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Quality of life in nursing homes: results of a qualitative resident survey

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Abstract
Purpose The growing importance of residential nursing care has been accompanied by an increasing demand for instruments measuring quality of life in nursing homes. Quality of life is a complex construct with both subjective and objective aspects that does not lend itself to being determined by a single measure. The aim of this study was therefore to identify dimensions of life that nursing home residents perceive as having a particular impact on their overall quality of life.
Methods Data were obtained from 9 men and 33 women from eight nursing homes by means of semi-structured narrative interviews. The interviews were analyzed using the documentary method.
Results Ten central dimensions of subjective quality of life were derived from the interview data: *social contacts, self-determination and autonomy, privacy, peace and quiet, variety of stimuli and activities, feeling at home, security, health, being kept informed,* and *meaningful/enjoyable activity*. Some of these dimensions are multifaceted and have further subdimensions.
Conclusion The aspects emerging as relevant to residents' subjective quality of life extend far beyond care- and health-related aspects. Nevertheless, some of the quality of life dimensions reconstructed are within the direct influence of the home (e.g., *variety of stimuli and activities* or *being kept informed*) and can possibly be improved by attending to the residents' objective situation.

Keywords Nursing home · Subjective quality of life (QoL) · Qualitative study · Old age

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Introduction

For some time now, gerontological research has dedicated considerable effort to identifying the general characteristics of a "good life" in old age. However, despite a wealth of studies on quality of life (QoL) in late adulthood, there has been little research focusing specifically on frail elder people and those who spend their final years in a nursing home [1–4]. One reason for this lack of research is that due to the nursing home's specific character as a "total institution" or enclosed microcosm [3, 5–8], gaining access to the institutionalized group of nursing home residents has proved to be difficult. Acclaimed ethnographic studies, such as those by Stannard [8], Henderson [9], and Gubrium [7], have attempted to assess and understand the world of the nursing home and the perceptions of its residents, but their perspectives on QoL were not the focus of this research [8–10].

QoL in older adults is a generally perceived as a multidimensional construct [11, 12]. At the very least, a distinction between "subjective" and "objective" aspects is made. Objective QoL primarily refers to quality of conditions (e.g., nutrition, objective functioning, housing) and to standards defined by experts; it is usually assessed by external rating. Subjective QoL refers to quality of experience (e.g. satisfaction with conditions, well-being), is by definition evaluated against individual standards, and measured by self-report [13]. Different approaches are applied in different

contexts; those taken in nursing homes generally reflect the specific aims of QoL assessment: to monitor the overall quality of the facility and to inform treatment and care decisions. Data on objective QoL provide useful information about whether benchmarks are being met, identifying areas in which conditions can be adjusted to meet these standards. However, individual needs, preferences, and satisfaction with conditions are not addressed. Yet, these aspects may provide crucial information with respect to treatment adequacy and potential for improvements within the microsystem of the nursing home. As such, the distinction between subjective and objective QoL does not reflect a more or less correct modeling of "reality," but complementary methodological approaches.

In recent years, media reports focusing on deficits and scandals in nursing home care have sparked considerable public interest in the QoL among nursing home residents [14, 15]. As a consequence, there has been an increasing demand for instruments capable of measuring this construct [16]. Previous studies assessing the QoL-priorities of nursing home residents have been subject to various methodological limitations [17]: (1) In many studies, researchers have asked representatives of nursing home residents (relatives, staff), rather than the residents themselves, what is important to them. Moreover, the responses of residents and their representatives have not always been analyzed separately [15]. (2) Research on QoL in nursing homes is often limited to care- or health-related aspects and underestimates the multidimensional character of QoL [4, 12, 18]. Although care-related aspects are of great relevance, they reflect only one of the dimensions to which nursing home residents assign subjective importance [17, 19]. The same applies when analyses are limited to aspects that can be directly influenced by the institution [20]. (3) Many of the quality assessment instruments administered in nursing homes focus on "objective living conditions" such as room environment, temperature, and noise [21]. In this approach, QoL is assessed in terms of objective measures of certain observable conditions of life. Having an external observer assess these conditions can shed light on the level of their presence or absence and thus be a first step in remediating possible deficits. However, the importance that individual respondents assign to these components remains unclear, as does their personal satisfaction with their circumstances. Moreover, discrepancies are often found between expert judgments and the reports of nursing home residents themselves [22–24]. Residents' subjective perceptions thus provide important supplementary information and broaden the perspective on the quality of an institution [12, 18, 20, 25]. (4) Irrespective of whether QoL is considered from an objective perspective (external assessment) or a subjective perspective (individual perception), most of the instruments used in previous quality assessments have been based on criteria drawn up by experts, for example, the Long QOL scales [18]. As such, investigations of QoL dimensions have been based not on empirically derived criteria, but on "a selection of theoretically reasonable dimensions" [3]. From this perspective, QoL is a construction on the part of experts that is assessed in terms of theoretically derived indicators. However, this approach risks overlooking dimensions relevant for the life satisfaction of residents and/or overestimating the importance of less relevant aspects [17, 26–28].

This context provided the background for a qualitative study that will ultimately form the basis for the development of a survey instrument to measure subjective quality of life in nursing homes (QUISTA; English title of the instrument: Subjective Quality of Life in Nursing Homes). As stated above, QoL is a complex construct that cannot be directly determined by a single measure, it needs to be operationalized in terms of a variety of individual dimensions. We sought to identify these dimensions by means of qualitative interviews, a methodological approach in which residents are asked to reflect on what constitutes life satisfaction for them. This article summarizes the key results of this qualitative study and presents the dimensions of subjective QoL that were elicited as being important to nursing home residents.

Methods

Data were collected from nine men and 33 women living in eight nursing homes in Berlin and surroundings by means of semi-structured narrative interviews. Access to the nursing homes was facilitated by a nonprofit roof organization that serves 48 independent nursing homes throughout the Berlin area as a service organization. Through several centrally organized information sessions, we were able to recruit eight long-term nursing care homes to participate in the study. Residents' participation was voluntary; each potential participant was informed about the background, methods, and objectives of the interviews and about data protection issues in a personal consultation before giving their informed consent.

Qualitative samples are not expected to meet the standards of statistical representativity. Rather, the aim is to capture the full range of possible orientations by means of interviews. We sought to obtain a sample covering a broad range of theoretically relevant socio-demographic characteristics by implementing a targeted and criteria-based recruitment procedure [29], but representativity was not an aim of the sampling procedure. In addition to the classic socio-demographic variables, we considered variables that play a role in the specific life context of the nursing home to be theoretically relevant, such as living situation

(single/shared room), required level of care (care level 1–3), and length of residence in the home. Table 1 shows the distribution of the sample on key characteristics. In order to prevent selective recruitment of participants by nursing home staff, interviewees were recruited directly by the interviewer in the context of a participant observation—that is, while residents were going about their everyday lives. During this participatory observation, the interviewers presented themselves to residents as researchers who wanted to understand life in a nursing home. They participated in various nursing home routines, such as mealtimes, activities, and walks. As they stayed in a home for several days, the interviewers were able to establish good personal contacts with residents. The conditions for participation were permanent residence in the nursing home and the ability to express oneself verbally.

Table 1 Basic socio-demographic data

Basic data on the interviewees		
	N	%
Total	42	
Gender		
Male	9	21.4
Female	33	78.6
Required level of care*		
None	2	4.8
Care level I	28	66.7
Care level II	8	19.0
Care level III	3	7.1
Not specified	1	2.4
Age		
Up to 80 years	14	33.3
>80 years	19	45.2
>90 years	9	21.5
Length of residence in home		
0–6 months	7	16.7
>6 months–1.5 years	12	28.6
>1.5–4 years	15	35.7
>4 years	5	11.9
Not specified	3	7.1
Mean (months)		[27.1]
Median (months)		[24.0]
Education (highest school level completed)		
None/elementary school	7	16.7
Non-academic track	27	64.2
Academic track	6	14.3
Not specified	2	4.8

* In Germany, people assessed as being in need of care receive care services that are regulated by law. The degree of impairment and the care services provided increase with each level of care (I, II, III)

Data collection

In order to ensure that our investigation was not limited by theoretical assumptions, we chose a reconstructive approach, in which the residents themselves reflect on what constitutes their QoL. This approach takes account of some of the unique features of the specific interview situation: The realms of experience (life worlds) of the residents differ fundamentally from those of the interviewers—as well as from one another. Thus, the method selected needs to facilitate the systematic exploration of this life world and to help researchers to understand it without applying their own structures of relevance. Moreover, the residents themselves might not always be consciously aware of what constitutes QoL or life satisfaction for them [2]. A qualitative method that is able to access knowledge located in the domain of implicit knowledge or unreflected behavior constitutes a valuable approach for analyzing potential dimensions of subjective QoL [30–32]. Semi-structured narrative interviews render it possible to elicit personal experiences that document residents' underlying orientations and structures of relevance, irrespective of whether or not they are consciously aware of them [34].

In our study, we asked participants to first tell the interviewer about their life in general, the time before they entered a nursing home, and the time after admission (*biographical narrative*). This very open first phase was followed by *specific narrative questions* relating to unpleasant and pleasant life situations in general and within the context of the nursing home. The interview was concluded by a number of *emotion-related questions*. Table 2 presents the respective questions included in the semi-structured interview.

All interviews were conducted by two trained and experienced interviewers (two of the authors); four supervision sessions (chaired by the principal investigator) were held regularly throughout data collection in the field in order to ensure on consistent procedures in interviewing and unexpected situations in the field. Interviews were tape recorded and transcribed. The aim of the transcription process was to conserve as much information as possible beyond the spoken word: To record not just *what* was said, but *how* it was said. The transcription rules applied covered emphases and accentuations, but also pauses and their length.

Analysis

The interview transcripts were analyzed using the documentary method [30–32]. The key objective of this approach is to distinguish the literal, explicitly stated meaning from the implicit "documentary meaning," which provides insights into interviewees' atheoretical knowledge. Researchers need

Table 2 Questions and narrative stimuli in the semi-structured interview

Phase	Questions from the interview script	
Stimulus for biographical narrative	I would like you to tell me about your life. Start by telling me about the time before you moved to the nursing home. And what about when you moved to the nursing home—please tell me about that.	
Narrative questions	Questions relating to both pleasant and unpleasant situations in life in general	(1) When you think about your earlier life and about your life today, so about your life as a whole, what makes your life good? Tell me about good things and experiences.
		(2) When you think about your earlier life and about your life today, what makes your life as a whole difficult? Tell me about situations or experiences that have caused you concern.
		(3) If you think back on all the good and bad things in your life that you have just told me about: Which of these things are most important to you?
	Questions relating to both pleasant and unpleasant situations in the home in particular	(1) Is there anything in the nursing home that causes makes you to feel ill at easediscontent? Can you remember situations here in the nursing home in which you did not feel very much at ease particularly content?
		(2) Is there anything about home life that makes you feel particularly at ease causes you to feel particularly content? Can you remember situations here in the home in which you feel/felt particularly content? Can you remember a situation in which you thought, "Oh, this is nice"?
		(3) And what is the most important thing for you here in the nursing home?
Emotion-related questions	(1) Do you sometimes feel sad here? When is that?	
	(2) Can you remember the last time you felt really happy here?	
	(3) Can you remember the last time you got angry here?	

to consider not only what is explicitly stated in the interview, but also what is indirectly documented about the interviewees and their collective orientations or habitus. The focus of interest is not on the truth content of what is said, but on the orientations conveyed in respondents' accounts. The experiences described are thus "documents" (expressions) of orientations that researchers can then reconstruct by using appropriate methods and instruments. To this end, the interviews were tape recorded, transcribed, and then interpreted in a multistep procedure comprising a "formulating interpretation," a "reflecting interpretation," and a "case description:"

- Formulating interpretation:
  - selection of relevant excerpts from individual interviews
  - thematic summary of these excerpts in whole sentences and in the interpreter's own words
- Reflecting interpretation:
  - formal interpretation and differentiation of text genres
  - explication of an orientation framework within which the themes are addressed
- Comparative analysis
  - individual cases are compared with one another

The outcomes of this process were then reviewed by a four-person team, comprising four of the authors.

Results

A total of ten core dimensions of subjective QoL in nursing homes emerged from the documentary method: *social contacts, self-determination and autonomy, privacy, peace and quiet, variety of stimuli and activities, feeling at home, security, health, being kept informed,* and *meaningful/enjoyable activity (see Fig. 1)*. Clearly, some of these dimensions are within the direct sphere of influence of the nursing home as an institution; others can only be influenced indirectly, if at all. Some dimensions are multifaceted and have further subdimensions; some interact or overlap with one another. In this section, we will illustrate the methodological approach taken by presenting one of the dimensions identified—social contacts—in some detail and providing relevant quotes from the interviews. The other nine dimensions are then presented in less detail.

Social contacts

The dimension of "social contacts" featured prominently in the interviews and proved to be very complex (Fig. 2), with four subdimensions being identified: *social climate*,

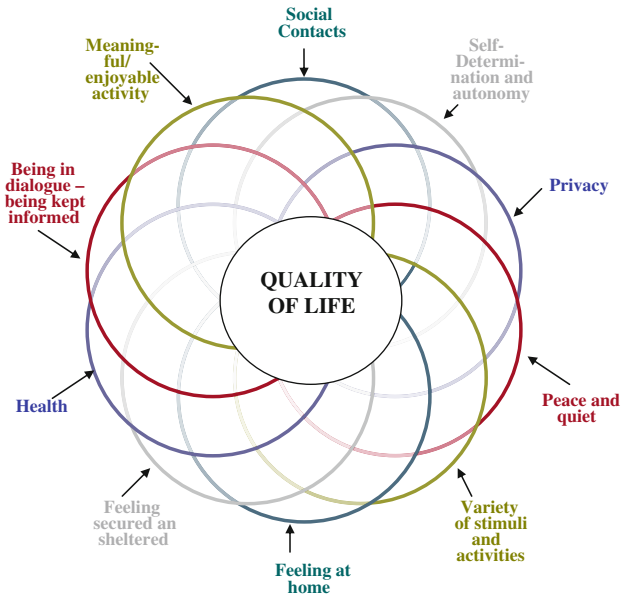

Fig. 1 Core dimensions of subjective quality of life in nursing homes

contact with other residents, *contact with nursing and care staff*, and *contact with one's family*.

Social climate refers to the interpersonal atmosphere of the home, with high importance being assigned to friendly and harmonious relationships. Residents who feel the atmosphere of a home to be unpleasant may choose to move to another home, as documented in the following excerpt:

> Interviewer: What was your experience of the transition from your apartment to the home?
> Interviewee: Well, you know, it was, um, I had to get used to it at first, but for the simple reason that I was, I was 100 % certain that I wasn't going to stay there. That was quite clear to me from the start. Everything was fine. The carers were good, the food was good. But I just didn't get on with the people there. It was—you know, it was like a wall. Yes. There was just no, no connection among the residents, and so I said to myself, the first opportunity I get, I'm getting out of here. [18/119–125]

A pleasant home climate was so important for this interviewee that other positive features of the first home were not able to compensate for deficits in the social climate.

A directly related subdimension that should, nevertheless, be considered independently concern personal *contact with other residents*. The interviews revealed that residents have different expectations regarding the quality of social relations in the home—from having someone to chat with, being able to do things for others, or sharing enjoyment and interests with others to having somebody they can trust.

Not all nursing home residents find it easy to make new friends and acquaintances. However, especially those who were lonely before moving into the home may experience a considerable improvement in their situation:

> Interviewee: "And since I've been here I've stopped having anxiety attacks like I had at home, you've probably not experienced that yet, but it's terrible, really, you can't imagine. It's a nervous thing. But I haven't had any since being here. And that's also because you're always together with other people, because you're not alone. It's very important, like I said, that you can do things for other people, that you can talk to other people." [16/259–265]

If, however, residents do not experience this kind of social exchange in the nursing home, there is a risk that the feeling of loneliness may persist despite the increased opportunities for contact with others. Another interviewee

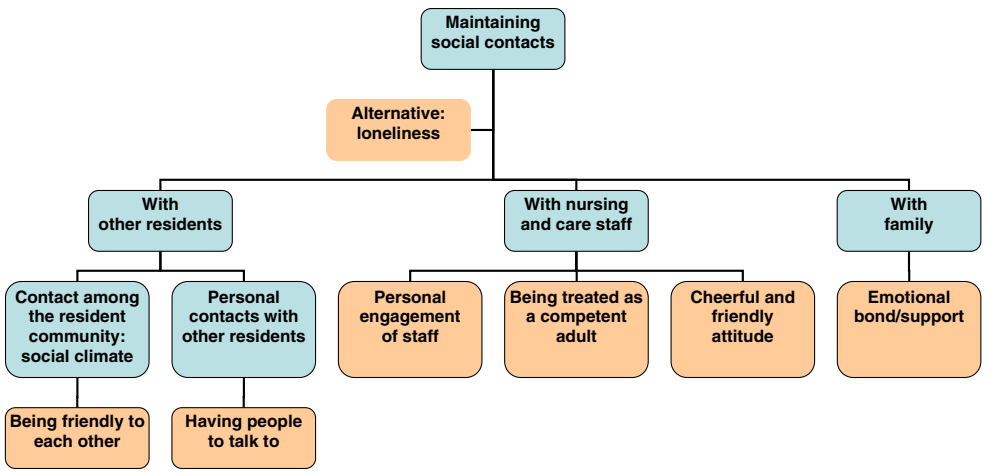

Fig. 2 The dimension "social contacts" and its subdimensions

sums up her experience as follows: "But now I'm here and, to all extents and purposes, I'm still alone. It's not what I was expecting" [15/312–313].

Contact with nursing and care staff is another subdimension of "social contacts." The main orientation emerging here is that it not considered sufficient for nursing staff to simply perform their job in a professional manner. Rather, personal commitment, engagement, empathy, and dedication are either expected or at least highly valued.

> Interviewee: "No, not really, no, it's all little things that I always really … well, you see, I'm a patient who's very grateful for a lot of things, yes a nurse brought me a little pot for a cactus that was just standing on the piece of paper it was wrapped in when my son brought it, you know, the thorns, a little cactus pot, and then they brought me one of those, um, lids from a jam jar out of the kitchen here and we put it in that and then one day a nurse saw it and she says Mrs N, look what I've brought you today, I've brought you a little pot, for the- well, she didn't know, she just saw that I needed it, it's just little things like that that make me happy, it's not big things that give me a boost now, but little things, mhm, I can be quite delighted if someone does just a little thing for, somehow, so that I know, ah you're welcome here, you can really accept it, I know that then." [41/412–425]

When asked what made her life good, this bed-ridden interviewee responds that the "little things" in life make her happy. She gives the example of a plant pot: If the pot is seen in purely material terms, it is indeed just a little thing. However, the interview documents another cause of her pleasure: The nurse's capacity to bring her a present without being asked, to see a need, to be attentive, and to show empathy. Other interviewees see being treated by staff as competent adults as a particularly important aspect of their interpersonal relationships; others consider it decisive that staff are kind and friendly toward residents.

As the fourth and final subdimension of social contacts, regular *contact with one's family* and visits from one's children can play an important role for social well-being in home environments that are often experienced as being rather anonymous. Residents who are no longer in contact with their own family sometimes experience considerably low levels of satisfaction:

> Interviewee: "When I see them celebrating their birthdays, and in come the relatives, sisters, brothers, and all the aunts and uncles, and yet I have [stressed] *nobody*. I have [stressed] *nobody*, not a single person." [3/197–200]

Self-determination and autonomy

As health-related impairments often increase with age, making it impossible for older adults to continue living independently at home, the move to a nursing home providing the necessary infrastructure and care may in fact help them to regain a certain amount of self-determination. From this perspective, moving to a nursing home can enable older adults to live relatively independent and self-determined lives.

> Interviewee: "And I wouldn't have been able to manage on my own any more, and I didn't want to, um, get on my son's nerves, that was also a reason." [16/548–549].

On another level, the feeling of self-determination also applies to residents' relationships with nursing and care staff. In this context, the want to make one's own decisions means not only being treated as a competent adult, but also, for example, having a say in the time that care services are provided.

> Interviewee: "So, Mrs A, today, today we're going to have a shower. I look, and say what, why today? I say, no, I say, not with me. I [laughing] I say, not today, I'm not showering. I say, I'd like to be told at least one day in advance that we're having a shower tomorrow, and at about what time." [14/970–975]

Privacy

Being dependent on nursing care often implies invasions of personal space, and violation of modesty boundaries can compromise quality of life. The concept of privacy also includes the inner world of emotion and thought. We were able to reconstruct four domains of privacy from the interviews: Two that are proximal to the body (using the toilet and personal hygiene) and two that are more distal (eating and private space). Where the domains thematized by respondents involve direct interaction between residents and staff, the quality of this relationship proved to have a significant influence on the QoL experienced—particularly where using the toilet and personal hygiene were concerned. Overall, the accounts indicate that invasions of personal space are associated with unpleasant feelings such as shame and disgust and are often subject to taboos [33].

> Interviewee: "… with number ones and number twos I still have a feeling that's still not good//mhm//it's not worked out yet, it's not, I've been training for a year or for more than a year it's and I'm still at well not at the point that I always manage, you see, and

that's a major thing I ought to say, that the nurses and the others, that they ought to be a bit more understanding there, it's a really bad, yes, well, it's not been said yet, everything, yes, you can tell them that, yes, as I said, the whole thing with number ones and number twos, it's a really bad thing//…" [29/280–289]

Peace and quiet

In the narrow sense, the need for "peace and quiet" simply refers to residents' need not to be disturbed by noise. In a wider sense, it concerns not only the noise and activity level of everyday home life, but also the need to spend time alone—and thus impacts interviewees' relationships with other residents and with staff as well. Specifically, it is important that residents are able to withdraw and spend time by themselves, if they choose so. Another important meaning of "peace and quiet" for nursing home residents is being able to determine their own level of activity and to "take it easy" at times—not having to be "doing something" all of the time.

Interviewer: "And what do you particularly like about being here in the nursing home?"
Interviewee: "Oh goodness, I'd say the peace and quiet. I need my peace and quiet. I go to the activities they offer here in the home normally, I do quite like going to them sometimes. It's a bit of a change. But otherwise I'm just glad to have a bit of peace and quiet." [17/59–64]

Variety of stimuli and activities

Events and festivities organized by the home not only have entertainment value. They also give residents the feeling of belonging to a group and provide an opportunity to break out of the routine of everyday home life. The same applies to day trips and walks.

Interviewee: "Well the most important thing here in the home, the most important thing is that you, above all [I coughs] in my opinion the activities are very important. Singing, for example that's important, that's, yes, and what else is it they do, oh we do gymnastics and, goodness, all sorts and memory training that's really important too. So activities in general are certainly important here, so that's And above all for the folks who can't walk any more, so that they're looked after too and that they get out and aren't just sitting in their rooms all the time (..)." [16/304–309)

Feeling at home

The importance of "feeling at home" could be derived from a variety of interview statements. It can relate to staying in a familiar area in which an older person has spent much of his or her life and where friends and acquaintances still live, feeling close to one's relations, even if they live elsewhere, having one's own room with familiar furniture and photos, or a feeling of belonging.

Interviewer: "Is there anything here in the home that makes you feel particularly at ease?"
Interviewee: "Mhm. Well. As I said, the whole environment to start with, yes, the, the feeling of being at home yes [clears throat] then, as I said, a mate here, a mate there, just off- off the cuff I could name you three three um um three men who um live on the premises here yeah, or um acquaintances, and women too, it's not like that, no: but the feeling of being at home is definitely worth a lot." [18/264–269]

Security

Two aspects of the "security" dimension emerged from the interviews: On the one hand, feeling financially secure and independent (i.e., existential security), on the other, feeling safe and sheltered. The latter includes health-related security in the sense of not having to worry about what will happen in case of emergency, but knowing that someone is always close by to help, and thus feeling protected.

Interviewer: "When do you feel particularly at ease here, or in which situations?"
Interviewee "Well, on the one hand, as I said, the fact that there's a certain feeling of security here (.) that you feel more secure, you know, I feel, I'm calmer inside//I: Hm//yes? That I'm um, well, looked after, let's say, or protected//I: Hm//Because when, because I often get palpitations" [14/709–714]

Health

The interviews documented four main aspects of health. *Mobility* plays a key role for nursing home residents in the context of health and illness. Remaining physically mobile is critical for independent and self-determined living and is generally seen as a prerequisite for being able to enjoy the remaining years of one's life:

Interviewee: "The the few years I have left to live, I want to enjoy them. I can still walk, more or less, well um what you can call walking. You don't need to put me in a chair yet, a wheelchair or one of them

one of them frames. Yeah I do and wash myself and everything" [18/159–162]

The importance of *sleep* was also mentioned repeatedly. For some residents, the night can be a lonely part of home life that is plagued by negative thoughts. Yet, restful sleep is viewed as a critical factor in a person's well-being. Physical *pain* is an equally relevant aspect. Pain impacts not only physical, but also mental well-being. However, it is important that health not be equated with physical integrity: Intact *cognitive abilities* are also a crucial aspect of a healthy body. Losing one's cognitive abilities, experiencing other residents losing theirs, and even the fear of that loss can be very painful processes.

> Interviewee: "… essentially you can only do all that if you don't have Alzheimer's, if you don't have Alzheimer's yet or Parkinson's, and the confusion isn't there, then you can still decide for yourself where to get out and where to go, but that's when it gets bad, and I'm a bit scared of that,//mhm//when none of that's possible any more …" [39/253–257]

Being in dialog: being kept informed

Another subjective QoL dimension that emerged from the interviews was residents' need for information, of being notified and advised on important matters, of being kept informed, and treated as competent adults. At the same time, residents need to know what is going on in the home on a day-to-day basis and, for example, which events are on offer. Another aspect of this dimension is that residents expect staff to be familiar with their likes and dislikes and to be aware of what is important to them.

> Resident: "The doctor drops by every now and then. He just turns up, and then he's off again. You're not prepared for him coming and then of course you forget what you wanted to ask him (…)" [17/85–88]

Meaningful/enjoyable activity

The interviews also revealed that resources such as being able to impart meaning to one's activities or experiences can help to increase subjective QoL. Meaning can be generated by activities that make residents feel useful and engaged and/or that give them pleasure, enjoyment, or other positive feelings.

> Intervierwer: "And then I'd like to know, can you tell me what quality of life is for you personally?"
> Interviewee: "In my eyes, quality of life is when you do something, something meaningful, especially when you can make others happy, that's, that's the meaning of life after all, when you do some- especially do something that makes you happy and that can also make others happy (.) [16/251–256]

Discussion

In the context of the present qualitative study, we elicited ten QoL dimensions that nursing home residents subjectively experienced as central to their well-being: *social contacts, self-determination and autonomy, privacy, peace and quiet, variety of stimuli and activities, feeling at home, security, health, being kept informed,* and *meaningful/enjoyable activity*.

The following discussion of these dimensions is limited to studies that have placed an explicit focus on the subjective perspective on QoL in nursing homes. However, in many of these previous resident and patient surveys, the dimensions of QoL assessed were theoretically derived. For example, the study by Estermann and Kneubühler [35] was based on five factors of subjective QoL: *empathy, autonomy, privacy, security*, and *acceptance* [3, 36]. Whereas autonomy, privacy, and security correspond directly with three of our quality dimensions, acceptance and empathy did not emerge as independent dimensions in our study. They are, however, included in the dimensions (or subdimensions) of *social contacts, privacy,* and *feeling at home*. The dimensions theoretically generated by Estermann and Kneubühler thus seem to represent a somewhat smaller range of the domains than those emerging as relevant in our own study.

Qualitative studies seeking to elicit life quality dimensions from the perspective of elderly nursing home residents are not common. The findings of the mixed-methods studies conducted by Kane and colleagues [18, 37] (with the dimensions of *comfort, functional competence, autonomy, dignity, privacy, individuality, meaningful activity, relationships, enjoyment, security*, and *spiritual well-being*) coincide with our own findings in many respects. However, there are some differences. While Kane and colleagues also identify "meaningful activity" as a relevant dimension of QoL, in their work this dimension refers to activities organized by the home or to predefined activities such as "getting outdoors as much as you want." By contrast, our participants focused more on activities that give them a feeling of being useful and/or give them pleasure, enjoyment, or other positive feelings—reflected in the dimension of *meaningful/enjoyable activity*. Likewise, our subdimension of "social climate," which concerns social relations with *all* people in the home, is not explicated in Kane's studies. Further aspects differing from Kane's approach are *self-perceived cognitive ability* and *being kept informed*.

As in our study, Robichaud et al. [28] used a semi-structured interview approach and found the quality of relations to peers and caregivers to play a decisive role in promoting residents' well-being. Mattiasson and Andersson [38] came to a similar conclusion in their mixed-methods study: Attentive and caring nursing staff and good relationships with other residents were at the top of residents' priority lists. However, most of the questions in the instrument used in this latter study had predefined response formats: The only open-ended questions related to certain narrowly defined domains of home life (*autonomy, security, social relations, activities,*, and *routines*).

Rather than approaching QoL from a comprehensive perspective, the studies described above considered only those dimensions that are within the sphere of influence of nursing homes. As such, the quality criteria identified as relevant are only partly overlapping with those that emerged from our study.

In an ongoing Europe-wide quantitative study on the care-related QoL of clients in institutional care, Saks and colleagues [20, 39] have shown that QoL in nursing homes depends on factors that extend far beyond care- and health-related aspects. Indeed, they conclude that the quality of interpersonal relationships (e.g., "listening if client raises concerns"), as also reflected in our "social contacts" dimension, is of preeminent relevance. However, these authors have not yet attempted a systematic and comprehensive compilation of (meaningfully) distinguishable quality criteria.

Given the different methodological approaches taken, the comparability of results reported in the studies described above with our own results is limited. Furthermore, the *labels* used do not always clarify the specific *content* covered by each dimension. Moreover, in view of cross-national differences in health and nursing care systems as well as in conditions of socialization and biographical trajectories, it is debatable to what extent the dimensions identified in other countries can be transferred to nursing home residents in Germany. Despite these limitations, many of the dimensions utilized or found in previous studies were also reconstructed from our interviews. This holds particularly for the domains of social contacts, self-determination, activities, security, health, and meaningful activity. Only the domain of *religion/spirituality* did not in our study emerge as relevant enough to be considered an independent dimension in our study. One reason for this finding might be that our interviews were conducted in Berlin and surroundings, an area that is traditionally less religious than other parts of Germany. Other domains, such as care and food, are represented as subdimensions of cardinal dimensions, such as "contact with nursing and care staff" (care) and "self-determination" (food). Finally, we reconstructed some dimensions that have not been explicitly featured in previous studies: "social climate/home atmosphere," "privacy," "cognitive abilities" as a subdimension of health, "peace and quiet," and "being kept informed" (including "staff awareness of likes and dislikes").

Beyond these substantive results, our findings underscore previous evidence that QoL in nursing homes needs to be conceptualized from a multidimensional perspective. Note that not all dimensions can always be clearly distinguished from one another; there may be some overlap [40]. For example, social contacts and activities can also be experienced as "meaningful/enjoyable activity." In the same vein, residents may expect to experience self-determination in their interactions with caregivers. In order to avoid misunderstandings and inaccurate interpretations, researchers must therefore pay careful attention to the specific contents of the categories used in quality evaluations.

As this study took a qualitative approach, it is unable to provide insights into the statistical importance of the aspects of QoL identified. Rather, it takes a first step in this direction by presenting an empirically derived pool of potentially important dimensions, the interrelationships of which will need to be determined in a follow-up study. Likewise, a quantitative assessment is needed to measure satisfaction with each of the life domains identified as important by the participants in this study. A questionnaire designed on the basis of these findings is currently being validated in a larger Germany-wide sample. We hope that this questionnaire will foster a new perspective on subjective QoL in nursing home residents.

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