**The experience of loneliness and living with sight loss in English care homes**

**Abstract**

Loneliness is a serious societal concern, especially the loss of social connections in later life. Those with sight loss living in care homes are thought to face particular challenges in social engagement, but research is scarce. This study aimed to examine the experience of loneliness amongst residents with sight loss; the different dimensions of loneliness; and their attitudes about the role of care homes in addressing these needs. Through in-depth interviews with 18 residents, supplemented by interviews with family members and care home managers, the research identified that residents were generally satisfied with their social situation. However, there was evidence that sight loss was not appropriately accommodated within the care home. In their efforts to enable all residents to engage in social activities, attempts to include those with sight loss could feel contrived, and residents with sight loss did not feel *meaningfully* involved. Residents described barriers to forming close associations, including the challenges of background noise in communal spaces and a sense that conversation in the care home lacked stimulation. Residents felt that opportunities to forge and maintain bonds with people outside the care home were limited. The research concludes that care homes should avoid inclusion-for-inclusion’s sake, and future research could study the effectiveness of interventions to improve care home links to the wider community.

**Keywords**

Loneliness, social isolation, sight loss, vision impairment, residential care.

**Introduction**

Loneliness is a significant concern in modern-day society, as growing attention is given to the social dimensions of physical and mental health, as well as broader life quality. Experiences of loneliness form part of a wider discourse on social exclusion, in which a complex web of personal and social factors, often linked to structural disadvantages in society, impinge upon wellbeing (Age UK 2012). Those who experience loneliness are known to be more likely to have depression and poorer health outcomes (Holt-Lunstad *et al.* 2010), although assigning causation is challenging (Victor *et al.* 2005). A perception has formed that loneliness is a particular problem in later life, although empirically it is only amongst the ‘oldest old’ that the prevalence of loneliness tends to rise above general population norms (Yang and Victor 2011). Nevertheless, later life loneliness is linked to events that degrade social networks, such as bereavements and changes in residence, and to physical and cognitive function that can decline in old age (Adams, Sanders and Auth 2004; Victor *et al.* 2005; Wilson *et al.* 2007; Wrzus *et al*. 2013). Tackling loneliness in old age is a recognised international priority (World Health Organization 2012), forming part of healthy ageing policies across the European Union, North America and Australia. In the UK, the needs of older people experiencing loneliness have been championed by the *Campaign to End Loneliness* and other initiatives by the third sector (Age UK 2018), and has achieved cross-party consensus in the political arena.

Many definitions of loneliness exist, however all share a common negative evaluation about the perceived absence or missing qualities within social relationships (de Jong-Gierveld, van Tilburg and Dykstra 2006). Loneliness is inherently subjective, and is usually contrasted with definitions of *social isolation*, which is viewed as an objective assessment that social networks are limited (Perlman and Peplau 1981). Whilst correlated, it is perfectly feasible to be isolated but feel no loneliness, or to feel lonely despite apparently ample social connections. Indeed, some research participants have attributed a preference for solitude as providing a resilience against loneliness in later life (McHugh Power *et al.* 2017). Loneliness is widely regarded as multidimensional, and most commonly has been examined through its *emotional* and *social* aspects (Weiss 1973). Emotional loneliness is said to occur when individuals feel a lack of close or intimate attachment to people with whom a psychological bond is shared, such as with close friends, family or spouses. By contrast, social loneliness results from a lack of belonging to a wider community of individuals who share some common social identity, such as values or interests (Paddock *et al.* 2019).

Despite concerns about old-age loneliness and social isolation dominating social discourse, this does not account for the resources and resilience that many older people can draw upon. Even amongst those living alone, it is far from inevitable that loneliness sets-in, and indeed many have superior mental wellbeing than their co-residing counterparts (Djundeva et al 2019). Studies have examined how older people seek to create meaning in their lives as they adapt to changing social networks, including bereavement. It appears that older people may come to identity as lonely where they are unable to maintain activities or relationships, and become overwhelmed by a sense of loss (Kirkevold et al (2012). In Taube et al (2016), loneliness in later life was conceptualised as being ‘in a bubble’, with some desirable aspects (enjoyable ‘aloneness’ and freedom), but often feeling excluded from events outside. In sum, loneliness is a subjective experience, and is both moderated and mediate by personal traits and social context.

Much of the extant research on loneliness has focused on community-dwelling older people (Gardiner *et al.* 2018; Heylen 2010; Victor *et al.* 2005; Victor *et al.* 2008;Wenger, *et al.* 1996). The experience of loneliness within residential settings has received less attention, despite entry to a care home often interrupting usual social networks. Rates of ‘severe loneliness’ are estimated to be at least twice as high amongst care home residents as those living in the wider community (Victor 2012), although causation is again difficult to attribute, since loneliness is also an independent predictor of entry to care homes (Hanratty *et al.* 2018). Historically, residential care settings have had a reputation for neglecting social needs, contributing to a negative stigma about what it means to need to enter a care home. Today, meaningful social occupation is now central to most descriptions of high quality care homes, which in England is cemented through NICE guidelines (NICE 2013), although evidence to support care homes’ social interventions is weak.

An emerging literature has highlighted how the experiences, causes and consequences of loneliness in care homes may be distinct for resident groups with different needs (Prieto-Flores *et al.* 2011). One disability common in later life is sight loss, defined here as any vision impairment that interrupts daily life and which cannot be corrected through eyewear. Estimates in the UK suggest as many as half of older residents in care homes have some form of sight loss (RNIB, 2010). In the general population, data from the English Longitudinal Study of Ageing indicates that vision impairment may impede the quality of social relationships, if not the quantity (Hodge and Eccles 2013; Zimdars *et al.* 2012;). Qualitative data has further suggested that challenges to communication linked to vision impairment may marginalise older people with sight loss and reinforce isolation (Heine and Browning 2004; Hodge and Eccles 2013).

Taken together, the context of care home living and sight loss might be thought to influence how feelings of isolation and loneliness are perceived. However, such research is scarce. The evidence-base relies on general descriptive accounts from broad-ranging discussions about care home life in general (Ward and Banks 2017), or else more targeted work on social relationships but spanning other sensory losses (Cook *et al.* 2006). Research from other resident groups, such as those with dementia, and from diverse cultural backgrounds, highlight the dangers of misunderstanding the nuances and idiosyncrasies of loneliness in care home environments (Clare *et al.* 2008; Manthorpe *et al.* 2010), where it is easy to assume that simply being resident in a communal environment affords automatic protection. Concerns arise as to whether the social needs and experiences of those with sight loss are being identified and understood, and whether countermeasures adopted by care homes, families and residents are appropriate. Moreover, recent evidence raises questions as to whether loneliness is something that older people feel is a ‘problem’ for other agencies to ‘fix’ (Kharicha *et al.* 2017). This paper reports new research which aimed to examine the experience of loneliness amongst care home residents with sight loss; the different dimensions of loneliness; and their attitudes to the role of care homes in addressing these needs.

**Methods**

This paper draws on data collected from interviews with residents with sight loss, family members and care home managers in the course of a mixed-methods study exploring relationships between isolation, loneliness and sight loss among older people in care homes. Ethical approval was obtained from London – Camberwell St Giles Research Ethics Committee (Reference: 17/LO/2080)

Individual residents, family members and managers were recruited from 11 care homes (residential (n=5), nursing (n=2), and combined residential and nursing (n=4)) located in the Yorkshire & Humber, North West and Midlands regions of England. These homes were identified as being ‘research ready’ through the Department of Health’s ‘Enabling Research in Care Homes’ (ENRICH) scheme. One care home was a specialist care home for people with sight loss. In identifying residents we sought individuals with sight loss, defined as any visual impairment that cannot be rectified through eyewear, and with capacity to consent to the research. Other than this, sampling was opportunistic, and in practical terms the number of residents with visual impairment *and* with capacity to consent was limited in any single care home. Eighteen residents gave consent and were interviewed (age range 66-98) with the majority aged over 86 and female. All interviewees were white British; three had no sight while the remaining participants retained limited sight. Participating care home managers plus five family carers were interviewed by telephone or face to face.

Each participant was interviewed once between September and November 2018. Resident and family member interviews explored the opportunities and challenges for social interaction and perceptions of isolation and loneliness. Care home manager interviews examined similar topics but with an added focus on the environment and staff needs. All interviews used a flexible, semi-structured topic guide.

Interviews were audio-recorded and fully transcribed.  Interview data were analysed using the Framework approach (Ritchie and Lewis 2003), an established and transparent approach well-suited to applied qualitative research and to team analysis. The researchers first read the transcripts, noting topics and themes relating either to the preconceived research questions or emerging from the interview data. The thematic framework was refined through team discussion using both a priori and emergent themes and used to compile a set of thematic charts in Excel. Each chart column denoted a sub-theme and each row an individual respondent. A summary of each participant's statements was then displayed in the relevant cells along with links back to their original transcript.

Once the data extraction was complete, the researchers worked together over several days to examine all the charted material and to compile a central chart for mapping and interpreting the full data set. In the central chart, the data were displayed according to the three types of participant, with the thematic data further analysed and categorised to enable the research team to compare and contrast accounts both within and between types of respondent. This iterative process continued until the team was satisfied that a comprehensive and accurate account of the data had been produced.

**Findings**

*Understanding of loneliness*

Our interviews sought respondents’ perspectives of whether loneliness was a problem, and what, if anything, might be done to address it. Several interviewees expressly stated that they were not lonely and ‘just [got] on with their life’ in the care home. Even where respondents noted they were isolated, they displayed significant resilience, which seemed to help them adapt to what many seemed to feel was inevitable. For some, they attributed isolation as a normal way of life, or else a feeling that it was easy to accommodate with their preferences:

I have never been one for going out and socialising really. (R8)

I’m used to being on my own… well [going out of the room] only means socialising with the others, which I don’t want to do. (R9)

Residents described becoming accustomed to the feeling of loneliness, the inevitability of loneliness or simply an acceptance of time passing and being content. Where loneliness was acknowledged as a concern, respondents indicated that they were reconciled with such emotions, and were not expecting solutions. One typical response was:

This is what I’ve come for, in’t it, to be cared for, and that’s what I get. ..I think to myself, …why do I worry when there’s some other people don’t even know what getting out of bed is? So I’m happy,… (R10)

Residents were able to feel relatively content by making comparisons with others they felt were worse off, and reminding themselves that feelings of loneliness tended to pass with time.

Yet beneath these very general assessments, there were aspects of care home life that appeared to concern residents with sight loss when it came to fulfilling their connectedness with others. The following findings are organised in three themes: intellectual engagement, environmental factors, and connections within and outside the care home.

*Intellectual engagement*

A common theme throughout the transcripts was a struggle to find meaningful and intellectually satisfying conversation within the home. Sight loss appeared to be a factor in two ways. First, entering a communal area often came with no choice of who to sit with, and residents were positioned without knowing who else was present. Managers explained that care staff would help residents by explaining seating options and identifying possible friends, but residents we spoke to either did not experience this, or else did not want this:

if I go down to anything I can't see who's next to me. Every time I need to say, 'Who are you?' you see, 'Who am I sitting next to?' or if you're sitting in a circle, 'Who are in the other parts of the circle?' I can't see people at all. … I'm all the time asking, 'Well who are you?... I want to be as normal as I can be…[it] would be demeaning [for the carers] to go round and tell me who was who every time. (R2)

At other times, simply not knowing who you are talking to prevented residents from building-up social bonds over time, and where residents had any hearing loss in addition to visual impairment, conversation was additionally challenging.

A second factor related to how residents with sight loss felt socially positioned relative to others. Some perceived that other residents shunned them, one feeling that “they don’t want to bother with a blind man”. However, also evident in the transcripts was how residents with sight loss positioned *others*. Several interviewees said that fellow residents had little of interest to discuss. They could be “boring”, or else were not “at my level” in terms of interests. Other residents with cognitive impairment were singled-out as being frustrating company: “well, I try my best to discuss things but it’s very difficult when people have lost their marbles*”*. The age-range of residents also played a factor, with an interviewee in their sixties saying that they had little in common with most residents in their eighties and nineties.

Every care home had an activity schedule which often provided opportunities for social engagement around shared pursuits. Managers reported that staff would read the activity schedule to all residents with sight loss, with regular prompts and reminders thereafter, but some residents and family members said a leaflet was simply left in the room. Residents generally acknowledged the breadth of activities the care homes offered, but there was a sense that these lacked stimulation. Our interpretation of the data was that care homes attempted to provide activities that would appeal simultaneously to as many residents as possible, but that in doing so they were interpreted as trivial and lacking meaning by some residents.

Well I don't want to play games … I'm a professional person and I've got high standards… I've been used to going to lectures and all sorts of things to stretch my memory… (R2)

Similarly, care home managers stressed that they went to great lengths to “encourage everyone to integrate”, and this was well evidenced in many examples they gave. Yet it was not always clear if activities were equally meaningful for everyone. The following excerpts from two managers provide further examples that attempts to be inclusive of people with sight loss may have been at the expense of how meaningful this participation was:

We also play bingo... residents that cannot see, we will always try and have either myself, my assistant or a volunteer sat with that resident, so if we're playing something like bingo, we can tell them they've got that number or so on.

If they were playing bowls on the floor and they, they could only vaguely see where things were, it’s just about saying, you know, “roll it a little bit to the right”, and that sort of thing

Arguably, these attempts at inclusion could be counter-productive, since the residents’ role in each example lacked a meaningful contribution. This may go some way to explaining why social activities lacked stimulation for this sample. One care home involved residents in the planning and organisation of activity schedules, and a resident we interviewed said that a transport engineering talk had been arranged for a small group of residents who engaged enthusiastically (although she had no interest herself). Residents in the specialist home spoke more positively about the group activities in the home and appeared to be more engaged in them. Examples include crosswords and puzzles that stimulated the mind, and regular outside speakers with interesting and relevant content. Several residents across all care homes showed interest in listening to volunteers reading a newspaper to them; this appeared to combine intellectual stimulation and a social experience. However, the specialist home was the only home where a volunteer read a newspaper to residents on a daily basis.

*Physical and environmental factors*

The majority of interviewees appeared to ‘keep themselves-to-themselves’ and spent much of their time in their rooms. While for some that was a choice, for others this signified an involuntary withdrawal in response to challenges they were experiencing in the care home. Some causes were practical and caused by significant difficulties in navigating communal areas. One blind interviewee relied on a sighted neighbour to walk him to the dining room. He explained that after his fellow resident left the home, he tried to get there on his own using his stick but he could not manage; he lost his confidence and stopped going out of his room, thinking his room was the only safe place. Some residents linked their preference for their own room to feelings of embarrassment. Several found it stressful to eat in front of other residents as they were conscious of other people watching them using their fingers and dropping the food. One interviewee reported an incident when he was told by the person sitting next to him that others were watching him eat ‘his way’.

Another important environmental factor was background noise, since reliance on hearing others (and being heard) becomes more important when visually impaired. The noise and background music in the dining room was reported as a source of frustration adding to the challenges of initiating or joining in conversations. Noise was also a factor identified by managers as a significant barrier to interaction, and there was concern that so much ‘coming and going’ must be disorientating for people with visual impairment. Family members commented that some sources of noise were an inevitable part of communal living, especially in a population often living with some hearing loss, but one also singled out residents with vocalised agitation that was a source of anxiety for their mother.

Most residents and family members noted that care home staff did their best to accommodate the environmental needs of people with sight loss. This was evident in interviews with managers. One had made changes within the care home to try and minimise trip hazards in corridors, such as by agreeing that all cleaning carts would always be on one side of the corridor. To reduce background noise, another care home had replaced loud alarms at the practitioners’ station with discreet pagers for each member of staff. One manager reported that residents with visual impairment were accommodated in an upstairs lounge area, amongst those with complex health needs and dementia, since it was a light, open area and less noisy. However, this may have contributed to the perception (noted above) that residents with sight loss were being socially positioned amongst those with the severest needs contrary to their wishes.

*Connections within and outside the care home*

The quality of social contacts *within* the care home was mostly described as superficial or similar. A common sentiment was that fellow residents were “friendly, but not friends”, or else a connection that would only go so far:

We don’t have much to say to each other… not what you would call a close friend, no… I mean we can be quite friendly and jolly on the surface, but it doesn’t mean much. (R6)

Explanations for this varied, with one resident perceiving that social life within a care home is “not like ordinary life” because the people you are in contact with in the home are not one’s own choice. Common interests were limited, and there was little appetite for small talk. Moreover, since life revolved around the routines of the care home, one resident remarked that “we experience the same things here so usually all we can talk about is ourselves and our past. Living in a home kills conversation.” Some consciously avoided close attachments because of fears new friends would decline in health or cognition, as is common in residential care, and they would feel the loss. Similar sentiments were expressed with regards to conversations with care home staff, where small talk was pleasant but shallow. Meaningful conversations were reported to be more likely with friends living outside the home, where talk would be of “things we’ve been to, things we’ve read, or things we’ve heard on the television”. However, interviews with care home managers did not indicate that forming or maintaining such emotional links were any more challenging for residents with sight loss than for other residents.

A keen desire to maintain or re-acquire connections from outside the home were tempered by the barriers people with sight loss face. The inability to navigate independently prevented some interviewees from continuing to engage in past social activities that they valued. One interviewee reported that since she moved to the care home a year ago, she had not been able to join her friends at coffee mornings at her local church, as it was far away from the care home and she was no longer able to get there on her own. Another resident said that simply not being able to read the newspaper meant that she did not know of local developments, especially since care workers did not appear to be interested or aware of what was going on in the community. The same resident explained how the sequence of sub-tasks involved in that process discouraged her from even very local activities:

They occasionally put a film on in [name of a place] which is just across the road here and it’s, again it’s, it’s reading the leaflets … I suppose I could go over … and ask if they’ve got a, a leaflet saying, showing forthcoming attractions and, and then I come back here and would get someone to read it to me, but then I, I can’t make a note of things ahead and remember to look at my diary, cos I can’t see in my diary. (R15)

Care home managers did display awareness of such challenges but did not feel these were unique to residents with sight loss. They were also unequivocal about the constraints they faced:

At the end of the day, the safety of all the residents is paramount so you can’t put [all our other] residents at risk because you’ve allowed a member of staff to take one individual to attend a social group. (CH1)

Two residents (from different care homes) reported that the help they had received from the church volunteers had enabled them to continue with the lunch clubs after moving to the care home. Family members perceived that residents would benefit from more input from local community groups, befrienders or volunteers. Manager opinions on the role of volunteers varied. Care homes that were affiliated with a charitable or religious group could draw on a steady supply of volunteers, committed to the welfare of residents, and were evidently appreciative of the role they could play. Other managers were less positive, concerned that volunteers were in short supply, or did not have long-term commitment to volunteering.

**Discussion**

The research addresses a knowledge gap of importance; how care home residents with sight loss experience social connection. In the context of significant attention to loneliness in later life, in England and internationally, there are several subgroups particularly neglected in mainstream research. Care home residents with sight loss might be thought to face acute challenges in social participation, but in the absence of research evidence, such assumptions go untested and with little information on which to build appropriate responses.

Our findings illustrate an apparent paradox in residents’ appraisal of their own situation. On the one hand, residents we spoke to did not ‘problematise’ loneliness or social isolation in the way that mainstream policy discourse might expect. Although contemporary interest is in loneliness across the life course, there remains a largely unchallenged assumption that isolation in old age is markedly more prevalent and more deleterious to wellbeing than for younger adults. This stance both overstates how common loneliness is in later life (Victor *et al.* 2005), but also understates the resilience of older people. The residents we spoke to were generally satisfied, at least superficially, with their social situation, even those acknowledging that they felt ‘lonely’. This tallies with studies concluding that feelings aligned with loneliness are inherently subjective, and are only regarded as problematic when there is a discrepancy between loneliness and the person’s expectations of social relationships in their situation (Heylen 2010). Ours is not the first research sample where participants acknowledged loneliness whilst simultaneously reporting value and meaning found in other aspects of their lives (Stephens et al 2015). This raises the question of the degree to which care homes, and society more widely, should be intervening to enhance social participation. Other studies have found that older lonely people may not expect or wish for the care system to intervene to address loneliness, with many viewing it as a private matter (Kharicha *et al.* 2017).

To the extent that care homes do provide options for social participation, our study found that aspects of care home life were not appropriately adapting to the needs of residents with visual impairment. One observation was that scheduled social activities within the care homes attempted to cater for the largest number of residents as possible, but in doing so, attempts at inclusion for those with visual impairment seemed contrived. This echoes research that care homes struggle to cater for individual preferences (Paddock *et al.* 2019), but perhaps also speaks to Theurer *et al.*’s (2015) call for an end to mass, institutionalised recreation in residential settings and providing more opportunities for meaningful interactions. It is notable that there is a poor evidence base for social activities within care homes in countering loneliness (Victor 2012) and we might conclude that success of care home activities are currently being judged against some other standard, such as inclusivity and numbers participating. Barbosa Neves *et al.*’s (2019) observation-based study found that efforts to include the most severely frail residents in social activities meant that many slept through them, and in music sessions, people might sing but would noticeably refrain from any social engagement with others. Similarly, enabling people with impaired cognition to participate in activities may mean that they no longer hold much meaning for those with higher intellectual functioning, and in fact lead to ‘childlike’ participation that can degrade people’s sense of dignity (Tse and Howie 2005).

Others have concluded that the ‘mere charade’ of entertainment schedules can mask the absence of meaningful social engagement, allowing staff to imagine that all is well when in reality being unaware of improvements that could be achieved (Henderson 1995; Katz 2000; Theurer *et al.* 2015). This idea has parallels with literature that sees organisations deploying care work as a form of social engineering, with staff enacting routines that give the impression of valued interpersonal activity, whilst divorced from the true nature of the engagement (Brown & Korczynski 2017; Lopez 2006). In is noteworthy that managers we interviewed appeared to offer little evidence of critical reflection about what care homes offered. One analysis might suggest that managers and staff using their emotional labour were engaged in a ‘false consciousness’. However, a more likely explanation might be that, under the many constraints facing the residential care sector, respondents sought to identify and focus on the small successes that such difficult work affords (Hande et al 2021).

This study also highlighted the nuanced challenges that residents face in their social interactions. Simple tasks, like being seated next to someone you know, become difficult, and noisy environments common to communal living environments can make visual cues in communication more important. Some residents we spoke to were conscious of how other residents positioned them, a factor also identified in Cook *et al.*’s (2006) analysis of residents with a range of sensory impairments. However, we also found that residents with visual impairment positioned others as well, particularly those with cognitive impairment, as also identified in Paddock *et al.*’s (2019) observation-based work. Arguably, this served to reinforce visually impaired residents’ perceptions of intellectual isolation, and of being an outsider within the care home.

Perhaps the most effective source of social fulfilment residents sought was to be found outside the care home. The process of entering residential care is known to cause a substantial interruption to usual relationships, which can degrade both the quantity and quality of social networks (Grenade and Boldy, 2008) and studies have illustrated the importance of maintaining links to the ‘outside world’ (Davies and Nolan 2006). Support through social networks can be crucial in counteracting feelings of isolation (Ward and Banks, 2017), and can be particularly helpful in supporting adaptation to sight loss (Houde 2007). Where residents receive weekly contact with family members, residents report significantly less loneliness (Prieto-Flores *et al.* 2011). However, for those without family, or with family unable to visit regularly, options are less promising. Some have reported that relationships between residents and care home staff can parallel those with family members, replacing the need for an intimate bond (Grenade and Boldy 2008), but evidence is mixed and the residents in our study generally reported no such sense of closeness.

Current policies in England promote the use of community ‘assets’ in promoting social inclusion, and these dovetail with the growth of social prescribing models in supporting public health. The principle of these approaches is that local areas often contain a wealth of community resources that may enhance wellbeing, but that access for some people is challenging (Chenoweth and Stehlik 2001). Given our findings that residents with sight loss felt the most fulfilling social engagement was with people and groups outside the care home, it may be that this is a fruitful focus for future practice attention. One-to-one befriending interventions are highly-valued by those using them (Cattan *et al.,* 2005; Ward and Banks, 2017), especially those who face practical barriers to going out (Jopling 2015). Similarly, the study reported here identified potential for the use of volunteers in care homes. Unfortunately, in common with other initiatives designed to expand connections between care homes and the wider community, the evidence-base is limited and inconclusive, with insufficient attention to whether they improve outcomes (Victor 2012) and can be sustained over time. We argue this is a priority for further research.

The study has limitations to be considered when interpreting the results. The study aimed to capture a broad range of views amongst care home residents with visual impairment, yet we faced constraints when sampling. The residents we spoke to were all white British, and the requirement that all participants must have capacity to consent may have been interpreted by care home staff (who identified potential participants) that this would prevent people with mild cognitive impairment or early stage dementia from taking part. A further limitation was the absence of interviews with care workers. The research team had intended to incorporate such views, but in practice it proved difficult for care homes to release staff from their roster, and those we spoke to were curiously reluctant to openly share their experiences. Our own reflections were that staff appeared nervous about ‘saying something wrong’, despite our assurances of confidentiality. A decision was taken to suspend those efforts, and to focus on residents, family and managers. This limits the perspectives we can report although the perceptions of residents is perhaps the more salient one in the context of this piece of work.

**Conclusion**

The study finds that residents with sight loss were broadly satisfied with their social interactions, and there was little demand for care homes to intervene further in alleviating their concerns. However, the interviews highlighted that care homes may be over-inclusive and lack reflection when engaging residents in scheduled social activities. Where activities are at the fringes of what residents with sight loss can meaningfully participate in, their involvement may be contrived and without meaning. Some care homes found simple means for reducing background noise that may interfere with social participation, but ultimately the most valued connections were expected to be found outside the home. A potential future line of enquiry would be to examine and test mechanisms for enhancing the capacity of care homes to make use of community assets and resources.

**Statement of ethical approval**

A favourable opinion was obtained from London – Camberwell St Giles Research Ethics Committee (Reference: [anonymised])

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No conflicts of interests are reported.

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**Corresponding address for corresponding author:**

[anonymised]