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REVIEW ARTICLE

Exploring frailty perspectives of older people and professionals: a systematic integrative review

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Abstract

Frailty is a common but complex phenomenon that is approached from theoretical and professional perspectives but rarely from the perspectives of older people and their essential stakeholders. Different or opposing perspectives on frailty at personal, organisational, and community levels can negatively affect care for frail older people. This systematic integrative review synthesises the perspectives on frailty of older people, health/social care professionals, informal caregivers, managers and policymakers, using thematic analysis. We use the Joanna Briggs Institute–Critical Appraisal Checklist to appraise the quality of 52 qualitative and mixed-method studies drawn from the PubMed/MEDLINE, CINAHL, PsycINFO, Embase, and Web of Science databases (inception–December 2023). Of these, 33 include the perspectives of older people, 27 of health/social care professionals, four of managers, and six of informal caregivers. Structuring the perspectives along six themes – 'the multidimensional nature of frailty', 'the dynamics of frailty', 'the complexity of frailty', 'frailty in relation to age', 'frailty in relation to health' and 'frailty in relation to dependence' – revealed substantive similarities in the conceptualisation of frailty between older people and professionals, *e.g.* regarding frailty's dynamic and multi-dimensional nature. However, older people and professionals differ in their interpretations of frailty: older people take a personal view, while professionals take a more practical view. The identified discrepancies in perspectives may affect care relationships and care for frail older people. Therefore, we advocate a systems approach that incorporates multiple perspectives to form a comprehensive

view of frailty and allows for a situation-specific shared understanding of frailty in older people.

Keywords: frailty; older people; perspectives; (shared) understanding; stakeholders

Introduction

Frailty is a common but complex phenomenon that is approached differently (D'Avanzo et al. 2017; Fried et al. 2004; Gobbens et al. 2010; Markle-Reid and Browne 2003; Rockwood and Mitnitski 2011; Sobhani et al. 2021). Three primary approaches to frailty can be distinguished. The first is the phenotypic biomedical approach that describes frailty as a physiological age-related state of increased vulnerability towards stressors (Fried et al. 2004). In the second, the accumulation of deficits approach, frailty results from the accumulation of deficits; the more disabilities or diseases someone experiences, the greater the risk of adverse health outcomes (Rockwood and Mitnitski 2011). The third, the multi-dimensional approach, defines frailty as a dynamic state in which an individual experiences losses in one or more domains of human functioning (*e.g.* physical, psychological, and/or social), which increases the risk of adverse outcomes (Gobbens et al. 2010).

Interestingly, these approaches are based on professionals' or theoretical perspectives on frailty in which the perspectives of older people themselves are often not included (Markle-Reid and Browne 2003). In addition, frailty research and its theoretical perspectives are mainly quantitative, paying only minor attention to personal perceptions. However, personal perceptions can enrich the picture of frailty and clarify the meaning of frailty to individuals. Previous studies have shown that perspectives on frailty might differ among professionals, and between professionals and older people (D'Avanzo et al. 2017; Sezgin et al. 2019). Older people classified as frail according to medical standards do not always feel frail or do not recognise the term frailty (Becker 1994; Grenier 2006). In addition, for older people, frailty encompasses more than an accumulation of physical deficits or problems (De Donder et al. 2019; Dury et al. 2018). For example, older people consider environmental factors, social contacts, and feeling down or anxious as essential factors of frailty (Bunt et al. 2021; Dury et al. 2018; Van Campen 2011). Moreover, older people often reject the term frailty for describing their state (Golbach et al. 2022; Markle-Reid and Browne 2003; Van Campen 2011).

Different or even opposing perspectives on frailty at personal, organisational, and community levels might potentially hinder or negatively affect care for frail older people (Gwyther et al. 2018; Sadler et al. 2019). The personal views and experiences of older people may predispose them to frailty and can direct their health behaviours (Bloem and Stalpers 2012; de Albuquerque Sousa et al. 2012). In addition, older people do not always acknowledge the risk of frailty that might hinder access to health and social care services (Bloem and Stalpers 2012; D'Avanzo et al. 2017; Grenier 2006). Furthermore, older people's, informal caregivers', and professionals' personal views and preferences have become increasingly important in health care, as reflected in recently widely used

care methods such as shared decision-making (SDM) and person-centred care (Ekman et al. 2011; Elwyn et al. 2017). These methods are based on open communication and collaboration between care professionals and patients to create shared understanding and decisions (Dy and Purnell 2012; Ekman et al. 2011; Pel-Littel et al. 2021). However, the latter can be complicated and face barriers. For example, multiple professionals care for frail older people; however, not everyone knows the older patients' preferences, which might hinder participation and SDM (Ekdahl et al. 2010). Last, the involvement of citizens and patients is also increasing and evident at community and organisational levels (Beter Oud 2022; Grootjans et al. 2022; Raad van Ouderen 2019). At an organisational level, management strategies are affected by societal developments such as the shift in health care from a focus on diseases towards a capability approach (Hirani and Richter 2017; Prah Ruger and Mitra 2015; Tinetti and Fried 2004). This approach provides an opportunity to act upon people's abilities and to allow people to take an active role in decisions about their health and care trajectory, to improve their quality of life and wellbeing (Forsyth et al. 2010; Graffigna and Barello 2018; Hirani and Richter 2017; Prah Ruger and Mitra 2015; Tinetti and Fried 2004).

Therefore, paying attention to the perceptions of older people and key stakeholders regarding frailty in older people is needed. This may help understand frailty in different settings and from different points of view, which might lead to alignment between older people and the multiple stakeholders involved in caring for frail older people. In addition, this approach provides an opportunity to address the capabilities and preferences of older people themselves, which fits with recent developments in health care as implementing methods such as SDM and person-centred care. Therefore, in this integrative systematic review, we aim to answer the following research question: what are the perspectives of older people and multiple stakeholders such as health and social care professionals, informal caregivers, policymakers, and managers regarding frailty in old age?

Methods

Design

We conducted an integrative review to allow for a combination of various methods to synthesise the findings and contribute to the presentation of varied perspectives on frailty as the phenomenon under study (Whittemore and Knafl 2005). We included qualitative and mixed-method studies, as this review focuses on older people's and stakeholders' perceptions regarding frailty in the ageing population. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines in this research and prospectively registered this review in the PROSPERO database on 11 February 2021 [registration code CRD42021226224].

Abbreviations

In this article, RG refers to the first author, Rianne Golbach; SB to the second author, Steven Bunt; HJ to the third author, Harriët Jager-Wittenaar; EF to the fourth author, Evelyn Finnema; HH to the last author, Hans Hobbelen; and NK to Nanda Kleinenberg, a researcher who was involved as an independent reviewer during the search update.

Data selection

We systematically searched the international PubMed/MEDLINE, CINAHL, PsycINFO, Embase, and Web of Science databases using a predefined search strategy (Additional file 1). We developed the search strategy in collaboration with an information officer. It consisted of five groups of terms, namely 'frailty', 'perception', 'stakeholders', 'qualitative or mixed-methods' and 'older people'. We conducted searches in December 2020 then updated in November 2022 and again in December 2023. In addition, we checked references and citations for relevant studies for inclusion.

We included studies if they met the following criteria and: (1) addressed perceptions of frailty by older people, informal caregivers, health and social care professionals, and policymakers or managers; (2) addressed frailty in the older population; (3) had a qualitative or mixed-methods design; (4) had full texts available; (5) were peer-reviewed; and (6) were published in English or Dutch. We limited the sample to those aged 60 years and older in agreement with the description of this population by the World Health Organization (2020). We excluded studies if they (1) were editorials, letters, opinion papers, conference abstracts or conference materials; (2) focused on frailty measurement tools; (3) aimed to define or operationalise frailty from a scientific perspective; (4) explored frailty from theoretical perspectives; or (5) addressed perceptions towards specific interventions, programmes or therapies for frailty.

We imported references selected from the database search into a reference manager (RefWorks) and eliminated any duplicates. Two researchers (RG and SB) independently screened titles and abstracts using the web-based application Rayyan (Ouzzani et al. 2016). We included studies for full-text screening if one or both reviewers determined that the study was eligible for inclusion. They then screened the full-text studies for eligibility by reading and rereading them and included them if both reviewers agreed upon inclusion. The two reviewers (RG and SB) discussed any disagreements about inclusion or exclusion; if they could not achieve consensus, they consulted a third researcher (HH) and asked them to give the final verdict. We followed the same procedure during the search update, with HH as the second independent reviewer. During the full-text screening, we determined the level of agreement between the two reviewers with Cohen's kappa (McHugh 2012). We documented the reasons for exclusion and completed a PRISMA flow diagram to visualise the screening process (Figure 1).

After the selection process, one researcher (RG) performed the data extraction and a second researcher (SB) checked it. We used a predeveloped Excel sheet to document the extracted data, such as authors, year of publication, country, objectives, methodology, perspectives and study sample.

Quality assessment

We performed a critical appraisal of the studies and two independent reviewers (RG and SB) discussed it using the Joanna Briggs Institute–Critical Appraisal Checklist for Qualitative Research (JBI-QARI) (Joanna Briggs Institute 2020). The JBI-QARI is an assessment tool that can be applied to various qualitative research designs. To meet the trustworthiness criteria for the quality of qualitative studies, we added one item regarding transferability to the list: '11. Are connections made between the study's data and broader community settings (*i.e.* transfer conceptual findings to other contexts)?'

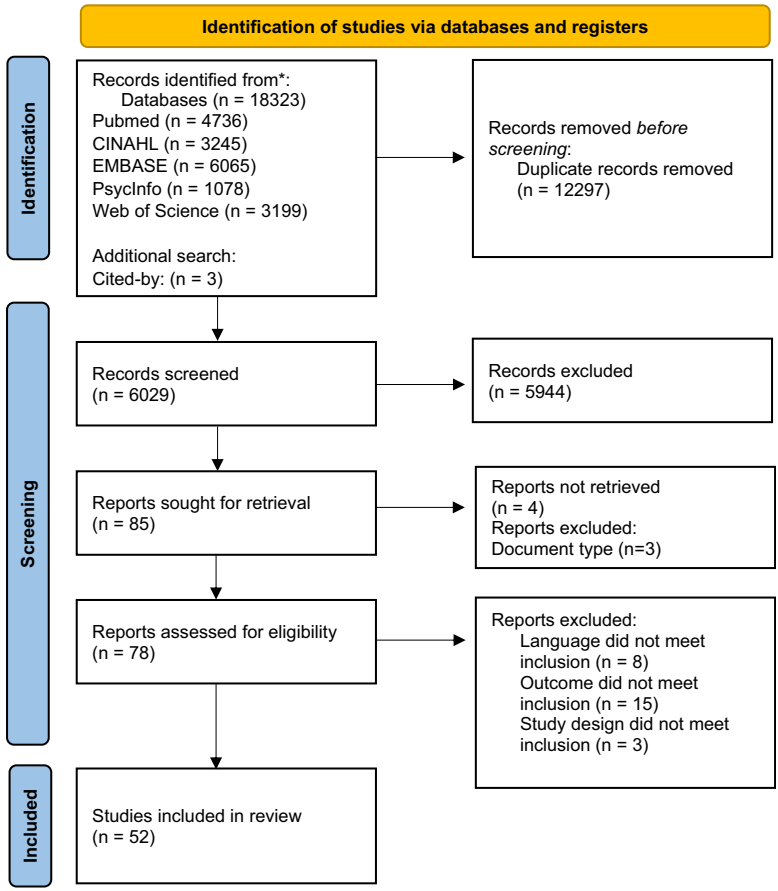

Figure 1. A flow diagram of the included studies.
Note: * refers to the total number of records found for the initial and the updated searches. The number of records and reports for the screening phase and the inclusion phase always include both initial search and updated search results.

(De Witt and Ploeg 2006). We used the quality assessment to gain an understanding of the strengths and weaknesses of the body of evidence.

Data analysis

We used a thematic synthesis to produce a textual report of older peoples' and stakeholders' perspectives on frailty (Braun and Clarke 2021). We performed the analysis in ATLAS.ti 22. After reducing the data to smaller units by line-by-line coding, we interpreted them analytically. Two reviewers performed the first steps of becoming familiar with the data and the initial coding (initial search RG and SB and search update RG and NK). They began coding the first study together and proceeded to code independently after agreeing on the coding process. They performed the coding inductively to avoid fitting the data into the scientific context of frailty or the researchers' analytical

preconceptions (Braun and Clarke, 2006, 2021). After completion of the independent coding and agreement between the reviewers, RG proceeded with the coding process, consulting either SB or NK when selecting segments or assigning specific codes was unclear. We determined definite decisions on the final themes and related subthemes with the consensus of the research team (RG, SB, HJ, EF and HH).

Results

We identified a total of 18,326 references from the searches. The removal of duplicates resulted in 6,029 references being eligible for abstract and title screening, after which we selected and screened 85 full texts, resulting in 52 included studies. During the full-text screening, we ascertained a Cohen's kappa of 0.564, which indicated moderate agreement between the two reviewers (Belur et al. 2021; McHugh 2012). The initial search resulted in 38 included studies, and the updated searches in November 2022 and December 2023 resulted in the addition of 7 and 6 studies suitable for inclusion, respectively. Checking references and citations yielded three additional studies, of which one was eligible. Hence, we included a total of 52 studies in this review. See Figure 1 for a flowchart of the search strategy.

Reasons for exclusion were that the outcomes, study design, language or publication type did not meet the inclusion criteria, or that the full text was unavailable. Of the studies, 33 presented older people's perspectives on frailty; 27 included professionals' perspectives; four addressed those of managers; and six addressed informal caregivers' perspectives. Ten studies presented the perspectives of multiple stakeholders simultaneously. None of the included studies addressed the perceptions of policymakers. The characteristics of the included studies are presented in Table 1.

The synthesis of the perspectives of older people and stakeholders on the concept of frailty led to categorisation into six themes. Three of them covered the conceptualisation of frailty by older people and stakeholders: 'the multi-dimensional nature of frailty'; 'the dynamics of frailty', which included the subthemes 'imbalance' and 'the course of frailty'; and 'the complexity of frailty', which included the subtheme 'frailty as dependent on context'. Subsequently, three themes addressed the relatedness of frailty with age, health and dependence: 'frailty in relation to age'; 'frailty in relation to health'; and 'frailty in relation to dependence'. The themes and perspectives of older people and professionals on the concept of frailty are visualised in Figure 2.

Understanding the concept of frailty

Perspectives of older people

Thirty-three studies addressed the perceptions of older people. Sixteen studies represented the perspectives of non-frail older people (Abley et al. 2011; Archibald, Lawless, Ambagtsheer et al. 2020; Gee et al. 2019; Grenier 2005, 2006; Grøn 2016; Kaufman 1994; Lekan et al. 2018; Puts et al. 2009; Sarvimäki and Stenbock-Hult 2016; Schoenborn et al. 2018; Shaw et al. 2018; Skilbeck et al. 2018; St John et al. 2019; van Damme et al. 2020; Warmoth et al. 2016). Two studies focused on the perspectives of pre-frail older people or individuals at risk for frailty (Archibald, Lawless, Ambagtsheer et al. 2020; Dury et al. 2018). Seventeen studies examined the perspectives of frail older

Table 1. Characteristics of the included studies

Author, year, country	Objective(s)	Methodology	Perspective[a]	Study sample (n)	QA[b]
Abley et al. 2011 UK	To increase understanding of the concept of vulnerability in old age by exploring the perspectives of both older people and health- and social-care professionals and subsequently improve community care for vulnerable older people.	Focus groups and interviews	Older people and care professionals	Older people (n = 21), social workers (n = 9), nurses (n = 5), rehabilitation assistants (n = 3), physiotherapists (n = 2), an occupational therapist (n = 1) and a podiatrist (n = 1)	9
Ambagtsheer et al. 2019 Australia	To explore GPs' perceptions, attitudes and experiences of frailty and frailty screening.	Focus groups	Care professionals	South Australian general practitioners (n = 22)	8
Andreasen et al. 2015 Denmark	To validate the Tilburg Frailty Indicator (TFI) on content by exploring the experience of the daily life of community-dwelling frail elderly shortly after discharge from an acute admission in relation to the physical, psychological and social domains of the TFI.	Semi-structured interviews	Older people	Frail elderly (n = 14, > 65 yrs, M = 80.6)	8
Archibald, Lawless, Ambagtsheer et al. 2020 Australia	To understand how older people, including frail older persons in residential aged care, perceive and understand frailty through an interpretive–descriptive qualitative study.	Focus groups	Older people	Non-frail, pre-frail, frail and very frail South Australian older adults (n = 39, > 50 yrs, 80.6 ± 9.6)	6
Archibald, Lawless, Gill et al. 2020 Australia	To understand orthopaedic surgeons' perceptions and attitudes towards frailty and frailty screening.	Interviews	Care professionals	Orthopaedic surgeons (n = 15)	10

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Table 1. (*Continued.*)

Author, year, country	Objective(s)	Methodology	Perspective[a]	Study sample (n)	QA[b]
Avgerinou et al. 2020 Greece	To explore the perceptions and attitudes of primary health care (PHC) professionals towards frailty in a country where geriatrics is not recognised as a specialty and to explore their training needs in the identification and management of frailty.	Focus groups	Care professionals	PHC professionals (n = 36, median age = 46)	8
Barbosa and Fernandes 2020 Brazil	To propose the concept of vulnerability of the elderly based on the Hybrid Concept Development Model.	Literature review and semi-structured interviews	Care professionals	Nurses (n = 9), a social worker (n = 1), a physiotherapist (n = 1) and a nutritionist (n = 1)	3
Bjerkmo et al. 2021 Norway	To explore how single-living frail older adults experience living with frailty in everyday life in rural Arctic areas in northern Norway.	Interviews	Older people	Single-living older people, women (n = 6) and men (n = 2) (> 80 yrs; range 82–93 yrs) in municipalities in the northernmost part of Norway	8
Bjerkmo et al. 2023 Norway	To learn more about home-dwelling older adults' lived experiences of being and becoming 'frail'.	Interviews	Older people	Home-dwelling single-living older people (n = 8) in municipalities in the northernmost part of Norway	11
Canbolat Seyman and Sara 2021 Turkey	To provide a more detailed understanding of older adults' opinions of frailty, the ageing process and the consequences of both.	Semi-structured interviews	Older people	Older people from the geriatric outpatient clinic, female (n = 8), male (n = 6) (> 65 yrs, 74.5 ± 8.7 yrs)	8
Canbolat Seyman and Sara 2022 Turkey	To provide comprehensive insight into orthopaedic nurses' perspectives regarding frailty.	Semi-structured interviews	Care professionals	Orthopaedic nurses, female (n = 16), male (n = 2) (32.4 ± 8 yrs)	10

Cluley et al. 2021a UK	To explore how key stakeholders in emergency care, including clinicians, patients and carers, make sense of frailty.	Situated interviews	Older people and informal caregivers	Older patients (n = 30) in the emergency department and their carers (n = 30)	8
Cluley et al. 2021b UK	To make sense of older people's perceptions of frailty by focusing on how and why frailty is perceived as it is.	Situated interviews	Older people	Older people (n = 30) in the emergency department	7
Coker et al. 2019 UK	To explore: (i) how community care staff from various specialties viewed frailty; (ii) whether they had a shared understanding; and (iii) how they assessed frailty in everyday practice.	Interviews	Care professionals	Community care staff (n = 22), health-care assistants, therapy assistants, psychiatric nurses, general nurses, occupational therapists, physiotherapists and social workers	8
Dury et al. 2018 Belgium	To gain insights into the lived experiences of frailty among older adults to determine which strengths can balance the deficits that affect frailty.	Questionnaires and semi-structured interviews	Older people	Potentially frail older adults (n = 121, > 60 yrs)	8
Escourrou et al. 2019 France	To explore the perception of elderly persons of the term and concept of frailty and to understand their perception of the risk of loss of independence.	Interviews	Older people	Frail elderly persons (n = 30, age 65–90 yrs)	6
Gee et al. 2019 New Zealand	To explore the potential for mutual understanding among the perspectives of older people and health professionals to help inform clinical practice and assessment.	Focus groups	Older people and care professionals	Older people (n = 18) and health professionals (n = 17), doctors (n = 3), nurses (n = 6), allied health professionals (n = 4), a supporting role professional (n = 1) and individuals working with older people within community-based organisations (n = 4)	8

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Table 1. (*Continued.*)

Author, year, country	Objective(s)	Methodology	Perspective[a]	Study sample (n)	QA[b]
Gee et al. 2021 New Zealand	To explore Māori (the Indigenous people of Aotearoa New Zealand) understandings of frailty, to help inform appropriate assessment and support for older Māori with frailty.	Focus groups	Older people and care professionals	Residents in a Māori-model supported living villa, female (n = 5), male (n = 1), > 65 yrs, range 66–88 yrs Health professionals (n = 14), Māori (n = 12), female (n = 13), older Māori (n = 19), 18–70 yrs with majority > 65 yrs, Māori (n = 10), mixed with Māori heritage (n = 2) and Pākehā (New Zealand European, n = 7)	8
Grenier 2005 Canada	To gain an understanding of how older women from various social locations made meaning and negotiated and re-storied frailty, disability and decline in their everyday lives.	Narrative interviewing	Older people	Frail and non-frail older women (n = 12)	9
Grenier 2006 Canada	To explore the distinctions within older women's narratives that represent a clash between the professional construct of frailty and the lived experiences of older women.	Narrative interviewing	Older people	Frail and non-frail older women (n = 12)	8
Grøn 2016 Denmark	To present findings from ethnographic fieldwork aimed at exploring empirically how vulnerability in old age is perceived and experienced in contemporary Denmark.	Observations and interviews	Care professionals, managers and older people	Professionals (n = 26), managers (n = 19), elderly (n > 100), n = 20 participated in group interviews	8
Gustafsson et al. 2012 Sweden	To elucidate health-care professionals' view of frailty in older persons.	Focus groups	Care professionals	Health-care professionals (n = 21, 26–60 yrs), nurses, occupational therapists, physiotherapists or social workers	9

Kaufman 1994 USA	To investigate ways that frailty is defined, framed and understood by older persons, their family members and their health-care providers in the context of a multi-disciplinary geriatric assessment service.	Observations and interviews	Older people, informal caregivers and care professionals	Community living elderly, family members, health professionals	9
Kennedy et al. 2021 Ireland	To explore the views of Irish health-care professionals and patients on frailty and its management in primary care.	Interviews	Older people, care professionals and managers	Frail older people (n = 3, 84–93 yrs), health-care professionals (n = 17), physiotherapists (n = 4), public health nurses (n = 3), general practitioners (n = 2), occupational therapists (n = 2), social workers (n = 2) and managers (n = 4)	7
Korenvain et al. 2018 Canada	To explore how family physicians conceptualise frailty and the factors they consider when making subjective decisions about patients' frailty statuses.	Interviews	Care professionals	Family physicians (n = 18)	10
Lekan et al. 2018 USA	To explore lay perspectives about frailty among African American adults.	Focus groups	Older people	African American older people (> 55 yrs, M = 71.2)	9
Lim et al. 2023 Singapore	To explore the experience and perceptions of frailty in hospitalised older adults and caregivers caring for older adults, in the context of resilience and self-efficacy.	Interviews	Older people and informal caregivers	Hospitalised older adults (n = 24, M = 70.4) and family caregivers (n = 10, M = 51.4)	10
Lloyd et al. 2020 UK	To understand the changing experiences of frail older people through the stories that they told.	Narrative interviewing	Older people, informal caregivers and care professionals	Moderate to severe frail older people (n = 13, 76–92 yrs), linked carers (n = 13) and health- or social-care professionals (n = 8)	9

(*Continued*)

Table 1. (*Continued.*)

Author, year, country	Objective(s)	Methodology	Perspective[a]	Study sample (n)	QA[b]
Manthorpe et al. 2018 UK	To inform policy debates about frailty by highlighting the current multiple understandings and uses of the term and by questioning assumptions about its shared understandings among the workforce supporting older people.	Secondary analysis of interview data	Managers and care professionals	Social-care managers and social-care practitioners (n = 240)	6
McCarthy et al. 2021 UK	To investigate medical student attitudes towards older persons and frailty over an entire medical student cohort.	Questionnaires and word clouds	Care professionals	Medical students (n = 187)	6
McGeorge 2011 UK	To explore how mental health nurses construct and operationalise the concept of 'age-related complexity'.	Interviews	Care professionals	Mental health nurses (n = 13)	11
Naik et al. 2010 USA	To describe social services and health professionals' perceptions of vulnerability among older adults living in the community and to determine how these professionals screen vulnerability in community and in-home settings.	Interviews and focus groups	Care professionals	Social services (n = 6), geriatrics team (n = 9), medical school (n = 8), case managers (n = 10) and an interdisciplinary group (n = 12), total n = 45, M = 44.2 yrs	8
Nicholson et al. 2012 UK	To understand the experience of home-dwelling older people living with frailty over time in order to develop the empirical evidence base for this group and to consider more fully how narratives of frailty can shape person-centred care provision.	Narrative interviewing	Older people	Frail community-dwelling elders (n = 17, ages 86–102)	10

Nicholson et al. 2013 UK	To understand the experience over time of home-dwelling older people deemed frail in order to enhance the evidence base for person-centred approaches to frail elder care.	Narrative interviewing	Older people	Frail older people (n = 15, > 85 yrs)	10
Nimmons et al. 2018 UK	To explore how medical students' conceptualisation of frailty and delirium changed following the introduction of this geriatric teaching week in Year 4.	Interviews and content clouds	Care professionals	Medical students in Years 4 and 5 (n = 21)	5
Obbia et al. 2020 Italy	To explore the views and experiences of primary care professionals working with older people on the concept of frailty.	Focus groups	Care professionals	Primary care professionals (n = 33, M = 48), general practitioners, district nurses, home care workers, physiotherapists and social workers	9
Pan et al. 2019 New Zealand	To investigate the perceptions of older adults in a New Zealand setting towards the term 'frail'.	Interviews	Older people	Frail older adults (n = 12, M = 82)	8
Puts et al. 2009 The Netherlands	To describe the meaning that older community-dwelling persons attach to frailty.	Interviews and a questionnaire	Older people	Frail (n = 11) and non-frail (n = 14) older persons (M = 78.7)	7
Robinson et al. 2023 UK	To evaluate a novel teaching approach to understand how medical students' reflections on an older person impact their views about person-centred care and frailty.	Word cloud and focus group	Care professionals	Third-year medical students (session 1 n = 53 and session 2 n = 51), students participating in the focus group (n = 5)	7

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Table 1. (*Continued.*)

Author, year, country	Objective(s)	Methodology	Perspective[a]	Study sample (n)	QA[b]
Roland et al. 2011 Canada	To explore therapists' perspectives on frailty and develop a definition of how they view and manage frailty in their practice.	Repertory grid-guided interviews	Care professionals	Community physical and occupational therapists (n = 11, M = 44, SD = 9.5)	8
Sarvimäki and Stenbock-Hult 2016 Finland	To illuminate the meaning of vulnerability to older persons themselves.	Interviews	Older people	Older persons (n = 14, ages 70–96 yrs)	10
Schoenborn et al. 2018 USA	To examine existing beliefs and knowledge about frailty, views about frailty as a medical syndrome, and informational needs and communication preferences for discussing frailty among community-dwelling older adults across the spectrum of frailty.	Focus groups	Older people	Community-dwelling older adults (n = 29, M = 76.3, SD = 7.8)	7
Schreuders et al. 2020 UK	To explore care home managers' perspectives of the term frailty, how the care of residents living with frailty is managed and whether existing frailty guidelines are useful in the care home context.	Interviews	Managers	Care home managers (n = 8)	8
Seeley et al. 2023 UK	To explore the conceptualisation and identification of frailty by multidisciplinary primary care clinicians in England.	Interviews	Care professionals	General practitioners (n = 12), advanced nurse practitioners (n = 4), clinical practitioners (paramedic practitioners, clinical pharmacists and physician associates) (n = 15)	8

Shaw et al. 2018 UK	To explore stakeholders' experiences of frailty and the meanings of frailty to individuals; to determine their understanding of and beliefs and views on the malleability of frailty through screening and prevention programmes; and to inform the development and evaluation of interventions that will be feasible in clinical practice.	Interviews and focus groups	Older people, informal caregivers and care professionals	Frail (n = 28) and non-frail older adults (n = 23), family caregivers (n = 16) and health- (n = 26) and social-care (n = 22) professionals	9
Skilbeck et al. 2018 UK	To explore how older people with complex health problems experience frailty in their daily lives.	Interviews and observations	Older people	Older people (n = 10, ages 77–91 yrs)	11
St John et al. 2019 Canada	To explore the definitions of frailty among older men and if these definitions match commonly used clinical definitions of frailty.	Surveys	Older people	Older airmen (n = 147, M = 93, SD = 2.7)	6
Su et al. 2023 Taiwan	To explore the lived experience of frailty in older patients with heart failure.	Interviews	Older people	Older people with heart failure (n = 13, M = 75.84)	8
van Damme et al. 2020 Canada	To explore stakeholders' (older adults, caregivers and health-care providers) perspectives on conceptualisations and definitions of frailty, factors that contribute to frailty and frailty screening tools.	Interviews and focus groups	Older people, informal caregivers and care professionals	Older adults and caregivers (n = 14), health-care providers (n = 14), physiotherapists (n = 2), nurse practitioners (n = 5), a pharmacist (n = 1), a physician's assistant (n = 1), geriatric emergency medicine nurses (n = 2), an occupational therapist (n = 1) and a geriatrician (n = 1)	9

(*Continued*)

Table 1. (*Continued.*)

Author, year, country	Objective(s)	Methodology	Perspective[a]	Study sample (n)	QA[b]
Voie et al. 2022 Norway	To explore how home care professionals conceptualised frailty in the context of home care.	Focus groups	Care professionals	Registered nurses and certified nursing assistants working in home care, men (n = 3), women (n = 11)	8
Warmoth et al. 2016 UK	To examine qualitatively older adults' perceptions of frailty and their beliefs concerning its progression and health consequences.	Interviews	Older people	Frail and non-frail older adults (n = 29, ages 66–98)	8
Young et al. 2022 UK	To explore the lived experiences of people who receive haemodialysis and are frail and identify what factors should inform the care of this group.	Interviews	Older people	Frail older people receiving haemodialysis (n = 25, 69 ± 10 yrs)	9

Notes: [a]refers to the perspectives on frailty addressed in the study. Some studies included multiple perspectives.
[b]refers to the quality assessment score on JBI-QARI + additional item on transferability (total score: 11).

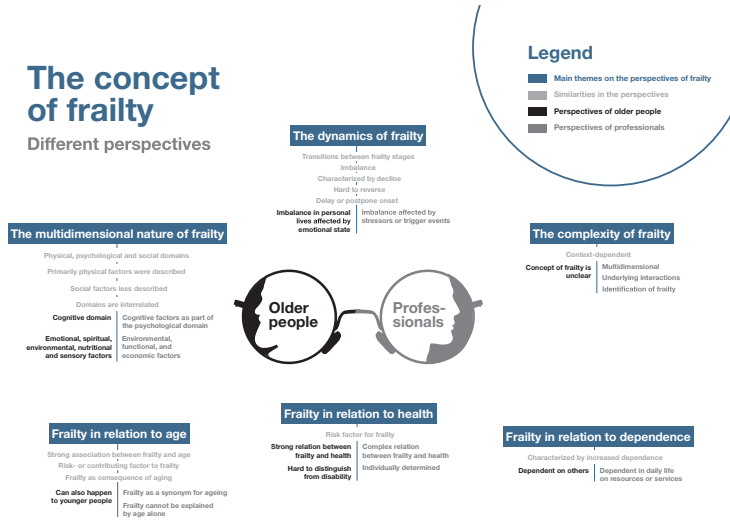

Figure 2. The concept of frailty.

people (Andreasen et al. 2015; Archibald, Lawless, Ambagtsheer et al. 2020; Bjerkmo et al. 2021, 2023; Cluley et al. 2021a, 2021b; Escourrou et al. 2019; Grenier, 2005, 2006; Kennedy et al. 2021; Lloyd et al. 2020; Nicholson et al. 2012, 2013; Pan et al. 2019; Puts et al. 2009; Shaw et al. 2018; Young et al. 2022), and the frailty status of participants was unclear in four studies (Canbolat Seyman and Sara 2021; Gee et al. 2021; Lim et al. 2023; Su et al. 2023).

The multi-dimensional nature of frailty

Many older people consider frailty as a multifaceted construct characterised by physical aspects such as reduced health and psychological, cognitive or social limitations (Andreasen et al. 2015; Archibald, Lawless, Ambagtsheer et al. 2020; Bjerkmo et al. 2023; Canbolat Seyman and Sara 2021; Cluley et al. 2021b; Dury et al. 2018; Gee et al. 2019, 2021; Lekan et al. 2018; Nicholson et al. 2012, 2013; Pan et al. 2019; Puts et al. 2009; Sarvimäki and Stenbock-Hult 2016; Shaw et al. 2018; Su et al. 2023; van Damme et al. 2020; Young et al. 2022) that can coexist or reinforce one another (Archibald, Lawless, Ambagtsheer et al. 2020; Nicholson et al. 2013). For some older people, physical limitations were the most noticeable factors of frailty (Bjerkmo et al. 2021; Canbolat Seyman and Sara 2021; Cluley et al. 2021a; Gee et al. 2021; Kennedy et al. 2021; Lim et al. 2023; Schoenborn et al. 2018; Su et al. 2023; van Damme et al. 2020; Young et al. 2022). Social aspects, such as social contacts, were mentioned less by older people compared to physical and psychological factors (Archibald, Lawless, Ambagtsheer et al. 2020; Bjerkmo et al. 2021; Lim et al. 2023; Puts et al. 2009; Schoenborn et al. 2018; Warmoth et al. 2016). The same occurred for other factors such as emotional (Abley et al. 2011; Nicholson et al. 2013), spiritual (Lekan et al. 2018), nutritional (Andreasen et al. 2015; Escourrou et al. 2019), sensory (Escourrou et al. 2019) and environmental

factors (Gee et al. 2021), but to a greater extent. In addition, psychological, emotional and cognitive factors were described as interlinked (Archibald, Lawless, Ambagtsheer et al. 2020; Puts et al. 2009; Shaw et al. 2018) or as separate dimensions (Escourrou et al. 2019; Pan et al. 2019; Puts et al. 2009).

In some studies, older people described the domains in which frailty manifests itself, for example physical, mental, cognitive, psychological, social or emotional frailty, as specific types of frailty, which indicates that someone can be frail in one or more domains (Archibald, Lawless, Ambagtsheer et al. 2020; Escourrou et al. 2019). Others expressed that other factors, for example psychosocial factors such as emotional well-being, mindset, strength, attitude, loneliness or depression, might mitigate or enhance frailty or vice versa (Archibald, Lawless, Ambagtsheer et al. 2020; Cluley et al. 2021b; Escourrou et al. 2019; Gee et al. 2021; Lekan et al. 2018; Lim et al. 2023; Puts et al. 2009).

The dynamics of frailty

We identified different perceptions of older people on the dynamics of frailty. Some older people emphasised the transitions between different stages of frailty (Archibald, Lawless, Ambagtsheer et al. 2020; Lekan et al. 2018; Skilbeck et al. 2018). They described that frailty can exist for shorter or longer periods, or described it as a condition you can go in and out of (Archibald, Lawless, Ambagtsheer et al. 2020; Bjerkmo et al. 2021, 2023; Cluley et al. 2021b). Another study focused on the notion that, while being frail, some physical, social and emotional connections were lost while others were sustained or new ones were created (Nicholson et al. 2013).

Imbalance

Several studies that incorporated older people's perspectives indicated that frailty is an imbalance in the personal lives of individuals that might be related to health deficits but can also exist on an emotional level and can be affected, for example, by contextual challenges (Bjerkmo et al. 2021; Grenier 2006; Lekan et al. 2018; Su et al. 2023). The emotional state, similar to a 'positive attitude' or a 'willing mind', might mediate the frailty balance (Bjerkmo et al. 2023; Cluley et al. 2021b; Lekan et al. 2018). In addition, older people might experience an imbalance as a consequence of frailty, which requires adaptation to new situations in which losses are prevalent, adopting new daily routines or creating new ways of coping (Nicholson et al. 2012, 2013; Skilbeck et al. 2018). Studies that focused on the experiences of older people living with frailty emphasised that uncertainty about the imbalanced state of frail older people might cause unease not only for those experiencing frailty but also for relatives (Lloyd et al. 2020; Nicholson et al. 2012).

The course of frailty

For many older people, frailty was characterised by a decline such as worsened health, limited mobility or fatigue (Bjerkmo et al. 2021; Canbolat Seyman and Sara 2021; Cluley et al. 2021a, 2021b; Lloyd et al. 2020; Nicholson et al. 2013; Skilbeck et al. 2018; Su et al. 2023; van Damme et al. 2020; Warmoth et al. 2016) and indicated, for example, by losses in one or multiple domains (Nicholson et al. 2013). Some older people described how multiple deficits can accumulate into frailty (Dury et al. 2018; Escourrou et al. 2019; Nicholson et al. 2013; St John et al. 2019). Others described frailty

as phases of sudden decline and relatively stable phases (Nicholson et al. 2012; Skilbeck et al. 2018).

In some studies, older people indicated frailty as end-stage, near the end of life, hard to reverse or bounce back from, and out of someone's control (Archibald, Lawless, Ambagtsheer et al. 2020; Bjerkmo et al. 2023; Cluley et al. 2021a; Escourrou et al. 2019; Kennedy et al. 2021; Lekan et al. 2018; Nicholson et al. 2012; Puts et al. 2009; Skilbeck et al. 2018). In contrast, some older people emphasised the personal actions someone can take to prevent or delay the onset of frailty, such as maintaining a healthy lifestyle and staying active (Archibald, Lawless, Ambagtsheer et al. 2020; Cluley et al. 2021b; Gee et al. 2021; Lim et al. 2023; Pan et al. 2019; Puts et al. 2009), engaging in social activities (Warmoth et al. 2016), having a positive mindset (Archibald, Lawless, Ambagtsheer et al. 2020; Cluley et al. 2021b; Lekan et al. 2018), being involved in spirituality and religious or traditional practices (Bjerkmo et al. 2023; Gee et al. 2021; Lekan et al. 2018; Young et al. 2022) and making good nutritional choices (Archibald, Lawless, Ambagtsheer et al. 2020; Gee et al. 2021; Lekan et al. 2018; Lim et al. 2023).

The complexity of frailty

Some older people were unfamiliar with the term frailty. However, others emphasised that the meaning was vague or lacked specificity (Archibald, Lawless, Ambagtsheer et al. 2020; Canbolat Seyman and Sara 2021; Escourrou et al. 2019; Su et al. 2023).

Frailty as dependent on context

Multiple studies indicated that older people felt particularly frail in certain situations, emphasising that feeling frail is highly context dependent or context specific (Abley et al. 2011; Bjerkmo et al. 2021, 2023; Gee et al. 2019; Grenier 2005; Nicholson et al. 2012; Sarvimäki and Stenbock-Hult 2016). Bjerkmo et al. (2021), who studied frailty in older people in a rural Arctic context, emphasised the complex interplay between the ageing body and contextual challenges such as long distances and limited access to professional and informal help. Older people across a spectrum of frailty described the context specificity, which included feeling frail in situations when they were dependent on others, for example in health-care situations or on public transport, or at home when someone had no control over going out, for example due to mobility issues (Abley et al. 2011; Bjerkmo et al. 2021). Other studies emphasised the contextual elements affecting the frailty experience, including living conditions, the climate, societal changes, geographical distances and cultural understandings or customs (Bjerkmo et al. 2021, 2023; Canbolat Seyman and Sara 2021; Gee et al. 2021).

Frailty in relation to age

Older people indicated that the losses or decline related to frailty were considered a consequence of ageing (Bjerkmo et al. 2021; Canbolat Seyman and Sara 2021; Cluley et al. 2021a, 2021b; Escourrou et al. 2019; Lim et al. 2023; Sarvimäki and Stenbock-Hult 2016; Warmoth et al. 2016) or that age can be a risk factor for or contribute to frailty (Pan et al. 2019). Although frailty was generally associated with old age according to older people (Escourrou et al. 2019; Lim et al. 2023; Pan et al. 2019; Sarvimäki and Stenbock-Hult 2016; Schoenborn et al. 2018; Skilbeck et al. 2018; Su et al. 2023; Warmoth et al. 2016), some studies indicated that frailty can also be present in younger individuals (Archibald, Lawless, Ambagtsheer et al. 2020; Lekan et al. 2018).

Frailty in relation to health

Older people perceived physical health and changes in health or health conditions as strongly related to frailty (Archibald, Lawless, Ambagtsheer et al. 2020; Bjerkmo et al. 2021; Canbolat Seyman and Sara 2021; Gee et al. 2021; Lim et al. 2023; Puts et al. 2009; Skilbeck et al. 2018; Warmoth et al. 2016). They described health as a possible cause, a determinant, or as affecting someone's experiences of their frailty (Puts et al. 2009; Warmoth et al. 2016). For some older people, frailty was challenging and difficult to distinguish from disability (Archibald, Lawless, Ambagtsheer et al. 2020; St John et al. 2019; Warmoth et al. 2016), and others described the impact of shorter or longer periods of illness or health issues that make someone experience frailty (Bjerkmo et al. 2021).

Frailty in relation to dependence

According to older people, frailty was related to age, health and dependence. In many studies, older people considered frailty as a loss of independence that is most often prompted by physical limitations such as mobility issues (Archibald, Lawless, Ambagtsheer et al. 2020; Canbolat Seyman and Sara 2021; Cluley et al. 2021b; Escourrou et al. 2019; Gee et al. 2021; Lekan et al. 2018; Lim et al. 2023; Nicholson et al. 2012; Puts et al. 2009; Warmoth et al. 2016). These may put them in situations where they are dependent on others and need to accept help, for example in care settings, on public transport or in transfers (*e.g.* climbing the stairs) (Abley et al. 2011; Bjerkmo et al. 2021; Canbolat Seyman and Sara 2021; Nicholson et al. 2013; St John et al. 2019; Young et al. 2022). Dependency on others also shows itself in the performance of tasks that require digital skills, such as dealing with mobile phones or computers (Bjerkmo et al. 2021; Dury et al. 2018; Gustafsson et al. 2012). Others emphasised that one can become dependent in one aspect of life, such as physical activities, but remain independent in other aspects, such as maintaining control over situations (Nicholson et al. 2013).

Perspectives of professionals

Twenty-seven studies addressed the perceptions of professionals that included healthcare professionals (Gee et al. 2021; Grøn 2016; Kaufman 1994; Lloyd et al. 2020; Robinson et al. 2023; Shaw et al. 2018; van Damme et al. 2020) such as physicians (Ambagtsheer et al. 2019; Archibald, Lawless, Gill et al. 2020; Avgerinou et al. 2020; Gee et al. 2019; Kennedy et al. 2021; Korenvain et al. 2018; McCarthy et al. 2021; Naik et al. 2010; Nimmons et al. 2018; Obbia et al. 2020; Seeley et al. 2023), allied healthcare professionals (Abley et al. 2011; Barbosa and Fernandes 2020; Coker et al. 2019; Gee et al. 2019; Gustafsson et al. 2012; Kennedy et al. 2021; Obbia et al. 2020; Roland et al. 2011; Seeley et al. 2023; van Damme et al. 2020) and nurses (Abley et al. 2011; Avgerinou et al. 2020; Barbosa and Fernandes 2020; Canbolat Seyman and Sara 2022; Coker et al. 2019; Gustafsson et al. 2012; Kennedy et al. 2021; McGeorge 2011; Obbia et al. 2020; Seeley et al. 2023; van Damme et al. 2020; Voie et al. 2022). In addition, social workers' perspectives were addressed (Abley et al. 2011; Barbosa and Fernandes 2020; Coker et al. 2019; Kennedy et al. 2021; Manthorpe et al. 2018; Naik et al. 2010; Obbia et al. 2020; Shaw et al. 2018). The different professions are specified in Table 1.

The multi-dimensional nature of frailty

In many studies, professionals agreed upon the multi-dimensional nature of frailty (Ambagtsheer et al. 2019; Archibald, Lawless, Gill et al. 2020; Canbolat Seyman and Sara 2022; Coker et al. 2019; Gee et al. 2019, 2021; Gustafsson et al. 2012; Kennedy et al. 2021; Korenvain et al. 2018; Naik et al. 2010; Nimmons et al. 2018; Obbia et al. 2020; Robinson et al. 2023; Roland et al. 2011; Seeley et al. 2023; Shaw et al. 2018) and emphasised that it cannot be distinguished by one single condition or characteristic. A combination of factors might trigger or contribute to frailty (Ableyet al. 2011; Archibald, Lawless, Gill et al. 2020; Kennedy et al. 2021; Roland et al. 2011).

Professionals accentuated the following dimensions of frailty: physical, psychological and social dimensions (Archibald, Lawless, Gill et al. 2020; Canbolat Seyman and Sara 2022; Coker et al. 2019; Gee et al. 2019, 2021; Kennedy et al. 2021; Obbia et al. 2020; Roland et al. 2011; Seeley et al. 2023; Shaw et al. 2018; van Damme et al. 2020). In addition, environmental, functional or economic factors were mentioned as components affecting frailty in late life (Canbolat Seyman and Sara 2022; Coker et al. 2019; Gee et al. 2021; Kennedy et al. 2021; Korenvain et al. 2018; Obbia et al. 2020; Seeley et al. 2023).

Cognitive factors, such as dementia or memory loss, were only minimally mentioned as a separate dimension (Gustafsson et al. 2012; Korenvain et al. 2018). Cognitive factors were more often considered as psychological aspects of frailty (Gustafsson et al. 2012; Korenvain et al. 2018; Manthorpe et al. 2018; van Damme et al. 2020). In several studies, professionals initially or exclusively considered frailty as a physical state, referring to physiological factors or physical problems that might result in reduced functional levels (Archibald, Lawless, Gill et al. 2020; Canbolat Seyman and Sara 2022; Manthorpe et al. 2018; McGeorge 2011; Shaw et al. 2018; Voie et al. 2022). In addition, professionals sometimes combined psychological and social factors into a psychosocial dimension of frailty (Obbia et al. 2020; Roland et al. 2011).

On the one hand, professionals described the different dimensions of frailty as interacting or coexisting factors (Archibald, Lawless, Gill et al. 2020; Canbolat Seyman and Sara 2022; Coker et al. 2019; Gee et al. 2021; Gustafsson et al. 2012; Kennedy et al. 2021; Roland et al. 2011). On the other hand, they explained that a combination of conditions in multiple domains might lead to multi-system failure and put someone at risk, or might lead to more severe frailty (Ambagtsheer et al. 2019; Archibald, Lawless, Gill et al. 2020; Avgerinou et al. 2020; Korenvain et al. 2018; Naik et al. 2010; Nimmons et al. 2018; Obbia et al. 2020; Roland et al. 2011).

The dynamics of frailty

Professionals perceived frailty as a mostly dynamic condition (Coker et al. 2019; Gee et al. 2021; Kennedy et al. 2021; Korenvain et al. 2018; Nimmons et al. 2018; Voie et al. 2022). They expressed how it can change over time, described as older people having good and bad days or seasons when older people appeared frailer than usual (Coker et al. 2019; Kennedy et al. 2021; Korenvain et al. 2018; Voie et al. 2022).

Imbalance

Professionals described frailty as a precarious equilibrium that is affected by stressors or trigger events that might result in negative outcomes (Ambagtsheer et al. 2019; Roland et al. 2011; Seeley et al. 2023). Professionals referred to this delicate balance as

a tipping point in which anything, such as a fall or bereavement, can put older people over the edge (Ambagtsheer et al. 2019; Obbia et al. 2020; Roland et al. 2011). They considered this balance as a general state of risk that might be prompted by an accumulation of health conditions and an inadequate response to stressors that makes it more difficult for people to return to baseline levels of health (Abley et al. 2011; Avgerinou et al. 2020; Kennedy et al. 2021; Nimmons et al. 2018; Roland et al. 2011). Some professionals stated that the imbalance might also be expressed in other areas of life, for example between care needs and care provided or in activities of daily living (ADL) (Abley et al. 2011; Gustafsson et al. 2012).

The course of frailty

Professionals also mentioned different perspectives about the course of frailty. A view that was identified in the studies was the notion of change over time in frailty status that can be captured on a spectrum of different levels of severity, for example from mild to severe frailty (Gustafsson et al. 2012; Korenvain et al. 2018; Manthorpe et al. 2018; Naik et al. 2010; Roland et al. 2011). Some professionals described the course of frailty as a cycle in which a worsening decline affected by multiple factors arises over time and is characterised by negative outcomes (Ambagtsheer et al. 2019; Archibald, Lawless, Gill et al. 2020; Canbolat Seyman and Sara 2022; Kennedy et al. 2021; Roland et al. 2011). In addition, most professionals agreed that frailty is challenging to reverse. However, the onset of frailty can be delayed or postponed, such as by remaining physically and socially active and/or with medication, nutritional interventions, and the right care and support (Abley et al. 2011; Ambagtsheer et al. 2019; Gee et al. 2021; Gustafsson et al. 2012; McGeorge 2011; Nimmons et al. 2018; Roland et al. 2011; Voie et al. 2022).

The complexity of frailty

In several studies, professionals emphasised the complexity of frailty (Archibald, Lawless, Gill et al. 2020; Coker et al. 2019; Gustafsson et al. 2012; Nimmons et al. 2018; Roland et al. 2011; Seeley et al. 2023; Shaw et al. 2018), such as regarding the interactions between and within its multiple facets (Gee et al. 2019, 2021; Gustafsson et al. 2012; McGeorge 2011). In addition, some professionals accentuated the difficulty in defining frailty since it is difficult to distinguish from other conditions (Avgerinou et al. 2020; Coker et al. 2019; Korenvain et al. 2018; van Damme et al. 2020) and they were not familiar with the term or thought it was imprecise (Canbolat Seyman and Sara 2022; Voie et al. 2022).

Frailty as dependent on context

Furthermore, according to professionals, the context seemed important regarding frailty's manifestation, course and adaptability (Abley et al. 2011; Archibald, Lawless, Gill et al. 2020; Kaufman 1994; Voie et al. 2022). They emphasised, for example, the differences in living conditions, social relationships, cultural differences and contacts with services that might influence frailty in older people in different ways depending on the situation (Abley et al. 2011; Gee et al. 2021; Kaufman 1994; Voie et al. 2022). In addition, professionals' contextual factors might affect the way they perceive or deal with frailty, as indicated by their workplace or educational background (Kennedy et al. 2021; Voie et al. 2022).

Frailty in relation to age

Professionals described frailty as strongly related to ageing (Archibald, Lawless, Gill et al. 2020; Avgerinou et al. 2020; Barbosa and Fernandes 2020; Canbolat Seyman and Sara 2022; Coker et al. 2019; Gustafsson et al. 2012; Kennedy et al. 2021; Korenvain et al. 2018; Nimmons et al. 2018; Obbia et al. 2020; Robinson et al. 2023; Seeley et al. 2023; Voie et al. 2022) and acknowledged that it is one of the greatest contributing factors or a risk factor for frailty (Archibald, Lawless, Gill et al. 2020; Kennedy et al. 2021; Korenvain et al. 2018). In addition, frailty was described as an inevitable consequence or even a synonym for ageing (Archibald, Lawless, Gill et al. 2020; Avgerinou et al. 2020; Nimmons et al. 2018; Voie et al. 2022). In contrast, in some studies, professionals emphasised that frailty cannot be explained by age alone (Coker et al. 2019; Gustafsson et al. 2012).

Frailty in relation to health

Professionals also related frailty to physical health and indicated that it develops as underlying medical conditions accumulate uniquely within patients, shifting patients on the frailty spectrum to more severe frailty (Avgerinou et al. 2020; Roland et al. 2011). In addition, health conditions such as comorbidities can be a risk for frailty or vice versa (Canbolat Seyman and Sara 2022; Gee et al. 2019, 2021). Other professionals emphasised the large variation among patients, some incredibly frail with only one health condition and others with multiple conditions managing quite well (Korenvain et al. 2018).

Frailty in relation to dependence

According to professionals, frailty was strongly associated with increased dependence in everyday life (Ambagtsheer et al. 2019; Archibald, Lawless, Gill et al. 2020; Barbosa and Fernandes 2020; Gee et al. 2021; Korenvain et al. 2018; McCarthy et al. 2021; Nimmons et al. 2018; Voie et al. 2022), such as relying on assistance in performing ADL (Gee et al. 2021; Gustafsson et al. 2012; Korenvain et al. 2018; Obbia et al. 2020; Roland et al. 2011; Voie et al. 2022). Some professionals emphasised that the loss of independence also affects other aspects such as mental health and can exacerbate frailty (Coker et al. 2019).

Perspectives of managers

Four studies addressed the perceptions of managers. Three studies recruited managers of health-care centres (Grøn 2016; Kennedy et al. 2021; Schreuders et al. 2020) and one study interviewed social-care managers (Manthorpe et al. 2018). In three studies, managers' perceptions were combined with the perceptions of other stakeholders (*e.g.* other professionals), which provided no clear impression of their point of view (Grøn 2016; Kennedy et al. 2021; Manthorpe et al. 2018). Managers in the third study described frailty, among other terms, as 'not sufficiently specific as to be useful'; in other words, frailty can mean different things to various people and therefore does not provide beneficial information for enhancing decisions in care management (Schreuders et al. 2020). Additionally, perspectives on frailty differed among managers, which could lead to inequitable care for frail older people (Schreuders et al. 2020).

Perspectives of informal caregivers

Six studies addressed the perceptions of informal caregivers next to those of professionals and/or older people (Cluley et al. 2021a; Kaufman 1994; Lim et al. 2023; Lloyd et al. 2020; Shaw et al. 2018; van Damme et al. 2020). Two studies included informal caregivers' perspectives in narratives (Kaufman 1994; Lloyd et al. 2020), two in focus groups (Shaw et al. 2018; van Damme et al. 2020), and two in interviews with older people and their carers (Cluley et al. 2021a; Lim et al. 2023). None of the studies specified their perspective separately. Informal caregivers together with older people emphasised the multi-dimensional and dynamic nature of frailty. Initially, they recognised the physical factors and, in addition, mentioned those that are social and psychological alongside cognitive, pharmaceutical, and nutritional factors (Lim et al. 2023; Shaw et al. 2018; van Damme et al. 2020). According to older people and informal caregivers, frailty was characterised by a reduced ability to respond to stress (van Damme et al. 2020). Although frailty was considered a sudden decline on several levels, people emphasised that it can be delayed and prevented (Kaufman 1994; Lim et al. 2023; Shaw et al. 2018; van Damme et al. 2020). Older people and informal caregivers emphasised the link between frailty, overall health declines, and independence (Cluley et al. 2021a; van Damme et al. 2020).

Discussion

In this systematic integrative review, we provided an overview of the perspectives of older people, health- and social-care professionals, informal caregivers and managers regarding frailty. We identified six main themes, reflecting the perspectives of older people and stakeholders: the multi-dimensional nature of frailty, the dynamics of frailty, the complexity of frailty and frailty in relation to age, health, and dependence. Although the studies showed substantive similarities in how older people and professionals view frailty, for example regarding its multi-dimensional nature or the strong relationship between frailty and age, they showed differences in how themes were interpreted.

The differences in perspectives were evident in how older people, in contrast to professionals, perceived frailty as an imbalance in their personal lives and recognised that someone's emotional state might affect the frailty balance and their way of dealing with decline (Grenier 2006; Lekan et al. 2018). Professionals characterised frailty as an imbalance in health status that is mainly triggered by stressors or events such as a urinary tract infection, the loss of a spouse, a fall, or hospital admission (Ambagtsheer et al. 2019; Roland et al. 2011). These events can shift people from a stable state to an imbalance in which they become frail and have difficulty recovering (Ambagtsheer et al. 2019; Obbia et al. 2020; Roland et al. 2011).

In addition, older people and professionals emphasised the strong relationship between frailty and increased dependence; however, their focus differed. Older people accentuated 'dependence on others', indicating a specific role in which they rely on the help of others (Abley et al. 2011; Nicholson et al. 2013; St John et al. 2019). Professionals described frailty on a more practical level, where frail older people require assistance in performing ADLs or are potentially dependent on resources such as using a walking aid

or moving a bed to the first floor (Gustafsson et al. 2012; Korenvain et al. 2018; Obbia et al. 2020; Roland et al. 2011). Incorporating the different interpretations of the concept of frailty according to the perspectives of older people and professionals might lead to a more comprehensive understanding of frailty since the knowledge and expertise of professionals might be complemented by the daily experiences of people living with frailty.

Perceptions originate from subjective experiences and emerge from interactions with our environment (Grishina 2010), which might affect the subjective meanings that older people and professionals assign to frailty and explain the differences in interpretations of the concept of frailty. In general, we found that older people discuss frailty from their own lived experiences or personal interpretations, which are guided by the emotional aspects of their perceptions of frailty, that is, the insider or emic perspective (Spiers 2000). In contrast, professionals' perspectives mainly contained elements of their knowledge, expertise or experiences in practice with frail older people, indicating an external evaluation or practical view of frailty, that is, the outsider or etic perspective (Spiers 2000). The insider's perspective of older people reveals challenges experienced by frail older people and the choices they make regarding dealing with frailty (Spiers 2000). In contrast, the outsider's perspective of professionals helps to clarify situations, for example by providing insights into factors related to and affecting frailty. Incorporating both perspectives might lead to a more comprehensive understanding of frailty and provide possible guidance for coping with or managing frailty in later life.

Older people, professionals and managers consider frailty a complex phenomenon with challenges in how to approach and deal with it. According to professionals, the complexity is evident in the unpredictable interaction between the multiple factors that define frailty (Gee et al. 2019; Gustafsson et al. 2012; McGeorge 2011) and, according to professionals and older people, in the specific contexts or situations in which frailty manifests itself (Abley et al. 2011; Archibald, Lawless, Gill et al. 2020; Gee et al. 2019; Grenier 2005; Kaufman 1994; Nicholson et al. 2012; Sarvimäki and Stenbock-Hult 2016). This follows previous studies showing that frailty is characterised by the complex interplay among physical, social, psychological, cognitive and environmental factors (De Donder et al. 2019; Markle-Reid and Browne 2003). To embrace the complexity and engage with its underlying logic, Greenhalgh and Papoutsi (2018) argue that we must recognise the changing interrelationships between components of complex systems (Cristancho 2016; Greenhalgh and Papoutsi 2018), such as the multiple dimensions and interacting factors of frailty. To deal with that complexity, it can be helpful to approach frailty from a systems approach, which requires a systems mindset.

A systems mindset, based on systems engineering and employed in medical education, suggests that individual components interact and work together as a whole (Cristancho 2016; Gormley and Fenwick 2016). This approach raises awareness of the changing conditions or contexts, which presents challenges in constantly having to reassess and interpret the situation (Cristancho 2016; Greenhalgh and Papoutsi 2018). A systems mindset demands an approach in which the perspectives of older people and the different stakeholders involved in their ecosystem, such as professionals, informal caregivers, and managers, are crucial in understanding how situations work amid disturbances (Cristancho 2016). To understand and manage the complexity of frailty, a systems mindset can provide insights. In addition, a systems mindset might allow

capability and resilience to manage the unknown, unexpected, and emerging features of frailty (Cristancho 2016; Greenhalgh and Papoutsi 2018).

The perspectives of both older people and professionals acknowledge the level of dependence as experienced or noticed in frail older people; however, although closely related, little attention is paid to frailty in relation to functioning. It is known that frailty not only occurs with decline or losses in one or multiple domains of human functioning but also affects functioning on several levels, such as impaired functioning in ADLs, performance decline, or diminishing self-reported functioning (Gobbens et al. 2010; Puts et al. 2005). Professionals emphasise increased dependence on ADL performance and reliance on assistance; for older people, the relationship of 'dependence on others' is more central. Functioning remains underexposed in the perspectives of older people and professionals. However, we advocate an approach that more strongly focuses on the capabilities and the functional ability of frail older people (Meijering et al. 2019; Prah Ruger and Mitra 2015; World Health Organization 2020), in which maintaining certain levels of functioning or even improving them might be possible. Therefore, insights into the levels of functioning of frail older people and opportunities to maintain or restore these levels are desirable, especially since older people perceive the surrender of independence and thereby dependence on others as an important pillar of frailty.

Older people's and professionals' perceptions largely reflect the ideas that tend to prevail regarding frailty in old age, for example, dependency, negative outcomes, imbalance, and decline (Cluley et al. 2021b; De Donder et al. 2019), which raises questions about the ideas of frailty that are still prevalent among older people and stakeholders and additionally about how we manage frailty in old age. In this review, we found that the perspectives of older people and professionals reflected frailty as an imbalance characterised by decline rather than an imbalance that can be restored. The negative frames prevalent in the literature on frailty and in the public debate might stereotype frail older people, but they also provide opportunities to address frailty more constructively. Images and perceptions can be detrimental to individuals experiencing frailty or self-identifying as frail, for example due to worsening health status, negative thoughts, or disengagement from physical and social activities (Richardson et al. 2011; Warmoth et al. 2016). Although frailty is often perceived negatively, opportunities for positive outlooks, self-management, and recognition of the wishes and needs of frail older people are reflected in older people's and professionals' perspectives. Both older people and professionals consider frailty as a condition that might be preventable or can be delayed (Abley et al. 2011; Ambagtsheer et al. 2019; Archibald, Lawless, Ambagtsheer et al. 2020; Gustafsson et al. 2012; McGeorge 2011; Nimmons et al. 2018; Pan et al. 2019; Puts et al. 2009; Roland et al. 2011). In addition, older people emphasised the ability to retain capacity while being frail or to create new connections to the world around them, for example by allowing a level of interdependence on others (Nicholson et al. 2012, 2013). We believe that a capability approach that allows for a focus on personal abilities and the potential benefits in addition to losses might help restore frail individuals' imbalances (D'Avanzo et al. 2017; De Donder et al. 2019).

Strengths and weaknesses

One of the strengths of this integrative systematic review was the inclusion of studies with a wide range of philosophical backgrounds or epistemological models

underpinning the authors' perspectives or methods, such as ethnographical, phenomenological, or constructivist. The inclusion of all types of studies led to a comprehensive synthesis for a broad understanding of frailty.

In addition, we used a robust protocol. To enhance the internal validity, we registered the protocol in the PROSPERO database before conducting the review.

However, the current study also has some limitations. First, the perspectives of managers, policymakers, and informal caregivers on the concept of frailty are underrepresented in the literature. None of the included studies incorporated the perspectives of policymakers, and those of informal caregivers were combined with those of older people in the included studies and thus could not be distinguished. The perspectives of managers were addressed separately in only one study. We showed the findings of these subgroups in the results. However, we could less extensively describe their perspectives compared to the perspectives of older people and professionals, which have been studied more extensively.

Second, we analysed the results on a group level and distinguished the stakeholders involved in the care of frail older people. Cultural and professional backgrounds that may have influenced perspectives were not specified in every study or not to the same extent. However, differences and similarities in perceptions might be found not only between stakeholders but also between and within professions or between groups of stakeholders from the same or different cultural backgrounds (Seeley et al. 2023). Therefore, some caution is required in interpreting the results.

Implications for practice and future research

Given the major challenges ahead in health care, such as increased participation, optimal SDM, and the important role of the patient network, the perspectives of policymakers, managers, and informal caregivers on the concept of frailty should be incorporated into research to a larger extent, to enrich the image of frailty in old age.

Although we found a base for a shared understanding of frailty between stakeholders, some caution is required because of the complexity and the considerable heterogeneity in the manifestation and experiences of frailty in old age. Therefore, we emphasise the importance of contextual factors and the different (etic and emic) sources of knowledge that are used and upon which decisions are made. In addition, the studies included in this review were mainly from Western countries; specific information on the perceptions of minorities or non-Western cultures is lacking, except for some studies (Barbosa and Fernandes, 2020; Bjerkmo et al. 2023, 2021; Gee et al. 2021; Lim et al. 2023; Su et al. 2023). Therefore, we argue for further research on more diverse research populations and the influence of contextual factors.

In addition, our results show that the perspectives on frailty of multiple stakeholders can lead to multiple corresponding or opposing perspectives on frailty. Therefore, we suggest a systems approach that incorporates the multiple perspectives on frailty, contexts, and the individual capacities of older people. This challenges health care to encourage open dialogue between older people and care professionals to explore foundations for a situation-specific shared understanding, which might strengthen the basis for SDM and person-centred care.

Conclusion

The overview provided in this systematic integrative review resulted in six themes reflecting the perspectives of older people and stakeholders towards frailty: the multi-dimensional nature of frailty, the dynamics of frailty, the complexity of frailty, and frailty in relation to age, health, and dependence. The results afford opportunities for a shared understanding of frailty as a multi-dimensional, dynamic, and complex concept. However, differences at the interpretational level can lead to mutual discrepancies in the understanding of frailty, which can complicate care relationships and hinder care for frail older people. Nonetheless, the findings offer opportunities to encourage a dialogue between older people and the stakeholders involved in caring for frail older people. We advocate a systems approach that allows multiple perspectives on frailty to form a comprehensive picture and is flexible to changing circumstances and contexts. This would create opportunities to genuinely embrace older people's perceptions and experiences in practice. In that case, we might develop a situation-specific shared understanding as grounds for strengthening SDM and person-centred care.

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