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Perspectives on the risks for older adults living independently

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ABSTRACT

Insight into risks concerning older adults living independently from their own perspective and their care provider's perspective is essential to address issues that may threaten their independent living. The most often mentioned perceived risks by older adults and their care providers in different regions in the Netherlands were: loneliness, falls, budget cuts in Dutch long-term care and not being able to call for help. The different perspectives of the respondents show a wide variety in risks, but also some similarities. The perspective of the frail older adults is required to gain insight into the priority of their perceived risks. An additional finding was the reluctance shown by the older adults to ask others in their social network for help. Results imply that possible preventive measures should not only focus on the medical or physical domain because older adults are likely to have other priorities to maintain self-reliance and live independently.

As countries develop, their populations continue to age and the number of older adults living independently will increase over time (United Nations, 2013). In the Netherlands, in 2010 4% of all people over 65 lived in an institution. However, the percentage of institutionalised adults of 80 years and over has dropped rapidly from 20% in 2000 to 14% in 2010 (Garssen and Harmsen, 2011). Because of the rising number of older adults, health care costs will continue to increase (Horst et al, 2011). In response to these developments, Dutch national government policy is focused on enhancing self-sufficiency and independent living. One of the intentions of this

policy is to reduce the increase of health care costs (Dutch House of Parliament, 2014). Since January 2015, institutionalisation in the Netherlands is only possible for people who need intensive care and 24-hour supervision. This means that in the years to come, more people with long-term complex problems are expected to live independently. Accordingly, they have to rely more extensively on their social network

OLDER ADULTS AND FRAILITY

Frailty among older adults is a widely discussed subject in research and policy (Gobbens et al, 2010a; Sternberg et al, 2011; de Vries et al, 2011). However, an internationally accepted definition is lacking. Existing definitions vary, though the focus is mainly on physical frailty (Chitat Leung et al, 2004; Gobbens et al, 2010a; van Campen, 2011). Frailty, however, does not only concern the decline of the physical condition, but also includes psychological and social aspects. The Dutch Institute for Social Research (SCP [Dutch acronym]) describes frailty as an accumulation of physical, psychological and/or social problems, which enhances the risk of negative health outcomes such as functional decline, institutionalisation or death (van Campen, 2011). This definition is what is used for this study. Gobbens et al (2010b) developed a conceptual model of frailty that describes the relationships between life-course determinants, disease or diseases, frailty, and adverse outcomes. This model was used as basis for the Tilburg Frailty Indicator (TFI), an instrument to operationalise frailty among older adults. It takes the three different domains of frailty (physical, psychological and social) into account. A systematic review analysing 10 different instruments showed that the TFI is an instrument that is potentially suitable to screen for frailty in primary care settings (Pialoux et al, 2012). In the Netherlands, the TFI has been used to estimate the proportion of frail older adults within the population aged 65 years and older. According to the SCP this proportion was 27% (van Campen, 2011).

RISKS AND RISK PERCEPTION

Frail older adults living independently may experience problems in multiple domains. A variety of risks could threaten their self-reliance and independent living. It is important to identify and monitor these risks in order to support independent living. The literature mainly covers the physical and medical domain, such as falls (Karlsson et al, 2013), polypharmacy (Davies et al, 2015) and fractures (Morrison et al, 2013). Also, medicalisation of complaints is mentioned in the literature. This medicalisation suggests that complaints of older adults are often interpreted as a result of a medical cause, while other domains of health or welfare are not taken into account when assessing the complaints or the solution for the complaints (Barsky and Borus, 1995; Mulley, 2012). However, in recent years there is increasing attention in the literature towards the social, psychological and cognitive domain. Examples are the increasing attention to loneliness (Honigh-de Vlaming et al, 2014) and dementia (Phelan et al, 2015). Literature regarding risks shows that risk perception may be different depending on the type of risk, the risk context, the personality of the individual, and the social context. However, the literature predominantly describes risks from the perception of professionals. Different factors

play a role in judging the severity and acceptability of risks, such as knowledge, experience, values, attitudes and emotions (Wachinger et al, 2012). Therefore, it is important to include different perspectives and in particular the older adults' perspective when assessing potential risks that could threaten the independent living of older adults or frail older adults, especially since self-reliance and independent living are becoming increasingly important in contemporary society.

OBJECTIVES

The aim of this study is to identify risks that could threaten independent living of frail older adults. The first objective was to identify the risks that could threaten the independent living of older adults from the perspective of older adults over 75 years; professional care providers and care and social organisations. The second objective was to ascertain if the identified risks were similar between the groups.

METHODS

The data in this manuscript was gathered as part of a larger study, in which a mixed methods approach was utilised to examine care networks of frail older adults living independently and how to regulate these networks (Verver et al, 2015). Data used for this manuscript was descriptive.

Ethical approval and informed consent

This larger study is funded by The Netherlands Organisation for Health Research and Development (ZonMw [Dutch acronym]). The study is embedded in the 'academic collaborative centre on supervision' (AWT [Dutch acronym]). In this collaborative centre, four different research institutions have worked together with the Dutch Healthcare Inspectorate (IGZ [Dutch acronym]) since 2011 in order to develop evidence-based supervision.

The larger study is approved by the Scientific Committee of the EMGO+ Institute and the Medical Ethical review committee of the VU University Medical Centre. The individual respondents in this study received an information sheet about the study from representatives of different organisations involved. After receiving this form, they signed an informed consent form where they agreed to participate in a face-to-face appointment with the researcher and sent it back using a return envelope before inclusion took place. Additionally, they signed an informed consent form during the interview with the researcher to permit the researcher to contact their care providers and ask them questions about their care. All information gathered about the respondents was only used for this study and was processed separately from respondent identifiers to protect the privacy and confidentiality of the respondents.

Recruitment and sampling

A letter explaining the study was sent to 15 organisations, including care and welfare organisations and housing cooperatives. These organisations were invited to provide information about their policy on frail older adults living independently. One week later they were approached by the researchers by phone and were invited to

participate. If the organisation agreed, an appointment was made for a face-to-face appointment during which a questionnaire was filled out. In addition, the representatives were asked to contact and inform frail older adults of 75 years and older living independently about the study in the following weeks. As described above, the representatives of the different organisations involved selected frail older adults and handed them informed consent forms and information about the study. Informed consent forms were signed by the participating older adults and sent directly to the researchers by mail using a return envelope. The researchers then contacted the older adults by phone to arrange a face-to-face appointment. During this appointment, the researcher filled out a semistructured questionnaire with the older adult and asked for informed consent to contact the care providers mentioned by the older adults to ask them questions about the care and risks for the older adult. Finally, these care providers were invited by letter for a structured questionnaire about care and support for frail older adults and perceived risks. After one week, they were contacted by telephone to complete the questionnaire.

Data collection

Data for this paper were gathered using:

Semi-structured questionnaires. These questionnaires were filled out during face-to-face appointment with representatives such as directors and policy employees of home care organisations, a volunteer organisation, a general practitioner, an assisted living accommodation and a housing cooperative who have a connection to frail older adults living independently. Qualitative data from the open-ended questions were used for the analyses.

Semi-structured questionnaires. These questionnaires were filled out during a face-to-face appointment with frail older adults living independently. Qualitative data from the open-ended questions and quantitative data from background characteristics and the TFI were used for the analyses.

Structured questionnaires. These questionnaires were completed by telephone with professional care providers of these older adults. Qualitative data from the open-ended questions were used for the analyses.

Data for this study were collected from September 2013 to June 2014. Data collection started with the semi-structured questionnaires with representatives of the organisations. Topics in this questionnaire were: risks, independence, frailty, refusal of care and potential actions taken by the organisations. Data used in this study were collected with the question: ‘what do you see as important risks for frail older adults living independently in general?’ Their answers were summarised by the researcher and sent to the representatives by email for checking. They were able to judge whether the summaries reflected their views.

The semi-structured questionnaire for the older adults contained questions about: health, involved formal and informal care providers, satisfaction with care received, frailty and risks. The degree of frailty was established by the researcher using the TFI. This instrument consists of 15 questions covering different domains of frailty: physical, social and psychological. The psychometric properties of the TFI have been established by Gobbens et al (2010a). The reliability for the TFI scale is: (unstandardised) Cronbach’s α 0.73. Their study showed that the components of the

TFI correlated as expected and significantly with various related measures. Also, there were significant ($p < 0.001$) correlations between the frailty domains: 0.42 between the physical and psychological domains, 0.19 between the physical and social domains and 0.18 between the psychological and social domains. The perceived risks for frail older adults living independently were asked as a single open-ended question. This question was: 'What do you see as important risks for yourself or for other older adults living independently?'. The face-to-face appointments with the frail older adults were audiotaped. Answers given by the older adults relevant to illustrate the used codes were translated into English and included in this paper.

During the phone call with the care providers, the researcher filled out the questionnaire with the answers given by the care providers. This questionnaire contained questions about: contact with involved care providers, collaboration agreements, communication, frailty and risks. Data used in this study were collected with the open-ended question: 'What do you see as important risks for this particular frail older adult and older adults living independently in general?'.

DEFINITIONS

In this study, we defined independent living as follows: older adults who either lived alone, with their spouse or other relatives in their own home. Older adults living in sheltered accommodation or housing designed for older people with on-call staff were excluded from the definition independent living.

During the recruitment phase, representatives of different organisations were asked to only contact older adults who, in their opinion, were frail, able to participate and to give informed consent. The definition of frailty used in this study (van Campen, 2011) was discussed with the representatives to clarify the target population for inclusion into

this study. It was then left up to the organisations to decide which older adults they approached for participation in the study. Information sheets and informed consent forms were handed to the representatives to inform the older adults and employees.

ANALYSIS

The aim of this paper is to identify risks that could threaten independent living of frail older adults, using open-ended questions from different perspectives. For this reason and because of the small numbers of the different groups, no statistical analysis was performed but a summative content analysis was done. All answers to the open-ended questions by the respondents were written down in the questionnaires by the researcher during the appointments. The researcher then digitalised the mentioned risks in Microsoft Excel 2010. A summative content analysis was done to categorise and code the risks (Hsiu-Fang and Shannon, 2005). Categories were made after a process of consideration and discussion by researchers DV and HM; the risk categories are included in the results section. For example, falls and other personal injuries caused by ageing were put together in one category. The researchers separately coded the mentioned risks. Subsequently, the researchers coded the domains of the risks. Thirty six of the total 178 risks were coded differently by both researchers, and 7 out of 28 risk codes were coded differently for the domains. Inter-coder agreement about the codes was reached by a process of reflection and

discussion between both researchers. Also, results were discussed with the co-authors (PR and CW). The frequency of the mentioned codes by the respondents in total was counted. As an illustration for the codes some answers of the frail older adults are included in the results section.

RESULTS

Response and background

We approached 15 organisations to participate in the study. Only six were able to find older adults who in their opinion were frail and willing to complete the face-to-face semi-structured questionnaire. The researchers received 32 informed consent forms from frail older adults and 29 questionnaires were completed. Three frail older adults were not able to participate; with two frail older adults it was not possible to make an appointment and one older adult was hospitalised just before the appointment. During the appointments, the frail older adults gave consent to the researcher to approach 90 care providers. Fifteen of the 90 care providers were mentioned twice, so 75 care providers remained. Of the 75 care providers approached 49% completed the structured questionnaire by phone. The remaining 51% mentioned other reasons not to participate: lack of time, lack of interest, lack of knowledge about the adults or overwhelming amount of research.

The care providers who completed the questionnaire had the following occupations: general practitioner (n=8), home care provider (n=6), nurse (n=3), day care provider (n=4), physiotherapist (n=4), geriatrician (n=2), cardiologist (n=2), pharmacist (n=1), orthopaedist (n=1), thrombosis service (n=1), psychologist (n=1), dermatologist (n=1), neurologist (n=1), ophthalmologist (n=1) and director of a meal service company (n=1). Table 1 shows an overview of the number of participating different organisations, frail older adults and their care providers and Table 2 shows the characteristics of the participating frail older adults. The majority of the older adults were female and the mean age was 83.6 years (SD=6.6). Also, 69% of the respondents were frail according to the TFI (Gobbens et al, 2010a) and the average size of their formal care network consisted of 4.7 (SD=1.81) care providers.

Risks

The risks mentioned during the study covered different domains. Ten risks were seen in the domain of social aspects; eight risks covered the domain organisation of care; seven risks the domain of health and three risks were seen in the domain of safety. When combining the risks from the perspectives of the different types of respondents (n=75), four risks were most often mentioned. First, 'no (or small) social network/loneliness' was mentioned by 32% of the respondents. Second, 'falls/personal injuries' was mentioned as an important risk by 28%. Third, the 'budget cuts in long-term care' were appointed as an important risk by 17.3%, as was the fourth identified risk of 'not being able to ask for help when something happens'. When looking only from the professional perspective (care and social organisations and care professionals, n=46), the following risks were mentioned most often: 'no (or small) social network/loneliness' (41.3%), 'falls/personal injuries' (30.4%), 'confusion or cognitive decline' (19.6%), 'soiling and neglect' (19.6%).

Risks seen by the older adults

The priority of risks seen by older adults is different than the professional perspective. The risks mentioned most often by the frail older adults were (n=29): 'not being able to ask for help when something happens' (24.1%), 'falls/personal injuries' (24.1%), 'budget cuts in long-term care' (17.2%), and 'no (or small) social network/loneliness' (17.2%). In total, 7 of the 29 frail older adults could not mention any risk at all. Four of those seven were not frail according to the TFI, which may partly explain the absence of perceived risks. Most older adults mentioned one or two risks (n=16), five mentioned three or four risks and one mentioned six risks. Table 3 shows the risks mentioned by the respondents and the number of different respondents that mentioned the specific risk, split by type of respondent. The different sizes of the groups should be taken into account when looking at the results. The final column displays the total number of respondents that mentioned a specific risk.

The following results elaborate on the perspective of the frail older adults in more detail. The risk for 'not being able to ask for help when something happens' included concerns of the older adults that it is difficult to call for help when frail older adults, for example, are not wearing a personal alarm. If they fall, they may be unable to physically reach a telephone to ask for help.

The risk of 'budget cuts' was often explained with worries about the consequences of those budget cuts and the uncertainty of those consequences. The majority of the frail older adults mentioned that they were satisfied with the care they received, but some were afraid that budget cuts in long-term care would result in receiving less or no care. One older adult said they cannot cut everything and that it has to stay the way it is; another explained that she can handle it the way it is, as long as her home care provider does her groceries. The risk of 'falling or other personal injuries' was particularly mentioned for frail older adults who lived alone, or when they are home alone. One older adult wondered what they have to do when one of them falls and is not able to crawl up, while the other one is not around.

Additional findings

Although it was not specifically mentioned as a risk, the frail older adults often said that they cannot ask their social network for help. They mentioned this in light of the changes in the long-term care in the Netherlands and the focus of the government on self-reliance and the social network of the older adult. An older adult explained that other people have their own lives and they do not want to bother them by asking for help. Another older adult clarified that the neighbours are also old and the few young couples all work full-time, therefore she did not see a possibility in asking them for help.

Almost all of the frail older adults did not want to move out of their current house, they wanted to stay independent for as long as possible. The majority seemed to accept the decline of their physical health as an aspect of 'growing old', but being and staying independent (and not bothering others) is an important condition for these frail older adults. One older adult clarified that she was grateful for every day that she gets and that she was still able to live in her own house.

DISCUSSION

Insight into risks that could threaten the independent living of frail older adults is important, especially since Dutch long-term care policy has shifted its focus to self-reliance and independent living for as long as possible (Dutch House of Parliament, 2013; Dutch House of Parliament, 2014). The perspective of frail older adults living independently is required to gain insight into the priority of their perceived risks. Therefore, policy and practice should address their perspective and take their reluctance to ask for help into account.

The risks mentioned in this study cover multiple domains, namely health, care, social aspects, financial aspects and safety aspects. The findings address issues much broader than the medical perspective, which is reflected in the majority of the existing literature. The results of this study therefore complement the existing literature by expressing risks from different perspectives and in different domains. The results imply that possible preventive measures for these risks should not only focus on the medical or physical domain. The frail older adults themselves perceive risks, such as 'not being able to ask for help when something happens', as an important threat for their self-reliance and independent living.

An interesting finding is that some risks mentioned by the different types of respondents overlap, such as 'falls/ personal injuries' and 'no (or small) social network/loneliness'. However, the differences between the perspectives are important when considering possibilities for improving the support to frail older adults to remain self-reliant and independent for as long as possible. Three interesting examples of differences are 'confusion/cognitive decline', 'soiling/neglect' and 'medication use'. All three were prominently mentioned by the organisations and care providers, but 'confusion/cognitive decline' was mentioned only once by the frail older adults themselves. This complementary information raises the question why these differences in perception of risks exist. Professionals seem to focus on risks that could threaten the health of the older adults, and the frail older adults focus on risks that could directly threaten their wellbeing and independent living. One explanation for this finding could be a difference in judgement of what should be considered a risk in this specific situation (Wachinger et al, 2012). For example, older adults may perceive physical and mental decline as a natural process of ageing (Stephens et al, 2010), while organisations or care providers may primarily focus on the possibilities to reduce this. Another explanation for this finding could be that frail older adults experience decline as a gradual process to which they adapt. They may not clearly see the risks related to the decline because they have found ways to deal with them (Reichstad et al, 2006). This study showed that not having a social network or just a small network is considered as an important risk. In addition, some frail older adults are reluctant to ask their social network for help and support. This does not match the Dutch policy expectation of increasingly involving the social network (Dutch House of Parliament, 2013), moreover there is a decreasing trend in the usage of informal care (Swinkels et al, 2015). The older adults in this study explain this by saying that other people, especially young people, have their own lives and they do not want to bother them. Changes in current society, where the number of working women rises more than the number of working men and double income families are more present (Smith and Ward, 1985; Statistics Netherlands, 2015) may contribute to this reluctance. The majority of the respondents do not want to bother relatives or other people in their

social network, because they are occupied with their jobs and own lives, and taking care of an older relative may be a severe burden for them. The research of Cahill et al (2009) in the United States also describes the reluctance that older adults have for family involvement in care. The theme most expressed in Cahill's research was 'not wanting to complicate the busy lives of adult children', which was also found in our study. Furthermore, a recent study in the Netherlands shows that family ties and the caring capacity of family is not always self-evident or strong enough and the provision of care or support could put pressure on the relationship (Vermeij, 2016). This implies that it is important to take the actual capacity of the social network of the older adult into account when considering the possibilities for independent living: not every older adult is able or willing to rely on their social network for help and support.

Implications for practice and policy

The different perceptions of risks show a broad variety but also similarities between the groups. When arranging care for frail older adults living independently, a professional perspective is necessary. However, the perspective of the frail older adults ought to be carefully considered, since they assess risks that could threaten their independent living. Moreover, risks differ per person and not every older adult is able or willing to address their social network. The different stakeholders can assess these risks together and discuss possible preventive measures.

The budget cuts in Dutch long-term care and its consequences, seem to worry many respondents. Adequate action to prevent negative consequences and confusion among the frail older adults may partly prevent their worries. Personalised information or personal contact about consequences of changes with regard to long-term care by the local government or involved care providers may reduce the uncertainties among the frail older adults. This should be done in a timely manner to avoid confusion. Also, monitoring potential consequences of the changes in long-term care can provide valuable information to support independent living for as long as possible.

This study shows that many frail older adults are reluctant or not able to ask their social network for help. This reluctance is a risk in itself and may be relevant in other countries as well, since the population of independent living older adults is rising (United Nations, 2013). Risks such as loneliness and neglect are present and may also increase when the frail older adult is expected to take the first step when help is needed. A way to respond to this reluctance is to map the networks of the frail older adults and its possibilities for care and support. To eventually gain insight in the self-reliance of the older adult, contact and cooperation between the local government, formal and informal care providers is necessary to optimise the results. Discussions between stakeholders and frail older adults about the sustainability of the situation of the frail older adults and when to intervene is a complementing step that could be helpful in the prevention of possible risks.

Moreover, it is important that professionals and also people in the social network of frail older adults monitor the sustainability of the situation and contact each other when an intervention is needed or when they are in doubt. This will be different for every older adult and interventions should therefore be tailored.

Different developments in the field of smart home technology should be able to intercept the risk of not being able to call for help when something happens.

However, devices such as in-home sensors can be perceived as obtrusive and older adults may therefore be reluctant to use them (Reeder et al, 2016).

Strengths

Different types of organisations were approached to reach frail older adults, with different care needs and living situations. The perspective of frail older adults themselves were taken into account instead of only the professional perspective. Since one researcher took all the questionnaires with the frail older adults and their care providers, there was no variation in background, and experience of the researcher.

In the end, all respondents were Dutch native speakers, no translation was needed and language barriers were not present. A second researcher was involved analysing the data to enhance intercoder agreement. The researchers did not occupy dual roles and they highlighted their confidentiality agreements during the face-to-face appointments, to encourage the respondents to give honest answers and limit the risk of social desirability.

Limitations

The response of the care providers in this study was moderate, even though a lot of effort was put into collecting the data. Also, the perspective of the informal care providers was not studied separately in this study. Informal care providers may raise different issues than the frail older adults so they are likely to complement the insight into possible risks.

The study has a relatively small number of respondents.

However, the study has an explorative nature and the intention was to show the variety in answers and the underlying thoughts from the various perspectives rather than finding statistical differences.

The selection of frail older adults was done by the representatives of the participating organisations, based on their experience. A more formal assessment of frailty was done by the researchers during the face-to-face appointment with the older adults. According to the criteria of the TFI 31.0% of the older adults were not frail. An explanation for this difference in perception of frailty may be that professionals can have other or additional criteria to identify someone as frail. Therefore, it was decided to not use the TFI as inclusion criteria.

The very frail and cognitively-impaired older adults may not have participated in the study because of the burden, which may have led to selection bias. Their perspective may have led to insight in other possible risks for a group that may already struggle with their independent living situation. Having only Dutch native speakers is an advantage for possible language barriers, however the perspective of (non-western) immigrants is lacking in this research. Since the socio-economic status and life expectancy of non-western immigrants tends to be lower than that of the Dutch society overall (Smits et al, 2014), frailty may occur at an earlier age and different risks may play a role. Moreover, different family structures and expectations of care are present, which may influence the possible risks. In 2011, only 3% of older adults in the Netherlands over 65 years were non-western immigrants (Garssen, 2011). Although this group was not reached, the results of this study are applicable for the majority of the older adults in the Netherlands.

Information bias may also have occurred. The frail older adults who were willing to participate could be more positive about care and welfare in general so they may

not experience risks. However, the opposite may also have occurred, people who were negative about the care they received could be willing to complain and therefore could have been more negative.

Implications

Within the care of frail older adults living independently there often are different care providers involved who have different considerations and interests. Their focus however, should be on the client. Education in elderly care should therefore pay attention to this and teach future professionals how they should address the perception of the client.

It would be interesting for future research to study methods on how to handle individual risks and provide tailored support, and how this relates to the quality of life and to the older adults. Another example would be to focus on the cooperation between care providers and how they can work together to minimise the perceived risks.

CONCLUSIONS

The results of this study show risks for frail older adults living independently that may threaten their independent living. The risks perceived by the frail older adults themselves do not necessarily align with the risks as perceived by professional care providers. The perspective of the frail older adults is required to gain insight into the priority of their perceived risks. The results of this study have implications for policy and practice, education and research, since the priority of the perceived risks are not necessarily aligned with the professional perspective. Therefore, policy and practice should address their perspective, take the caring capacity of their social network and their reluctance to ask for help into account, with the aim to eventually maintain self-reliance, wellbeing and independent living of the frail older adult.

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Table 1. Overview of participating organisations, older adults and their care providers				
Type of organisation	Number of older adults who consented	Number of older adults participated	Number of care providers approached	Number of care providers participated
1 Municipality	0	–	–	–
2 General practitioner	8	7	18	9
3 Assisted living accommodation	5	5	6	3
4 Home care organisation	9	7	28	12
5 Home care organisation	4	4	17	3
6 Volunteer organisation	1	1	2	0
7 Welfare organisation	0	–	–	–
8 Welfare organisation	0	–	–	–
9 Housing cooperatives	4	4	18	10
	1a	1	1	0
Total	32	29	(90 minus 15 double applications) 75	37
One older adult was approached via the network of the researchers				

Table 2. Characteristics of the older adults		
	Mean (SD)/Percentage	Range
Age (years)	83.6 (6.6)	68–95
Gender: female	75.9%	–
Living alone	75.9%	–
Frailty	6.17 (2.54) 69.0% Tilburg frailty indicator (TFI)	0–15
Ethnicity: Dutch	100%	–
Care network size	4.7 (1.81)	1–10 (excluding the dentist and informal care providers)

Table 3. Risks mentioned in the questionnaires by different types of respondents

Risks	Organisations n=9 (%)	Older adults n=29 (%)	Care providers n=37 (%)	Total n=75 (%)
No (or small) social network, loneliness	5 (55.6)	5 (17.2)	14 (37.8)	24 (32)
Falls/personal injuries	5 (55.6)	7 (24.1)	9 (24.3)	21 (28)
Budget cuts (not being able to be admitted in an institution/decline of home care)	5 (55.6)	5 (17.2)	3 (8.1)	13 (17.3)
Not being able to ask for help when something happens	1 (11.1)	7 (24.1)	5 (13.5)	13 (17.3)
Confusion, cognitive decline	2 (22.2)	1 (3.5)	7 (18.9)	10 (13.3)
Lack of signalling function, living alone		4 (13.8)	5 (13.5)	9 (12)
Neglect	3 (33.3)	0	6 (16.2)	9 (12)
Medication use, multiple medications	2 (22.2)	0	6 (16.2)	8 (10.7)
Abuse/exploitation/robbery	4 (44.4)	2 (6.9)	2 (5.4)	8 (10.7)
Decline in mobility	1 (11.1)	2 (6.9)	4 (10.8)	7 (9.3)
Dependence of older adults	2 (22.2)	3 (10.3)	2 (5.4)	7 (9.3)
Bad coordination of care/no integrated care	3 (33.3)	0	3 (8.1)	6 (8)
Reluctant to ask for help	2 (22.2)	0	3 (8.1)	5 (6.7)
Digital environment, changing society	2 (22.2)	0	2 (5.4)	4 (5.3)
Interior of home and type of home	0	2 (6.9)	2 (5.4)	4 (5.3)
Bad/little communication from care providers	0	1 (3.5)	2 (5.4)	3 (4)
Lack of informal care providers	0	0	3 (8.1)	3 (4)
Lack of knowledge and oversight about their health and care providers	0	0	3 (8.1)	3 (4)
Low quality and variety of care	1 (11.1)	0	2 (5.4)	3 (4)
Malnutrition	1 (11.1)	1 (3.5)	1 (2.7)	3 (4)
Not going outdoors	1 (11.1)	1 (3.5)	1 (2.7)	3 (4)
Finance of care in the Netherlands	0	1 (3.5)	1 (2.7)	2 (2.7)
Being an informal caregiver	0	0	2 (5.4)	2 (2.7)
Complex/many different care providers	0	1 (3.5)	1 (2.7)	2 (2.7)
Lack of capacity for home care	0	0	2 (5.4)	2 (2.7)
The person's attitude	0	2 (6.9)	0	2 (2.7)
Losing the ability to control own life	1 (11.1)	0	0	1 (1.3)
No children (or deceased children)	1 (11.1)	0	0	1 (1.3)