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Quality of Life in Nursing Homes: A Theoretical and Empirical Review

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Abstract Quality of life is a complex and multi-dimensional notion which individuals and their families try to attain. This paper provides an overview of quality of life literature guided by Lawton's (1983: 351) "Four Sectors of the Good Life"." This model of organization demonstrates a multidimensional conceptual view of quality of life in which theoretical and empirical domains were recognized in the literature. Parameters used to understand quality of life and how it is studied provide the framework of the review, specifically in the nursing home setting. Quality of life is of growing importance because people are living longer and population projections suggest an increase in elderly over the next few decades will steadily increase.

QUALITY OF LIFE: A MULTIDIMENSIONAL VIEW

Quality of life is important to many individuals, families, professionals and health care researchers because of increased longevity and more Americans aging due to the baby boom generation and immigration. In the Midwest the aging population is increasing and projected to continue (NDcompass.org 2013) and nursing home utilization is higher than in many other areas of the United States (Markeson 2003). Therefore, understanding aspects of nursing homes, such as quality of life is of particular importance to this region of the country. Research suggests the analysis of nursing homes is an important issue because of the interplay between multiple family members before and after nursing home placement (Caron 1997; Janzen 2001; Nandan 2006). This concept is supported by the enmeshed nature of family systems,

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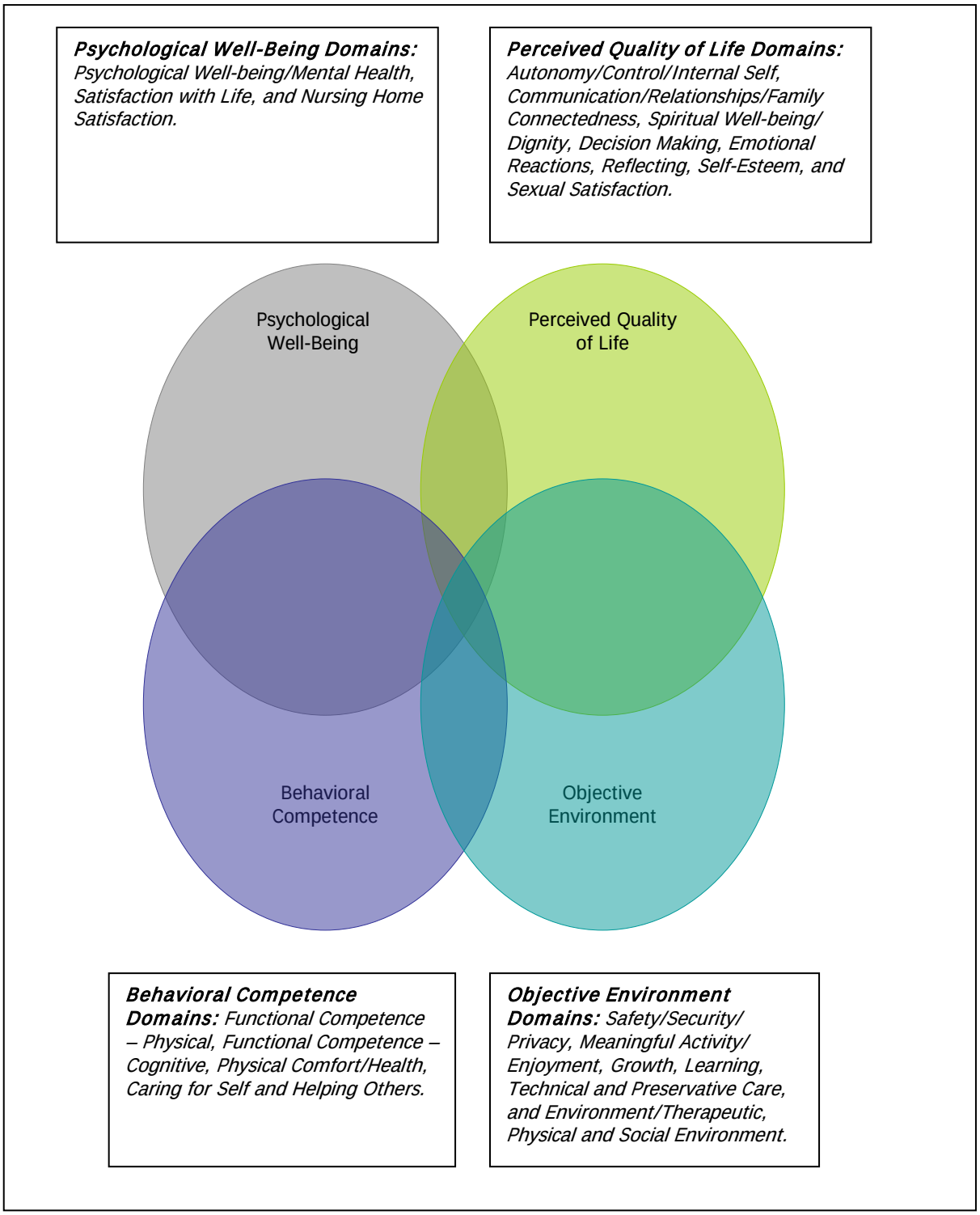
specifically with roles, relationships, involvement, interaction, and caregiving which continue after a change in environment, such as moving to a nursing home (Friedemann et al. 1997; Gaugler 2005; Janzen 2001; McKee, Houston and Barnes 2002; Nandan 2006). Individual family members (i.e., the older adult family member or other family members) are consumers of long-term care, and have expectations for that care and services from the facility. With the changing demographics in the United States, specifically the growing number of elders living to older ages, there is an increased need for nursing homes and simultaneously a need to thoroughly understand family caregiving issues including quality of life. Therefore, this critical review examines quality of life within the context of nursing homes.

This review of literature on quality of life is organized and guided by Lawton's (1983: 351) "Four Sectors of the Good Life." This model of organization allows for a multidimensional view of quality of life, both the theoretical and empirical domains found in the literature. The literature was selected on overarching parameters utilizing Lawton's definition of quality of life which states, "Quality of life is the multidimensional evaluation, by both intrapersonal and social-normative criteria, of the person-environment system of an individual in past, current, and anticipated" (1983: 6). The multidimensional view allows for a critical review of the quality of life literature through multiple domains which postulate what and how quality of life has been examined (See Figure 1).

Quality of Life Literature Emerged from Quality of Care

Quality of life has traditionally been examined through medical and health sciences lenses. Nearly all early research on quality of life during the mid 1980's was reported in medical journals and began to appear in psychological journals by the late 1980's. Research was health related and medically focused due in part to the fact that the data were collected from ill

Figure 1. A Multidimensional View of Quality of Life for Old Adults in Nursing Homes Four Sectors: Model for Conceptual Structure and Literature Content (Lawton's Model).



patients primarily in health care settings (Lawton 1991), with illnesses and diseases such as cancer, (Habu, Saito, Sato, Takeshita, Sunagawa and Endo 1988), hypertension (Wenger 1988), and stroke (Niemi, Laaksonen, Kotila and Waltimo 1988). Therefore, much of the quality of life literature was directly linked to quality of care (Bowers 1988; Challiner et al. 1995; Glass 1988; Grau et al.1995; Janzen 2001; Kane 2001; Lawton 1991; Peak 2002).

Quality of life literature from a medical perspective examines the relationship of quality of life and quality of care (Bowers 1994; Cohn and Sugar 1991; East and Binney 1989; Glass 1988; Kane 2001; Lawton 1991). Kane (2001:297) suggested "a good quality of life (QOL) should be elevated to a priority goal for [long term care] rather than a pious afterthought to quality of care." Similarly, East and Binney (1989) supported the notion that it was appropriate to link quality of care and quality of life, noting that the two concepts are both somewhat similar and also somewhat different issues with older adults. It may be appropriate to examine them both separately and in combination to learn from one another (East and Binney 1989; Glass 1988). Researchers studying quality of care from a medical model have found that good quality of care was a predictor of good or high quality of life. Glass (1988:426) stated, "for nursing home residents, quality of life is largely determined by the quality of care they receive." Several researchers challenged this notion due to the complex nature of the quality of life concept that cannot be adequately examined through medical outcomes alone (Challiner et al. 1995; Farber et al. 1991; Janzen 2001; Kane 2003).

Challiner et al. (1995), while studying quality of life, quality of care, and the relationship between the two, examined the combination of several perspectives (models) of quality of life and quality of care, specifically, the medical, social, and psychological perspectives. Also, policy regulations in health care, specifically with long-term care, suggest objective measures to access quality of care in long term care (LTC) settings (Bowers 1988; Challiner et al. 1995). As

research moved into social sciences and other fields, more emphasis on all facets of quality of life emerged (Lawton 1991). A result of the quality of life and quality of care debate was the complexity of concepts and multiple perspectives which have gained ground in the research literature (Challiner et al. 1995; Cohn and Sugar 1991; Farber et al. 1991; Kane 2003). Therefore, the use of Lawton's multidimensional view of quality of life was identified by the author as a useful framework to build the review structure and organization around because of the multiplicity of lenses.

Lawton's Multidimensional View of Quality of Life

Lawton's (1983) four sectors of quality of life provide a framework for understanding the complexity of the multidimensional domains which include: 1) Behavioral Competence; 2) Perceived Quality of Life; 3) Objective Environment; and 4) Psychological Well-being. Each of these sectors will be described. The four sectors of quality of life can overlap and have been found to be inter-related in the research literature. Lawton (1993) suggested overlap in the multidimensional view of quality of life is present as a result of the nature of sectors and domains which include both objective and subjective perspectives. After each sector is discussed, the multiple domains found in the literature within one of the four sectors of quality of life will be discussed conceptually as well as operationally.

Four Quality of Life Sectors

Much of the quality of life literature captures concepts into "domains" of quality of life (Kane 2001; Kane et al. 2000; Lawton 1991; Stewart and King 1994). Included in these domains is a wide range of subjective aspects of quality of life as well as physical and cognitive aspects, such as cognitive functioning (Stewart and King 1994). Different language (i.e., terminology) is used to examine and measure quality of life concepts within the research literature. However, the domains remain relatively similar (Cohn and Sugar 1991). The content

area of each domain impacts how each concept or domain is defined conceptually and empirically measured. The variation of definition encourages investigator adaptation when studying quality of life (Stewart and King 1994).

The first sector, Behavioral Competence, is defined as aspects of one's quality of life that "...accommodate any external observable facet of a person" (Lawton 1991:8). For example, this could include one's roles, biological health, functional health, cognition, time use, and social behavior. Relevant domains found in the literature and be explained in the upcoming section of this review include functional competence – physical; functional competence – cognitive; physical comfort/ health, caring for oneself and helping others. The second sector is Perceived Quality of Life. This sector includes the "internal structure that parallels directly the sector of behavioral competence" (Lawton 1991:9). Lawton (1991:9) further discussed "...by definition, Perceived QOL is subjective." Examples of perceived quality of life can include pain, cognitive self-efficacy, quality of spare time, and relationships with one's children and spouse. Subjective domains found in the literature include autonomy, control, internal self, communication, relationships, family connectedness, spiritual well-being, dignity, decision making, emotional reactions, reflecting, self-esteem, and sexual satisfaction.

Objective Environment is a third sector and is often associated with "...some forms of behavioral competence and not others and to constitute a subset of important conditions of the dimensions of perceived QOL" (Lawton 1991:10). Lawton (1991:10) stated the "...environment has a more diffuse relationship to dimensions within these sectors." Examples of objective environment could include water and air quality, physical access to the dwelling as well as physical structural aspects within a home, neighborhood, social networks, objective physical entities which enact self-care, intellectual stimulation, and social behavior. Specific domains

include: safety, security, privacy, meaningful activity, enjoyment, growth, learning, technical and preservative care and environment/ therapeutic, physical and social environment.

The fourth sector of Lawton's is Psychological Well-being and is more than the "sum of competences and satisfactions" (Lawton 1991:11). The self is made up of a complex model which includes all past, present, and future experiences. Several examples of the psychological well-being sector include mental health, cognitive judgments, life satisfaction, and emotions. The domains reviewed in the literature, to be discussed, include psychological well-being/ mental health, and satisfaction with life, and nursing home satisfaction.

SECTOR 1: BEHAVIORAL COMPETENCE

Functional Competence - Physical

Functional competence or physical functioning is one aspect of quality of life of great importance for older adults in the nursing home (Stewart and King 1994). Functional competence is usually an objective measure ranging from activities of daily living and upper and lower body movement, such as walking or climbing stairs. Functional competence might include an older adult's ability to go places inside and outside of the nursing home facility (Gaugler et al. 2004).

Functional competence is conceptually discussed in the literature as possessing medical limitations (Mosher-Ashley and Lemay 2001). One reason older adults live in a long-term care facility is due in part to several physical limitations. Physical limitations have been found to lead to lower life satisfaction as well as less control over one's life. Conversely, physical limitations have been found to be unrelated to one's level of life satisfaction. (Mosher-Ashley and Lemay 2001). It is important to note differences in how an individual perceives their own functional competence which, in turn, greatly impacts how they perceive other aspects of their quality of life.

Kane et al. (2000:10) discussed functional competence of nursing home residents as defined in the following way: "Within the limits of their physical and cognitive abilities, residents are as independent as they wish to be." This definition of functional competence allows the resident to be the point of reference rather than just a subjective or objective measure of the researcher. Functional competence as a domain of quality of life in regard to the research of Kane and colleagues (2000), allows the resident to determine of their status allowing for the individual perception. The concept of functional competence is similar to but not the same as one's functional abilities (Kane et al. 2000).

Challiner and colleagues (1995) examined dependence as a functional competence concept of quality of life. This research used a life history approach beginning with interviews and followed up with structured questionnaires to examine functional competence, specifically dependence (Challiner et al. 1995). Using this mixed-method approach of biographic data collection to gather the life history of residents and using structured questionnaires, Challinger and authors (1995) may have facilitated a more critical response from the participants. Specifically, dependence and independence of residents was measured using the Barthel index score to assess dependence on activities of daily living (Mahoney and Barthel 1965). Morale was measured using Lawton's (1972) dimensions of morale index. The findings suggested quality of life is good if a resident has high morale and high independence with their activities of daily living (ADLs) (Challiner et al. 1995).

Functional Competence - Cognitive

Functional competence regarding cognitive status or one's abilities is often conceptually defined as cognition (Lawton 1993). Cognition or a person's ability to think and reason on many levels is often measured by the Mini-Mental State Examination (Folsgtein, Folstein, and McHugh 1975). About one-half of the nursing home population has a dementia related illness

(Markeson 2003). Therefore, it is important to include these residents and their families in research because they make up a large proportion of nursing home residents. However, much of the research literature does not have residents included in the study with cognitive limitations (Aller et al. 1995; Iwasiw, Goldenber, Bol, and MacMaste 2003; Peak 2000). Many issues prohibit cognitively impaired residents and their families to be included in research studies. A possibility for why people with dementia are not included is vulnerability issues. Getting adequate informed consent forms to satisfy Institutional Review Boards (IRB) might be difficult with persons who have difficulty fully understanding the research and consent process.

Even with these reasons discussed, there are a few research studies that have included people with dementia in their samples (Kane et al. 2000; Ready, Ott, Grace, and Fernandez 2002). Researchers often use proxies (i.e., a substitute or representative) with elderly populations, specifically in nursing homes due to cognitive impairment. A proxy for elders living in nursing homes is often close family or staff member(s) of the nursing home facility (Totten 2004). Kane (2001) included persons with dementia in the study of quality of life from the original data set with the presented study. Data was collected from residents even if an impairment of cognitive functioning occurred during the interview process. Response categories for identified dementia-related residents were dichotomous rather than the Likert scales were used with the rest of the sample.

Physical Comfort and Health

Stewart and King (1994) and Kane (2001) discussed physical comfort as a domain of quality of life. These researchers conceptually define the domain “pain in general” or to have “specific pain”. Physical comfort, therefore, can range depending on the severity of the discomfort. Specific pain could include back pain or chronic leg pain, for example. The severity or intensity can vary and the extent, duration, and frequency of the pain may or may not

interfere with one's daily activities potentially resulting in a change of one's quality of life within this domain.

Health is a related but different domain of quality of life from physical comfort (Stewart and King 1994). Health or perceived health can include current health, future health, past health, or one's resistance to illness. This domain has been assessed by asking an older adult (i.e., individual perception) if they are satisfied with their level of health or more objectively their health may be observably rated or with the use of medical records (Stewart and King 1994). Therefore, the concept of health has been measured both objectively and subjectively.

Caring for Self and Helping Others

Two domains of quality of life which have inductively emerged from qualitative study includes caring for oneself and helping others (Aller and Coeling 1995). Orem's Theory of Self-care was relevant to Aller and Coeling's (1995) research findings concerning "self help," which is a concept they used to define the meaning of quality of life from the resident's perspective. Aller and Coeling (1995) discussed how Orem's theory of self-care explained "self-help" as being an important aspect of resident quality of life. However, Aller and Coeling did not go beyond mentioning the theory. By doing so, the reader cannot interpret conclusive connections with how the researchers felt Orem's theory was applicable to their findings or to quality of life of the resident in a nursing home.

SECTOR 2: PERCEIVED QUALITY OF LIFE

Role of Individual Perceptions

Debate surfaces as to whether quality of life is the same for one person as it is for another (Bubolz and Sontag 1993; Cohn and Sugar 1991; Lawton 1991). Within a family, members can have differing perceptions based on individual experiences and one's point-of-view (Bubolz and Songtag 1993; Cohn and Sugar 1991). The individual's perception is

important and influential through social interaction within a family and society. Therefore, a discussion of how an individual or the "self" perceives aging and quality of life is important before moving forward with multiple perceptions.

George Herbert Mead (1934) discussed the social self as being influenced by others around oneself and within oneself. He stated, "self is constituted not only by an organization of these particular individual attitudes of others, but also by an organization of the social attitudes of the generalized other or the social group as a whole to which he belongs" (Mead 1934:158). When understanding family level perceptions, an examination of the individual, a person who is part of the family "organization" is also necessary to consider. Families are constructed of individuals bringing more than one perception to a phenomenon, incorporating two, three, or more family members depending on how many are a part of the family unit.

Approaches to examining perceptions vary and several researchers utilized qualitative methods when, for example, examining domains of autonomy, control, and the internal self as aspects of quality of life (Aller and Coeling 1995; Bowers 1988; Friedemann et al. 1997; Iwasiw et al. 2003; Peak 2000). This is a consistent mode of inquiry for the interpretive science perspective (Brown and Paolucci 1979). Qualitative research provides for the researcher(s) opportunity to build rapport with participants, whereas with quantitative research methodologies building rapport is more difficult and usually does not occur due to the structure or nature of the data collection methods. Qualitative approaches often involve small samples of participants who are interviewed, observed, or "visited" in their own environment (Copeland and White 1991) as is often done with residents of a nursing home. The engagement of researcher and participant can build trust, unfolding a wealth of personal information about the phenomenon, and reveal personal meanings regarding one's quality of life which may have not been understood otherwise.

Minimal empirical research has examined how an older adult resident living in a nursing home perceived their own quality of life (Cohn and Sugar 1991). However, many studies have identified factors of self-perceptions impacting outcomes on health in old age (Deeg and Kriegsman 2003; Ginac, Cott and Badley 2000; Hong, Zarit and Malberg 2004; Levy, Slade and Kasl 2002). Levy et al. (2002) longitudinally examined six waves of data collection to understand how 433 participants viewed their own health. Specifically, the research found positive self-perception of one's aging benefits their functional health in old age (Levey et al. 2002). This suggested an individual's own perceptions of self can be both positive and negative as they age. This adds complexity for understanding multiple perspectives because individuals in a family system may likely perceive aging and aspects of aging quite differently than those of their family members.

Autonomy, Control, and Internal Self

Conceptually, autonomy has been defined in many ways including authenticity, independence, informed consent, and self-rule (Kane 1991). The concept of autonomy is heavily embedded in philosophy and means decision making is made at the direction of one's self (Kane 1991) However, as Collopy (1988:316) pointed out, self-rule can be further elaborated or paraphrased into "a whole family of value-laden ideas, including individual liberty, privacy, free choice, self-governance, self-regulation, and moral independence."

Autonomy is an important aspect of quality of life due to the fact that throughout their lives, people want to have the capacity to make decisions or have a sense of control over what they are doing and the decisions they make (Boyle 2004; Cohn and Sugar 1991; Stewart and King 1994). Maintaining a sense of personal responsibility and having personal choices and values is important during our life span and is important during later life as well (Boyle 2004). The need for personal control with older adults is associated with many losses, such as

independence (as opposed to an increase in dependence) or loss of the mind (Lachman, Ziff and Spiro 1994).

Several researchers have examined autonomy as an aspect of quality of life (Boyle 2004; Kane 2001; Kane 1991; Kane et al. 2000; Guse et al. 1999; Stewart and King 1994). The measure of autonomy (i.e., personal choice) and individuality was used in Kane (2001), Guse et al., (1999), and Cohn and Sugar (1991). In Kane's (2001) discussion of her research, as well as in the work of many other researchers (Hofland 1988, 1990; Seligman, 1976), autonomy is important to an elder's quality of life. Kane (1991, 2001), Guse and colleagues (1999) and Cohn and Sugar (1991) suggest encouraging residents to utilize personal choices in their daily lives and maintaining individuality as a resident in a nursing home setting are important to an elder's quality of life. Specifically, Kane (2001:298) stated there are important contributions of "...this property of autonomy to the well-being, mental health, and even physical health of cognitively intact older people."

Maintaining identity or a sense of personhood is another concept within the domain of autonomy (Iwasiw et al. 2003). Iwasiw and colleagues found listening to residents and their family members helped the staff (e.g., nurses) identify information to improve resident quality of life by promoting individualism. The findings of this research (Iswasiw et al. 2003), and other research (Cohn and Sugar 1991; Duncan-Myers and Heubner 2000; Ratz et al. 1999) support that residents need to be treated with respect and this can be achieved by getting to know the resident as a person. Iwasiw et al. (2003) further discussed enhancement or improvement of quality of life in nursing homes can be achieved by providing individualized care, acknowledging personal histories, values, and preferences of the resident. Therefore, quality of life in the nursing home is about identifying personhood within each resident.

Autonomy was examined in a study by independence and dependence of 286 older adults examining their ability to adapt to chronic illness (Gignac et al. 2000). Gignac and colleagues defined autonomy by a common definition used in research which is the ability to make decisions for oneself, to have personal choices and values (Boyle 2004). Older adults' perceptions of autonomy including independence, dependence, helplessness, emotional reactivity and coping efficacy were measured and outcomes found varied. The loss of independence and feelings of the development of dependence were highly correlated with one another. These findings suggest the amount of independence or feelings of dependence one perceives affects an elder's perceptions of coping efficacy and feelings of helplessness.

Cohn and Sugar (1991) examined patterns of perceptions between family and residents in accordance with quality of life. Five out of eleven decision-making items used in this study used to measure autonomy, identified similarities between residents and family. Residents reported issues of autonomy important to their quality of life included access to a telephone, a place to be alone, transportation availability, choice of roommates, and having keepsakes nearby. Family members agreed with residents on four of five issues, (though not in the same rank order) with the exception of choice in food replaced transportation as being important to quality of life in regard to making autonomous decisions. These findings suggested dimensions of autonomy were operationally measured in the study but differed by population (Cohn and Sugar 1991).

Communication, Relationships, Family Connectedness

Communication, relationships, and social networks were identified and related quality of life domains. Each domain has been found to be significantly related due to the interactions between an older adult and family members within the conceptual definitions and dimensions.

Communication can be conceptually defined as the verbal and nonverbal interactions between two or more people (Cohn and Sugar 1991). Communication has also been defined conceptually as the ability to communicate with others (Aller and Coeling 1995). Relationships with various people, including family and friends, was found in the literature as an important domain of quality of life. Kane et al. (2000:10) conceptually defined relationships with nursing home residents as, "residents engag[ing] in meaningful person-to-person social interchange with other residents, staff, and/or family and friends outside the facility."

Family connectedness was another distinct concept of relationships and was defined as those families who maintained an emotional bond with the resident, as well as provided regular updates concerning family events (Friedemann et al. 1997). A number of studies (Aller and Coeling 1995; Cohn and Sugar 1991; Friedemann et al. 1997) examined comparable domains of quality of life because the concepts have similar definitions.

Residents and family members had similar perceptions in regards to the importance of quality of life within the social-emotional environment, specifically to the role of relationships with relatives (Cohn and Sugar 1991). Respondents were asked to rate the importance of relationships with relatives, friends outside the facility, friends inside the facility, and facility staff. Both groups of respondents, family members and residents, reported relationships with relatives to be a critical aspect to their quality of life. More than 50 percent of the resident respondents felt their relationships with all relatives, friends inside and outside of the facility, and staff were all important to quality of life (Cohn and Sugar 1991).

Less Frequently Discussed Quality of Life Domains

Much less research has examined and explored additional quality of life domains including: 1) Spiritual well-being; 2) Dignity; 3) Decision-making; 4) Emotional reactions; 5) Reflecting; 6) Self-esteem; and 7) Sexual satisfaction.

Spiritual Well-Being and Dignity

Spiritual well-being and dignity as domains of quality of life have had very little attention given to them. However, both of these domains have been found to be important domains of quality of life to nursing home residents (Kane 2000, 2001, 2003). Conceptually, spiritual well-being is defined as whether or not the "resident's needs and concerns for religion, prayer, mediation, spirituality, and moral values are met" (Kane 2000:10). Dignity is conceptually defined as the level to which "residents perceive their dignity is intact and respected, and they do not feel belittled, de-valued, or humiliated" (Kane 2000:10).

Decision-Making, Emotional Reactions, and Reflecting

Similar to the domains of spiritual well-being and dignity, decision-making, reactions, and personal reflections have had very little research and attention given to them (Iwasiw et al. 2003). Through an exploratory and inductive study, decision-making in regards to moving into the nursing home, emotional reactions to the nursing home, and personal reflection emerged from the data (Iwasiw et al 2003). However, these three domains of quality of life have yet to be empirically measured.

Self-Esteem and Sexuality

Two more domains of quality of life found in the literature have limited research are self-esteem and sexuality (Stewart and King 2003). Self-esteem is conceptually defined as one's general esteem, physical esteem (e.g., appearance and competence), social self-esteem, and one's intellectual self-esteem. Dimensions of this domain can include satisfaction with self or the agreement of statements about one's self. The sexuality domain of quality of life is conceptually defined as both sexual functioning and intimacy (Stewart and King 2003). Both self-esteem and sexual satisfaction do not have validated empirical measures.

SECTOR 3: OBJECTIVE ENVIRONMENT

Meaningful Activity and Enjoyment

Meaningful activity is an important aspect of quality of life (Kane 2000; McKee et al. 2002). Meaningful activity can be found in the literature with varying conceptual definitions, such as pleasant events (McKee et al. 2002), involvement in activities, (Tornatore and Grant 2004), or the actual language of meaningful activity (Kane 2000). Conceptually defined, meaningful activity is the perception that life is complete with meaning and interesting things which one sees or experiences (Kane 2000).

When an older adult moves to the nursing home, meaningful activities do not necessarily cease (Kivnik 1993; McKee et al. 2002; Ryan and Scullion 2000). The nature of an elder's activity level and roles before the move to a nursing home will affect their activity level after the move as well. For example, a resident who actively engages in activities around them might continue to do so, or if they are more of a spectator, they may choose to maintain that role in their day-to-day activities (Kane 2000). According to Kane (2000:297), "still others, such as Kivnik (1993) has demonstrated, can make meaningful contributions to their families, the nursing homes, or the community at large despite their physical dependency on care."

Meaningful activity is measured in various ways. McKee et al. (2002) assessed meaningful activity based on a 53-item inventory called the Pleasant Events Schedule – Alzheimer Disease (PES-AD). This scale, designed by Teri and Logsdon (1991), was designed to help family caregivers identify activities appropriate and enjoyable for those older persons with Alzheimer's disease. McKee et al. (2002) altered the inventory and streamlined it to 39-items which were then rated four times. The ratings included: "whether or not the 'opportunity' for the activity to take place occurred; secondly, the 'frequency' with which it occurred during the last month (none/few/often); and thirdly, whether or not the activity had been 'enjoyed in

the past' by the cared person; fourthly, whether or not the activity was 'enjoyed now' by the cared persons" (p. 741). The researchers found use of the PES-AD was a reliable measure for examining quality of life within the domain of meaningful activity.

Safety, Security, and Privacy

Safety, security, and privacy are three domains found in the quality of life literature with little attention, but are domains of quality of life important to nursing home residents (Kane et al. 2000; Kane 2001; Lawton 1991). Kane et al. (2000) defines safety and security in the following way: "Residents feel secure and confident about their personal safety, ability to move about freely, the security of their possessions and the good intentions of staff. They know and understand the rules, expectations, and routines of the facility" (p. 10). Privacy is conceptually defined as: "Residents have bodily privacy, can keep personal information confidential, can be alone as desired, and can be with others in private" (p. 10).

Technical and Preservative Care

Bowers (1994) suggests the caregiving typology of technical and preservative care is a way to understand quality of life because of the connection to quality of care from the resident's family perceptions and from staff. Conceptually, the caregiving typology of care was used to study quality of life. An attribute to this domain is a constructed concept and measure. However, it has yet to be validated for its present use. The study focused on family perceptions, consequently finding family members consider most tasks the nursing home's responsibility. Also suggested, is that family members do feel responsible to act as a manager by monitoring and evaluating their family member's quality of care. Family members feel it is their duty to teach individualized resident care to staff in order to obtain high quality of care and promote the resident's "self". Using a measure, such as the caregiving typology, assumes

quality of care is an adequate measure of quality of life. This approach combines two different concepts, quality of life and quality of care for nursing home residents (Bowers 1994).

Growth and Learning

Growth and learning are two domains which emerged from Friedmann, Montgomery, Maiberger and Smith's (1997) inductive research on quality of life. These domains suggest that if residents can continue to learn and grow while living in the facility, their quality of life is maintained (Friedmann, et al. 1997). Both of these domains have yet to be empirically studied and there are no validated measures found.

Environment: Therapeutic, Physical and Social

Guse and Masesar (1999) found that being able to enjoy nature, being outside, and the ability to help others (Guse and Masesar 1999:536) contributed to having higher quality of life from the resident's point of view. Cohn and Sugars' (1991) research also focused on individual perspectives of residents and their family members' views on quality of life specifically within the nursing home environment. Differences in perceptions of the physical and social environment were found between the residents and the family members. A possible explanation for these may stem from variation between a resident's role in the nursing home environment and the role of family member(s) living in another environment outside of the nursing home. Resident and family perceptions were quite positive and similar for overall perceptions of quality of life. However, greater variations were found in specific content areas of quality of life. Participants were asked the question, "Do residents feel they have good quality of life?" The majority of respondents (73 %), including the resident, agreed their life in the institution was "contented, comfortable, and meaningful" (Cohn and Sugar, 1991: 36). In response with the content domain of care, residents focused primarily on activities contributing to their quality of life, followed by basic needs, and then professional care next. Researchers

found the majority of residents felt physical problems were "not at all" an important part of their quality of life. Family members, however, held the perception that physical problems are an important aspect of quality of life for residents in a nursing home (Cohn and Sugar 1991).

SECTOR 4: PSYCHOLOGICAL WELL-BEING

Psychological Well-Being

Psychological well-being is the remaining quality of life outcome to be understood. Psychological well-being is typically another subjective measure of well-being of one's life within the research (Hickey and Bourgeois 2000). Included in this concept can be depression, anxiety, anger or irritability, loneliness, and stress (Gaugler et al. 2004; Hickey and Bourgeois 2000; Sterwart and King 1994). Psychological well-being can also include an older adult's interest in life or an assessment of their overall outlook on life (Stewart and King 1994). Psychological well-being can encompass aspects of mental health and social well-being and is sometimes discussed as simply "well-being" in the literature (Gaugler et al. 2004).

Researchers have found psychological well-being of nursing home residents significant and an important domain of quality of life in nursing homes (Gaugler et al. 2004). Several researchers have discussed the importance of understanding depression or psychological well-being and its relationship to quality of life. Gaugler and colleagues (2004:773) stated, "social relationships and interactions also appear to be integral to the well-being of residents; results indicate higher levels of social cohesiveness in the long-term care environment, participation in activities, and close relationships and interactions with staff and family are strongly correlated with positive mood and lower levels of depression." These findings illustrate the conceptual overlap with many domains of quality of life in one of the four sectors as they were discussed in the literature.

Farber et al. (1991) examined depression and emotional well-being as an important measure and aspect of quality of life. Good quality of life in this research was measured by the quality of relationships between the nursing home resident and family member(s). This research specifically found significant correlation between the quality of relationship between the nursing home resident and family member impacting the resident's emotional well-being. Suggesting the *quality* of relationship rather than the frequency of interaction between a family member and resident is related to higher levels of emotional well-being. Therefore, Farber et al. (1991) suggested by examining (or measuring) the quality of family interactions rather than frequency of interactions are more important to improving resident well-being and decreasing depression.

Nursing Home and Life Satisfaction

Life satisfaction is another important aspect of psychological well-being as it relates to quality of life in the nursing home setting. (Moser-Ashley and Lemay 2001; Tornatore and Grant 2004). The concept of satisfaction can include current, past, or present life in the nursing home setting (Hickey and Bourgeois 2000; Snowdon 1986; Stewart and King 1994).

Farber et al. (1991) and Mosher-Ashley and Lemay (2001) examined nursing home life satisfaction and operationally measured for depression, hopelessness, and life satisfaction to assess quality of life. Social support from family and friends (e.g., help with tasks or help with finances) was examined and was found to be associated with increased life satisfaction. Another finding of this research was that life satisfaction is closely associated with an older adult's physical health. Many of the residents had age-related medical problems but did not have low life satisfaction; this suggests that life satisfaction closely related to mental/emotional health and not just physical health. The researchers (Farber et al. 1991; Mosher-Ashley and Lemay 2001) measured quality of life by assessing emotional and physical well-being with social

support thereby bridging quality of life measures through physical health (i.e., a medical model), emotional health (i.e., a psychological model), and social support (i.e., a social model).

Nursing home satisfaction has historically been measured through the examination (or through the surveying of) of a family member rather than the resident. The Ohio Nursing Home Resident Satisfaction Survey and the Ohio Nursing Home Family Survey are among the few large scale surveys allow the resident voice to speak to their satisfaction of the nursing home (Straker, Ehrichs, Ejaz and Fox 2002; Straker and Ejaz 2001). Other long-term care and acute care settings (i.e., home healthcare) have been more progressive with asking the resident or patient about life satisfaction. However, little is known about nursing home life satisfaction from the resident and family members combined as an aspect of quality of life.

Quality of Life Sectors and Domains are Inter-related.

Aspects of quality of life can overlap and be related (Lawton 1993). The multidimensional view of quality of life examines the domains within the four sectors to allow for interrelationships or overlap to occur. As introduced earlier, this can be a result of including the subjective nature of quality of life meanings to objectively examining the phenomenon (Lawton 1993). Lawton (1993:12) suggested, "[a] …reason for giving objective measures of person and environment a major position in quality of life is that such measures provide an anchoring point from which individual perceptions may deviate." It is this deviation in perceptions provides a range of meanings and overlap of these meanings to the literature. As a result, multiple domains and concepts have been examined for this literature review.

Mosher-Ashley and Lemay (2001) discussed how moving into a long-term care facility can be challenging to an older person's sense of autonomy, independence, and sense of control. Adjusting to staff or family members completing daily tasks for the resident can be difficult. These researchers found residents who viewed living in the facility as a "benefit" had

high life satisfaction. Residents who felt they were forced or had to live in the long-term care facility were less satisfied with their lives (Mosher-Ashley and Lemay 2001).

Good quality of life in this research was defined as the quality of relationship between the nursing home resident and a family member (Farber et al. 1991). Significant correlations between the quality of relationship with the nursing home resident and family member with nursing home life satisfaction were found. These findings suggest improving quality of family interactions and the type of interaction, rather than frequency of interactions alone, is more influential to improving quality of life, specifically the measure of life satisfaction as an outcome of one's quality of life.

Quality of life as a more complex whole, rather than single domain inquiry was discussed in the literature with several indexes being discussed (Arling et al. 2005; Challiner et al. 1991; Farber et al. 1991; Guse, et al. 1999). Several measures were found that were used to examine quality of life in nursing homes (Challenger et al. 1991; Farber et al. 1991; Guse, et al. 1999). Guse et al. (1999) used two scales. These scales include the Rated Latitude of Choice Scale and the Quality of Institutional Life Scale. The latter of the two seems an appropriate scale for measuring quality of life for institutional elders. However, the scale is yet to be validated. Farber et al., (1991) uses quantitative relational measures, specifically the Quality of Relationships Scale.

The Cornwell-Brown Scale for Quality of Life (2002), a validated quality of life measure, has been used to assess community dwelling of older adults with dementia. The scale includes ratings negative and positive affectivity, physical complaints, and satisfaction (Ready et al. 2002). Future research could adapt this scale to nursing home setting and include residents with dementia.

The measures or scales researchers have utilized to examine quality of life have had limited or no validation. Quality indicators (QIs), such as those collected through the Minimum Data Set (MDS), have paved the way for a systematic source of quantifying quality in nursing homes (Arling et al. 2005). The QIs identified and collected in the MDS are important for quality assessment of nursing home residents. However, the focus remains primarily on quality of care (QOC) factors rather than QOL.

DISCUSSION

To date, conceptual and theoretical literature dominated the quality of life literature. However, quality of life research needs to move in a direction linking theory and empirical research (Lawton 1991). Literature gaps could be eliminated by building a conceptual model from system theories and through empirical testing the quality of life model. Two suggested frameworks, family systems theory and human ecological theory, have surfaced from the review. Much of the quality of life literature either was at a conceptual level or empirical level, with even less research explicitly bridging the two together (Caron 1997; Copeland and White 1991; Nandon 2006).

Methodologically, using multiple family members versus a single family member or one older adult to provide a perspective of quality of life could be used. With the addition of dementia as a factor in nursing homes residents, multiple perspectives could move research from an individual voice or one person representing another family member, as with a single "proxy," to future research including multiple informants. Further in-depth empirical approaches to studying families are suggested. Family gerontological research in nursing homes settings with multiple family member voices was missing in the literature. Implications include future research from multiple family perspectives by developing sound operational measures for dyadic and triadic family levels. More thorough and complex empirical research

approaches to understand the "whole" family unit, congruence, and quality of life should be completed.

According to Bubolz and Sontag (1993:419), "human ecology theory is unique in its focus on humans as both biological organisms and social beings in interaction with their environment." Bubolz and Sontag (1993:437) stated, "quality of life of humans is defined in terms of the extent to which basic needs are met and values realized." Different systems that might interact with one another could suggest families, nursing home residents, and the nursing home environment are interconnected systems in the nursing home environment.

Only a few researchers have moved beyond a two person family perspective, adding depth to include three perspectives (Pruchno et al. 1997). Assessing aspects of resident quality of life requires a multiple perspective view because many facets contribute to one's quality of life (Abeles et al. 1994; Lawton 1997). Therefore, an expanded conceptualization of quality of life in nursing homes is needed to fully understand the nursing home experience of residents today and in the future when even more elder adults rely on this form of long term care.

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