

EMPIRICAL STUDIES

In the borderland of the body: How home-dwelling older people experience frailty

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Abstract

Rationale: The increasing number of frail home-dwelling older people has sharpened the focus on discovering and implementing suitable treatment and care in clinical practice, aiming to prevent loss of physical functioning and preserve their autonomy and well-being. People's embodied experiences may yield rich descriptions to help to understand frailty. Thoroughly understanding older people's individual perceptions is especially relevant because the numbers of home-dwelling older people are increasing, and people tend to develop more health problems and become frailer as they age. Their perspectives are important to develop knowledge and high-quality care.

Aim: To explore the lived experiences of frail home-dwelling older people.

Methods: We conducted a phenomenological study to obtain in-depth descriptions of the phenomenon. We interviewed 10 home-dwelling older adults (seven women and three men, 72–90 years old) in depth about their lived experience of frailty. We analysed the data using a hermeneutic phenomenological approach described by van Manen.

Findings: The lived experience of frailty is described in one essential theme: frailty as being in the borderland of the body, including three interrelated subthemes: (1) the body shuts down; (2) living on the edge; and (3) not giving up.

Conclusions: Our study gives insight into lived experiences with frailty among home-dwelling older people related to their own body. Older people's experience of meaningful activities strengthened their feeling of being themselves, despite their frail and deteriorating body. Healthcare providers must consider the strategies of frail older people to consider both their vulnerabilities and self-perceived strengths. The resources and deficits of frail older people present in the state of being frail need to be recognised.

KEY WORDS

embodiment, frailty, home-dwelling, in-depth interview, lived experience, older people, phenomenology, strength, well-being

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INTRODUCTION

In health care, frailty refers to a loss of biological reserves that reduces the body's ability to recover from illness and other stressful events [1–3]. Frailty is defined in several ways, usually as a progressive age-related decline resulting in reduced reserves of capacity and an increased risk of adverse health outcomes [1–3]. Further, frailty is used as an umbrella term that covers ageing decline and loss in health and well-being, including physical, mental and social functioning [4–9]. Frailty affects about 10% of people 65 years and older [10], and the prevalence increases progressively with age, affecting about 65% of those 90 years and older [11]. Frail older people are at significantly higher risk of future challenges with activities of daily living [12–18]. The increasing number of frail home-dwelling older people has sharpened the focus on discovering and implementing suitable treatment and care in clinical practice, aiming to prevent loss of physical functioning and to preserve their autonomy and well-being [19–21]. Depression and independence are both adverse outcomes of frailty and might threaten frail older people's well-being and autonomy [22, 23].

Various frailty treatment models have been developed and investigated, producing a considerable diversity of treatment [21, 24]. Consequently, most quantitative studies investigating treatment are inconclusive [9, 10, 19–21, 25–27], although multidisciplinary treatment including exercising and healthy diet seems to have favourable effects [17, 21, 28]. It is therefore not possible to conclude what treatment and care are most appropriate [17, 28]. Clinical practitioners tend to view frailty within a biomedical and functional framework without emphasising the older people's perspectives [29]. Treatment and care aimed at preventing undesirable outcomes of frailty therefore risk failing to meet the needs and desires of older people [30, 31]. Even with extensive attention and research globally, literature exploring the experience of frailty from older people's perspectives is lacking [23, 29, 32]. However, a few qualitative and mixed-methods studies have provided valuable insight, revealing how frail older people experience frailty, such as whether they define themselves as frail or not [7, 8, 33–35]. Studies show that frailty harms older people's daily lives [7, 8, 20]. People may experience living with frailty as being disconnected from life: being trapped in a frail and deteriorated body [36]. Further, the experience of fluctuating health relates to episodes of uncertainty that threaten older people's resilience [23]. Qualitative studies of the bodily experiences of frail home-dwelling older people are especially lacking [29, 32, 34, 37, 38].

People's embodied experiences may yield rich descriptions to help in understanding the experience of health, illness [39] and frailty [29, 32, 38, 40]. Thoroughly understanding older people's individual perceptions is especially relevant because the numbers of home-dwelling older people

are increasing, and people tend to develop more health problems and become frailer as they age [3, 11, 28]. This study aimed to explore the lived experiences of frail home-dwelling older people. The research question guiding our investigation was as follows: How do home-dwelling older people experience frailty?

THEORETICAL FRAMEWORK

The study is rooted in a phenomenological understanding of the body, health and illness. Merleau-Ponty emphasised the body as the primary site of knowing the world [41]. We are seamlessly embedded in the social world we inhabit. Embodiment refers to the lived body, how we bodily live in meaningful ways in relation to the world and others [41]. The lived body is ambiguous, having a dual status: we both have and are our body. The body is both the subject and object of intentionality as we constantly navigate everyday life. Intentionality indicates the inseparable connectedness of the person to the world [42].

METHOD

We designed the study as a hermeneutical phenomenological study, inspired by the methods of van Manen [42]. Hermeneutical phenomenological research is the study of the lifeworld: the world as we immediately experience it pre-reflectively, rather than as we conceptualise, categorise or reflect on it [43]. The grounding in phenomenology means that it seeks to understand in-depth specific phenomena in the lifeworld by focusing on the experience and perceptions of those who live them through [41]: in this case, the lived experiences of frailty from the perspectives of home-dwelling older adults. Researchers must be attentive and open to realise the meanings of a phenomenon. We therefore thought carefully about how to access the experiences we wanted to obtain. In preparing the interview guide, we considered which questions we wanted to ask and how to stimulate participants to describe their experiences vividly and immediately. The researchers include three experienced health researchers and one PhD student with experience from qualitative and quantitative research, ageing and phenomenology. Bracketing describes the act of setting aside different perceptions of reality in the natural world to study the essential structures of the world [42]. The researchers were conscious about their pre-understanding and were aware of its strengths and limitations. Our point of departure as healthcare workers is that frailty negatively affects older people's lives and frail home-dwelling older people need comprehensive health services, and this therefore provides an important context for studying their lived experiences.

RECRUITMENT AND PARTICIPANTS

We used a purposive sampling strategy and sought participants who could provide insight into the phenomena studied [44]. Head nurses at two geriatric outpatient clinics invited the participants. To be eligible, people had to be enrolled in home health care for at least 3 months and meet three of five of Fried's frailty criteria: unintentional weight loss, self-reported exhaustion, weakness, slow walking speed and low physical activity [1]. Fried's phenotype model is a widely used assessment tool in research literature. It enables better clinical operationalisation in numerous healthcare practice settings [45]. It is well suited to examine community-dwelling

older adults and feasible in clinical contexts outside and inside Norway [18, 46]. People 65 years and older with Mini-Mental State Examination scores ≤ 18 were excluded. The participants, seven women and three men, were 72–90 years old. Six lived with their partner and four lived alone. One withdrew because of deteriorating health. Table 1 presents the participants' characteristics.

INTERVIEWS

We carried out 10 in-depth interviews and one follow-up interview from December 2018 to December 2019 in settings

TABLE 1 Participants

Participant	Age (years)	Sex	Education	Civil status	Formal caregivers	Informal caregivers
1	72	Female	High	Married	Home health care. Regular general practitioner, physiotherapist, occupational therapist, hospital ward, outpatient clinic	Husband, children, friends
2	82	Female	Low	Widow. Lives alone	Home health care, Nursing home, hospital ward, regular general practitioner, outpatient clinic, physiotherapist, support person, pre-hospital care	Siblings, children, neighbours
3	78	Female	High	Lives alone	Regular general practitioner, hospital ward, nursing home, outpatient clinic, occupational therapist, pre-hospital care Has refused to receive home health care	Sister and nephew
4	88	Male	Low	Lives alone	Regular general practitioner, home health care, outpatient clinic, hospital ward, Norwegian Labour and Welfare Administration Has refused nursing home	Sister
5	90	Male	High	Married	Home health care, nursing home, hospital ward, regular general practitioner, outpatient clinic, physiotherapist	Daughter and son-in-law
6	84	Female	Low	Widow, lives alone	Home health care, nursing home, hospital ward, regular general practitioner, outpatient clinic, physiotherapist	Children and grandchildren
7	90	Male	Low	Married	Home health care, nursing home, hospital ward, regular general practitioner, outpatient clinic, physiotherapist, occupational therapist	Daughter-in-law, son, grandchildren
8	87	Female	High	Married	Home health care, nursing home, regular general practitioner, outpatient clinic, physiotherapist, occupational therapist	Daughter-in-law, son, grandchildren
9	89	Female	High	Married	Home health care, nursing home, hospital ward, regular general practitioner, outpatient clinic, physiotherapist, occupational therapist	Husband, son
10	82	Female	Low	Married	Home health care, nursing Home, hospital ward, regular general practitioner, outpatient clinic, physiotherapist	Husband, grandchild

chosen by the participants. The first author performed all interviews face to face. We conducted a pilot interview before collecting data. The interview guide had open questions such as: 'How do you experience living at home with your daily ailments?' and 'Can you tell me about an ordinary day?'. The interviewer tried to ask as few questions as possible and encourage participants to speak freely and elaborate on their stories, asking: 'How did you experience that?' and 'Can you tell me more?'. Having a phenomenological attitude also meant enduring silence and waiting patiently for answers. The interviewer was aware of the participants' vulnerability and offered breaks. The interviews lasted for 35–95 min, averaging 63 min. The interviewer audio-recorded the interviews and transcribed them verbatim.

ETHICAL CONSIDERATIONS

All participants gave written and oral informed consent. The study was presented to the Western Norway Regional Committee for Medical and Health Research Ethics and approved by the Norwegian Centre for Research Data (Ref. 61202). Data were stored and the study completed in accordance with ethical guidelines and the Helsinki Declaration [47].

DATA ANALYSIS

Van Manen describes the phenomenological method not as a controlled set of procedures but as a way towards human understanding [42]. There is an active search for meaning, from an open attitude of wonder. In phenomenological research, writing and rewriting are at the core of reflection and thoughtfulness and deeply interwoven analytical processes [48]. The first author wrote drafts and reflective texts and we discussed them. We started the procedure by reading through all the interviews to get an overall impression. The first author wrote short reflective notes on impressions after reading each interview. We read through the interviews and, after reflective discussions, selected meaningful text units and grouped them by categories. Various questions were posed about the excerpts, asking: What is this about? The first author tried to vary the frames of reference, using contrasts and contradictions, approaching the phenomenon from diverging perspectives. Then, we wrote condensed descriptions and explored them across the participants, seeking similarities and differences. We explored, articulated and reinterpreted, omitted, added or reformulated themes. This way of approaching the text, by moving back and forth, between writing, rereading the material, rewriting and having reflective dialogues, is called holistic reading [42]. We further refined the themes through reflective writing. We aimed to describe the lived

meanings of frailty. We introduce one essential theme describing frailty as being in the borderland of the body, including three interrelated subthemes: (1) the body shuts down; (2) living on the edge; and (3) not giving up.

The essential theme summarises the whole, and the three subthemes describe nuances and variations of living with frailty, including quotes from the participants.

FINDINGS

In the borderland of the body

Living with frailty meant living with an unpredictable body, limiting and shrinking their lifeworld. This bodily experience entailed slow deterioration and an ever-present risk of acute illness and incidents. Frailty was thus perceived as a warning that the participants' lives were about to take an unexpected turn. The experience of frailty changed the participants' lives. The disruption of everyday life, the confrontation with pain, suffering and uncanniness inevitably drew new attention towards the body, its condition, pain and functioning. Nevertheless, they expressed strong will to maintain meaningful activities.

Crossing the threshold into frailty was perceived as deeply existential, a situation they could not escape or recover from, forcing the participants to reorganise their everyday life. The participants were living in the borderland of the body, trying to figure out how to deal with their altering body and sustain the lives they had built for themselves. Although the capacity of their bodies fluctuated, the participants used their personal resources and support from others to continue, attempting to manage their day-to-day situation. The participants had experienced loss and bereavement, change and insecurity before. In the current situation, they drew on this experience and yet strived to maintain a sense of well-being in their lives. Frailty was a balancing act between living within bodily limitations and holding on to themselves and their lifeworld.

The body shuts down

The participants experienced living with frailty as living with a weak and unpredictable body. The stories of the body shutting down also expressed losses, including who they were and how they lived in the world. Participants experienced physical impairment and incapacity, and the body set the agenda for everyday life.

An 82-year-old woman described the decay in her body.

It is like I can see that my fingers crook. I wake up with my fingers all crooked, and I have to bend them into the right position [lifting her

hand, turning it around and demonstrating how she bends her fingers into the right position]. If only my arthritis could be a little better. But otherwise I think I am doing well. I did a lot of needlework earlier, including crocheting, knitting and embroidery. But I can't hold the needles anymore, and then I get grumpy, because the knitting needles fall on the floor, and I can't pick them up. ... But you see, I no longer care about housework, and the vacuum cleaner and I have been enemies for a long time. I don't have to worry about that, I mean, because I can't use it. I have such poor hands, and I'm glad if I can just grab a cup or hold a plate!

For some participants, a strong physical body was connected to work and practical chores in daily life. This was important for their feeling of being in the world. An 88-year-old man described a situation in which he got injured while working with wood. Even if he could find an alternative to heating the house with firewood, this activity had been a regular habit throughout his life. The injury affected other parts of his body that were starting to shut down as well.

It all started with me splitting wood. I was about to split a big wooden cube. And when I lifted the ax over my head, it was difficult to turn in the right position. And then suddenly, I twisted my body, and then my hand hurt so bad. Afterwards I got such tremors; I couldn't even write my name. After the incident, there has been little activity. So then I was hospitalized, and now I am not allowed to use my hands. So I have stopped the work outside. There is very little to do after I got problems with my hands and was no longer able to work. After that I got problems with my stomach and trouble with constipation. This caused some irregularities with sleep, and the medication was not so easy to dose. So I have to make sure I am near the toilet.

The lived experiences of having a strong physical body but gradually declining altered his way of being in the world. The strong body had been his force in the world, but now he perceived his body holding illness and weakness as well. The damage to his hand led to inactivity and constipation problems. He had difficulties dosing his medication for constipation, which led to waking at night with an urgent need to defecate. Fear of defecating in his bed or trousers made him stay close to the toilet. Not being able to work outside anymore represented a loss of the force in the world on which he built his life. Participants faced disruption of daily life from ongoing and increasing impairment.

Living on the edge

Participants experienced reduced strength, slower reactions and physical impairment and incapacity. Breathlessness was overwhelming and frightening. Participants lived at constant risk, despite a slow life, high age and a modest daily schedule. A 72-year-old woman with significantly reduced lung capacity lived at home with her husband. She experienced panic when she felt breathless.

The experience of not breathing: I could crawl up the wall to get a breath of air. I have an urgent need for oxygen. Like tonight, I couldn't sleep. I found no position where I could breathe. So I got up and sat at my desk in the office. I took a dose of medicine, and then I fell asleep at the desk. I was not able to get up on my feet on my own. ... I couldn't move, and then I fell asleep [...] you can worry about falling asleep and then falling on the floor. I am afraid of injuring myself unnecessarily. I get tired of not being able to breathe. The doctors haven't told me much, there is not that much that can be done. I must take my medication and keep exercising. There is nothing more that can be done. I know that when it becomes difficult for me to breathe, it's game over.

She described not being able to breathe sufficiently as living on the edge. Every decision and action, even the smallest mistakes, might be fatal. She knew that if she did not take care of herself, she would decline even faster. She worked hard to keep her body in shape to prevent further loss of muscle mass and felt great responsibility for her health. This was experienced as tiring and time-consuming but deeply meaningful, because it was the only way to obtain more time with her loved ones.

Living with frailty implied a body with fluctuating capacity. Participants had to adjust daily activities to the abilities of their body. Activities previously taken for granted were perceived as risky. This led to bodily uncertainty. Falls or episodes of breathlessness brought the fear of further decline. The participants experienced that each incident worsened their situation, as the body's reserves were gradually drained. Although trying their best to be careful, they sometimes slipped due to forgetfulness or inattention. An 82-year-old woman living alone in a large house described fracturing her femur.

I had locked the door before I went to bed, of course, and I walked inside with my walker. Suddenly, I fell flat on the floor. I do not know what happened, but I think the handle on the walker was a bit slippery. ... I was injured. ...

I didn't faint. I was completely numb, so I did not feel any pain. That's absolutely true. I have brittle bones and all of that, but I did not notice any pain. Because I had put my mobile phone on charge for the night, I managed to crawl across the floor to get the white cable and then I pulled it down. I called my niece, and she called the ambulance, which arrived just before she did [after just over an hour]. The paramedics had to break in through the porch door. It was totally okay. It was necessary. I tried to get up, but you know, it was impossible.

The participants said that they had techniques for getting up after a fall, but this did not necessarily work in practice. The experience of falling without being able to get back up underscored the physical impairment and incapacity of their body. Participants started questioning their capability to walk on stairs without falling or get to the door when the doorbell rang without tripping over their feet. Serious events such as falls, acute breathlessness or injury focused increased attention on the body. Decline in vital functions accumulated for each new episode, increasing their explicit awareness of their body and its strength and frailty. They became more familiar with their unpredictable and yet predictable situation. They knew where it was going, and anything could happen anytime.

Not giving up

Participants experienced their lifeworld as narrowed through illness and bereavement. Their potential to act and move was limited. They could no longer get out and see other people whenever they wanted, since this required planning and support from others. Being frail made participants wonder what the future would bring. Their life involved balancing between feeling safe in a smaller space and risking moving around a little.

To keep safe, participants quit meaningful activities and hobbies. They described these activities as being too risky and feared the consequences if they lost their balance while walking in nature or fell when entering the fishing boat. They experienced quitting activities their bodies could not endure anymore as a loss.

A 90-year-old man could no longer use his car or fishing boat due to illness and old age. Living in a rural area, he depended on support from others to socialise.

Well, I'll be sitting a lot inside. At home. I cannot even get around doing any work outside. And I have the fjord. I have been fishing

for several years but not this year. They [male friends and fishermen] have tried to convince me to join them. But no. ... I have such a hard time getting myself into the boat and out of the boat. ... No ... life is not going to be any different. I'll take a small round inside the house and look out the window [tapping his fingers on the table]. I hope it gets better when this year is over. ... I have an electric scooter now. I waited 4 months for it. I am so old, so I wanted one with a cabin on to protect me from the storms out here. At least I can come around and talk to people.

Despite decline and loss, participants hoped and strived to find other meaningful activities in which the body was less prominent. They worked hard to achieve a meaningful and livable relation with their altering body.

A 90-year-old man lived with his wife and spent most of his time at home. He enjoyed a quiet life. But the silence and loneliness were altering his experience of being himself, of being someone who mattered in the world. He had volunteered as an organist but stopped playing in the church several years ago. A visit at the nursing home inspired him to resume his hobby.

I started playing the piano again. My wife convinced me to play. I played for the residents at the nursing home. And good heavens; they applauded, I have never played so bad in my entire life, but they clapped, good heavens. ... they clapped and stomped. And cried. Now I found out that I need to practice a little, and then I will play at the nursing home. I'm happy to please others.

Engaging with familiar activities made participants feel connected to their lifeworld and being themselves. Participants fought the feeling of frailty and adjusted activities, so they could still experience meaningful activities, such as attending an art class or discussing literature. These activities enhanced participants' feeling of well-being, making their problems less prominent. Some participants had reconciled themselves with life as it was. They tried to maintain their daily activities indoors: reading the newspaper, walking around the house, listening to the radio or watching television and talking with their family on the phone. Daily activities sustained participants' feeling of connectedness to their familiar world. Keeping up their daily activities was not effortless due to pain and a slower body, but they could perform them without having to plan in detail what to do. These activities were deeply embodied, meaning that they knew some parts of life could continue.

DISCUSSION

This study explored the lived experiences of frail home-dwelling older people. The main finding was that living with a frail body is an ambiguous situation of balancing frailty, strength and a constantly altering body.

The subtheme 'the body shuts down' describes bodily decline, lacking strength and ability to perform daily activities as one aspect of frailty. These findings are in accordance with previous studies describing frailty as a negative physical and mental condition [1, 2, 4, 6–9, 49, 50]. Inability to perform daily activities reduced participants' socialisation, making them less attached to their lifeworld. The experience of their body shutting down affected participants' mood and well-being, which in turn intensified the effects of physical disability. In addition, Skilbeck et al. showed that poor mood disturbs frail older people's daily routines [23], and Pan et al. emphasised that frail older people identified their independence by performing daily activities [51].

Our findings expressed in 'living on the edge' underscore that participants had a great risk of injury even though they lived a slow life without much exuberance. This mirrors other studies, underpinning frail older people's significant risk of future challenges with activities of daily living [12, 13, 15, 16, 52]. Negative health outcomes are expected, revealing the complex interactions in the frail body [51]. Participants faced different possible dilemmas when they had difficulties performing activities of daily living; participants might ask others for help, thereby losing a sense of independence. The other options are managing on their own, continuing to live on the edge or adapting former activities to reduce the risk. Our findings show that participants were not giving up (sub-theme 3). These findings add important insight to previous research, showing that participants adjusted previous activities to keep up meaningful activities, still being independent. For example, losing the driving licence made one participant find a new alternative in an electrical scooter to get around. Previous research describes living with frailty as a life in existential loneliness, entrapment and being disconnected from life [36]. Our findings support this to a certain extent, especially when participants lived through their most frail episodes. However, our findings underscore that, living through experiences of frailty, participants gained deeper knowledge about their altering body. Participants describe a fear of being left with a dreary and meaningless everyday life, comprising either no activities at all or participating in activities of no interest to fill the day. Pickard argues that one aspect of health is being able to be and do what one values [29]. This has parallels to Koskinen et al., who state that vitality in suffering enables change [53]. Given our understanding of subthemes 1 and 2, frailty might be experienced as a downward spiral of losses of physical functioning, social engagement and a pervasive risk of injury when performing daily activities,

which is in accordance with the definition of frailty [1, 4, 5, 8, 9, 54]. This downward spiral might lead to symptoms such as reduced life satisfaction or depression, which is a known adverse outcome of frailty [22, 52]. Our findings show that participants realised they could not escape or recover from this situation, and the realities of life led participants to elicit and use their resources to find new strategies and meaningful activities. Previous research states that older people's personal strength is a resource for living a meaningful life [33, 55]. This is corroborated by other research describing frail older people's creativity as a capacity to connect to changing circumstances and adapt to being frail [23, 35, 37].

The overarching theme 'in the borderland of the body', regarding embodiment, shows that the experience of frailty is an ambiguous experience. According to Merleau-Ponty, the lived body enables access to the world, but when threatened by illness and physical decline, this access changes and may threaten one's sense of self and unreflective being in the world [41]. Our findings may thus indicate that living with frailty limited participants' opportunities to live a familiar and meaningful life at home close to their belongings and significant others. Participants had to adapt to their capacity and according to their resources and others available to them. Their focus on the body took precedence, meaning giving the body's limitations and health problems priority. Nevertheless, participants still intuitively are themselves and strive to maintain the sense of being a body, even though illness pushes this limit. Despite their losses, participants struggled to hold onto and live the lives they had built for themselves. They used past experiences of overcoming life challenges to endure and to hold onto what was most important for them.

Frailty has been described as loss of bodily integrity and embodied agency, meaning that frail older people lose their capability to be what they want to be and do what they want to do [7, 56]. Nevertheless, our findings show that participants adjusted their activities due to their altering body and lifeworld. The feeling of inadequacy when meeting former friends in arenas or situations that had become too challenging might be the starting point to find other meaningful and less physically demanding activities: for example, in an art class the body is less prominent. At first, the experience of frailty was frightening and limiting. Participants' bodily borderlines seemed impossible to cross; their lifeworlds were shrinking. As participants got more familiar with their altering body, they started to negotiate these borders, adjusted their activities and tried to push and expand the borders to get more space and possibility to be themselves. According to Merleau-Ponty, the body is both the subject and object of intentionality as we constantly navigate everyday life.[41] Considering this, our understanding may underscore the demanding balancing act participants faced. They acknowledged their limitations but strived to balance the desire to live and the necessity of being safe. In contrast, accepting frailty without negotiating its limits might lead older people to

give up and identify themselves as frail, risking reduced functioning and further decline.[23, 34, 38, 51] Consistent with our findings, Warmoth found that frail older people consider being active important, even at lower levels than previously [7].

As highlighted in previous studies [8, 20, 23, 36, 57], participants experienced frailty in old age as being thrown into an unpleasant journey of uncertainty and unpredictability that changed life itself. Living with frailty inevitably entailed that the body and its shortcomings tended to take over, yet also gave priority to the importance of maintaining other meaningful aspects of one's life and to stay open for ways to continue to do this. If healthcare providers only consider biological changes, they will fail to provide adequate care to this group of people. Further, healthcare providers should more extensively investigate older people's own experiences and resources when developing sound care for this group.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

Our study gives insight into the lived experiences with frailty related to the body of home-dwelling older people. Finding out what frail home-dwelling older people consider valuable is therefore important when planning and providing care for such people. Social life is important and affects the health and ability of the individual to manage at home and experience well-being, something that is fundamental in care. In our study, meaningful activities often took place in or related to people's home or neighbourhood and accompanied by significant others. Healthcare providers should more extensively involve and utilise older people's resources and provide care in accordance with this as far as possible. This implies a holistic approach, which requires collaboration with the older people, family members and healthcare providers on different levels. This requires a more flexible organisation of the home healthcare services, in which healthcare providers can adjust the time and care based on the daily condition of the older person. Healthcare providers must strive to facilitate daily living for older people in collaboration with their significant others to plan a manageable life at home as long as possible. This study explored frail older people's experiences of frailty and life at home in depth, describing in detail meaningful activities as essential to feel as oneself and live a good life and hence for experiencing health and well-being. Frail older people's resources need to be recognised.

STRENGTHS AND LIMITATIONS

The study was conducted with frail older people in rural Norway. The cultural setting should be considered regarding the transferability of findings. However, we have shown

some parallel findings in previous studies, indicating that the essential meanings highlighted might be relevant across cultural differences. The sample size was small, but the interviews provided rich experiential data. The strength is that we give voice to vulnerable older people and their perceptions of the phenomenon of frailty related to their body, which is unique. To increase the credibility, dependability, transferability and confirmability [58] of the findings, we aimed for a varied sample, and the first author used her clinical experience when planning and preparing the interviews, preparing the interview guide, and all authors read and participated in the analysis.

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AUTHOR CONTRIBUTIONS

BES, JD and AMS designed the study. The first author collected the data. All authors read and analysed the data. The first author drafted the manuscript, and all authors contributed to the final manuscript.

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