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Improving interprofessional practice for vulnerable older people: gaining a better understanding of vulnerability

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A key focus for professionals working with older people in the community is on those who are vulnerable, although this vulnerability is not well defined. This study sought the views of health and social care professionals and older people on vulnerability, identifying significant differences between professional and older people's perspectives. It found that for older people, vulnerability is an emotional response to being in a specific situation, whereas for professionals, the vulnerability of those on their case loads relates to them having certain or a combination of characteristics (physical, psychological and social). The paper concludes that interprofessional care for older people in the community could be improved firstly by asking older people if they ever feel vulnerable and if so, in what situations and secondly by focusing team efforts on addressing the issues raised by older people in response to these questions.

Keywords: Vulnerable, aged, aged 80 and over, interprofessional care, community

INTRODUCTION

Although often used to describe older people in health and social care practice, the term vulnerable is not well defined in policy or the literature, except for in relation to adult protection. National policy on adult protection defines a vulnerable adult as a 'person who is, or may be, in need of community care by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (Department of Health, 2000).

The researcher's clinical practice highlighted frequent use of the term, within geriatric medicine and primary care, mostly to refer to those who would otherwise be described as frail. There is no research evidence suggesting that the terms are synonymous. In fact frailty has been defined as a 'clinical syndrome encompassing diverse vulnerabilities, weaknesses, instabilities and limitations' (Rodin & Mohile, 2007). This suggests that vulnerability is just one aspect of frailty. The National Service Framework (NSF) for older people simply described frail older people as those who are 'vulnerable as a result of health problems such as stroke or dementia'. The identification of potentially vulnerable older people was an aim of the Single Assessment Process (SAP) also part of the NSF. It stated that the SAP should fit with current approaches to the proactive identification of potentially vulnerable older people, but no definition of vulnerability was given (Department of Health, 2001).

In addition to the above we know of no research on the views of older people as to how they define their own vulnerability.

Despite the dearth of research on vulnerability in old age and lack of clarity in national policy, research does suggest that vulnerability comprises two distinct concepts, of etic vulnerability, likened to externally evaluated risk, determined by an outsider and measurable, and emic vulnerability, concerning an individual's personal interpretation of vulnerability and based on their own 'experience of exposure to harm through challenges to their integrity' (Spiers, 2000, p. 718). The latter can only be described from the person's perspective and is not quantifiable.

The literature to date indicated that the term 'vulnerable' is used widely in relation to adult protection where it is clearly defined. It is also frequently used in national policy (for England), but without clarity of meaning and literature encompassing older people's views is significantly lacking. It is important to define the concept of vulnerability due to our rapidly ageing populations where multi-morbidity is the norm; these people requiring multiagency care and support.

This article reports findings from a wider study which explored patient centred care for vulnerable older people in the community. The specific aim of this article is to increase understanding of the concept of vulnerability in old age by exploring the perspectives of both older people and health

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and social care professionals, and subsequently improve community care for vulnerable older people.

METHODS

A social constructionist methodology was used based on the theoretical perspectives of symbolic interactionism (Blumer, 1969). The latter has three fundamental premises: firstly that people act towards things on the basis of the meanings they have for them, secondly that these meanings come from one's social interaction with others and thirdly that such meanings are dealt with and modified by an interpretive process used by the person (Blumer, 1969).

Sampling

The sampling was purposive (Silverman, 2005), with those who were considered by the researcher to be in a position to offer important insights or perspectives on the research topic, being invited to participate. This included older people across a continuum of vulnerability, some living independently at home, and others relying heavily on health and social services, and health and social care professionals currently working with older people. Older participants were either known to a local branch of Age Concern (now Age UK) or to one of three local specialist older people's community teams. Permission was sought from potential participants for their contact details to be given to the researcher. Professionals working within all three of the specialist older people's community teams in the area were invited to and participated in focus groups. These teams were chosen because of their interprofessional composition and their work with older people. Professionals working for a single primary health care team were also included. This primary health care team was chosen as it provided focused input for older patients e.g. dedicated nurse specialist post for older patients and because of its interprofessional composition (including social work). Further, primary health care teams were not included as data saturation had been achieved.

As data collection progressed gaps in the data emerged and so subsequent sampling was done in response to this (e.g. although, the first two focus groups were held with community teams, very few social workers had been involved, therefore a focus group specifically for social workers was held).

Data collection

Focus groups were the preferred method of data collection however older people who were either unwilling or unable to participate in a focus group were offered an individual interview at home. Separate focus groups were planned for older people and professionals. Where possible, professionals working in the same team attended the same focus group to facilitate discussions about specific cases. Focus group size varied from two to eight participants. All focus groups and interviews were recorded and transcribed verbatim.

A topic guide was used for both focus groups and interviews, to elicit participants' thoughts, experiences and ideas concerning vulnerability in old age and to facilitate discussion amongst group members. Older participants were asked to give examples of being vulnerable from their perspective and then probed for more information e.g. why they were vulnerable. Professionals were asked to talk about the people on their case loads that were vulnerable and in particular what it was that made them vulnerable. General discussion about the nature of vulnerability in old age was encouraged in all focus groups/interviews.

It was agreed that should distress be caused during a focus group or interview, the individual concerned would be given the opportunity to withdraw from the discussion, take a break or end the interview. Should a significant physical or mental health problem become evident during the focus group/interview, the participant would be advised to visit their GP. Information collected from participants was anonymised and data was stored securely, either electronically in a password protected file or in a locked filing cabinet. The requirements of the Data Protection Act were adhered to when accessing and using participants' personal details.

Data analysis

The analysis was based on the constant comparative method described originally by Glaser (1965). In this way, early findings were 'checked out' and explored further in subsequent focus groups/interviews. Analysis started at the time of the first focus group and continued during data collection, informing the process throughout. Description, analysis and interpretation were all addressed, this being necessary for data transformation (Wolcott, 1994). Description is about determining 'what is going on'. Simple descriptive codes were applied to the data. The processes involved in analysis and interpretation (according to Wolcott) tend to overlap. At this stage, the researcher expands and extends the data. This 'working up from the data' (Richards, 2005) was accomplished by writing concise notes about what was of interest and why against sections of text, and informed further coding. Notes included the researcher's opinion and thoughts either about a possible reason for what was said or for the emergence of a specific concept or idea. Therefore, coding as well as being used to reduce and organise the data was also used to 'expand, transform and reconceptualise the data' (Coffey & Atkinson, 1996). A computer-assisted qualitative data analysis software package, NVIVO (version 2) was used; this enabled storage and retrieval of large amounts of data.

Ethical approval was sought and gained from the Local Research Ethics Committee prior to commencement of the study. Informed written consent was obtained from all participants. All participants completed a proforma giving personal details such as age, gender, services received (older people), professional group (professionals).

FINDINGS

The study had 42 participants: 21 older people (three males and 18 females) and 21 professionals. There were nine

social workers, five nurses, three rehabilitation assistants, two physiotherapists, one occupational therapist and one podiatrist. The age, living situation and gender of the older participants are shown in Table I.

A total of eight focus groups (four with professionals and four with older people) and three interviews were held undertaken. Out of those held with professionals, two were held with specialist older people's community teams and were therefore attended by a range of disciplines. One was held with a primary health care team which comprised nurses and a social worker and the fourth was held with social work team. Out of those held with older people, one was held with older people who were all known to a local befriending service, and another with a group of older people from the same sheltered housing complex who attended the same lunch club. The third and fourth were held with people known to a specialist older people's community team: one married couple and two older ladies who did not know each other.

Seven codes relating to vulnerability were generated as a result of data analysis, each having a hierarchy of codes associated with it. Examples include: accounts of own vulnerability, accounts of vulnerable cases, situations of vulnerability, feelings associated with vulnerability, staff types of vulnerability and vulnerability contributory factors. The findings presented here arose from the data coded at these seven codes.

Older people's and professionals' constructions of vulnerability in old age are distinctly different. For older people, vulnerability is an emotional response to being in a specific situation over which one has little or no control. For professionals, a vulnerable older person is one who has certain characteristics or risk factors or a combination thereof, such as being mentally and physically frail and living alone.

Older people's perspectives

For older people, vulnerability is about feeling vulnerable in a particular situation, when 'at the mercy' of one or more other people. When asked to talk about their own vulnerability, older people spoke exclusively about feelings associated with being in certain 'situations of vulnerability'. Vulnerability involves an emotional response which is dependent on being in a particular situation. Older people do not see themselves as vulnerable in general.

Table I. Characteristics of older participants: age and living situation according to gender.

Age range (years)	No. of male participants	No. of female participants	Total
70–79	1	7	**8**
80–89	2	4	**6**
90–99	0	6	**6**
Unknown	0	1	**1**
Total	**3**	**18**	**21**
Living situation			
Living alone	1	8	**9**
Living alone in sheltered accommodation	0	6	**6**
Living with spouse	2	2	**4**
Living with more than one other person	0	2	**2**
Total	**3**	**18**	**21**

Older people spoke about a wide range of situations in which they felt vulnerable. These situations fell into three main categories: (1) being at home; (2) going out; (3) health care related. The 'being at home' category included situations such as being unable to go out independently (linked to being wheelchair bound), being at home alone whilst other family members were out during the day and being at home alone when strangers call. Examples of 'going out' situations were: travelling by bus, crossing the road, walking in the park and waiting for transport such as buses and taxis, and health care situations included: waiting for an ambulance in an emergency and arriving home after a spell in hospital. Each of these categories had an element of being at the mercy of one or more other people, whether it is a family member, a member of the general public or an employee such as a bus driver or a health professional.

The three illustrations below demonstrate the emotional response component of older people's vulnerability. In the first data extract, the emotional responses are fear and worry related to the situation of being at home alone when the person one lives with is out. This older person lived with her daughter and did not feel vulnerable in general. However, did not always know when her daughter would return. This was disempowering and added to her feelings of vulnerability. She acknowledges that her poor mobility contributes to her not going out, but this is secondary to her emotional response and the lack of control she has over the situation (not knowing when her daughter will return):

> 'Well I've been frightened when I've been left too long on my own. If they've (family) gone away for the day and I've been left behind you know, I start to worry and fret and I start feeling me age when I know that they're not coming back on time you know… So I feel vulnerable then, but she (daughter) doesn't do it (go out) a lot, but when she does do it I feel vulnerable… I can't go with her. I can't walk very far, so I can't go'. (Participant 8.1 – older person)[1]

In the second illustration, feeling vulnerable is associated with the fear of falling whilst on the bus. Feeling vulnerable is linked to the attitude and approach of the bus driver, with the older person feeling very much 'at the mercy' of the bus driver. The reference to the differing attitudes of bus drivers supports this:

> 'I feel on public transport, on a bus you're very, very vulnerable to being thrown onto the floor or when I think all it takes is a little bit of thought from the driver, and some are very good but some are dreadful. And you know you feel as though they slammed the brake on deliberately while you were half way up the aisle of the bus. Or they don't give you time to sit down before they start off from the stop. And even when you're getting off the bus, unless you're almost level with him to be able to say, I'm not, you know give a minute a two, a second or two. Because I think a lot of elderly people especially if they've got a problem walking or anything, now I at the moment I have a stick, and I find it

very difficult using the stick on a bus, getting on and off a bus with it if the driver doesn't cooperate'. (Participant 3.1 – older person)

In the third illustration, feelings of abandonment associated with the situation of arriving at home after a spell in hospital are expressed by four older people. There was a general consensus that feeling vulnerable in this situation was commonplace. Older people are at the mercy of the professionals who plan their discharge from hospital. Again these older people did not describe themselves as vulnerable in general:

'Now I live by myself, I have no-one and I was sent out to my home, to a cold house... with no heating, nothing at all... You're just brought home and dumped and that was it...' (Participant 3.5 – older person)

'Well I felt abandoned. You've in a safe place (in hospital) safe and comfortable and well safe I think is the biggest thing, and then you go home, and I don't live alone... but I just felt abandoned...' (Participant 3.1 – older person)

'I think with the hospitals now there's no aftercare... to me to be poorly and not up to standard and come into a cold home with no-one to give you a cup of tea or even a kind word, I think that's shocking!' (Participant 3.6 – older person)

Vulnerability is conceptualised by older people as an emotional response to being in certain situations and each of the situations has an element of 'being at the mercy' of others.

Professionals' perspectives

Professional constructions of vulnerability are quite different to older people's constructions. They are associated with certain characteristics and fall into six main categories: (1) mentally and physically frail and living alone; (2) having no 'significant other'; (3) victims of crime'; (4) 'At risk' or having a 'number of risk factors' or unable to manage one's own risks; (5) in an abusive or potentially abusive social 'set up'; (6) potentially harmful imbalance between care needs and the care provided.

The categories identified are wide ranging covering a number of physical, psychological and social factors as well as factors related to care provision. Unlike older people's constructions, they do not comprise emotional responses to being in a particular situation.

The first category is illustrated by the data extract below. As indicated in the following extract, there is some flexibility as to the exact combination of factors that result in a person being vulnerable, this being implied by the use of the words 'maybe' and 'perhaps', but the importance of living alone and of having a number of areas of mental and physical frailty are evident:

'I suppose we all have our own little box in the head that goes in with that word (vulnerable)... I think of the person that lives alone, the person who looks frail, underweight, osteoporotic maybe, has falls, dizziness, perhaps cognitively impaired, thinks they can do everything for themselves and we don't think they can. I just think of them as being hugely vulnerable, like little china doll type things going to be battered about and I like sometimes feel "oh my God" you know about this person'. (Participant 1.5 – podiatrist)

'Having no significant other' emerged from discussions about older people who had no one in their lives to provide any physical or psychological assistance or support. Having no one to 'speak up' for you (suggesting the need for advocacy) and having no one to provide any kind of help are key components of this:

'I think people that haven't got a lot of support or haven't got any family around are more vulnerable or (they haven't got) people that can speak up for them to help to identify the problems. Even people who are quite articulate and cognitively with it, if they haven't got somebody that says, "well yes actually there is a problem here" I think that they're more vulnerable...' (Participant 1.2 – physiotherapist)

Although this type of vulnerability was conceptualised as applying to older people who have 'no significant other', it is evident from the extracts that living alone and being socially isolated are also relevant. Older people who were crime victims (rape and burglary) were also seen as vulnerable by the different professionals interviewed:

'I think people who have been in a crime, subject to a crime say "I felt so vulnerable" and it's a really bad thing to say. I had you know like a woman who was raped. I remember her saying that. "That's the first time in my life I've felt vulnerable"... I mean we had a woman who, £7000 was stolen from under her bed... she came across as saying all the time... "I feel terrible now, I can't even open the door at night and all of the time"... Yes, fear is the thing'. (Participant 1.1 – occupational therapist)

Issues of risk were discussed at length by professionals. Those considered vulnerable had a number of risk factors; the more risk factors, the more vulnerable the person was considered to be. The risk factors discussed were mostly those routinely assessed as part of good practice e.g. risk of falls, malnutrition or environmental risk; some of which had become policy imperatives e.g. falls risk assessment (Department of Health, 2001).

Also relevant was risk management, with those unable to manage their own risk being seen as the most vulnerable by the professionals. Two main reasons for inability to manage one's own risks emerged – not being in control and lacking insight into risks:

'I always kind of think it's somebody who doesn't have kind of control, or have insight, or there's some reason why they don't have the ability to make safe decisions. I mean you can see somebody who is maybe very physically stable for whatever reason, over maybe a chronic illness, but they're very clear what they want and they can kind of say well you know and they've an understanding... It's more people who don't have control over, and somebody else almost has, you think they're in a very vulnerable position because they're not able to make decisions or change or have insight into the fact that they are at such risk'. (Participant 1.4 – social worker)

Older people who were in abusive or potentially abusive social 'set ups' were also seen as vulnerable by professionals

interviewed. An example is being in an abusive relationship with a family member with whom one lives. Use of the term vulnerable in relation to safeguarding/adult protection is well established following national policy in this area (Department of Health, 2000). Many professionals spoke about vulnerability in relation to adult abuse, giving examples of people on their case loads. An older person who is vulnerable is someone who requires protection. One of the social workers explained how someone who is physically vulnerable can also be subject to financial and/or emotional abuse from relatives which renders them even more vulnerable. The notion of one aspect of vulnerability, making one even more vulnerable in another way, was also expressed by a podiatrist in another focus group.

The final characteristic that emerged from the data that the professionals associated with vulnerability in old age related to the complete care package. Someone who experiences an imbalance between care needs and care provided is seen as vulnerable. Examples include break-down of a care package e.g. due to carer illness, an increase in care needs linked to onset of illness such as dementia and simply not accessing services required such as personal care, due to lack of awareness. The illustration below highlights how a failure to adequately manage a complex multifaceted care package is seen as instrumental in vulnerability:

> 'People… are vulnerable, whether it be for physical reasons, emotional reasons, where the whole of the care infrastructure is breaking down… because they've lost control of something, something's not being managed… It's not uni-disciplinary… it's multidisciplinary, so there're a number of areas that have all been affected. I think this person's vulnerable because any part of it could break down at any point'. (Participant 2.2 – social worker)

Older people's and professionals' constructions are distinctly different, the latter being associated with individual characteristics.

DISCUSSION

This study indicated that distinct differences between the way older people view their own vulnerability and the way professionals view their vulnerability. For older people, vulnerability is conceptualised as an emotional response to being in a specific situation when one, is 'at the mercy of others'. From the perspective of professionals, vulnerability in old age is associated with individuals who have certain characteristics.

Figure 1 shows the difference in these conceptualisations. It shows how for older people vulnerability comprises three components: a specific situation, a sense of being out of control and a negative emotional response. Although these three elements vary, each is apparent whenever an older person talks about their own vulnerability. This is in contrast to health and social care professionals' conceptualisation of vulnerability in old age, where being vulnerable is more of a permanent feature, although not necessarily irreversible, existing for as long as certain characteristics or combinations of characteristics remain. The characteristics

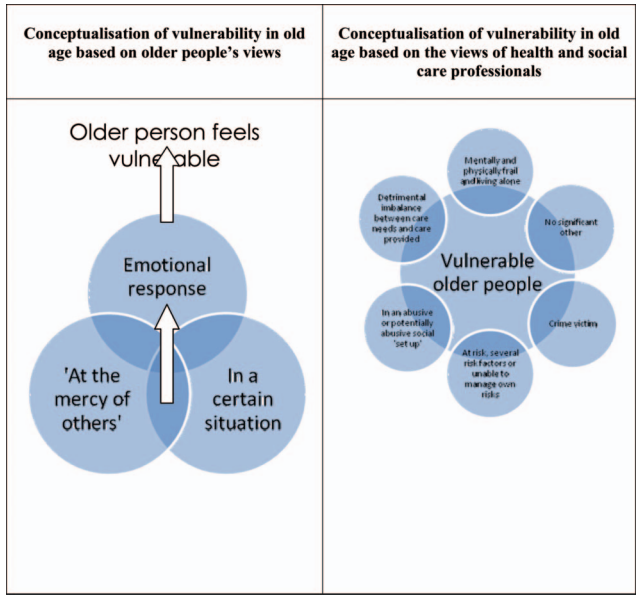

Figure 1. Older people's and professionals' constructions of vulnerability in old age.

comprise physical, psychological and social factors, such as physical frailty, having no 'significant other' and living alone.

As indicated above, the conceptual difference which exists between older people and professionals means that the latter group needs to be clear as to which concept of vulnerability is informing their professional and interprofessional practice. Are they aiming to identify and reduce the feelings of vulnerability felt by older people in certain situations, as identified by them, or to identify those who from a professional viewpoint possess the characteristics associated with vulnerability and intervene to tackle these issues? Currently, the focus is on the latter, examples being falls (Scott, Votova, Scanlan, & Close, 2007), malnutrition (Kondrup, Allison, Elia, Vellas, & Plauth, 2003), pressure ulcers (Bergstrom, Braden, Laguzza, & Holman, 1987), wandering (Robinson et al., 2006) and the identification and subsequent safeguarding of people at risk of abuse. Older people are not asked about their own feelings of vulnerability. Many of the combinations of characteristics that professionals associate with vulnerability, e.g. mentally and physically frail and living alone relate to a number of complex underlying medical, social and environmental factors and as such are not easily resolved.

In relation to vulnerability, interprofessional practice might be strengthened by asking older people if they ever feel vulnerable and if so, in what situations, using their responses to guide team interventions, focusing where possible on alleviating or resolving problems associated with these individual 'situations of vulnerability'. This will help to realign the endeavours of professionals with the perspectives of older people, thus promoting patient centred interprofessional practice.

To be effective, interprofessional teams must have joint goals, something that is often problematic due to a lack of

common understanding and values amongst team members (e.g. Hall, 2005). Working together as a team to respond to the situations in which older people feel vulnerable would provide such goals. For good collaboration between professionals working in interdisciplinary teams, trust is essential especially where there are risks to patients (Mayer, Davis, & Schoorman, 1995). Three key factors assist in building trust, namely: competence, receptivity and shared values and principles (Mayer & Davis, 1999; Mayer, et al., 1995). A shift in focus towards assessing and then intervening according to older people's feelings of vulnerability would engender shared values and principles within teams, this in turn improving interprofessional practice. It is already known that interprofessional care provides a number of benefits over uniprofessional care (Barrett, Curran, Glynn, & Godwin, 2007). This might be further enhanced by adopting an older person's perspective on vulnerability.

The fact that distinct differences emerged between older people's views about their own vulnerability and the views of professionals about the vulnerability of older people on their case loads, corresponds closely to the distinction made between *emic* (individual's personal interpretation) and *etic* (externally evaluated risk) vulnerability (Spiers, 2000). However, the various elements of vulnerability from older peoples' and professionals' stand points are hitherto, unstudied and this study furthers knowledge in this area.

The importance placed on the views of older people in this study was a strength. The views of older people on the concept of vulnerability were found to be distinctly different to those of professionals, this having important implications for clinical practice. Nevertheless, this study contains a number of limitations. For example, only 3 older men took part in the study in contrast to 18 women. Therefore, the results must be viewed as relating predominantly to older women. Another limitation is the lack of GP involvement in the study. Although GPs were invited to focus groups, they were unable to attend. GPs are the first point of contact for the majority of patients with health and social care problems in the UK due to their gate-keeping role and therefore their views would have added another valuable dimension to the findings of this study.

CONCLUSIONS

In conclusion, interprofessional care for older people in the community can benefit from an increased understanding of the concept of vulnerability in old age (see Figure 1). Understanding that the way older people feel about their own vulnerability is likely to be very different to how health and social care professionals view vulnerability in an individual provides a starting point for changing the way interprofessional care for older people is delivered. A shift towards asking older people about the situations in which they feel vulnerable and intervening accordingly is suggested instead of sole reliance on professional perspectives of vulnerability.

Adopting such an approach is a significant change and one that will require interdisciplinary team development. Interprofessional education may improve knowledge, skills, beliefs and attitudes (e.g. Cooper, Carlisle, Gibbs, & Watkins, 2001) and may also help to remove barriers between professionals (e.g. Pittiloe & Ross, 1998) and might therefore be used to facilitate such developments. A lack of common education and interprofessional experience (Reese & Sontag, 2001) is challenging for teams in practice (Hall, 2005). Interprofessional education focusing on implementing a patient centred approach to vulnerability in old age would assist in developing common understanding and team values necessary for high quality interdisciplinary care.

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Declaration of interests

The authors report no conflicts interest. The authors are solely responsible for the contents of this paper.

Note

1. The identifier 8.1 shows that this person attended Focus Group 8 and was Participant 1.

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