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INVESTIGATING SOCIAL CONNECTION, COMMUNICATION, AND ENGAGEMENT CHALLENGES IN RESIDENTIAL AGED CARE

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ABSTRACT

Residential aged care has increasingly embraced person-centred care; however, many residents continue to experience loneliness, limited engagement, and communication difficulties despite receiving adequate physical care. This study explored residents' lived experiences of social connection, communication, and engagement in residential aged care. An interpretivist qualitative design was employed in an Australian residential aged care facility. Ten cognitively intact residents aged 70–100 years participated through open-ended interview questions. Data were analysed using Braun and Clarke's thematic analysis framework. Five themes emerged: loneliness and emotional isolation, communication barriers and feeling unheard, limited meaningful engagement, the need for personalised relationships, and greater participation in care decisions. Residents consistently emphasised that meaningful relationships, attentive communication, and personalised engagement were fundamental to wellbeing and quality of life. Quality aged care extends beyond clinical and physical support. Strengthening social connection, communication, and resident-centred engagement is essential for enhancing wellbeing and achieving genuinely relationship-centred care.

KEYWORDS: Residential aged care; Loneliness; Person-centred care; Communication; Resident engagement; Quality of life; Qualitative research.
JEL Classification: I10, I18, I31, J14, Z13

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1. INTRODUCTION

The world is growing older at a pace without historical precedent. The United Nations (2019) projects that the number of people aged 65 and over will more than double between the mid-2020s and 2050, rising from roughly 0.8 billion to about 1.6 billion, so that older adults will outnumber children under five for the first time in recorded history. This demographic transition is most advanced across the high-income economies of the OECD (2023), where falling fertility and lengthening life expectancy have together inverted the age pyramid. Australia sits firmly within this pattern: people aged 65 and over now constitute around one in six Australians, a share expected to climb steadily over the coming decades (Australian Institute of Health and Welfare, 2023).

As populations age, the demand for formal long-term care expands, and a growing minority of older adults move into residential aged care. The transition is rarely simply about declining health. It reflects intersecting pressures, including the dispersal of families across cities and continents, the erosion of traditional household-based caregiving, and the accumulation of complex chronic conditions that domestic settings cannot safely manage. Investment in human health and capability is, in this sense, an economic as well as a clinical concern, because the productivity and welfare of ageing societies depend heavily on how well health and care systems convert resources into wellbeing (Anowor, Ichoku, Onodugo, Ochinanwata, & Uzomba, 2023). Residential care has therefore moved from the margins of social policy to its centre, raising an urgent question that is the focus of this article: what kind of care do older people actually receive once they arrive?

Residential aged care was historically organised around a medical logic. Its priorities were physical health, clinical observation, medication management and the prevention of harm. Within this model the resident was, in effect, a patient, and a good facility was one that kept its patients safe, fed and clinically stable. This orientation produced real gains in survival and safety, and it remains indispensable. Yet it is increasingly recognised as insufficient.

A contemporary understanding of care places quality of life, emotional wellbeing, social participation and dignity alongside clinical safety rather than beneath it (Brownie & Nancarrow, 2013). This holistic turn is grounded in evidence that health is not merely the absence of disease but a product of biological, psychological and social conditions acting together. Just as the returns to health spending depend on how investment translates into functioning and capability rather than on inputs alone (Anowor, Ichoku, & Onodugo, 2020), the value of residential care depends on whether it sustains a life worth living and not only a body kept alive. Person-centred care has become the dominant expression of this philosophy, asserting that services should be organised around the individuality, preferences and relationships of each resident (Kitwood, 1997).

The difficulty is that the rhetoric of holistic, person-centred care has outrun its delivery. Across well-resourced systems, residents who are physically cared for nonetheless report being lonely, unseen and disconnected (Victor, 2012). In Australia, population data indicate that roughly one in six people aged 75 and over experiences loneliness and around one in nine reports social isolation, with both rising sharply during the COVID-19 period (Australian Institute of Health and Welfare, 2023; Hwang et al., 2020). These are not marginal discomforts. Loneliness and social isolation are associated with depression, accelerated cognitive decline, cardiovascular risk and elevated mortality, with effect sizes that rival established physical risk factors (Holt-Lunstad et al., 2015; Valtorta et al., 2016).

The paradox is stark. A resident can be surrounded by staff, peers and structured activity yet remain emotionally alone. Communication is frequently rushed and transactional, shaped by time pressure and workforce shortages rather than by the resident's need to be heard. Engagement, where it exists, is often delivered as group-based, time-limited activity coordinated for a cohort rather than tailored to an individual. The result is a gap between the clinical adequacy of care and its human adequacy, a gap that residents experience daily but that task-oriented systems are poorly equipped to detect.

Research has illuminated parts of this problem but rarely the whole. A substantial literature examines loneliness interventions, often as discrete programmes evaluated in isolation (Gardiner et al., 2018). A second body of work concentrates on dementia care, where engagement is studied chiefly as a behavioural management strategy (Cohen-Mansfield et al., 2010). A third strand privileges the perspectives of staff, managers and families, treating residents as the objects rather than the authors of knowledge about their own lives (Bourbonnais et al., 2018). Each contributes valuable insight, yet the fragmentation is itself a limitation. Few studies examine social connection, communication and engagement simultaneously, as a connected system, from the standpoint of cognitively intact residents speaking for themselves. This matters because these

three dimensions are not independent. The quality of communication shapes whether connection forms; the depth of connection shapes whether engagement feels meaningful; and meaningful engagement, in turn, sustains the relationships through which residents feel known. Treating them separately risks missing the very interdependence that determines wellbeing. The present study addresses this gap by foregrounding residents' own accounts and analysing the three dimensions together.

This study explores the lived experiences of residents in a residential aged care facility regarding social connection, communication and engagement, with particular attention to how these experiences are shaped by, and expose the limits of, prevailing models of care. In doing so it seeks to translate residents' perspectives into a coherent framework capable of informing practice and policy beyond a single national context.

1.1 Research Questions

RQ1. How do residents experience social connection within residential aged care?

RQ2. What communication barriers affect residents' wellbeing?

RQ3. What engagement challenges limit meaningful participation and quality of life?

2. LITERATURE REVIEW

2.1 Social Connection and Loneliness in Residential Aged Care

Loneliness is best understood not as objective aloneness but as the subjective experience of a deficit between the relationships a person has and those, they desire. Weiss (1973) drew an enduring distinction between social loneliness, arising from the absence of an adequate social network, and emotional loneliness, arising from the absence of a close, intimate attachment. A third form, existential loneliness, has since been added to describe a deeper disconnection bound up with meaning, mortality and the loss of a former self (Bolmsjö et al., 2019). These distinctions matter in aged care because residents may be embedded in a busy social environment yet starved of the intimate bonds that ease emotional loneliness, or conversely retain a confidant yet feel cut off from community.

Cacioppo and Hawkley (2009) reframed loneliness as a biologically consequential state rather than a passing mood, showing that it activates threat-related vigilance, disturbs sleep and dysregulates stress physiology, thereby contributing to cognitive and cardiovascular decline. Hawkley and Cacioppo's (2010) regulatory-loop model further explains why loneliness becomes self-perpetuating: heightened sensitivity to social threat fosters withdrawal, which confirms the very isolation the person fears. In residential settings, bereavement, reduced mobility and institutional routine can each set this loop in motion (Cattan et al., 2005). The health stakes are not abstract; the welfare consequences of poor health among older populations are substantial and cumulative (Anowor, Nwonye, Okorie, & Ojiogu, 2019), which is precisely why loneliness warrants treatment as a care priority rather than an inevitable feature of late life.

2.2 Communication in Residential Aged Care

Communication is the medium through which connection is built or lost, and in aged care it operates across three relationships at once: between residents and staff, between residents and family, and among residents themselves. Each is vulnerable to disruption. Communication with staff is frequently compressed by workload, so that exchanges become task-focused and instrumental rather than relational (Carpiac-Claver & Levy-Storms, 2007). Communication with family can be attenuated by geographic distance and infrequent visits, while peer communication is impeded by the heterogeneity of residents' health, language and temperament.

Several barriers recur in the literature. Sensory decline, particularly hearing impairment, erodes the ease of conversation; cognitive change can slow or fragment exchange; linguistic and cultural diversity introduces further friction in increasingly multicultural facilities; and chronic staffing pressure leaves little room for the unhurried dialogue through which residents feel genuinely heard. The consequence is that communication is too often reduced to information transfer when residents experience its absence as a failure of recognition. Importantly, communication quality is consequential for outcomes and not merely for satisfaction: where it is poor, clinical incidents, distress and strained relationships rise, whereas attentive communication supports continuity and safety (Eklund et al., 2019).

2.3 Resident Engagement and Participation

Engagement in aged care denotes the active involvement of residents in social interaction, activity and decision-making about their own lives (Petriwskyj et al., 2014). It spans a spectrum from simple participation in recreational programmes to genuine influence over the shape of daily life. Evidence consistently links sustained, meaningful engagement to better mood, preserved cognition, reduced reliance on psychotropic restraint and fewer

responsive behaviours. Yet engagement is frequently operationalised in its thinnest form. Activity is commonly organised on a group basis and coordinated for an entire cohort, which improves community atmosphere but struggles to meet individual emotional and cognitive needs (Smit et al., 2016).

Two features distinguish meaningful engagement from mere occupation. The first is individualisation: activity that connects to a resident's history, culture and identity carries emotional weight that generic programming cannot (Cohen-Mansfield et al., 2010). The second is autonomy: residents who help decide how their time is spent experience engagement as self-expression rather than as something done to them. Where institutional routine displaces choice, participation can paradoxically deepen the sense of being managed. The challenge for care systems is therefore not to add more activity but to make engagement personal and self-directed.

2.4 Person-Centred Care

Person-centred care provides the dominant conceptual frame for these aspirations. McCormack and McCance's (2017) person-centred nursing framework locates good care in attributes of the practitioner, the care environment and care processes, foregrounding shared decision-making, knowing the person and sustaining authentic relationships. The VIPS framework expresses a parallel commitment, emphasising valuing people, treating them as individuals, taking their perspective and providing a supportive social environment (Brooker, 2007). Relationship-centred care extends the logic further, insisting that the bonds among residents, staff and families are themselves the vehicle of good care rather than a backdrop to it (Nolan et al., 2004).

The recurring finding across this literature is implementation failure rather than conceptual weakness. Documentation burden, rigid rostering and compliance pressure repeatedly hollow out person-centred intentions, leaving interactions task-focused and time-bound (Moyle et al., 2016). Audits of the VIPS framework, for instance, have found that only a minority of facilities fully adhere to its principles in practice (Rösvik et al., 2013). The gap is not between a good idea and a bad one but between policy and the conditions required to enact it.

2.5 Literature Gap and Conceptual Positioning

Taken together, the literature treats loneliness, communication and engagement as adjacent but largely separate problems, and tends to view residents through the lens of staff, families or programme designers. What is missing is an integrated account that holds the three dimensions together and derives that integration from residents' own testimony. The conceptual position of this study is that social connection, communication and engagement form a single interdependent system underpinning psychological wellbeing and quality of life, and that cognitively intact residents are uniquely placed to reveal how that system succeeds or fails. The empirical work that follows is designed to surface those interdependencies directly.

3. THEORETICAL FRAMEWORK

This study is anchored in three complementary theories that, read together, explain why social connection, communication and engagement are central to wellbeing in later life rather than peripheral comforts. No single theory accounts for the phenomenon; their integration is the point.

3.1 Person-Centred Care Theory

McCormack and McCance's (2017) person-centred care theory supplies the normative foundation. It holds that good care expresses individuality, protects dignity and is enacted through relationships in which the resident is genuinely known. Within this lens, social connection and communication are not amenities but the means by which care becomes person-centred at all. A resident who is not heard cannot be known, and a resident who is not known cannot be cared for as an individual (Kitwood, 1997). The theory thus links the relational dimensions examined here directly to the quality of care itself.

3.2 Social Needs Theory

Weiss's (1973) social needs theory explains the texture of the loneliness residents describe. By distinguishing emotional loneliness, born of the absence of intimate attachment, from social loneliness, born of an inadequate network, it predicts that adding generic group activity may relieve one form while leaving the other untouched. This helps account for the recurring observation that residents embedded in a populated environment can still feel profoundly alone: their networks may be intact while their intimate attachments are not (Drageset et al., 2011). The theory directs attention to the kind of connection residents lack, not merely its quantity.

3.3 Socioemotional Selectivity Theory

Carstensen's socioemotional selectivity theory completes the account by explaining what older

adults prioritise (Carstensen, 1992; Carstensen et al., 1999). As the perceived horizon of time shortens, people shift from information-seeking goals toward emotionally meaningful ones, preferring fewer but deeper and more rewarding relationships. For residents, this implies that the value of interaction lies less in its frequency than in its emotional resonance. A single unhurried, attentive conversation may matter more than many brief, transactional exchanges. The theory reframes residents' requests for someone simply to talk to as a rational expression of late-life priorities rather than as a modest or trivial want.

3.4 Proposed Conceptual Model

Integrating these theories yields a directional model linking the relational conditions of care to its ultimate outcome. Social connection establishes the relational ground; communication quality determines whether that ground is fertile; resident engagement converts connection and communication into meaningful participation; together these sustain psychological wellbeing, which is the proximate determinant of quality of life. The model, shown in Figure 1, treats each stage as enabling the next, so that a deficit early in the chain constrains everything downstream.



Figure 1. Proposed conceptual model linking social connection, communication quality and engagement to psychological wellbeing and quality of life.

4. METHODOLOGY

4.1 Research Philosophy

The study is located within an interpretivist paradigm. Because the object of inquiry is the subjective meaning residents attach to their relationships, communication and participation, knowledge is treated as constructed through residents' own accounts rather than discovered as objective fact. This orientation privileges depth, context and the resident's voice over generalisation, and it shapes every subsequent methodological choice.

4.2 Research Design

A qualitative, exploratory descriptive design was adopted. Descriptive qualitative inquiry is well suited to capturing experiences and perceptions in the participants' own terms while remaining close to the data, avoiding heavy theoretical abstraction at the point of description (Sandelowski, 2000). The design prioritises participant-centred rigour, transparency and analytical coherence over statistical generalisation.

4.3 Study Setting

The research was conducted at a single residential aged care facility in Australia accommodating 42 residents aged between 70 and 100 years. The setting offered access to long-term residents able to reflect on sustained experience of institutional care, while also imposing the single-site limitation discussed later.

4.4 Participants, Inclusion and Exclusion Criteria

Eligibility required residents to have lived in aged care for at least one year and to be free of any diagnosis of dementia or cognitive impairment, ensuring that participants could give informed, coherent accounts of their experiences. Of the 42 residents, 10 were excluded at the outset owing to dementia diagnoses and placement in the dementia support unit, leaving 32 potentially eligible residents. The final sample comprised 10 residents aged 70–100 years, with lengths of stay ranging from 3 to 20 years. Their distribution by age band is summarised in Table 1 and Figure 2.

Table 1. Participant characteristics (N = 10).

P1	88	8
P2	74	3
P3	90	12
P4	77	7
P5	70	8
P6	98	20
P7	100	18
P8	87	11
P9	88	10
P10	74	7

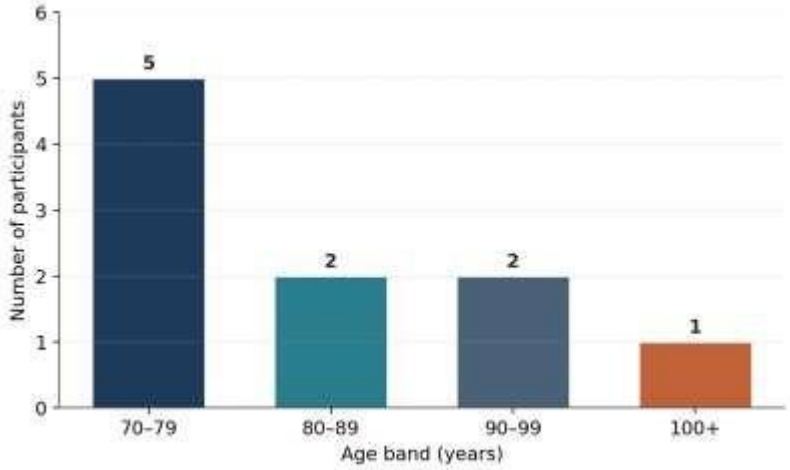


Figure 2. Age distribution of consented participants by decade band.

4.5 Sampling Technique

Purposive sampling was used to select residents who met the inclusion criteria and could provide insightful, coherent responses (Palinkas et al., 2015). This non-probability strategy is consistent with the interpretivist aim of securing information-rich cases rather than a statistically representative sample. A sample of ten was judged adequate for a focused descriptive study, supporting thematic saturation in keeping with established qualitative guidance that prioritises analytical depth over breadth (Guest et al., 2006).

4.6 Recruitment

Recruitment proceeded in three stages. All eligible residents first received written information about the study's purpose and procedures. A brief screening questionnaire was then administered to confirm cognitive capacity, with appropriate allowance for mild, age-typical disorientation. Finally, remaining residents provided written informed consent, including consent to verify the absence of cognitive impairment in their records. Attrition across these stages, owing to declining health, lack of interest or communication difficulty, produced the final sample of ten. Residents unable to write were assisted so that their words were recorded verbatim, preserving authenticity.

4.7 Data Collection

Data were generated using a researcher-developed, open-ended questionnaire designed to elicit detailed accounts of residents' experiences and expectations concerning social connection, communication and engagement. Open questions allowed residents to respond in their own words and at their own length. Content validity was established through expert face validation by three registered nurses with at least five years of aged care

experience, yielding a scale-level content validity index of 0.96, which exceeds conventional thresholds for acceptability (Polit & Beck, 2006). Items judged ambiguous or redundant were revised or removed before administration.

4.8 Data Analysis

Responses were transcribed and analysed thematically following Braun and Clarke's (2006) six-phase approach: familiarisation with the data; generation of initial codes; searching for themes; reviewing themes against the coded extracts and the full dataset; defining and naming themes; and producing the analytic account. Coding was inductive, with codes drawn directly from residents' words rather than imposed from prior theory, and NVivo supported the organisation, clustering and refinement of codes into themes. Theoretical interpretation was reserved for the discussion so that description remained grounded in the data.

4.9 Trustworthiness

Rigour was addressed using Lincoln and Guba's (1985) criteria. Credibility was supported by verbatim recording of responses and close grounding of themes in participants' own words. Dependability and confirmability were pursued through a transparent, auditable coding process and by separating description from interpretation. Transferability is supported by thick description of the setting and participants, while acknowledging that findings from a single site are offered as analytically rather than statistically generalisable.

4.10 Ethical Considerations

Ethical approval was obtained prior to data collection. Participants received verbal and written information and provided written informed consent, with the freedom to skip questions or withdraw at any time. Confidentiality was protected by reporting age in bands, anonymising responses and storing data securely on institutional servers. To manage the potential conflict arising from the researcher's staff role at the facility, independent lifestyle officers, rather than the researcher, facilitated all interactions with participants.

5. FINDINGS

Five themes were generated from residents' accounts. The first four address residents' experiences of connection, communication and engagement and their views on what would change them (RQ1–RQ3); the fifth concerns residents' wish for a stronger voice in their own care. Theme prevalence across the sample is summarised in Figure 3. To protect anonymity, residents are identified by code (P1–P10).

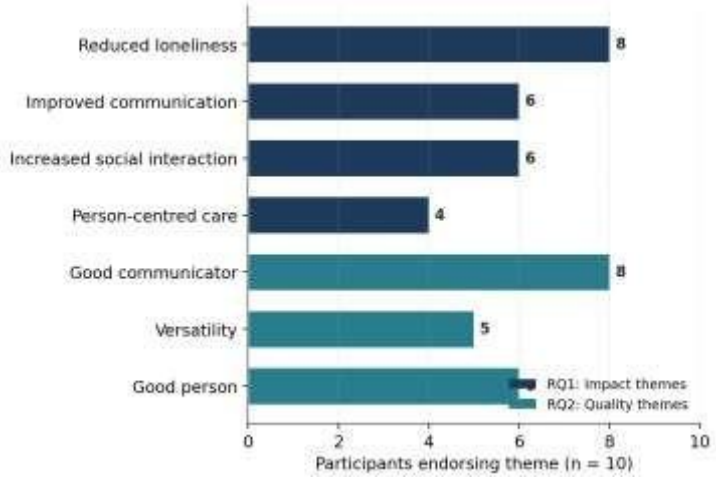


Figure 3. Prevalence of themes across participants (N = 10).

Theme 1: Loneliness and Emotional Isolation

Loneliness was the most pervasive experience reported, named by eight of the ten residents as frequent or constant. Crucially, residents distinguished between being among people and being connected to them. Their isolation intensified at particular moments, especially at night and in the wake of bereavement, when the institutional environment felt least able to console. When asked how often they felt lonely or isolated, residents answered plainly:

"At night, when staff are not calling in."

"When in an environment like this, you often feel isolated."

"More isolated now, as most of my friends are

deceased."

"Every day; [I] don't have any regular family around."

The two residents who did not report frequent loneliness attributed this directly to relational contact rather than to activity or amenity, one noting that some staff were "very good" and another that regular family visits made the difference. The contrast is instructive: what separated the lonely from the connected was the presence of attentive human relationship. Several residents articulated the depth of the experience in longer reflections. P1 observed simply that having experienced loneliness, they knew "how important company is," while P8 anticipated that consistent companionship would mean not "feeling lonely all the time."

Theme 2: Communication Barriers and Feeling Unheard

The second theme centred on communication, and specifically on the experience of not being listened to. Residents distinguished between the volume of interaction, which task-based care supplies, and its quality, which they found lacking. The recurring grievance was being unheard amid routine. As residents put it:

"By listening. Most of the time, no one listens."

"Hopefully, someone to talk to and discuss my problems."

"Yes, someone to confide in — can have a confidential conversation."

Six residents indicated that a dedicated, unhurried listener would transform their experience of communication. P5 longed for "conversations that are not rushed," and P6 noted that being listened to "will help improve communication, as no one listens most of the time." Notably, P9 added a mature qualification, hoping that any such role would "not overwhelm residents," signalling that residents sought attuned communication rather than simply more of it. The sub-themes that emerged, staff availability, generational distance and the feeling of being unheard, all pointed to the same underlying deficit: communication compressed into task delivery leaves little space for recognition.

Theme 3: Limited Meaningful Engagement

The third theme concerned the shallowness of available engagement. Residents valued existing activities but experienced them as routinised, group-oriented and insufficiently personal. Six residents reported limited meaningful social interaction in their current setting. Their hopes for change were modest and concrete, oriented toward individualised contact rather than more programming:

"Someone to break the boredom and add mental stimulation."

"Possible interest or distraction, help with problems, or occasional shopping."

"Someone that you can rely on, especially when you don't have family around."

Residents described engagement that would be reliable, individualised and woven into ordinary life rather than confined to scheduled group events. Sub-themes of routine activity, lack of individualisation and reduced autonomy together indicated that the problem was not the absence of activity but the absence of activity that felt chosen and personal. P2's observation that "many people are confined to their rooms without the opportunity to go outside" captured how thin engagement can shade into containment.

Theme 4: The Need for Personalised Relationships

A fourth theme was residents' desire for genuine, trust-based relationships rather than interchangeable service contacts. Person-centred recognition, being known as an individual with a history, emerged as a distinct and strongly felt want. Residents emphasised one-to-one connection, trust and emotional support:

"Take an interest in my life experience … [staff] should learn more about me."

"Getting to know each individual is very important."

"Needs time to get to know the person."

These accounts reveal a striking and somewhat unusual orientation toward the past. Residents wished to be known through their life histories, not merely managed in the present. P1 hoped a staff member would take "an interest in my early active life and experiences," and P3 stressed that genuine knowing "takes time." The relational depth residents sought, trust, reliability, emotional support, is precisely what fleeting, rotating contact cannot provide.

Theme 5: Desire for Greater Participation in Care Decisions

The final theme, closely tied to person-centred care, was residents' wish for a stronger voice in decisions about their lives. Residents welcomed the prospect of their preferences and perspectives shaping care, and some valued the idea of an additional, independent viewpoint. P8 suggested that "maybe another opinion" could help, while P2's reflection that "feeling wanted is crucial" linked

participation in decisions to a sense of mattering. Residents did not seek control so much as inclusion: to be consulted, to have their histories and preferences inform care, and to be treated as competent partners rather than passive recipients. This desire connects the preceding themes, since meaningful participation depends on being heard, known and engaged.

6. DISCUSSION

The findings are interpreted here through the study's theoretical lenses rather than restated. Across all five themes, a single message recurs: residents who are clinically cared for can remain socially and existentially isolated, and the conditions that relieve that isolation are relational rather than procedural.

6.1 Understanding Loneliness Beyond Physical Presence

Residents' insistence that they felt alone while surrounded by people is exactly what Weiss's (1973) social needs theory predicts. The facility supplied a social network, relieving social loneliness, while leaving emotional loneliness, the absence of intimate attachment, untouched. The intensification of loneliness at night and after bereavement reflects moments when the gap between network and intimacy is widest (Drageset et al., 2011). Socioemotional selectivity theory deepens the reading: as time horizons shorten, residents prioritise emotionally meaningful contact, so a single attentive relationship can outweigh abundant superficial interaction (Carstensen et al., 1999). Their requests for "someone to talk to" are therefore not minor; they name precisely the form of connection late-life priorities make most valuable. Because the downstream health consequences of unrelieved isolation are severe and cumulative for older populations (Anowor, Nwonye, Okorie, & Ojiogu, 2019; Valtorta et al., 2016), addressing emotional loneliness is a clinical imperative and not a soft extra.

6.2 Communication as a Determinant of Wellbeing

Residents experienced communication not as information exchange but as recognition. To be listened to was, in their words, to be able to "confide," to discuss "my problems," to feel that someone took time. This aligns with person-centred care theory, in which knowing the person is the precondition of caring for them: a resident who is not heard cannot be known (McCormack & McCance, 2017). The grievance that "no one listens" therefore describes a failure of recognition rather than of logistics, and P9's hope not to be "overwhelmed" shows residents sought attuned, reciprocal communication (Carpiac-Claver & Levy-Storms, 2007). Communication, on this reading, is a determinant of wellbeing because it is the channel through which dignity, validation and emotional connection are conveyed. Where care systems treat the returns to investment as a function of human functioning rather than inputs alone (Anowor, Ichoku, & Onodugo, 2020), the quality of communicative time, not merely its quantity, becomes the variable that matters.

6.3Engagement as a Missing Dimension of Care

The thinness of engagement residents described reflects a system that prioritises tasks over relationships. Group-based, scheduled activity satisfies the appearance of engagement while missing its substance, which residents located in individualisation and reliability (Smit et al., 2016). Their wish for a dependable person "you can rely on" and for activity tailored to personal interest indicates that meaningful engagement requires continuity and personalisation that rotating, task-driven contact cannot supply (Cohen-Mansfield et al., 2010). Engagement is thus a missing dimension not because facilities do nothing but because what they do is organised around throughput rather than around the resident. Just as the value of human capital lies in how investment is converted into capability and productive participation rather than in expenditure alone (Anowor, Eze, & Ukpere, 2025), the value of engagement lies in whether it converts activity into meaning for the individual.

6.4 Implications for Person-Centred Care

The study's most distinctive finding — residents' orientation toward their life histories — carries direct implications for person-centred care. Residents wished to be known through their pasts, not merely managed in the present, inverting the present- and future-oriented emphasis of much activity programming (Kellett et al., 2010). Authentic person-centred care, on this evidence, requires three things residents themselves named: genuine listening, relationship-building over time, and shared decision-making (Edvardsson et al., 2010). The health and welfare returns to such care are not separable from its economic logic, since systems that strengthen the human functioning of ageing populations enhance both wellbeing and the broader productivity of care investment (Anowor & Ukpere, 2025). Person-centred care fails not for lack of a good idea but where institutional conditions deny staff the time

and continuity these relationships demand (Moyle et al., 2016).

6.5 A Resident Engagement Framework

Synthesising the themes yields the study's principal contribution: a Resident Engagement Framework that treats social connection, communication support and meaningful engagement as three interdependent pillars supporting psychological wellbeing and, through it, quality of life. The framework, shown in Figure 4, is derived directly from residents' accounts rather than imposed on them. Its logic is that the pillars are mutually reinforcing: communication support builds connection, connection makes engagement meaningful, and meaningful engagement sustains the relationships through which residents feel known (Nolan et al., 2004). Weakness in any pillar undermines the others, which is why piecemeal interventions, a loneliness programme here, a communication module there, have limited reach (Gardiner et al., 2018). The framework's claim is that wellbeing emerges from the three operating together.

Figure 4. The Resident Engagement Framework: three interdependent pillars supporting enhanced quality of life.

7. THEORETICAL CONTRIBUTIONS

The study makes three theoretical contributions. First, it extends person-centred care theory by grounding it in residents' own articulation of what being known requires, and by surfacing the unexpected centrality of life-history recognition to that experience. Second, it integrates literatures that are usually kept apart, showing empirically that loneliness, communication and engagement are not separate problems but facets of one relational system, and thereby challenging the fragmentation that characterises current research. Third, it develops a multidimensional, resident-derived framework of wellbeing, the Resident Engagement Framework that operationalises this integration and is portable across care contexts. In combining Weiss's social needs theory, Carstensen's socioemotional selectivity theory and person-centred care theory, the study demonstrates that each illuminates a different facet of the same phenomenon and that their integration explains residents' experience more fully than any one alone.

8. POLICY AND PRACTICE IMPLICATIONS

8.1 For Governments and Regulators

Quality standards and accreditation regimes should measure relational outcomes, not only clinical and safety indicators (Royal Commission into Aged Care Quality and Safety, 2021). If loneliness, communication quality and meaningful engagement are not assessed, they will not be prioritised. Embedding resident-reported relational measures into accreditation would align regulatory incentives with the dimensions of care residents value most, and would make the human adequacy of care visible alongside its clinical adequacy.

8.2 For Aged Care Providers

Staffing and service models should protect time and continuity for relationships rather than treating interaction as a residual of task completion. Providers might designate responsibility for individualised engagement, incorporate residents' life histories into care planning, and design activity around personal preference and choice rather than cohort-level scheduling (Kellett et al., 2010). The aim is not more activity but engagement that is continuous, personal and self-directed.

8.3 For Workforce Development

Training should build communication and relationship-centred competencies, including active listening, life-history work and attuned, non-rushed dialogue, and should equip staff to recognise emotional as distinct from social loneliness (Eklund et al., 2019). Investment in these capabilities is best understood as investment in the human capital of the care workforce, with returns that accrue to residents' wellbeing and to the quality and sustainability of care itself (Anowor, Eze, & Ukpere, 2025).

8.4 Strengths and Limitations

The study's principal strength is its resident-centred standpoint, foregrounding the voices of those who live in care rather than those who observe or manage it, and yielding rich, grounded qualitative evidence with strong content validity. By examining connection, communication and engagement together, it captures interdependencies that single-focus studies miss.

Several limitations qualify the findings. The single-site design constrains transferability to facilities with different operational models or resident profiles (Sandelowski, 2000). The small sample, while adequate for depth, limits breadth. The exclusion of residents with cognitive impairment, though ethically and methodologically warranted, omits a large and important segment of the aged care population whose experiences may differ and whose engagement needs are documented elsewhere

(Bourbonnais et al., 2018). Self-selection may have shaped perspectives, since those who declined could differ systematically from participants. Finally, data collected at a single time point preclude analysis of change over time. These limitations indicate that the findings are offered as analytically generalisable insight and as a basis for the framework, rather than as statistically representative estimates.

9. CONCLUSION

Residents in this study were, by clinical measures, cared for. They were safe, fed and medically supervised. Yet most were lonely, many felt unheard, and few experienced engagement that felt personal or chosen. Their accounts make clear that quality of life in residential aged care is shaped as much by human connection as by physical care, and that technically competent services can still leave residents socially and existentially isolated.

The five themes generated here, loneliness and emotional isolation, communication barriers, limited meaningful engagement, the need for personalised relationships, and the desire for a voice in care, are not separate complaints but expressions of a single deficit in relational care. The Resident Engagement Framework developed from these accounts offers a way to address that deficit directly, treating social connection, communication support and meaningful engagement as interdependent pillars of wellbeing rather than as discrete add-ons.

The future of residential aged care lies not only in delivering safe clinical services but in fostering meaningful relationships, attentive communication and purposeful engagement (Victor, 2012). Residents' own testimony, including their striking wish to be known through their life histories, points the way. Honouring it will require aged care systems worldwide to move beyond task-oriented models toward genuinely relationship-centred care, care organised not around what is done to residents, but around who they are (Brownie & Nancarrow, 2013).

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