised by Shaw et al. (2017) and Gwyther et al. (2018). In this context, we would also like to point out that, based on their clinical vision and/or using a frailty assessment instrument, professionals may believe that a person is frail and that interventions need to be deployed, but the older person in question may have a different view on this. Older people do not talk about themselves in terms of frailty; they don't use the term “frail” to describe their situation. Older people are mainly concerned with their quality of life (The Netherlands Institute for Social Research, 2011). In addition, interventions should be tailor-made and thus should meet the needs and wishes of the individual.

Some limitations of this study should be noted. Firstly, pharmacists and occupational therapists did not come forward as volunteer participants, but should have been included for their actual and potential role in delivering effective primary care. Secondly, the professionals' working experience is related to the organisational model of the Italian healthcare system, which is based on universal coverage funded by a solidarity tax. However, the social and health issues facing this region bear similarities to other parts of Europe, particularly those which have similar social and physical geographies (Gwyther et al., 2018; OECD/EU, 2016; Shaw et al., 2017). A key strength of this study was the multi-professional nature of all the focus groups which contained at least one each of the following: a home care worker, general practitioner, physiotherapist, district nurse and a social worker.

At present, the detection of early frailty and its subsequent management is a promising approach in tackling the challenges of an ageing population. Such a strategy will encourage the use of preventive interventions and foster the goal of older people ageing in place (Kendig, Honge Gong, Cannon & Browning, 2017), which is desired by most people facing frailty. However, this study of the views and experiences of Italian health and social care professionals has shown that currently, there is some difficulty in identifying those who are frail and those who may become frail. At present, frailty in older adults is primarily considered part of the ageing process and the term “frail” is often confused with the presence of multi-morbidity and/or known disability. This study has also shown a lack of agreement among professionals, including nurses, that preventive interventions are realistically achievable without either local investment or efforts being made to improve the financial situation of many of the frail and poor older people they encounter. A training programme that provides more awareness of frailty in older people and disentangles frailty from the complications caused by the presence of disability and multi-morbidity could help professionals to be more confident in early detection and prevention. Much more may be required to be done in order to shift the current approach of reactive intervention and advice giving to maintain physical health in adversity, which is currently adopted by most health and social care professionals. There is a need to move towards a more collaborative consultative approach which fosters resilience within older people. Tackling the underlying poverty and the poverty of circumstance that some older people face requires affirmative political action, which is beyond the scope of the health and social care professionals who participated in this study. However, they would clearly welcome positive action that would reduce current austerity measures.

Implications for practice

- Primary care professionals experience difficulty in identifying those who are frail and those who may become frail. Using an multidimensional assessment instrument can help professionals to achieve this goal.
- Strong inter-professional collaboration is needed to roll out the assessment of frailty in practice.
- Interventions aimed at frailty should be tailor-made and thus should meet the needs and wishes of an older person.

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CONFLICT OF INTEREST

The authors declare that they have no conflict of interest.

AUTHOR CONTRIBUTIONS

All authors have made substantial contributions to all of the following: (a) the conception and design of the study, or acquisition of data, or analysis and interpretation of data; (b) drafting the article and critical revision for important intellectual content; and (c) final approval of the submitted version.

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REFERENCES

Apostolo, J., Cooke, R., Bobrowicz-Campos, E., Santana, S., Marcucci, M., Cano, A., … Holland, C. (2017). Predicting risk and outcomes for frail older adults: An umbrella review of frailty screening tools. *JBI Database of Systematic Reviews and Implementation Reports*, *15*(4), 1154–1208. https://doi.org/10.11124/jbisrir-2016-003018

Bardach, S. H., & Rowles, G. D. (2012). Geriatric education in the health professions: Are we making progress? *Gerontologist*, *52*(5), 607–618. https://doi.org/10.1093/geront/gns006

Beland, F., & Hollander, M. J. (2011). Integrated models of care delivery for the frail elderly: International perspectives. *Gaceta Sanitaria*, *25*(Suppl 2), 138–146. https://doi.org/10.1016/j.gaceta.2011.09.003

Berrut, G., Andrieu, S., Araujo de Carvalho, I., Baeyens, J. P., Bergman, H., Cassim, B., Benetos, A. (2013). Promoting access to innovation for frail old persons. IAGG (International Association of Gerontology and Geriatrics), WHO (World Health Organization) and SFGG (Societe Francaise de Geriatrie et de Gerontologie) Workshop-Athens January 20–21, 2012. *Journal of Nutrition, Health, and Aging*, *17*(8), 688–693. https://doi.org/10.1007/s12603-013-0039-2

Bilotta, C., Bowling, A., Case, A., Nicolini, P., Mauri, S., Castelli, M., & Vergani, C. (2010). Dimensions and correlates of quality of life according to frailty status: A cross-sectional study on community-dwelling older adults referred to an outpatient geriatric service in Italy. *Health and Quality of Life Outcomes*, *8*, 56. https://doi.org/10.1186/1477-7525-8-56

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Center for Policy on Ageing (2009). *Ageism and age discrimination in secondary health care in the United Kingdom. A review from the literature*. Retrieved from http://www.cpa.org.uk/information/reviews/CPA-ageism_and_age_discrimination_in_secondary_health_care-report.pdf

Cesari, M., Prince, M., Thiyagarajan, J. A., De Carvalho, I. A., Bernabei, R., Chan, P., … Vellas, B. (2016). Frailty: An emerging public health priority. *Journal of the American Medical Directors Association*, *17*(3), 188–192. https://doi.org/10.1016/j.jamda.2015.12.016

Clemens, E. L., & Hayes, H. E. (1997). Assessing and balancing elder risk, safety and autonomy: Decision-making practices of health care professionals. *Home Health Care Services Quarterly*, *16*(3), 3–20. https://doi.org/10.1300/J027v16n03_02

Colaizzi, P. (1978). Psychological research as the phenomenologist's view it. In R. Vale, & M. King (Eds.), *Existential–phenomenological alternatives for psychology* (pp. 48–71). New York: Oxford University Press.

Craig, J. V., & Smyth, R. L. (2007). *The evidence-based practice manual for nurses* (2nd ed.). Edinburgh, UK, New York, NY: Churchill Livingstone.

DeSantis, L., & Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*, *22*(3), 351–372. https://doi.org/10.1177/019394590002200308

Fairhall, N., Langron, C., Sherrington, C., Lord, S. R., Kurrle, S. E., Lockwood, K., … Cameron, I. D. (2011). Treating frailty–a practical guide. *BMC Medicine*, *9*, 83. https://doi.org/10.1186/1741-7015-9-83

Fairhall, N., Sherrington, C., Kurrle, S. E., Lord, S. R., Lockwood, K., Howard, K., … Cameron, I. D. (2015). Economic evaluation of a multifactorial, interdisciplinary intervention versus usual care to reduce frailty in frail older people. *Journal of the American Medical Directors Association*, *16*(1), 41–48. https://doi.org/10.1016/j.jamda.2014.07.006

Fried, L. P., Ferrucci, L., Darer, J., Williamson, J. D., & Anderson, G. (2004). Untangling the concepts of disability, frailty, and comorbidity: Implications for improved targeting and care. *Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *59*(3), 255–263. https://doi.org/10.1093/gerona/59.3.M255

Fried, L. P., Tangen, C. M., Walston, J., Newman, A. B., Hirsch, C., Gottdiener, J., … McBurnie, M. A. (2001). Frailty in older adults: Evidence for a phenotype. *Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, *56*(3), M146–M156. https://doi.org/10.1093/gerona/56.3.M146

Frost, R., Belk, C., Jovicic, A., Ricciardi, F., Kharicha, K., Gardner, B., … Walters, K. (2017). Health promotion interventions for community-dwelling older people with mild or pre-frailty: A systematic review and meta-analysis. *BMC Geriatrics*, *17*(1), 157. https://doi.org/10.1186/s12877-017-0547-8

Gabbay, J., & le May, A. (2004). Evidence based guidelines or collectively constructed "mindlines?" Ethnographic study of knowledge management in primary care. *BMJ*, *329*(7473), 1013. https://doi.org/10.1136/bmj.329.7473.1013

Gobbens, R. J., Luijkx, K. G., Wijnen-Sponselee, M. T., & Schols, J. M. (2010). Toward a conceptual definition of frail community dwelling older people. *Nursing Outlook*, *58*(2), 76–86. https://doi.org/10.1016/j.outlook.2009.09.005

Gobbens, R. J., & van Assen, M. A. (2014). The prediction of quality of life by physical, psychological and social components of frailty in community-dwelling older people. *Quality of Life Research*, *23*(8), 2289–2300. https://doi.org/10.1007/s11136-014-0672-1

Gobbens, R. J., van Assen, M. A., Luijkx, K. G., & Schols, J. M. (2012). The predictive validity of the Tilburg Frailty Indicator: Disability, health care utilization, and quality of life in a population at risk. *Gerontologist*, *52*(5), 619–631. https://doi.org/10.1093/geront/gnr135

Gobbens, R. J., van Assen, M. A., Luijkx, K. G., Wijnen-Sponselee, M. T., & Schols, J. M. (2010). The Tilburg Frailty Indicator: Psychometric properties. *Journal of the American Medical Directors Association*, *11*(5), 344–355. https://doi.org/10.1016/j.jamda.2009.11.003

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

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., Jaime Dauden, E. A., D'Avanzo, B., Kurpas, D., Bujnowska-Fedak, M., … 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

Herrmann, F. R., Osiek, A., Cos, M., Michel, J. P., & Robine, J. M. (2005). Frailty judgment by hospital team members: Degree of agreement and survival prediction. *Journal of the American Geriatrics Society*, *53*(5), 916–917. https://doi.org/10.1111/j.1532-5415.2005.53278_6.x

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare*. Oxford, UK: Wiley-Blackwell.

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, *7*(7), e1000316. https://doi.org/10.1371/journal.pmed.1000316

Kaethler, Y., Molnar, F. J., Mitchell, S. L., Soucie, P., & Man-Son-Hing, M. (2003). Defining the concept of frailty: A survey of multi-disciplinary health professionals. *Geriatrics Today*, *6*, 26–31.

Kendig, H., Honge Gong, C., Cannon, L., & Browning, C. (2017). Preferences and Predictors of Aging in Place: Longitudinal Evidence from Melbourne. *Australia*, *Journal of Housing For the Elderly*, *31*(3), 259–271. https://doi.org/10.1080/02763893.2017.1280582

Knight, P. V., Oliver, D., Wyrko, Z., Gordon, A. L., & Turner, G. (2014). Frailty related aspects of care are under-recognised in UK medical curriculums. *BMJ*, *348*, g3325. https://doi.org/10.1136/bmj.g3325

Lacas, A., & Rockwood, K. (2012). Frailty in primary care: A review of its conceptualization and implications for practice. *BMC Medicine*, *10*, 4. https://doi.org/10.1186/1741-7015-10-4

Lang, I. A., Hubbard, R. E., Andrew, M. K., Llewellyn, D. J., Melzer, D., & Rockwood, K. (2009). Neighborhood deprivation, individual socioeconomic status, and frailty in older adults. *Journal of the American Geriatrics Society*, *57*(10), 1776–1780. https://doi.org/10.1111/j.1532-5415.2009.02480.x

Levy, B. R. (2001) Eradication of ageism requires addressing the enemy within. *Gerontologist*, *41*(5), 578–579; discussion 580. https://doi.org/10.1093/geront/41.5.578

Loffe, H., & Yardley, L. (2004). Content and thematic analysis. In D. F. Marks, & L. Yardley (Eds.), *Research methods for clinical and health psychology* (1st ed., pp. 56–68). London, UK: Sage Publications.

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.e9–671.e16. https://doi.org/10.1016/j.jamda.2016.04.018

Luo, Y., Hawkley, L. C., Waite, L. J., & Cacioppo, J. T. (2012). Loneliness, health, and mortality in old age: A national longitudinal study. *Social Science and Medicine*, *74*(6), 907–914. https://doi.org/10.1016/j.socscimed.2011.11.028

Lutenbacher, M., Cooper, W. O., & Faccia, K. (2002). Planning youth violence prevention efforts: Decision-making across community sectors. *Journal of Adolescent Health*, *30*(5), 346–354. https://doi.org/10.1016/S1054-139X(02)00345-2

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

Marmot, M., & Wilkinson, R. (2006). *Social determinants of health* (2nd ed.), M. Marmot, & R. Wilkinson (Eds.). Oxford, UK: Oxford University Press.

Morgan, D. L. (1988). *Focus groups as qualitative research*, 1st ed.. Newbury Park, CA: SAGE.

OECD/EU (2016). *Health at a glance: Europe 2016: State of health in the EU cycle*. Retrieved from https://ec.europa.eu/health/sites/health/files/state/docs/health_glance_2016_rep_en.pdf

Perissinotto, C. M., Stijacic Cenzer, I., & Covinsky, K. E. (2012). Loneliness in older persons: A predictor of functional decline and death. *Archives of Internal Medicine*, *172*(14), 1078–1083. https://doi.org/10.1001/archinternmed.2012.1993

Pickard, L. (2015). A growing care gap? The supply of unpaid care for older people by their adult children in England to 2032. *Ageing and Society*, *35*(1), 96–123. https://doi.org/10.1017/S0144686X13000512

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Prince, M. J., Wu, F., Guo, Y., Gutierrez Robledo, L. M., O'Donnell, M., Sullivan, R., & Yusuf, S. (2015). The burden of disease in older people and implications for health policy and practice. *Lancet*, *385*(9967), 549–562. https://doi.org/10.1016/s0140-6736(14)61347-7

Puts, M. T., Lips, P., & Deeg, D. J. (2005). Static and dynamic measures of frailty predicted decline in performance-based and self-reported physical functioning. *Journal of Clinical Epidemiology*, *58*(11), 1188–1198. https://doi.org/10.1016/j.jclinepi.2005.03.008

Rockwood, K., Song, X., MacKnight, C., Bergman, H., Hogan, D. B., McDowell, I., & Mitnitski, A. (2005). A global clinical measure of fitness and frailty in elderly people. *CMAJ*, *173*(5), 489–495. https://doi.org/10.1503/cmaj.050051

Roland, K. P., Theou, O., Jakobi, J. M., Swan, L., & Jones, G. R. (2011). Exploring frailty: Community physical and occupational therapists' perspectives. *Physical & Occupational Therapy in Geriatrics*, *29*(4), 270–286. https://doi.org/10.3109/02703181.2011.616986

Roland, K. P., Theou, O., Jakobi, J. M., Swan, L., & Jones, G. R. (2014). How do community physical and occupational therapists classify frailty? A pilot Study. *Journal of Frailty & Aging*, *3*(4), 247–250. https://doi.org/10.14283/jfa.2014.32

Romero-Ortuno, R. (2014). Frailty index in Europeans: Association with determinants of health. *Geriatrics & Gerontology International*, *14*(2), 420–429. https://doi.org/10.1111/ggi.12122

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334:AID-NUR9>3.0.CO;2-G

Shankar, A., McMunn, A., Demakakos, P., Hamer, M., & Steptoe, A. (2017). Social isolation and loneliness: Prospective associations with functional status in older adults. *Health Psychology*, *36*(2), 179–187. https://doi.org/10.1037/hea0000437

Shaw, R. L., Gwyther, H., Holland, C., Bujnowska, M., Kurpas, D., Cano, A., … D'Avanzo, B. (2017). 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

Shosha, G. A. S. (2012). Employment of Colaizzi's strategy in descriptive phenomenology: A reflection of a researcher. *European Scientific Journal*, *8*(27), 31–43.

Stolz, E., Mayerl, H., Waxenegger, A., & Freidl, W. (2017). Explaining the impact of poverty on old-age frailty in Europe: Material, psychosocial and behavioural factors. *Eur J Public Health*, *27*(6), 1003–1009. https://doi.org/10.1093/eurpub/ckx079

Szanton, S. L., Seplaki, C. L., Thorpe, R. J. Jr, Allen, J. K., & Fried, L. P. (2010). Socioeconomic status is associated with frailty: The Women's Health and Aging Studies. *Journal of Epidemiology & Community Health*, *64*(1), 63–67. https://doi.org/10.1136/jech.2008.078428

The Netherlands Institute for Social Research (2011). *Frail older persons in the Netherlands*, C. Van Campen (Ed.). The Hague, The Netherlands: The Netherlands Institute for Social Research.

Theou, O., Brothers, T. D., Rockwood, M. R., Haardt, D., Mitnitski, A., & Rockwood, K. (2013). Exploring the relationship between national economic indicators and relative fitness and frailty in middle-aged and older Europeans. *Age and Ageing*, *42*(5), 614–619. https://doi.org/10.1093/ageing/aft010

Travers, J., Romero-Ortuno, R., Bailey, J., & Cooney, M. T. (2019). Delaying and reversing frailty: A systematic review of primary care interventions. *British Journal of General Practice*, *69*(678), e61–e69. https://doi.org/10.3399/bjgp18X700241

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, *15*(3), 398–405. https://doi.org/10.1111/nhs.12048

Vellas, B., Balardy, L., Gillette-Guyonnet, S., Abellan Van Kan, G., Ghisolfi-Marque, A., Subra, J., … Cesari, M. (2013). Looking for frailty in community-dwelling older persons: The Gerontopole Frailty Screening Tool (GFST). *Journal of Nutrition, Health & Aging*, *17*(7), 629–631. https://doi.org/10.1007/s12603-013-0363-6

Wong, C. H., Weiss, D., Sourial, N., Karunananthan, S., Quail, J. M., Wolfson, C., & Bergman, H. (2010). Frailty and its association with disability and comorbidity in a community-dwelling sample of seniors in Montreal: A cross-sectional study. *Aging Clinical and Experimental Research*, *22*(1), 54–62. https://doi.org/10.3275/6675

World Health Organization (2017). *Integrated care for older people: Guidelines on community-level interventions to manage declines in intrinsic capacity*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/258981/9789241550109-eng.pdf?sequence=1&isAllowed=y

Zuliani, C., Soavi, C., Maggio, M., De Vita, F., Cherubini, A., & Volpato, S. (2015). Counteracting inflammation and insulin resistance with diet and exercise: A strategy for frailty prevention? *European Geriatric Medicine*, *6*(3), 220–231. https://doi.org/10.1016/j.eurger.2014.11.010

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APPENDIX 1

INTERVIEW SCHEDULE

Q1:	What is your understanding of the concept of frailty?
Q2:	How would you feel about identifying those who may be frail or may become frail?
Q3:	If you have been involved in frailty identification before, what were your experiences?
Q4:	What do you think about the use of preventive interventions within this area?
Q5:	Do you have experiences of frailty prevention strategies that you could share? (as the heat wave or the Tuscany project).
Q6:	Who do you believe is in the best position to detect prefrail and frail condition at an early stage?
Q7:	What elements might be useful for you to identify a person in a state of frailty? What might hinder you?

Brief summary of the main points raised during the focus group interviews

Q8:	Are there any points that you would like to make that we have not discussed yet?