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To cite this article: Michal M. Misiak, Jennifer Bethell, Hannah Chapman & Andrew Sommerlad (26 Apr 2024): How can care home activities facilitate social connection in residents? A qualitative study, *Aging & Mental Health*, DOI: [10.1080/13607863.2024.2345130](https://doi.org/10.1080/13607863.2024.2345130)

To link to this article: <https://doi.org/10.1080/13607863.2024.2345130>



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Published online: 26 Apr 2024.



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How can care home activities facilitate social connection in residents? A qualitative study

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ABSTRACT

Objectives: Good social connection is associated with better physical and mental health but care home residents experience barriers to social connection. Activities present a potential avenue for improving social connection in care homes but residents often experience loneliness despite access to activity programmes. We therefore aimed to identify what aspects of activities facilitate social connection in care home residents.

Method: Qualitative study using semi-structured interviews that were analysed using Thematic Analysis. A purposive sample of 35 participants, including 12 residents, 10 family caregivers, nine care home staff and four clinicians, recruited from UK care homes.

Results: We found four main themes describing features of activities important for facilitating social connection: (1) *personalisation* with respect to residents' interests, social preferences, and cognitive ability; (2) activities which foster a *sense of community*; (3) finding and emphasising *things in common* that residents share; and (4) facilitating a *sense of involvement* with others.

Conclusion: We identified the key aspects of activities which facilitate social connection in care homes. These findings can be applied to a range of existing and newly designed activities in care homes and inform the development and testing of psychosocial interventions aiming to improve social connection.

ARTICLE HISTORY

Received 13 November 2023

Accepted 13 April 2024

KEYWORDS

Social connection; loneliness; care homes; long-term care; activities; thematic analysis

Introduction

There are over 400,000 people living in care homes in the UK (Competition & Markets Authority, 2017), and it is estimated that about one-quarter of people over 65 will need residential care at some point (Department of Health & Social Care, 2012). Care home residents frequently experience physical illness (Gordon et al., 2014), frailty (Kanwar et al., 2013), sensory decline (Backman et al., 2021), or mental illness (van der Wolf et al., 2019) and over 70% of care residents are estimated to live with dementia (Prince et al., 2014). Moving to a care home also leads to changes in daily routine, autonomy, identity, and the social world of residents (Groenvynck et al., 2021). Those factors can impact residents' social connection (Bethell et al., 2021; Cohen-Mansfield et al., 2016).

Social connection is an umbrella term encompassing the numerous ways and the extent to which individuals connect to others (Holt-Lunstad, 2018), and comprises objective elements, such as the individual's social network (Berkman et al., 2000) and social engagement (Leedahl et al., 2018), and subjective aspects, such as social connectedness and loneliness (O'Rourke & Sidani, 2017; Prohaska et al., 2020). Social connection is a key component of human experience and is beneficial for quality of life of older adults (Cohen-Mansfield et al., 2016) and cognition (Sommerlad et al., 2023), particularly for care home residents (Bethell et al., 2021; Lem et al., 2021). Social connection is also considered one of four key factors to good quality of life

in care homes (Bradshaw et al., 2012), contributing to a sense of home (Rijnaard et al., 2016).

However, lacking company and intimate relationships were among the most commonly reported unmet needs of care home residents (Tobis et al., 2018) and loneliness among residents is twice as prevalent in care homes compared to the general community (Victor, 2012). This is partly related to dementia and differences in cognitive ability, which can lead to difficulties in making new acquaintances (Barbosa Neves et al., 2019). Living in a dementia-specific care home, or in a home with a higher proportion of residents with dementia, has been associated with worse social connection (Lapane et al., 2022). Sensory problems such as visual impairment and hearing loss may also affect social interaction and development of relationships (Cook et al., 2006).

Care home activities, which can be structured or spontaneous, group or individual, and involve participation of family members or the wider community, are offered by most care homes through activity programming with social and therapeutic recreation which may include, but is not limited to, music, pet visits, gardening, bingo, or discussion groups (Ice, 2002). These may foster social connection among residents by creating an atmosphere of community and participation (Edvardsson et al., 2010) and facilitate feelings of thriving and psychological wellbeing (Bergland & Kirkevold, 2006), good adjustment after relocation (Davison et al., 2019), and better quality of life (Nygaard et al., 2020). The UK National Institute for Health and

Care Excellence therefore recommends residents to be enabled to participate in ‘meaningful activities’ tailored to their needs and preferences (National Institute for Health & Care Excellence, 2013).

Despite the potential benefits of activities, their provision and quality may be suboptimal. Engaging residents can be difficult due to physical and cognitive impairment, and insufficient resources to provide adequate variety of activities (Tak et al., 2015). Activity programming may not promote social connection (Theurer et al., 2015) due to a lack of meaningful activities, monotonous days and poor-quality interactions (Harmer & Orrell, 2008), and residents describe loneliness amid company, despite having access to a range of activities (Knight & Mellor, 2007). These factors have led to calls to transform existing ‘institutionalised recreation’ or ‘cruise ship living’ social programming (Theurer et al., 2015) into activity promoting meaningful connections and personal growth. Refocusing the role of activities from providing passive entertainment and distraction to enabling resident contributions and peer support has been proposed as an important step for achieving this (Theurer et al., 2015).

While existing observational and intervention research has identified strategies which might support social connection in this population (Bethell et al., 2021), to our knowledge no previous study offered a qualitative exploration of the specific ways in which activities promote social connection. Yet an understanding of this has potential to guide improvements to the form and content of future activity programming practices. This study therefore aims to examine how care home activities help foster social connection in residents. We will investigate what aspects of activities help facilitate social connection and how they do this, by exploring the perspectives of UK care home residents, family caregivers and care home staff and clinicians.

Methods

Study design

We conducted a qualitative interview study, as part of the SONNET study (*Social connection in long-term care home residents*) which aims to understand social connection in care home residents and improve its measurement through the development and testing of a new instrument (ClinicalTrials.gov identifier: NCT05315960). Ethical approval was granted by the Brighton & Sussex National Health Service (NHS) Research Ethics Committee and the Health Research Authority (22/LO/0145). Informed consent was obtained from all participants whose mental capacity to give consent was assessed in line with the UK 2019 Mental Capacity Act.

Participants and recruitment

Participants were residents, family caregivers of residents, staff or clinicians working in English care homes (defined according to the international consensus; Sanford et al., 2015). Participants were aged over 18 years. Inclusion and exclusion criteria for each participant group were:

- Residents: we included those with and without dementia, but excluded those with active severe mental illness, impaired consciousness level or communication difficulties which would preclude the interview. We also

excluded any resident if they lacked mental capacity to consent to participation.

- Family caregivers: we included those who saw the resident at least monthly, and excluded family caregivers with dementia, severe mental illness or physical limitations preventing participation.
- We included staff and clinicians who worked in care homes currently or within the past 2 years.

We used purposive sampling (Etikan, 2016), aiming to interview participants with varied characteristics including age, sex, socioeconomic status and ethnicity. To explore multiple perspectives, we recruited residents with and without dementia, family caregivers representing spousal, sibling, and parent/child relations, and professionals representing a range of occupations. We recruited from care homes across England, and with varying quality of care as reflected by Care Quality Commission regulatory ratings (Care Quality Commission, 2023). We planned to interview until thematic saturation was reached, i.e. where interviews yielded no new data to develop the themes, which we judged during our iterative analysis of data while recruiting and undertaking study interviews. We anticipated a sample size of around 20–30 participants to allow saturation (Guest et al., 2006).

Residents, family members and clinicians were recruited from care home liaison teams in three NHS trusts: Camden and Islington NHS Foundation Trust, Oxford Health NHS Foundation Trust, and Northumbria Healthcare NHS Foundation Trust, and from a London care home organisation. Staff were recruited from the above sources and through dissemination of information about the study to the ENRICH national care home research network (<https://enrich.nihr.ac.uk/>). Potential participants were informed about the study by clinicians, or by viewing information about the study in newsletters. People who expressed interest were given an information sheet and 48 h for consideration, after which the research team contacted them and arranged a meeting to obtain informed consent and conduct the interview.

Procedure

Data collection took place between May and December 2022. Individual interviews, dyadic interviews for some care home staff, and a focus group for clinicians were semi-structured and led by one researcher (MM a postgraduate student, AS a psychiatrist, HC a research assistant, and two research nurses from one NHS trust), and co-facilitated by a second researcher in some cases. Resident interviews were conducted in-person in private spaces in care homes to allow participants to speak freely about their experiences. Staff and clinician interviews were conducted online using Microsoft Teams and family interviews in person or online.

After collecting demographic data, interviews lasting 30–60 min were based on a topic guide exploring the nature and determinants of social connection in care homes including the role of activities in promoting this. Two versions of the guide were used for residents/caregivers and staff/clinicians. Example questions are ‘What activities are important to you/they within the care home?’ with probing regarding specific examples; ‘Have these activities been helpful for improving your/their social connection?’; ‘Did the activity help interaction with other residents?’ and other probing regarding social experience of care

home activities. Interviews were audio-recorded and transcribed verbatim. Participants received a £20 shopping voucher as thanks for participation.

Data analysis

Thematic analysis based on Braun and Clarke (2006) was used. Our approach to theme identification was theory-driven and guided by our study aims. The interview guide, interviewing process and data analysis were shaped by our theoretical assumptions regarding the conceptualisation of social connection reflecting observed and perceived experiences of the existence, roles and sense of connection within our relationships, and that it is important for human health (Liougas et al., 2024). We used open coding to enable novel understandings of the topic to develop, assuming the position of critical realism (Braun & Clarke, 2021) where we acknowledged that how participants experienced reality is shaped by their culture, language and other factors and we considered these (Braun & Clarke, 2021).

The analysis followed the six-step approach (Braun & Clarke, 2006) using NVivo 12 (QSR International Pty Ltd., 2018). Initial high-density coding was conducted on a subsample of five interviews selected to provide a range of views and an initial coding framework was developed from this. We applied this to other interviews, iteratively refining the framework and stopped when we judged we had summarised the diversity of meanings. We then explored patterns of codes and organised these into themes and subthemes (Braun & Clarke, 2021). A coding journal was used throughout the process to write analytic memos regarding each data item, along with mind maps to explore connections and refine the framework. One researcher (MM) coded all interviews, with regular discussion (with JB and AS) throughout the construction of the coding framework and coding process.

Reflexivity

The research team consisted of a postgraduate student with academic training relating to social connection in care homes, and a research assistant with postgraduate psychology training, supervised by a consultant old age psychiatrist and an epidemiologist. The main assumptions the team brought to the study were that social connection has important benefits for people in care homes, and that it may be facilitated by activities; we were mindful that participants' differing perspectives should be represented in our analysis. We used peer discussions, reflexive journaling and diagramming in line with guides for thematic analysis (Braun & Clarke, 2022) to ensure credibility and trustworthiness during data analysis (Nowell et al., 2017). We report our methodology according to COREQ criteria (Tong et al., 2007) in Appendix 1.

Results

We interviewed 35 participants during 30 interviews (27 individual, two dyadic and one focus group with four participants). Demographic characteristics are shown in Table 1.

Data were collected from 12 residents, ten family relatives, nine care home staff, and four clinicians. Twenty-eight participants were female (80%) and 29 participants were White (83%).

Nineteen participants (54%) were based in London and 16 (46%) in other locations. We identified four qualitative themes with nine subthemes which are presented in Table 2.

Personalisation

Many participants referred to the importance of an individualised approach to residents' activities. Person-centredness and knowing the resident were essential to building social relationships through activities. Quotes are anonymised with letters signifying participant type: R (residents), F (family), P (care staff) and C (clinicians).

'I think before you can make these social connections, you've got to understand the person (...) see their capabilities, their likes, their dislikes.' [F1]

Participants stated the type and level of desired connection differs amongst residents and understanding the historical context of their social life is essential to adequately respond to their needs, particularly for people with dementia who sometimes cannot express their wishes. Identifying activities appropriate for their cognitive ability, interests and preferences was helpful to gauge the right level of support for social engagement:

'some people say "I never want to do a group, I'd die" and other people would say "you know, I love to be surrounded by people"' [C1]

Some participants highlighted that family is an important source of insight into resident's personalities to guide activities, which is not always effectively used:

'family members have a wealth of information and knowledge (...) it's just never tapped into' [F1]

Addressing cognitive barriers and complex needs

Tailoring activities was viewed as especially important in the context of differences in cognitive ability and complex needs of residents:

'they might not be able to participate in group activities because of the level of their dementia or the distress' [C2]

Residents with sensory impairment, depression or anxiety, or lack of motivation found it more difficult to engage socially. People with dementia were generally said to be less able to participate in activity programmes because of memory and communication problems. However, sensory activities such as music or exercise were reported to support connection in people with dementia by creating excitement, eye contact and conversation irrespective of cognitive ability:

'Dancing and singing means we do their era of songs. Because most of the residents have dementia, they are in different levels. (...) But most of them are in their young age, so then they remember all those things.' [P1]

Appropriate support for residents with more complex needs helped them overcome disability and increased their participation:

'we have one lady who had a stroke who isn't able to verbally communicate at all (...) but because she understands everything you need a few other people around who can carry a conversation that she can follow.' [P2]

However, some residents expressed that forming friendships is impossible due to those barriers:

Table 1. Demographic characteristics of study participants.

| | | Residents (n = 12) | Family (n = 10) | Care home staff (n = 9) | Clinicians (n = 4) | Total (n = 35) |
|--|------------------------------|--------------------|--------------------|-------------------------|--------------------|----------------|
| Gender – n (%) | Female | 9 (75) | 7 (70) | 9 (100) | 3 (75) | 28 (80) |
| Age (years) | Mean | 82.4 | 66.3 [†] | 40.0 | 40.0 | |
| | Range | 74-91 | 55-83 [†] | 24-60 | 33-51 | |
| Ethnicity – n (%) | Asian | 0 (0) | 0 (0) | 2 (22) | 0 (0) | 2 (6) |
| | Black | 0 (0) | 0 (0) | 0 (0) | 0 (0) | 0 (0) |
| | Mixed | 0 (0) | 1 (10) | 0 (0) | 0 (0) | 1 (3) |
| | White | 9 (75) | 9 (90) | 7 (78) | 4 (100) | 29 (83) |
| | Other | 2 (17) | 0 (0) | 0 (0) | 0 (0) | 2 (6) |
| | Not disclosed | 1 (8) | 0 (0) | 0 (0) | 0 (0) | 1 (3) |
| Education – n (%) | Lower secondary (<16 yrs) | 2 (17) | 0 (0) | 1 (11) | 0 (0) | 3 (9) |
| | Higher secondary (18 yrs) | 3 (25) | 1 (10) | 0 (0) | 0 (0) | 4 (11) |
| | Degree | 3 (25) | 2 (20) | 4 (44) | 1 (25) | 10 (29) |
| | Postgraduate | 0 (0) | 4 (40) | 2 (22) | 3 (75) | 9 (26) |
| | Other | 0 (0) | 1 (10) | 2 (22) | 0 (0) | 3 (9) |
| | Not disclosed | 4 (33) | 2 (20) | 0 (0) | 0 (0) | 6 (17) |
| Marital status – n (%) | Single | 1 (8) | 2 (20) | | | |
| | Married | 2 (17) | 6 (60) | | | |
| | Divorced | 2 (17) | 0 (0) | | | |
| | Common-law | 0 (0) | 1 (10) | | | |
| | Widow | 7 (58) | 0 (0) | | | |
| | Other | 0 (0) | 1 (10) | | | |
| Employment status – n (%) | Employed | 0 (0) | 4 (40) | | | |
| | Unemployed | 0 (0) | 1 (10) | | | |
| | Retired | 12 (100) | 4 (40) | | | |
| | Other | 0 (0) | 1 (10) | | | |
| Care home CQC* rating – n (%) | Requires improvement | 1 (8) | 0 (0) | 3 (33) | | |
| | Good | 11 (92) | 4 (40) | 4 (44) | | |
| | Outstanding | 0 (0) | 0 (0) | 2 (22) | | |
| | No data | 0 (0) | 6 (60) | 0 (0) | | |
| Self/relative-reported diagnosis of dementia of resident – n (%) | Yes | 6 (50) | 8 (80) | | | |
| | No | 6 (50) | 2 (20) | | | |
| Length of time resident resided in care home – n (%) | Less than 1 year | 4 (33) | 4 (40) | | | |
| | 1-5 years | 6 (50) | 4 (40) | | | |
| | More than 5 years | 2 (17) | 1 (10) | | | |
| | Not disclosed | 0 (0) | 1 (10) | | | |
| Relationship to resident – n (%) | Child | | 5 (50) | | | |
| | Sibling | | 1 (10) | | | |
| | Spouse/Partner | | 3 (30) | | | |
| | Friend | | 1 (10) | | | |
| Role – n (%) | Doctor | | | 0 (0) | 2 (50) | |
| | Psychologist/nurse | | | 0 (0) | 2 (50) | |
| | Recreation/activity worker | | | 2 (22) | 0 (0) | |
| | Personal support/care worker | | | 2 (22) | 0 (0) | |
| | Manager/administrator | | | 5 (56) | 0 (0) | |
| Years of experience – n (%) | <5 y | | | 4 (44) | 0 (0) | |
| | 5–10 y | | | 2 (22) | 2 (50) | |
| | >10 y | | | 3 (33) | 2 (50) | |
| Working pattern – n (%) | Full-time | | | 7 (78) | | |
| | Part-time | | | 2 (22) | | |

*CQC = Care Quality Commission in England.

[†]Age data available for 8 family participants.

Table 2. Themes and subthemes identified through thematic analysis.

| Main theme | Subthemes |
|----------------------|---|
| Personalisation | Addressing cognitive barriers and complex needs Connecting to the past |
| Sense of community | Involving people from outside the home To still matter |
| | A bit of normality |
| Things in common | Matching residents |
| Sense of involvement | Giving and receiving support Expressing feelings and opinions Taking initiative |

'I don't know anybody here. Because they are not capable of knowing people anyway.' [R1]

A staff member remarked that some residents try to distance themselves from those with cognitive impairment during activities:

'a lot of the residential residents didn't want the dementia care residents in their space. You know, "Why do they have to come and join us?"' [P3]

Some residents were frustrated by being offered an activity which was not aligned with their cognitive ability:

'I would never ever play bingo in my life. Bloody stupid game. (...) chess is more interesting.' [R2]

Professionals supported the view that a range of activities should be offered to adequately respond to varying needs:

'we can't generalize the activities most of the times here, because of their levels of dementia (...) are totally different.' [P1]

An activity coordinator suggested that offering both separate and joint activities eventually improved social integration:

'we did separate [them] a little bit and say, "these kind of things are really for you and these kind of things are really for you, but also these things are for us all to do together". I think that made a big difference.' [P3]

Connecting to the past

Reminiscence activities connecting residents with their past encouraged social interactions:

'He's always ready to talk about a painting or about pottery. He was also a potter. (...) I suppose it makes him feel that he's, you know, the person that he always was.' [F2]

Activities nurturing personal interests supported a sense of continuity with previous life and encouraged residents to actively maintain their social habits:

'I used to have people over, (...) we played bridge, which of course we are playing here' [R3]

Sense of community

Some participants considered feelings of belonging to a bigger group characterised by a 'family dynamic' important, including through involvement of residents in wider community activities.

Involving people from outside the home

Activities were thought to build social connection if they involved non-residents in the life of the home or involved residents in the outside community life, for example through parties or family visits. Families feeling comfortable within the home helped create a more social atmosphere as they would engage with residents other than their relative:

'Some of [the residents] will engage a lot with other people's relatives. So if I visit, you know, there'll be a couple of them who will always say hello and ask questions, and that's nice.' [F3]

Residents also enjoyed meeting each other's families:

'I met her son. He was a very personable young man, and so we'd all send each other messages. And we'd say, "Thinking of you today".' [R6]

To still matter

Activities giving an important role or celebrating the individual as a valued member of the community carried the potential of strengthening connections. One professional described that good social connection is:

'the sense that people (...) still matter and that what they do and what they think and what they say still means.' [P5]

This was supported by activities such as birthday parties or bidding farewell and honouring the life of a deceased resident, which was viewed as a way to strengthen the community spirit:

'And we've had a funeral here this morning (...). If anybody passes away, we fill the hallway and we clap people out and the residents are all there with us' [P5]

A bit of normality

Keeping residents involved in daily activities and running the household, and placing minimal restrictions on their independence were discussed as ways of preserving social identities and facilitating connection:

'I think they should be having a bit of normality for themselves. Being in a care home shouldn't stop them from being a social animal, they should still be able (...) to go out, able to do their day-to-day things' [P6]

For some residents, scheduled meals and activities reminded them of school discipline. Participants expressed the need for activities to be more relaxed and respect times when residents do not want to be disturbed. Efforts to reduce the institutional nature of care homes, such as joining residents for meals or casual coffee mornings, were viewed positively.

A sense of normality was promoted by embedding activities within natural settings, such as a relaxed café or bar in a care home. Residents' preference for socialising in more 'ordinary' spaces could also be supported by means of creating a familiar atmosphere:

'We even put the café music on sometimes, so it's like they sat in a café together and we found that works quite well. Because it's like taking them into a different setting' [P7]

Things in common

Having things in common helped residents connect to others. Shared backgrounds, interests and life circumstances promoted bonding among residents:

'We eat together every day and we got friendly. And we have a lot in common. We have been to the same places and we had all these funny little coincidences.' [R4]

and between residents and staff:

'one resident lived near where I live now. (...) So we have that in common. So I'm familiar with the streets that he's telling me where we lived on. We have this proper conversation' [P7]

Activities emphasising shared backgrounds facilitated social cohesion, such as preparing for a military celebration together in a veterans' care home:

'they're all there polishing their medals and getting ready, so they have that in common.' [P5]

Conversely, some residents who had different interests to others in the home reported feeling alienated, which indicated that residents do not always have things in common and that personalised activities are therefore crucial:

'I'm on a different wavelength (...). All the things that I'm interested in, other people don't seem to be interested in.' [R2]

Matching residents

Many professionals suggested matching residents with similar interests to connect them and create friendships. Some care homes described a structured 'buddy system' where new residents are paired with existing residents to help them settle:

'we do as much as we can to find out about the person before they come in. (...) then the wellbeing team pair them up with somebody. And then that person takes them under their wing.' [P5]

Others put residents together for an activity to facilitate engagement and encourage social interaction:

'she's bit by bit, dipping her toe into activities, so she joined a coffee morning last week (...) we made sure that she was sitting next to somebody who she could have a little chat with.' [P8]

Some staff would try to increase opportunities for friendships among residents who made an initial connection:

'You see that they've kindled their own thing (...) how can we support that? Maybe we take just the two of them for a walk in the garden together (...) you create those friendships how they would naturally occur at any other age' [P3]

Residents echoed that befriending support can be beneficial:

'I think when people first come here, they must have people who've been here, and I don't mean for two weeks, I mean a year or so, who can help them.' [R4]

Conversely, not being offered sufficient support could result in residents struggling to find people to connect with:

'One gentleman who has just come, I think he's finding it very difficult. He comes in, waits to see where he can sit and who he thinks he might be able to converse with.' [R5]

Sense of involvement

Many participants indicated residents should feel involved with others in emotionally and intellectually meaningful ways, such as being able to contribute to the lives of others, express oneself and exercise agency and choice within the social world of the home.

Giving and receiving support

Opportunity to both give and receive support from other residents was considered important for building relationships:

'ultimately social connection is about you feeling happy as well as helping the other person, really it's mutual' [P2]

During activities such as renovating a dollhouse or making a bird feeder, communication was stimulated by the need to support each other and work together:

'Someone struggling with something will always give like instructions, or 'yeah, do it like this'. So they are always communicating with each other' [P9]

Sharing one's expertise also encouraged meaningful interactions, such as when a resident with mobility issues would not accept help from staff:

'I even had residents who used to use Zimmer frame showing another one how to use a Zimmer frame. (...) when it comes from a resident, I think they take it better.' [P6]

Mutual support was perceived as important for a sense of belonging and wellbeing in the care home. However, at times, residents did not know how to support others who needed help without assistance from staff or activity coordinators:

'I think there are people who come in here and feel very lost. And I would love to be able to talk to them but I'm never sure if they want that.' [R3]

Expressing feelings and opinions

Activities facilitating discussion and emotional openness contribute to meaningful relationships. One resident stated that meeting his brother allows him to speak his mind without being judged:

'I am very grateful when he comes because at least I can talk to him direct and be honest about the situation.' [R2]

Another felt that activities providing a space for exploring each other's feelings towards their circumstances and life in the care home were lacking:

'we perhaps should have some kind of thing where we just get together and say what we're actually feeling and how we're feeling about the place, which we haven't got.' [R3]

Similarly, activities encouraging discussion on personal and general topics stimulated engagement and may tackle withdrawal and boredom of care home life. Themed discussions where staff guide the conversation were found to be a helpful strategy to keep the interaction going:

'they also have a session (...), when one of the staff will just talk about stuff that's been in the newspapers (...) that's quite positive as well because that's actively encouraging people to talk and give their opinions.' [F3]

One staff member described adjusting such activities for people with cognitive impairment by adapting group size and breadth of the topic:

'a smaller group discussion, things like poetry, taking very nice poems and picking out one theme from the poem and really talking about, "OK, the moon. Do you have a memory about the moon?"' [P3]

Taking initiative

Initiating activities and exercising independence facilitated social connection. Participants highlighted that residents would follow the initiative of another resident more readily than from staff:

'And they really are like the three amigos. So if they're gonna do something together, if one does, the other one will.' [F4]

It was important to support residents' choice and respond to their pace and readiness to engage. Creating opportunities for resident-led activities can produce better results than encouraging participation in formal activities which can be seen as nagging:

'I leave Jenga out. And then you walk in and two people will be playing Jenga. But if I ask them, they'll be like, "no, I'm not playing that with you", but because they've done it themselves, they'll do it.' [P4]

Discussion

This qualitative study of English care home residents identified key aspects of activities which fostered social connection: 1) *personalisation* according to residents' preferences and needs; 2) building a *sense of community*; 3) emphasising *things in common*; and 4) fostering a *sense of involvement* by enabling residents to give and receive support, express feelings and opinions, and take initiative. To our knowledge, this is the first exploration of stakeholders' views on how care home activities facilitate social connection in residents, improving our understanding of the potential utility of activities in enhancing resident quality of life.

This study complements previous research on interventions targeting aspects of social connection in care homes (Bethell et al., 2021; Brimelow & Wollin, 2017; Mikkelsen et al., 2019; Quan et al., 2020). Existing literature reviews highlighted which activities (e.g. gardening; Brimelow & Wollin, 2017) appear helpful for social connection but did not detail which aspects of

activities may improve social outcomes. Other studies emphasise cooperation between residents (Brimelow & Wollin, 2017), group structure (Mikkelsen et al., 2019) and adjustments, such as enabling residents with varying mobility needs to participate (Quan et al., 2020). However, such studies do not situate facilitators in the context of overall social experience in care homes and their applicability to other activities may be limited.

A review (O'Rourke et al., 2018) of interventions addressing social connectedness in older adults classified them by type and explored their theorised mechanism of action, and effect on indicators of social connectedness. For example, 'Activity Group' interventions were believed to promote relationships through discussions, and target connectedness factors such as belonging or support (O'Rourke et al., 2018). However, activity types such as 'Skills Courses' (e.g. learning computer skills to access social resources) have specific considerations and their benefits may be difficult to translate to other activities. Our study develops this previous body of research, by considering which aspects of a range of care home activities may be leveraged across various activities to facilitate positive social experiences, and so informs future researchers and policymakers on how specific activities can best be delivered to encourage social connection.

Our findings regarding sense of significance and personalisation complement previous studies exploring meaningful activity in care homes (Harmer & Orrell, 2008) and components of good person-centred care (Edvardsson et al., 2010). This suggests a close relationship between social connection and those dimensions of care, highlighting that activities may contribute both to person-centredness and social connection. Our findings about *personalisation* of activities are consistent with previous studies highlighting the need to know residents in their social context (McCormack, 2004), and adapting activities for the interests and ability of residents with dementia (Nygaard et al., 2020). One participant suggested having both separate activities targeted at people with different cognitive needs, and joint activities emphasising that the home is a space for everyone. Future research could identify the impact of different activity models on social connection outcomes among residents with different levels of cognitive ability.

Studies highlighting the role of families in enabling connection to the outside world are consistent with our *Sense of community* theme (Davies & Nolan, 2004; Kang et al., 2020). Additionally, familiar and homelike areas in the home are important for promoting social connection, in line with our *A bit of normality* subtheme (Buckley & McCarthy, 2009; Lowndes et al., 2021). In our study, activities enabling interaction between visiting families and all residents were thought to improve social connection in the wider home. Online groups keeping relatives connected to daily life in the home, or support groups for families, may help relatives become comfortable with participating in the home community. This suggests adequate activity provision could start at an earlier and broader stage of involving the wider community in the life of the home.

Not having *things in common* was previously identified as indicating poor integration of residents (Buckley & McCarthy, 2009), consistent with our results. Matching new residents with peers with similar interests might accelerate settling in and social engagement (Ellis & Rawson, 2015). The variety of pairing strategies reported by our participants (including matching residents on arrival and supporting flourishing connections) suggests they can be used flexibly. However, while staff focused

on these proactive approaches, some residents revealed a lack of connection with other residents as they could not find common ground with others and sought the company of familiar family or friends, or sometimes staff with whom they felt greater connection. Previous literature has highlighted that experiences of reciprocity and peer support can nurture a shared social identity (Theurer et al., 2015) and feelings of belonging and personal significance (Kang et al., 2020). This demonstrates how the subthemes *To still matter* and *Giving and receiving support* are intertwined, and underlines a need for activities facilitating mutual contributions. Participants in this study mentioned desire to help fellow residents, but expressed uncertainty about ways to achieve this. Staff can play an important role in enabling and empowering residents to support their peers.

Participants signalled that activities could provide an appropriate space for *Expressing feelings and opinions*, which appears especially important considering that some residents avoid peers with similar negative life events (Bonifas et al., 2014). Mutual support groups developed for care homes can facilitate relationships by creating a suitable environment for residents to open up about their fears and burdens (Theurer et al., 2014). Finally, our *Taking initiative* subtheme links to the finding that having limited influence on the content of activities can impact residents' perceived autonomy (Moilanen et al., 2021). The option to choose who they interact with, when, and what they do, promotes quality of life (McCabe et al., 2021), highlighting the importance of a balanced approach in encouraging residents to participate in activities and creating opportunities where they take the lead.

Strengths and limitations

We interviewed four participant groups, profiting from their diversity of experiences to build a rich understanding of how different stakeholders perceive the impact of activities on social connection. However, our study has limitations. While we aimed to recruit diverse participants, most participants were White and female (including all staff), which may potentially limit the generalisability of findings to people with different characteristics. For instance, older adults from other ethnic and cultural backgrounds may experience and cope with loneliness in different ways (Rokach et al., 2004) and may get less enjoyment and social connection from culture-specific activities. In addition, included residents had to have mental capacity to participate so we could not obtain direct experience of people with more severe dementia, limiting the transferability of our findings to this group, although we did ask relatives and staff about the social experience of those with severe dementia. We largely spoke to care homes rated as good, which may reflect the willingness of staff and residents of high-quality care homes to share their experiences and therefore may not have captured how sparse or poorly organised activities affect social connection. Relatively few participants described disliking care activities, even though our interview guide did ask about less enjoyed activities, which may reflect bias whereby more sociable participants agreed to participate in our study.

Our findings must be considered in light of the different components of social connection (Berkman et al., 2000; Holt-Lunstad, 2018; Leedahl et al., 2018; Machielse, 2015; O'Rourke & Sidani, 2017; Prohaska et al., 2020). We did not differentiate between its different components, which poses risks that

participants more often discussed, for example, activity aspects which improved social network (Berkman et al., 2000; Leedahl et al., 2018), whereas social connectedness may have greater impact on health and wellbeing (Ashida & Heaney, 2008). While in some cases it is possible to map which component of social connection participants were referring to (e.g. social support), our approach of discussing social connection broadly potentially helped find a common ground for all participants and thus identify more universally recognisable facilitators of social activities. Future research may examine which types of activities affect particular components of social connection.

Conclusions and implications

This study established key features of care home activities positively impacting residents' social connection. Our findings may inform delivery of existing care home activities, and the design of new ones. Care home professionals who struggle to improve social connection in residents within current programming could enrich their activities with resident matching, a focus on emotional openness, feelings of worth, residents having greater choice and being encouraged to take initiative in activity programming, eliciting mutual support, building activities around shared interests, or conducting them in a natural setting. Mixing different strategies might help create activities which appeal to and integrate residents with different preferences.

Studies have found inconsistent effect of specific activities on social connection (Bethell et al., 2021; Brimelow & Wollin, 2017), suggesting that the delivery of the activity may be more important than its content. Our findings might therefore inform the development of complex person-centred psychosocial care home interventions (Ballard et al., 2018), by elucidating how activities could be delivered to maximise social benefits for residents. Finally, insights from the current study hold potential for implementation in training staff to increase flexibility and effectiveness in facilitating social connection during activities, with the potential to improve care and quality of life for residents.

Acknowledgments

The authors would like to thank all residents, families, and care home staff and clinicians for participation in the study. We would like to thank Louise Jones and Debera Drew from Northumbria NHS Trust for conducting interviews.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This Project has been made possible with the financial support of Health Canada, through the Canada Brain Research Fund, an innovative partnership between the Government of Canada (through Health Canada) and Brain Canada, and the Alzheimer's Association (Re: ARCOM-22-875327). To date, Health Canada has invested over \$130 million through the CBRF which has been matched by Brain Canada Foundation and its donors and partners.

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References

- Ashida, S., & Heaney, C. A. (2008). Differential associations of social support and social connectedness with structural features of social networks and the health status of older adults. *Journal of Aging and Health, 20*(7), 872–893. <https://doi.org/10.1177/0898264308324626>
- Backman, C., Demery-Varin, M., Cho-Young, D., Crick, M., & Squires, J. (2021). Impact of sensory interventions on the quality of life of long-term care residents: A scoping review. *BMJ Open, 11*(3), e042466. <https://doi.org/10.1136/bmjopen-2020-042466>
- Ballard, C., Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., Woods, B., Garrod, L., Testad, I., Woodward-Carlton, B., Wenborn, J., Knapp, M., & Fossey, J. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLOS Medicine, 15*(2), e1002500. <https://doi.org/10.1371/journal.pmed.1002500>
- Barbosa Neves, B., Sanders, A., & Kokanović, R. (2019). "It's the worst bloody feeling in the world": Experiences of loneliness and social isolation among older people living in care homes. *Journal of Aging Studies, 49*, 74–84. <https://doi.org/10.1016/j.jaging.2019.100785>
- Bergland, Å., & Kirkevold, M. (2006). Thriving in nursing homes in Norway: Contributing aspects described by residents. *International Journal of Nursing Studies, 43*(6), 681–691. <https://doi.org/10.1016/j.ijnurstu.2005.09.006>
- Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). From social integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*(6), 843–857. [https://doi.org/10.1016/S0277-9536\(00\)00065-4](https://doi.org/10.1016/S0277-9536(00)00065-4)
- Bethell, J., Aelick, K., Babineau, J., Bretzlaff, M., Edwards, C., Gibson, J.-L., Hewitt Colborne, D., Iaboni, A., Lender, D., Schon, D., & McGilton, K. S. (2021). Social connection in long-term care homes: A scoping review of published research on the mental health impacts and potential strategies during COVID-19. *Journal of the American Medical Directors Association, 22*(2), 228–237.e25. <https://doi.org/10.1016/j.jamda.2020.11.025>
- Bonifas, R. P., Simons, K., Biel, B., & Kramer, C. (2014). Aging and place in long-term care settings: Influences on social relationships. *Journal of Aging and Health, 26*(8), 1320–1339. <https://doi.org/10.1177/0898264314535632>
- Bradshaw, S. A., Playford, E. D., & Riaz, A. (2012). Living well in care homes: A systematic review of qualitative studies. *Age and Ageing, 41*(4), 429–440. <https://doi.org/10.1093/ageing/afs069>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. <https://doi.org/10.1191/1478088706qp0630a>
- Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research, 21*(1), 37–47. <https://doi.org/10.1002/capr.12360>
- Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. SAGE Publications.
- Brimelow, R. E., & Wollin, J. A. (2017). Loneliness in old age: Interventions to curb loneliness in long-term care facilities. *Activities, Adaptation & Aging, 41*(4), 301–315. <https://doi.org/10.1080/01924788.2017.1326766>
- Buckley, C., & McCarthy, G. (2009). An exploration of social connectedness as perceived by older adults in a long-term care setting in Ireland. *Geriatric Nursing, 30*(6), 390–396. <https://doi.org/10.1016/j.gerinurse.2009.09.001>
- Care Quality Commission. (2023). *Care Quality Commission*. Retrieved September 7, 2023, from <https://www.cqc.org.uk>
- Cohen-Mansfield, J., Hazan, H., Lerman, Y., & Shalom, V. (2016). Correlates and predictors of loneliness in older-adults: A review of quantitative results informed by qualitative insights. *International Psychogeriatrics, 28*(4), 557–576. <https://doi.org/10.1017/S1041610215001532>

- Competition and Markets Authority. (2017). *Care homes market study: Final report*. <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf>
- Cook, G., Brown-Wilson, C., & Forte, D. (2006). The impact of sensory impairment on social interaction between residents in care homes. *International Journal of Older People Nursing*, 1(4), 216–224. <https://doi.org/10.1111/j.1748-3743.2006.00034.x>
- Davies, S., & Nolan, M. (2004). 'Making the move': Relatives' experiences of the transition to a care home. *Health & Social Care in the Community*, 12(6), 517–526. <https://doi.org/10.1111/j.1365-2524.2004.00535.x>
- Davison, T. E., Camões-Costa, V., & Clark, A. (2019). Adjusting to life in a residential aged care facility: Perspectives of people with dementia, family members and facility care staff. *Journal of Clinical Nursing*, 28(21–22), 3901–3913. <https://doi.org/10.1111/jocn.14978>
- Department of Health and Social Care. (2012). *Caring for Our Future: Reforming care and support* (Cm 8378). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136422/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf
- Edvardsson, D., Fetherstonhaugh, D., & Nay, R. (2010). Promoting a continuation of self and normality: Person-centred care as described by people with dementia, their family members and aged care staff. *Journal of Clinical Nursing*, 19(17–18), 2611–2618. <https://doi.org/10.1111/j.1365-2702.2009.03143.x>
- Ellis, J. M., & Rawson, H. (2015). Nurses' and personal care assistants' role in improving the relocation of older people into nursing homes. *Journal of Clinical Nursing*, 24(13–14), 2005–2013. <https://doi.org/10.1111/jocn.12798>
- Etikan, I. (2016). Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1–4. <https://doi.org/10.11648/j.ajtas.20160501.11>
- Gordon, A. L., Franklin, M., Bradshaw, L., Logan, P., Elliott, R., & Gladman, J. R. F. (2014). Health status of UK care home residents: A cohort study. *Age and Ageing*, 43(1), 97–103. <https://doi.org/10.1093/ageing/af077>
- Groenvynck, L., Fakha, A., de Boer, B., Hamers, J. P. H., van Achterberg, T., van Rossum, E., & Verbeek, H. (2021). Interventions to improve the transition from home to a nursing home: A scoping review. *The Gerontologist*, 62(7), e369–e383. <https://doi.org/10.1093/geront/gnab036>
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods*, 18(1), 59–82. <https://doi.org/10.1177/1525822X05279903>
- Harmer, B. J., & Orrell, M. (2008). What is meaningful activity for people with dementia living in care homes? A comparison of the views of older people with dementia, staff and family carers. *Ageing & Mental Health*, 12(5), 548–558. <https://doi.org/10.1080/13607860802343019>
- Holt-Lunstad, J. (2018). Why social relationships are important for physical health: A systems approach to understanding and modifying risk and protection. *Annual Review of Psychology*, 69(1), 437–458. <https://doi.org/10.1146/annurev-psych-122216-011902>
- Ice, G. H. (2002). Daily life in a nursing home has it changed in 25 years? *Journal of Aging Studies*, 16, 345–359.
- Kang, B., Scales, K., McConnell, E. S., Song, Y., Lepore, M., & Corazzini, K. (2020). Nursing home residents' perspectives on their social relationships. *Journal of Clinical Nursing*, 29(7–8), 1162–1174. <https://doi.org/10.1111/jocn.15174>
- Kanwar, A., Singh, M., Lennon, R., Ghanta, K., McNallan, S. M., & Roger, V. L. (2013). Frailty and health-related quality of life among residents of long-term care facilities. *Journal of Aging and Health*, 25(5), 792–802. <https://doi.org/10.1177/0898264313493003>
- Knight, T., & Mellor, D. (2007). Social inclusion of older adults in care: Is it just a question of providing activities? *International Journal of Qualitative Studies on Health and Well-Being*, 2(2), 76–85. <https://doi.org/10.1080/17482620701320802>
- Lapane, K. L., Dubé, C. E., Jesdale, B. M., & Bova, C. (2022). Social connectedness among long-stay nursing home residents with alzheimer's and dementia: Exploring individual and facility-level variation. *Dementia and Geriatric Cognitive Disorders*, 51(3), 249–261. <https://doi.org/10.1159/000525343>
- Leedahl, S. N., Sellon, A., & Chapin, R. K. (2018). Assessment of multiple constructs of social integration for older adults living in nursing homes. *Journal of Gerontological Social Work*, 61(5), 526–548. <https://doi.org/10.1080/01634372.2018.1451938>
- Lem, K., McGilton, K. S., Aelick, K., Iaboni, A., Babineau, J., Hewitt Colborne, D., Edwards, C., Bretzlaff, M., Lender, D., Gibson, J.-L., & Bethell, J. (2021). Social connection and physical health outcomes among long-term care home residents: A scoping review. *BMC Geriatrics*, 21(1), 722. <https://doi.org/10.1186/s12877-021-02638-4>
- Liougas, M. P., Sommerlad, A., O'Rourke, H. M., McGilton, K. S., & Bethell, J. (2024). Social connection measures for older adults living in long-term care homes: A systematic review protocol. *Systematic Reviews*, 13(1), 67. <https://doi.org/10.1186/s13643-024-02468-6>
- Lowndes, R., Struthers, J., & Ågotnes, G. (2021). Social participation in long-term residential care: case studies from Canada, Norway, and Germany. *Canadian Journal on Aging=La Revue Canadienne du Vieillessement*, 40(1), 138–155. <https://doi.org/10.1017/S0714980820000318>
- Machielse, A. (2015). The heterogeneity of socially isolated older adults: A social isolation typology. *Journal of Gerontological Social Work*, 58(4), 338–356. <https://doi.org/10.1080/01634372.2015.1007258>
- McCabe, M., Byers, J., Busija, L., Mellor, D., Bennett, M., & Beattie, E. (2021). How important are choice, autonomy, and relationships in predicting the quality of life of nursing home residents? *Journal of Applied Gerontology: The Official Journal of the Southern Gerontological Society*, 40(12), 1743–1750. <https://doi.org/10.1177/0733464820983972>
- McCormack, B. (2004). Person-centredness in gerontological nursing: An overview of the literature. *Journal of Clinical Nursing*, 13(3a), 31–38. <https://doi.org/10.1111/j.1365-2702.2004.00924.x>
- Mikkelsen, A. S. B., Petersen, S., Dragsted, A. C., & Kristiansen, M. (2019). Social interventions targeting social relations among older people at nursing homes: A qualitative synthesized systematic review. *Inquiry: A Journal of Medical Care Organization, Provision and Financing*, 56, 46958018823929. <https://doi.org/10.1177/0046958018823929>
- Moilanen, T., Kangasniemi, M., Papinaho, O., Mynttinen, M., Siipi, H., Suominen, S., & Suhonen, R. (2021). Older people's perceived autonomy in residential care: An integrative review. *Nursing Ethics*, 28(3), 414–434. <https://doi.org/10.1177/0969733020948115>
- National Institute for Health and Care Excellence. (2013). Mental wellbeing of older people in care homes (NICE Quality standard QS50). <https://www.nice.org.uk/guidance/qs50/chapter/About-this-quality-standard>
- Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, 16(1), 160940691773384. <https://doi.org/10.1177/1609406917733847>
- Nygaard, A., Halvorsrud, L., Grov, E. K., & Bergland, A. (2020). What matters to you when the nursing home is your home: A qualitative study on the views of residents with dementia living in nursing homes. *BMC Geriatrics*, 20(1), 227. <https://doi.org/10.1186/s12877-020-01612-w>
- O'Rourke, H. M., & Sidani, S. (2017). Definition, determinants, and outcomes of social connectedness for older adults: A scoping review. *Journal of Gerontological Nursing*, 43(7), 43–52. <https://doi.org/10.3928/00989134-20170223-03>
- O'Rourke, H. M., Collins, L., & Sidani, S. (2018). Interventions to address social connectedness and loneliness for older adults: A scoping review. *BMC Geriatrics*, 18(1), 214. <https://doi.org/10.1186/s12877-018-0897-x>
- Prince, M., Knapp, M., Guerchet, M., Mccrone, P., Prina, M., Comas-Herrera, A., Wittenberg, R., Salimkumar, A. (2014). *Dementia UK: Second edition – Overview*. Alzheimer's Society. <https://hal.archives-ouvertes.fr/hal-03516999>
- Prohaska, T., Burholt, V., Burns, A., Golden, J., Hawkey, L., Lawlor, B., Leavey, G., Lubben, J., O'Sullivan, R., Perissinotto, C., van Tilburg, T., Tully, M., Victor, C., & Fried, L. (2020). Consensus statement: Loneliness in older adults, the 21st century social determinant of health? *BMJ Open*, 10(8), e034967. <https://doi.org/10.1136/bmjopen-2019-034967>
- QSR International Pty Ltd. (2018). *NVivo Qualitative Data Analysis Software (Version 12)*. Computer software. .
- Quan, N. G., Lohman, M. C., Resciniti, N. V., & Friedman, D. B. (2020). A systematic review of interventions for loneliness among older adults living in long-term care facilities. *Ageing & Mental Health*, 24(12), 1945–1955. <https://doi.org/10.1080/13607863.2019.1673311>
- Rijnaard, M. D., van Hoof, J., Janssen, B. M., Verbeek, H., Pocornie, W., Eijkelenboom, A., Beerens, H. C., Molony, S. L., & Wouters, E. J. M. (2016). The factors influencing the sense of home in nursing homes: A systematic review from the perspective of residents. *Journal of Aging Research*, 2016, e6143645–16. <https://doi.org/10.1155/2016/6143645>

- Rokach, A., Orzeck, T., & Neto, F. (2004). Coping with loneliness in old age: A cross-cultural comparison. *Current Psychology, 23*(2), 124–137. <https://doi.org/10.1007/BF02903073>
- Sanford, A. M., Orrell, M., Tolson, D., Abbatecola, A. M., Arai, H., Bauer, J. M., Cruz-Jentoft, A. J., Dong, B., Ga, H., Goel, A., Hajjar, R., Holmerova, I., Katz, P. R., Koopmans, R. T. C. M., Rolland, Y., Visvanathan, R., Woo, J., Morley, J. E., & Vellas, B. (2015). An international definition for nursing home. *Journal of the American Medical Directors Association, 16*(3), 181–184. <https://doi.org/10.1016/j.jamda.2014.12.013>
- Sommerlad, A., Kivimäki, M., Larson, E. B., Röhr, S., Shirai, K., Singh-Manoux, A., & Livingston, G. (2023). Social participation and risk of developing dementia. *Nature Aging, 3*(5), 532–545. <https://doi.org/10.1038/s43587-023-00387-0>
- Tak, S. H., Kedia, S., Tongumpun, T. M., & Hong, S. H. (2015). Activity engagement: Perspectives from nursing home residents with dementia. *Educational Gerontology, 41*(3), 182–192. <https://doi.org/10.1080/03601277.2014.937217>
- Theurer, K., Mortenson, W. B., Stone, R., Suto, M., Timonen, V., & Rozanova, J. (2015). The need for a social revolution in residential care. *Journal of Aging Studies, 35*, 201–210. <https://doi.org/10.1016/j.jaging.2015.08.011>
- Theurer, K., Wister, A., Sixsmith, A., Chaudhury, H., & Lovegreen, L. (2014). The development and evaluation of mutual support groups in long-term care homes. *Journal of Applied Gerontology: The Official Journal of the Southern Gerontological Society, 33*(4), 387–415. <https://doi.org/10.1177/0733464812446866>
- Tobis, S., Wieczorowska-Tobis, K., Talarska, D., Pawlaczyk, M., & Suwalska, A. (2018). Needs of older adults living in long-term care institutions: An observational study using Camberwell assessment of need for the elderly. *Clinical Interventions in Aging, 13*, 2389–2395. <https://doi.org/10.2147/CIA.S145937>
- Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care, 19*(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>
- van der Wolf, E., van Hooren, S. A. H., Waterink, W., & Lechner, L. (2019). Well-being in elderly long-term care residents with chronic mental disorder: A systematic review. *Aging & Mental Health, 23*(3), 287–296. <https://doi.org/10.1080/13607863.2017.1408773>
- Victor, C. R. (2012). Loneliness in care homes: A neglected area of research? *Aging Health, 8*(6), 637–646. <https://doi.org/10.2217/ahe.12.65>

Appendix 1: COREQ 32-item checklist for reporting qualitative research

| Number | Item | Description | Page no. |
|--------|--|---|----------|
| 1. | Interviewer | Individual interviews, dyadic interviews for some care home staff, and a focus group for clinicians were semi-structured and led by one researcher (MM a postgraduate student, AS a psychiatrist, HC a research assistant, and two research nurses from one NHS trust), and co-facilitated by a second researcher in some cases. | Page 7 |
| 2. | Researcher credentials | Author 1: BSc, MSc Author 2: BSc, MSc, PhD Author 3: BSc, MSc Author 4: BSc, MBBS, MSc, PhD, MRCPsych | n/a |
| 3. | Occupation | The research team consisted of a postgraduate student with academic training relating to social connection in care homes, and a research assistant with postgraduate psychology training, supervised by a consultant old age psychiatrist and an epidemiologist. | Page 8 |
| 4. | Gender | Authors 1 and 4 are male. Authors 2 and 3 are female. | n/a |
| 5. | Experience and training | Authors 1 and 3 had undergraduate- and postgraduate-level experience in research methods and additional academic training in qualitative methods. Authors 2 and 4 are experienced researchers in the field of social connection in care homes and dementia. | n/a |
| 6. | Relationship established | Residents, family members and clinicians were recruited from care home liaison teams in three NHS trusts: Camden and Islington NHS Foundation Trust, Oxford Health NHS Foundation Trust, and Northumbria Healthcare NHS Foundation Trust, and from a London care home organisation. Staff were recruited from the above sources and through dissemination of information about the study to the ENRICH national care home research network (https://enrich.nihr.ac.uk/). | Page 6–7 |
| 7. | Participants' knowledge of the interviewer | Authors 1, 2 and 3 had no previous relationship with any of the participants. Author 4 had no previous relationship with any of the residents, family members or care home staff, but had a professional relationship with two of the four clinicians interviewed in a focus group. | n/a |
| 8. | Interviewer characteristics | Interviews were led by one researcher (MM a postgraduate student, AS a psychiatrist, HC a research assistant, and two research nurses from one NHS trust), and co-facilitated by a second researcher in some cases. | Page 7 |
| 9. | Methodological orientation and theory | Thematic Analysis based on Braun and Clarke approach was used. Data analysis was approached from the position of critical realism. A combination of deductive and inductive approaches was used – while pre-defined research objectives shaped the interview guide and the coding process, open coding was used to allow for exploration of newly developing issues around the topic. | Page 7–8 |
| 10. | Sampling | We used purposive sampling (Etikan, 2016), aiming to interview participants with varied characteristics including age, sex, socioeconomic status and ethnicity. To explore multiple perspectives, we recruited residents with and without dementia, family caregivers representing different relations, and professionals representing a range of occupations. We recruited from care homes across England, and with varying quality of care as reflected by Care Quality Commission regulatory ratings (Care Quality Commission, 2023). We planned to interview until thematic saturation was reached and anticipated a sample size of around 20–30 participants to allow saturation (Guest et al. 2006). | Page 6 |
| 11. | Method of approach | Residents, family members and clinicians were recruited from care home liaison teams in three NHS trusts: Camden and Islington NHS Foundation Trust, Oxford Health NHS Foundation Trust, and Northumbria Healthcare NHS Foundation Trust, and from a London care home organisation. Staff were recruited from the above sources and through dissemination of information about the study to the ENRICH national care home research network (https://enrich.nihr.ac.uk/). Potential participants were informed about the study by clinicians, or by viewing information about the study in newsletters. People who expressed interest were given an information sheet and 48 h for consideration, after which the research team contacted them to ask if they wished to meet. | Page 6–7 |
| 12. | Sample size | We interviewed 35 participants during 30 interviews. Data were collected from 12 residents, ten family relatives, nine care home staff, and four clinicians. Twenty-eight participants were female (80%) and 29 participants were White (83%). Nineteen participants (54%) were based in London and 16 (46%) in other locations. | Page 9 |

continued

| Number | Item | Description | Page no. |
|--------|--------------------------------|---|---------------------|
| 13. | Non-participation | Three residents refused participation, one resident was deemed to lack capacity to consent to participation. No carers, staff or clinicians refused to participate. No participants dropped out during the study. | n/a |
| 14. | Setting of data collection | Resident interviews were conducted in-person in private spaces in care homes to allow participants to speak freely about their experiences. Staff and clinician interviews were conducted online using Microsoft Teams and family interviews in person or online. | Page 7 |
| 15. | Presence of non-participants | Some care home residents chose to be interviewed in presence of a family member. | n/a |
| 16. | Description of sample | 35 participants: 12 residents, ten family relatives, nine care home staff, and four clinicians. Twenty-eight participants were female (80%) and 29 participants were White (83%). Nineteen participants (54%) were based in London and 16 (46%) in other locations. | Page 9, Table 1 |
| 17. | Interview guide | After collecting demographic data, interviews lasting 30–60 min were based on a topic guide exploring the nature and determinants of social connection in care homes including the role of activities in promoting this. Two versions of the guide were used for residents/caregivers and staff/clinicians. | Page 7 |
| 18. | Repeat interviews | No repeat interviews were carried out. | n/a |
| 19. | Audio/visual recording | Staff and clinician interviews were conducted online using a video-calling platform and family interviews both in person and online. Interviews were audio-recorded and transcribed verbatim. | Page 7 |
| 20. | Field notes | No field notes were made. | n/a |
| 21. | Duration | Interviews took between 30 and 60 min. | Page 7 |
| 22. | Data saturation | We planned to interview until thematic saturation was reached and anticipated a sample size of around 20–30 participants to allow saturation (Guest et al. 2006). | Page 6 |
| 23. | Transcripts returned | We did not return the transcripts to the participants. | n/a |
| 24. | Number of data coders | Author 1 coded all interviews for consistency, with regular discussion (with Authors 2 and 4) throughout the construction of the coding framework and coding process. | Page 8 |
| 25. | Description of the coding tree | The analysis followed the six-step approach (Braun & Clarke, 2006) using NVivo 12 (QSR International Pty Ltd., 2018). Initial high-density coding was conducted on a subsample of five interviews selected to provide a range of views. Overall coding stopped when the framework was judged to summarise the diversity of meanings (Braun & Clarke, 2022). A coding journal was used throughout the process to write analytic memos regarding each data item, along with mind maps to explore connections and refine the framework. One researcher (MM) coded all interviews, with regular discussion (with JB and AS) throughout the construction of the coding framework and coding process. | Page 8 |
| 26. | Derivation of themes | Thematic analysis based on Braun and Clarke (2006) was used. Our approach to theme identification was theory-driven and guided by pre-defined research objectives. Theoretical assumptions regarding the conceptualisation of social connection shaped the interview guide, interviewing process and data analysis. We used open coding to enable novel understandings of the topic to develop, assuming the position of critical realism (Braun & Clarke, 2022). | Pages 7–8 |
| 27. | Software | NVivo 12 | Page 8 |
| 28. | Participant checking | We did not conduct participant checking. | n/a |
| 29. | Quotations presented | Participant quotes are included in the manuscript to illustrate the themes identified in thematic analysis. Quotes were anonymised using the following letters: R = Resident, F = Family member, P = Care home Professional, C = Clinician working in care homes. We took special care to make sure that illustrative quotes come from a range of participants instead of focusing on a select few. | Pages 9–18 |
| 30. | Data and findings consistent | Themes in the study were established based on converging experiences and opinions of multiple participant groups, which demonstrate consistency of data and findings. Furthermore, the Discussion section explores how the thematic framework relates to previously established concepts such as Person-Centred Care and meaningful activity, and how the themes and subthemes complement each other. | Pages 9–18, 20–21 |
| 31. | Clarity of major themes | The Results section explores the meanings of the four main themes and several subthemes developed through thematic analysis. They are also presented in Table 2. | Pages 8–18, Table 2 |
| 32. | Clarity of minor themes | Subthemes were identified along the main themes through thematic analysis in order to demonstrate the nuanced meanings which build the main themes with greater clarity. Subthemes are presented in the Results section by using sub-headings within each main theme section, and in Table 2. | Pages 8–18, Table 2 |