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INTERCULTURALITY AND QUALITY OF LIFE IN RESIDENCES FOR SENIORS IN CATALONIA[1]

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Abstract: Protocols for evaluating social services consider several variables to measure the quality of their services, but not always attaches importance to intercultural competences of social service professionals. Focusing research in the area of residences for seniors this study analyzes the imagery of cultural otherness present in patients and workers, and tries to identify the significant variables that determine and/or influence coexistence and the appearance of conflicts arising from cultural diversity communication.

Keywords: *Multiculturalism, Old age, Quality of life.*

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BACKGROUND AND STATE OF THE ART

"*The demographic changes of recent years increased life expectancy and a falling birth rate have prompted a very significant increase in the social influence of seniors in our society. This increase has been accompanied by a greater diversity in the group of seniors in terms of age, health and social status, and by the introduction of a new discourse: that of the active seniors*".[2]

For the purpose of this research, short- and medium-term **demographic projections** must be taken as a point of departure to make it possible to hypothesise as to a notable increase in the potential users of the social services, and at the same time an increase in the percentage of immigrant staff in Residences for Seniors. While we cannot go into details here, the main conclusions presented by the Statistics Institute of Catalonia[3] indicate that Catalonia will have a population of some 8 million inhabitants by 2021, and that this figure will be close to 9 million inhabitants by 2040. Birth and death rate figures point to a cyclical trend in natural growth, which will fall in the short- and medium term, reaching a forecast minimum around 2025, after which it will begin to increase again for 10 years. Hence, the increase in the Catalan population cannot be expected to hinge on natural growth, but rather on the immigrant population. Over the 2002-2008 period the population increased considerably, driven by the boom in external migration, with an annual median of 122,000 net migrants. On the other hand, the projected results indicate that the demographic pyramid will evolve towards a more older-aged distribution in the medium term, and above all in the long term. Thus, the number of inhabitants aged 65 and above will grow throughout the projection period, albeit with particular intensity at the end of the fourth decade of the 21st Century, by which time the generations born in the nineteen-seventies will have reached retirement age. When these generations do reach retirement age, the population aged 65 and above will surpass historic maximums, and the relative weight of the elderly

[2] These words introduce the policy targeting seniors of the Ministry of Social Welfare and Family of the Government of Catalonia. http://www20.gencat.cat/portal/site/bsf/menuitem.c7a2fef9da184241e42a63a7b0c0e1a0/?vgnextoid=0231a4b1e51a4210VgnVCM1000008d0c1e0aRCRD&vgnextchannel=0231a4b1e51a4210VgnVCM1000008d0c1e0aRCRD&vgnextfmt=default

[3] Institute of Statistics of Catalonia (2009). Population projections for 2021-2041 (basis 2008). Main results. Section 7. Barcelona.

population will exceed 25% by 2040. On the other hand, life expectancy is expected to continue to rise, contributing to an increase in the elderly population and more particularly in the number of inhabitants aged 80 and above. In the year 2011, the number of inhabitants aged 65 and above was 1,245,700, constituting an increase of 71,000 inhabitants in absolute terms and 6% in relative terms. All the age groups that comprise the population aged 65 and above will undergo positive growth, but growth will be strongest in the oldest age group, i.e. 80 years and above, which will increase by 12% in a mere 3 years.[4]

Alongside the demographic projections, the policy implemented by the Ministry of Social Welfare and Family of the Government of Catalonia should also be taken into account, and more particularly so following the approval of **Law 12/2007, of October 11, on social services** (http://www.gencat.cat/eadop/imatges/4990/07284064.pdf). Section III of its Foreword states that "*the social services are one of the systems of the welfare state, together with the social security, the health system, the education system, employment policies, housing policies and other public actions. The social services are the ensemble of interventions whose objective is to guarantee citizens' basic needs, paying attention to the maintenance of their personal autonomy and promoting the development of personal competencies in a framework of respect for people's dignity*". Indeed, the transformations and the new realities in Catalan society (the diversity of families and cohabitation units, the new poverty pockets, the risk of inequalities, the situations of dependence in which many people live and the ensuing complexity for families, as well as changes in the job market, are but some examples) pose new challenges to social cohesion and inclusion that require the planning, evaluation and coordination of the services guaranteed through the social services. Thus, article 5 of the Law states that the public system of social services is governed by the principles of universality, equality, public responsibility, solidarity, citizens' participation, globality, subsidiarity, prevention and community dimension, the promotion of social cohesion, harmonisation, coordination, personalised and all-inclusive care, respect for people's rights, the fostering of personal autonomy, efficiency, efficacy, quality and continuity of services... This explains the interest of analysing, from the ethical standpoint, the value of the intercultural

[4] See the projection by age brackets at http://www.idescat.cat/dequavi/?TC=444&V0=1&V1=7.

competencies of both the users and the staff of Residences for Seniors in order to evaluate their potential as a variable that may generate conflict and/or coexistence.[5]

The composition of our societies has become progressively more complex. This diversity configures a constellation of cultures that creates strong microidentities and, at the same time, fragments the collective macroidentity. This in turn spawns changes in the way people live and coexist, because the experience of the paradoxal plurality of human beings is heightened as their proximity of coexistence increases, and also the need to resolve aspects of relationships where not only differences, but also disparities, exist.[6]

It therefore becomes necessary to rethink public policies in our multiple-identity societies, when the homogenising function traditionally performed by the social services is threatened by the crisis, and with it redistribution and equal opportunity policies. We face the challenge of combining diversity and cohesion through the creation of cohabitation and all-inclusive spaces which, far from promoting homogeneity, make it possible to construct shared projects that are respectful of the diversity of identities. It is, first and foremost, a task of mediation, i.e. of developing community and participation-based work that is sensitive to the cultural plurality of communicative codes.[7]

This is precisely why this Project seeks to introduce an aspect which the social services' assessment standards have hitherto tended to overlook: the importance of the intercultural competencies of both staff and users of the Residences for Seniors as an underpinning element of quality of life. Since, as the projections suggest, increasingly more immigrant staff will be employed in Residences for Seniors, the possibility of misunderstandings through communication errors caused by the different world

[5] Cortés, A. (2001) Los conflictos éticos en las personas mayores a través de la teoría cultural-ecológica. *Revista Multidisciplinar de Gerontología*, 11(3), pp. 109-115.

[6] Marín, F.X. (2007) Interculturalidad: solidaridad moral y alfabetización cívica. Comunicación. *Revista Internacional de Comunicación Audiovisual, Publicidad y Estudios Culturales*, 5, pp. 391-403.

[7] Riera, C. (2009) *Serveis socials, acció comunitària i participació ciutadana: un nou marc per a la inclusió. Nous escenaris, reptes, estratègia i metodologia*. Papers d'Acció Social, 10. Barcelona: Departament d'Acció Social i Ciutadania; Pascual, J., Rovira, E. (coords) (2008). *Diversitat cultural i globalització: nous reptes per al moviment associatiu*. Barcelona: Fundació Desenvolupament Comunitari – Ajuntament de Barcelona.

views of belonging is potentially increased. The cultural factor should therefore be addressed as a variable of paramount importance with regard to self-perception of a life with dignity.

We therefore propose addressing the progressive inclusion of the construct of intercultural competencies as an important part of the criteria for assessing the quality of the service rendered in Residences for Seniors. As all the studies designed in this regard indicate, intercultural competency is a pivotal element that is also related to the capacity of *learning to know* (have a better and critical understanding of the multiple facets of the setting), *learning to do* (know how to face up to situations that call for the use of selective knowledge), *learning to coexist* (be ready to face up to possible conflicts, respecting plurality of viewpoints) and *learning to be* (in a process of existential self-learning through which, when all is said and done, we build ourselves). We are therefore talking about improving the effectiveness of cultural sensitivity and of communication competencies, taking into consideration the analysis of different cultural dimensions which (often unconsciously introjected) condition identity: the basic conception of the human condition, the relationship between reality and truth, the moral evaluation of people, the connection between profession and interpersonal relationships, the use of language, the conception of power and hierarchies, the management of uncertainty, the evaluation of space and the experience of time, the feeling of belonging to the group, the management of anxiety in the face of the unknown, the creation of expectations, confronting one's own prejudices and stereotypes, roles and their ritualisation, styles of learning, the play between endogroups and exogroups, duality between individualism-collectivism, universalism-particularism, masculine-feminine...

Just as people's identity responds to underlying cultural assumptions, so too is the identity of organisations and companies a reflection of them. The ensemble of cultural determinations (since for the human being there is no extracultural possibility...) establishes the guidelines of the different business strategies. Depending on whether a society gives priority to the individual or the group, autonomy or hierarchy, monochronic or polychronic time, meaning will be given, in one way or another, to what a work team's mission is, to what extent things have to be explained, what profile a worker should have, how priorities are determined, how timetables are established, how budgets are drawn up, how responsibilities are assessed, what style of leadership should be used, how decisions are taken, what the group's working language is or what communication strategies

are implemented, how conflicts are managed, what is understood by negotiation, the role of women, how personnel are recruited, how permanent training and retraining requirements are prepared, how job mobility is understood, what things are appreciated in dealing with clients or partners...

This is what is at stake when we talk about intercultural competence as a capacity to diagnose, interact and cope. It is through the filter of cultural parameters that we evaluate our own possibilities and limitations, we are more or less willing to critically review our own attitudes, accept or marginalise all other kinds of alterities, subscribe to the company philosophy and work-related values or not, develop attentive listening or act stubbornly, have the ability to work as a team or else lean towards individualism, have leadership or negotiation capacity or not, be open to ongoing training or not, be receptive to the management of complexity or not, generate a feeling of belonging to the company or not..., all of the factors related to the quality of the service that is rendered to society.

STUDY OBJECTIVES

The **main objective** of the Project presented is:

- To provide some food for thought on good practices in intercultural competencies in Residences for Seniors within the framework of the quality of social services in Catalonia.

This objective, in turn, can be broken down into **secondary objectives:**

- To analyse the "quality of life" construct used in the Government of Catalonia's social services evaluation system and include the intercultural dimension in it.
- To determine the imagery on cultural alterity present in the users and immigrant staff in Residences for Seniors.
- To detect the significant variables that determine and/or condition coexistence and the appearance of communication conflicts derived from the cultural diversity present in Residences for Seniors and propose intervention strategies.

THEORETICAL FRAMEWORK

No matter how we look at it, our societies have become border zones, an area of convergence of people with different cultural identities; and this calls at least for a multidisciplinary approach where the ethical dimension acts as an underpinning axis: we are all different by nature, but inequalities are imposed upon us. For this reason, the claim for justice and equality is directly linked to respect, in other words to the challenge of welcoming and embracing alterity. It is therefore particularly urgent that we reflect upon what society needs to channel and dampen the tension that living in culturally plural environments may generate. In this regard, research allows us to select two significant variables that will be studied: intercultural competencies and quality of life.

First of all, **intercultural competencies.**[8] This is a complex construct, as endorsed by the studies conducted in the areas of communication, psychology, education and business management. Proof of this is the terminological diversity to be found: intercultural communication competencies, intercultural communicative effectiveness, intercultural adjustment, intercultural adaptation, intercultural success, intercultural effectiveness, intercultural awareness... In any event, the works of Guo-Ming Chen, now mandatory, propose a summary based on three major domains:[9]

- Cognitive (cultural comprehension): knowledge of the influence of culture in the process of construction of one's own identity, as well as the capacity to diagnose the world of the culturally different other.

[8] Marín, F.X., Navarro, A.J. (2010) Cultural Alterity within Companies: Overviews Regarding the Intercultural Competencies in the Workplace. *Ramon Llull Journal of Applied Ethics*, 1, pp. 61-77; Marín, F.X., Navarro, A.J. (2011) Cultural Alterity and Acknowledgement. A Research Project on the Plural Societies of the Mediterranean. *Ramon Llull Journal of Applied Ethics*, 2, pp. 213-234; Marín, F.X., Navarro, A.J., Ballarin, J.M. (2012) Knowledge and acknowledgement: concept of alterity as a tool for social interaction. *Ramon Llull Journal of Applied Ethics*, 3, pp. 135-154.

[9] Chen, G.M. (1989) Relationships of the dimensions of intercultural communication competence. *Communication Quaterly*, 37, pp. 118-133; Chen, G.M. (1990) Intercultural communication competence: some perspectives of research. *The Howard Journal of Communication*, 2, pp. 243-261; Chen, G.M. (1992) A test of intercultural communication competence. *Intercultural Communication Studies*, 2, pp. 62-83.

- Affective (cultural sensitivity): sensitivity to the culture of others, embodied in the rejection of ethnocentrism and the incorporation of respect, empathy, appreciation and acceptance of other cultures.
- Behavioural (cultural interaction): the ability to interact with members of other cultures, with the capacity to intervene efficaciously in the event of the emergence of conflicts due to the presence of different world views.

Therefore, the development of intercultural competency is an ongoing active learning process that involves a transformation of the person's identity. It is a process with a substantial existential component, i.e. that is produced, above all, through direct experience with the different other. In this way, intercultural competency is basically the result of a process of self-learning in which, through individual and/or collective interaction with the environment, one tries to analyse the importance of the perspectivist look at reality, of cooperative work and negotiation skills, of communication management, and, ultimately, of the weight of values in the construction process (reconstruction, deconstruction) of identity.[10]

From this standpoint, it is very interesting to trace the evolution of the theoretical approach to professional competencies in the last few decades of the 20th Century.[11] We are specifically interested in ascertaining the elements that have led interculturality to no longer be analysed with the emphasis on the *competencies* or *qualifications* to carry out defined activities linked to a given profession (i.e. the notion of task prevailing over the notion of function integrated in the business system, with greater importance attached to instruction rather than the promotion of joint responsibility and initiative within the system, and therefore sharing a vision of segmented and additive organisation that seldom involve dynamics of interdependence between functions), but rather on the basis of *competency* parameters.[12]

[10] Marín, F.X. (1012) Identitat, territori i mobilitat: apunts per a una antropologia de la immigració. *Aloma*, 30 (2), pp. 13-22.

[11] Echeverría, S.B. (2001) Configuración actual de la profesionalidad. *Letras de Deusto*, 31 (91), pp. 35-55; Echeverría, S.B. (2002) Gestión de la competencia de acción profesional. *Revista de Investigación Educativa*, 20 (1), pp. 7-43.

[12] Hofstede, G. (1980) *Culture's consequences: international differences in work-related values*. Beverly Hills: Sage Publications; Sodowsky, G.R., Taffe, R.C., Gutkin, T.B., Wise, S.L. (1994) Development of the multicultural inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, 41 (2),

This is how companies began to implement strategies that sought to answer this need for intercultural training, seeking to facilitate adaptation by the manager to the foreign culture and thus optimise the possibility of effective performance at work.[13] In this regard, we see how specific-culture-focussed models have been gradually abandoned (i.e. training on the target country or cultural group) in favour of models that attach greater importance to the development of general human relationship-based competencies (communication, flexibility, negotiation, teamwork...). In other words, rather than having knowledge of a specific culture, international managers need to be aware of the keys that indicate cultural differences, and that it is more important to identify which dimensions of the culture are relevant rather than know the mainstream tendencies in each specific country.[14] This factor will be useful with regard to the ultimate goal of this Project, since hitherto most of the efforts made to promote communication between users and immigrant staff in Residences for Seniors have focused on developing conversation guides in Catalan.[15]

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pp. 137-148; Sodowsky, G.R., Kuo-Jackson, P.Y., Richardson, M., Corey, A.T. (1998) Correlates of selfreported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control racial ideology and multicultural training. *Journal of Counseling Psychology*, 45 (3), pp. 256-264.

[13] Aneas, A. (2003) *Competencias interculturales en la empresa. Un modelo para la detección de necesidades formativas*. PhD thesis. Barcelona: University of Barcelona.

[14] Cushner, K., Brislin, R.W. (1996) *Intercultural interactions. A practical guide*. 2nd ed. London: Sage Publications.

[15] Thus, focusing the debate on personalised care that takes cultural diversity reduced to the exclusive matter of speaking the language into account is patently insufficient. "*The Government of Catalonia is therefore obliged to guarantee that users of Residences for Seniors in the country can communicate with their caregivers in Catalan. in this case, the right to use one's own language deserves special consideration in view of the situation of the group in question: elderly people who are often sick, have no family and sometimes have serious physical or mental limitations. People who, now that they are older, need the warmth of conversation more than ever. But many healthcare service professionals are born outside Catalonia, they do not speak Catalan and have never had the chance to learn it, which makes it more difficult for them to communicate with the Catalan-speaking seniors they are looking after*". Departament d'Acció Social i Ciutadania [Department of Social Action and Citizenship]. (2010) *A la residència, en català: guia de conversa,* p. 2.

The second variable studied is **quality of life.**[16] Coming from the industrial environment, the development of actions linked to quality management and ongoing improvement has had a strong impact on the world of the social services: healthcare services to people must be delivered efficaciously and efficiently, which means including work assessment mechanisms. Indeed, in the last decade this construct has become an underpinning axis of social service assessment methodology, both in the detection of possibilities of improvement and the implementation of monitoring systems.[17]

For the purpose of this research, we revised the current **quality assessment protocols**, leaving the indicators featured in the 1999 assessment protocol, such as care to the resident (personalised care plan, promotion of autonomy, drug treatment, risk prevention, nutrition, function maintenance, the resident's hygiene, care protocol, accompaniment), comfort, environment and hotel services (food quality, personalisation and privacy of the environment, accessibility and safety, hygiene of the environment, image) and organisation (how the team works, ongoing training, documentation of care given to residents)[18] in the background. We have also dispensed with the evaluation items of the 2000 protocol (interdis-

[16] Armadans, I., Manzano, J., Soria, M. (2007) Envejecimiento y calidad de vida: anàlisis de los conflictos en personas mayores activas y en la convivencia en centros de tiempo libre. *Revista Multidisciplinar de Gerontología*, 17 (1), pp. 7-12; Aymerich, M., Casas, F. (2005) Calidad de vida de las personas mayores. In Pinazo S., Sánchez M. (dir). *Gerontología: actualización, innovación y propuestas*. Madrid: Pearson Prentice Hall, pp. 17-144; Marñin, M., García, A. (2004) Calidad de vida en la tercera edad desde la salud y ele stado de bienestar psicosocial. *Mapfre Medicina*, 15 (3), pp. 177-185.

[17] See the Manual for social service quality improvement teams produced in 2000 by the Fundació Avedis Donabedian and the Department of Welfare and the Family. ttp://www20.gencat.cat/docs/dasc/01Departament/02Funcionsiestructura/articles/Millora_qualitat_ICASS/Eines_suport_i_publicacions/Manual_millora_qualitat/Manual_millora_qualitat.pdf. The Manual revolves around three major axes: improvement teams (forms of working, types of teams, working methodology, group dynamics and meeting management), quality assessment and improvement methodology (detection of improvement possibilities, prioritisation, causal analysis, definition of criteria, design of assessment studies, improvement actions analysis, strategies for change) and monitoring systems. The incidence of intercultural factors in the first axis is evident (although it is not mentioned in the Manual).

[18] Departament de Benestar Social [Department of Social Welfare] (1999) *Avaluació externa de qualitat dels centres de l'ICASS*. Àrea de serveis: residències assistides de gent gran. Indicadors d'avaluació de qualitat. Barcelona.

ciplinary team meetings, individualised and interdisciplinary care plan, training in handling death, ongoing assessment, the resident's reference person, confidentiality standards, documentation dossier and drug treatment)[19] and of the indicators provided for in the 2005 protocol (care or attention to the person and their family, the satisfaction of interest groups, organisational and management aspects of the residence, coordination with other sectors and organisations).[20]

In any case, the research conducted in recent decades explains the progressive importance attached to **quality of life** as an axis for person-centred planning, results assessment and improvement projects. Since the 1980s (when the focus was on elements such as self-determination, inclusion, skill-building and the equality necessary for existential satisfaction) and the decade of the 90s (which define, apply and evaluate the construct) through to current studies (which prioritise the fact that quality of life provides a sense of reference is an absolute principle for increasing well-being, it is useful to implement changes in the organisation and in systems, and provides a language and a common shared systematic framework for all the groups involved in social services), it is possible to follow the consensus established between specialists which culminates in the four basic conceptual principles of the quality-of-life construct:[21]

- It is multidimensional and is affected by personal and environmental factors and by their interaction.
- It has the same components for everyone.
- It includes subjective and objective elements.
- It improves with self-determination, resources, a purpose in life and a feeling of belonging.

[19] Departament de Benestar Social [Department of Social Welfare] (2000) *Avaluació externa de qualitat dels centres de l'ICASS. Recomanacions per a l'elaboració dels plans de millora contínua de les residències assistides per a gent gran. Indicadors d'avaluació de qualitat*. Barcelona

[20] Departament de Benestar i Família [Department of Welfare and the Family] (2005) *Avaluació externa de qualitat dels centres de l'ICASS*. Àrea de serveis. Llars residencials per a persones amb discapacitat derivada de malaltia mental: indicadors d'avaluació de qualitat. Barcelona.

[21] Verdugo, M.A. (dir) (2006) *Cómo mejorar la calidad de vida de las personas con discapacidad. Instrumentos y estrategias de evaluación*. Salamanca: Amarú.

Thus, quality of life helps to foster a change in the microsystem (family, home, peer group, job), the mesosystem (neighbourhood, community, service agencies and organisations) and the macrosystem (social policies, socio-political trends, economic systems and factors related to society that affect own values and beliefs directly, as well as the meaning of concepts). In this regard, the application of this model constitutes a new way of addressing interventions with the service users, as this requires a planning focussed on the person's needs and evaluating whether the support provided is suitable. All in all, it generates a work methodology that knits together planning, action and assessment, i.e. it helps to assess the outcomes of the intervention, it permits the optimisation of resources and makes it possible to deliver care adjusted to the specific needs of each and every one of the social services users and also helps to detect emerging needs.

In this regard, there are different dimension classifiers according to the authors consulted, but they all agree that there is a need for a multidimensional framework that is summarised in 8 quality of life dimensions that mirror a person's well-being:[22]

- **Emotional well-being:** the condition in which one has everything they need to live with dignity; personal satisfaction defined by concepts such as happiness, health, peace of mind, safety and security, acknowledgement, self-esteem, satisfaction, being in control of stressing situations...
- **Interpersonal relationships**: leading a full life as a human being in terms of relationships, being involved in group situations that are conducive to emotional stability and mental health.
- **Material well-being:** personal satisfaction guaranteed by situations of control of the physical setting and of the resources and properties that may provide comfort, safety/security, environment...
- **Personal development**: the evolutional and transitional aspects that refer to the dynamism and personal mastery of competencies and education, training and rehabilitation, progress and growth.
- **Physical well-being:** state of satisfaction and plenitude, feeling good and good health.

[22] Verdugo, M.A., Jenaro, C. (2010) *Calidad de vida. Manual para profesionales de la educación, salud y servicios sociales*. Madrid: Alianza.

- **Self-determination:** capacity to take decisions that affect oneself, establish goals and personal landmarks as an expression of autonomy.
- **Social inclusion:** integration in the community, accepting the role of each and every one of us, participating in the specific activities of the social group to which the person belongs, with the support of others.
- **Rights:** use of rights as an expression of human dignity, fully and without limitations.

This approach has multiple interests if we consider that it is based on the European Foundation for Quality Management (EFQM) model: it brings in a systems perspective and a methodological pluralism that combines objective and subjective items where it will be easy to include the dimension provided by intercultural competencies. As the authors who devised the theoretical and methodological framework for the ICASS state,[23] quality of life is a multidimensional concept that includes a number of dimensions that reflect positive values and life experiences. If this is analysed taking the **ICASS Quality Plans** into account, it transpires that the underpinning principles are accountability and professional development, as well as the prioritisation of user and relative participation to adapt services to their expectations, define standards and improve care. In this way, the different quality improvement plans have led to the identification of a whole series of elements that have acted as facilitators in the implementation of actions in the realm of quality:

- One of the core aspects is that measuring care processes and their standardisation becomes key, as well as the exchange of experiences between professionals and the generation of good practices inside each group.
- Moreover, awareness and the need for quality to pervade the organisation. Quality should not be perceived as an independent element, alien to the day-to-day activity of organisations, but rather as a variable inherent in all aspects related to people care.

[23] Schalock, R.L., Verdugo, M.A. (2003) *Calidad de vida. Manual para profesionales de la educación, salud y servicios sociales*. Madrid: Alianza, p.34; Schalock, R.L., Felce, D. (2004) Quality of life and subjective well-being:conceptual and measurement issues. In Emerson E., Hatton C., Thompson T., Parmenter T.R. (eds). *International handbook of applied research in intellectual disabilities*. London: John Wiley and Sons, pp. 261-279.

- Another important aspect is that quality, from the services standpoint, falls essentially to the professionals that render these services and to the tools they have to do their job.
- Moreover, in all the actions we carry out, the social services professionals must never lose sight of the fact that the user is the cornerstone. Very beneficial feedback is provided when the user has participated actively in the care processes or in the necessary actions.

This is materialised in good practices manuals, when they insist not only on the need for contributions from different methodological and paradigmatic approaches, but particularly on the urgency of taking the profile of the residents and of the personnel into account to adapt practices to them and to respond to their care needs.[24] In this regard, it is obvious that the quality of life construct has evolved from the notion of awareness-raising to one of an agent of change: we have progressively learned to distinguish between the social indicators pertaining to the external conditions of the service and the perception of the user of the service that mirrors a major concern for social dynamics and includes factors pertaining to social support and integration, autonomy and self-confidence, expectations and values.[25]

[24] Departament de Benestar i Família [Ministry of Social Welfare and Family] (2005) *Manual de recomanacions de bones pràctiques. Llars residencials per a persones amb discapacitat derivada de la malaltia mental [Good Practices Recommendations Manual. Residential Homes for people with mental illness-derived disability]*. Barcelona. The Manual focuses on 7 areas of action: individualised care, daily-life activities, habits related to the maintenance and the use of the space in the home, training, integration in the community environment, the special situations of residents and relational and organisational aspects.

[25] ICASS (2007) *Dossier documental sobre el model de Qualitat de Vida en els Serveis Socials de Catalunya*. Barcelona; Schalock, R.L., Bonham, G. (2003) Measuring outcomes and managing for results. *Evaluation and Program Planning*, 26 (3), pp. 229-235; Schalock, R.L. (2001) Outcome-based evaluation. 2nd ed. New York: Kluwer Plenum; Cummins, R.A. (1998) The second approximation to an international standard of life satisfaction. *Social Indicators Research*, 43, pp. 307-334; Cummins, R.A., Lau, A.L.D. (2004) The motivation to maintain subjective well-being: a homeostatic model. *International Review of Research in Mental Retardation*, 28, pp. 255-301; Perry, J., Felce, D. (2005) Correlation between subjective and objective measures of outcomes in staff community housing. *Journal of Intellectual Disability Research*, 49 (4), pp. 278-287.

As is evident, the study of the role of intercultural competencies can be introduced into all these aspects. The same should be said of the quality of life dimensions which the Evaluation Plans aim to address more intensely: the rights of the person, personal development, well-being (emotional, physical and material), interpersonal relationships, independence to take decisions and social integration. In this same order of things, we should not lose sight of the fact that the Social Services Law of 2007 reflects different elements included in the White Paper on Services of General Interest of the Commission of the European Communities (2004) which, among other guiding principles of sectorial politics (enabling public authorities to operate close to the citizens, achieving public service objectives within competitive open markets, ensuring cohesion and universal access, maintaining a high level of quality, security and safety, ensuring consumer and user rights, controlling and evaluating service performance, respecting diversity of services and situations, increasing transparency, providing legal certainty) explicitly mentions respect for cultural diversity.[26]

In view of the objectives of our study, we have therefore focused, in the section dedicated to the resident's relationships and rights (welcome on admission, leisure activities, relationship with the family and with the community, resident and family satisfaction, respect for confidentiality) as a natural sphere of implementation of intercultural competencies in accordance with the Carta de Drets i Deures de la Gent Gran de Catalunya [Charter of Rights and Obligations of Senior Citizens in Catalonia].[27] Regarding the Project's main objective, it should be mentioned that according to the 2009 Report published by the Departament d'Acció Social i Ciutadania [Department of Social Action and Citizenship], ethics play a decisive role in the practice of social services professionals. This assertion is reflected in the **model de Qualitat de Vida en els Serveis Socials de**

[26] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52004DC0374:ES:HTML

[27] DOGC 4021 of December 1, 2003. This Charter revolves around 5 axes: dignity, independence, self-realisation, support and participation. Regarding our project, it should be mentioned that Right 1.3 (respect for our beliefs, culture and/or language as a distinguishing characteristic of the person) and Duty 1 (not to discriminate on account of age, gender, ethnic origin, disability, economic circumstances or any other condition, and to behave with and exhibit attitudes of tolerance, acceptance and dialogue that help to avoid such discrimination).

Catalunya editats per l'ICASS[28] [model of Quality of Life in the Social Services of Catalonia published by the ICASS], when it establishes a mission (define the lines of social action that make it possible to progress towards an inclusive, welcoming and supportive model of society), values (efficacy and efficiency, equality, accessibility, speed, professionalism, sensitivity, pre-emption) and quality policy principles (ethical and transparent behaviours, orientation of action towards results that can be measured by indicators, competent leadership, client-oriented efficiency in information treatment). However, the intercultural competencies dimension is not addressed in any of the courses programmed on ethics applied to social and psychoeducational intervention whose object is to promote good practices and to extend the resources needed to detect and address situations in which ethical conflicts appear[29].

Here there is a decisive element: the ethics of professions reflect upon the purposes that afford legitimacy to a professional activity in the context of the models provided by society where the profession is exercised. We cannot talk about well-being or quality of life without reflecting upon the ethics that regulate professional work, and in many cases it should be remembered that this will mean introducing a new vocabulary and new practices that help to define the new scenarios of our changing society. Codes of good practices, ethical committees and corporate social responsibility must be institutionalised to afford visibility to the ethical calls of the society which social services target, acknowledging pluralism and promoting it.[30]

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[28] Departament d'Acció Social i Ciutadania [Department of Social Action and Citizenship] (2009) *La planificació de la qualitat en l'ICASS: eines per a la integració de la qualitat en els serveis d'atenció a les persones*. Subdirecció General de Programació i Avaluació de l'Institut Català d'Assistència i Serveis Socials. Papers d'Acció Social, 9. Barcelona.

[29] The courses seek to convey the switch from a patient-focused intervention approach to a person-focused approach, i.e. one that considers the person as a fully-fledged member of society, prepares an individualised care plan in keeping with the person's changing needs, that understands the perspective of the service user and offers a support-driven social psychology to promote the perception of well-being. The contents of these courses place the accent on the relational context as a care priority and on personal competencies to look after people, but at no point is the intercultural dimension mentioned as a variable that merits specific consideration.

[30] Román, B. (2009) Ètica en els serveis socials. Professions i organitzacions. 2nd ed. Papers d'Acció Social, 7. Barcelona: Departament d'Acció Social i Ciutadania [Department of Social Action and Citizenship], p.11.

METHODOLOGICAL FRAMEWORK

Two models were considered to design the **questionnaire** on intercultural competencies in Residences for Seniors:

First of all, the quality of life measurement instruments as established by the World Health Organisation were analysed based on its definition of health, not only as the absence of disease or illness (i.e. taking physical and psychological decline as a model, and placing the emphasis on healing needs), but rather as the condition of complete physical, mental and social well-being (in other words, focusing on the positive aspects that constitute quality of life such as the maintenance of autonomy, social activity, adaptability or self-esteem). In this regard, quality of life consists of the individual's perception of their position in life within the context of their culture. Therefore, and more specifically, we have to consider the WHOQOL (World Health Organization Quality of Life) [31] questionnaire, generated through opinion groups comprised of health services users, health-care personnel and the population in 15 countries. The initial 2000 questions were reduced to a first working instrument that contained 236 items that span 6 areas and 29 facets of quality of life. This was used as the basis for the WHOQOL-100, comprised of 100 items that assess quality of life around 6 areas (physical health, psychological health, levels of independence, social relationships, environment, spirituality, religion and personal beliefs) and 24 facets, each one of them represented by 4 questions. On the other hand, the WHOQOL-BREF comprises 26 questions (one for each one of the 24 facets of the WHOQOL-100 plus a further two questions on overall quality of life and general health) organised around 4 areas: physical health, psychological health, social relationships and the environment. The **WHOQOL-OLD**, specific for

[31] WHOQOL Group. (1993) Study Protocol for the World Health Organization Project to develop a Quality of Life Assessment Instrument (WHOQOL). *Qual Life Res*, 2, pp. 153-159; World Health Organization (1993) Report of WHOQOL. Geneva. Focus Group Work; WHOQOL Group (1996) What quality of life? World Health Organization Quality of Life Assessment. *World Health Forum*, 17 (4), pp. 254-256; WHOQOL (1998) Group. Development of the World Health Organization WHOQOL-BREF quality of life assessment. *Psychological Medicine*, 28 (3), pp. 551-558; Lucas, R. (1998) *La versión española del WHOQOL*. Barcelona: Ergon.

seniors and prepared from the field work done initially in 23 countries, includes the following 24 questions:[32]

- **Sensory abilities**
  - Do impairments to senses affect your daily life?
  - Do loss of sensory abilities affect participation in activities?
  - Do problems with sensory functioning affect your ability to interact?
  - Could you rate your sensory functioning?

- **Autonomy**
  - Do you have freedom to make your own decisions?
  - To what extent do you feel in control of your future?
  - Are people around you respectful of your freedom?
  - Are you able to do the things you'd like?

- **Past, Present and Future Activities**
  - Are you satisfied with the opportunities you have to continue achieving?

[32] Power, M., Quinn, K., Schmidt, S. WHOQOL-OLD Group. (2005) Development of the WHOQOL-OLD Module. *Qual Life Res*, 15 (10), pp. 2197-2214. See also Bowling, A. (1995) What things are important in people's lives? A survey of the public's judgements to inform scales of health quality of live. *Social Science and Medicine*, 41 (10), pp. 1447-1462; Bowling, A. (1996) The effects of illness on quality of life. *Journal of Epidemiology and Community Health*, 50, pp. 149-155; Bowling, A. (2003) Let's ask them: a national survey of definitions of quality of life and its enhancement among people aged 65 and over. *International Journal of Aging & Humans Development*, 56 (4), pp. 269-306; Farquhar, M. (1995) Elderly people's definitions of Quality of Life. *Social Science & Medicine*, 41, pp. 1439-1446; Fry, P.S. (2000) Whose quality of life is it anyway? Why not ask seniors to tell us about it?. *International Journal of Aging & Human Development*, 50, pp. 361-383; Gerin P., Dazord, A., Boissel, J, Chifflet, R. (1992) Quality of life assessment in therapeutic trials: rationale for and presentation of a more appropriate instrument. *Fundamental & Clinical Pharmacology*, 6 (6), pp. 263-276; Hileras, P.K., Jorm, A.F., Herlitz, A., Winblad, B. (2001) Life satisfaction among the very old: a survey on a cognitively intact sample aged 90 years or above?. *International Journal of Aging & Human Development*, 52 (1), pp. 71-90; Penning, M.J., Strain, L.A. (1994) Gender differences in disability, assistance and subjective well-being in later life. *Journal of Gerontology*, 49 (4), pp. 202-208; Raphael, D., Brown, I., Renwick, R., Cava, M., Weir, N., Heathcote, K. (1997) Measuring the quality of life of older persons: a model with implications for community and public health nursing. *International Journal of Nursing Studies*, 34 (3), pp. 231-239.

  - Have you received the recognition you deserve in life?
  - Are you satisfied with what you have achieved in life?
  - Are you happy with things to look forward to?

- **Social participation**
  - Do you have enough to do each day?
  - Are you satisfied with the way you use your time?
  - Are you satisfied with your level of activity?
  - Are you satisfied with the opportunities to participate in the community?

- **Death and dying**
  - Are you concerned about the way you will die?
  - Are you afraid of not being able to control death?
  - Are you scared of dying?
  - Do you fear pain before death?

- **Intimacy**
  - Do you feel a sense of companionship in life?
  - Do you experience love in your life?
  - Do you have opportunities to love?
  - Do you have opportunities to be loved?

The GENCAT quality of life scale was then considered, which makes it possible to create a common reference framework for all social services professionals and which, by harmonising methodologies, becomes a support tool for service planning.[33] The GENCAT Scale is comprised of 69 items organised around 8 thematic dimensions:

- Emotional well-being
  1) They are satisfied with their present life; 2) They present symptoms of depression; 3) They are happy and in good spirits; 4) They show feelings of incapacity or insecurity; 5) They present anxiety symptoms; 6) They are satisfied with themselves; 7) They have

[33] Verdugo, M.A., Arias, B., Gómez, I.E., Schalock, R.L. (2008) *Escala GENCAT. Formulari de l'Escala GENCAT de qualitat de vida. Manual d'aplicació de l'Escala GENCAT de qualitat de vida*. Barcelona: Departament d'Acció Social i Ciutadania [Department of Social Action and Citizenship].

behavioural problems; 8) They are enthusiastic about doing any kind of activity.

- **Interpersonal relationships**
  9) They do activities they like with other people; 10) They have the relationship they desire with their family; 11) They complain about the lack of stable friends; 12) They have a negative outlook of their relationships with friends; 13) They say they feel undervalued by their family; 14) They find it difficult to strike up a relationship with another person; 15) They get on well with workmates; 16) They say they feel loved by people who are important to them; 17) Most of the people they interact with are in a similar situation; 18) They have a satisfactory sex life.

- **Material well-being**
  19) The place where they live prevents them from leading a healthy life; 20) The place where they work meets safety standards; 21) They have the material goods they need; 22) They are unhappy with the place where they live; 23) The place where they live is clean; 24) They have the economic resources necessary to cover their basic needs; 25) Their income is insufficient to be able to indulge in certain whims; 26) The place where they live is adapted to their needs.

- **Personal development**
  27) They find it difficult to adapt to situations that arise; 28) They have access to the new technologies; 29) Their job allows them to learn new competencies; 30) They find it difficult to effectively handle problems; 31) They do their job competently and responsibly; 32) The service they attend takes their personal development and the learning of new competencies into consideration; 33) They participate in the preparation of their individual programme; 34) They lack motivation at work.

- **Physical well-being**
  35) They have sleep problems; 36) They have technical aids if they need them; 37) Their eating habits are healthy; 38) Their health allows them to lead a normal life; 39) Their personal hygiene is good; 40) The service they attend supervises the medication they take; 41)

Their health problems cause pain and malaise; 42) They find it difficult to access health care resources.

- **Self-determination**
  43) They have personal goals, objectives and interests; 44) They choose how they wish to spend their free time; 45) The service they attend takes their preferences into account; 46) They defend their ideas and opinions; 47) Other people take decisions on their personal life; 48) Other people decide how to spend their money; 49) Other people decide when they go to bed; 50) They organise their own life; 51) They chooses whom they live with.

- **Social inclusion**
  52) They use community environments; 53) Their family gives them support when they need it; 54) There are physical, cultural or social barriers that hamper their social inclusion; 55) They lack the support they need to participate actively in the life of their community; 56) Their friends give them support when they need it; 57) The service they attend promotes their participation in different community activities; 58) Their friends are limited to the people that use the same service; 59) They are rejected or discriminated by others.

- **Rights**
  60) Their family violates their privacy; 61) They are treated with respect in their immediate environment; 62) They have information about their fundamental rights as a citizen; 63) They find it difficult to defend their rights when the latter are violated; 64) The service they attend respects their privacy; 65) The service they attend respects their possessions and their right to ownership; 66) Some of their legal rights are limited; 67) The service they attend respects and defends their rights (confidentiality, information about their rights as a user); 68) The service respects privacy of information; 69) They are the object of exploitation, violence or abuse.

These preliminary models were used to prepare a protocol of interviews and a questionnaire that permits the identification of elements of coexistence and conflicts in Residences for Seniors. Three Residences in Barcelona were chosen (Sibelius, Bonaire and Las Violetas), and in each one of them, 36 people with the following profile were interviewed:

- **Sibelius Residence**
  1 member of the management team
  2 social or health staff
  6 auxiliary nurses
  4 residents

- **Bonaire Residence**
  1 member of the management team
  2 social or health staff
  4 auxiliary nurses
  2 residents

- **Las Violetas Residence**
  1 member of the management team
  2 social or health staff
  6 auxiliary nurses
  5 residents

The questionnaire that was given to these 42 participants combines quantitative and qualitative items, since the idea is to determine, on the one hand, the anthropological concept of old age, and on the other the possible influence of intercultural factors in the interaction between staff and users of the Residences for Seniors. Hence, the WHOQOL and the GENCAT Scale were used to establish 3 areas around which the interviewees were conducted:

- **Self-determination**
  1. The auxiliary staff of the Residence take user preferences into account
  2. In the Residences, users can defend their own opinions and ideas
  3. The auxiliary staff accept that the users can decide when they want to go to bed
  4. The auxiliary staff allow users to decide the clothes they wear
  5. The auxiliary staff help users to decide when they can leave the Residence

- **Interpersonal relationships**
  6. The auxiliary staff treat the users with kindness

7. The auxiliary staff explain all the things they are about to do to or for the users to the latter
8. The auxiliary staff generate trust in the users
9. The users would rather be taken care of by people from here
10. The users find it easier to communicate with people from here

- **Responsibility at work (only for management and professionals). This determines whether the staff's cultural origin affects coexistence/conflict with regard to the following items**
  11. Time organisation and management
  12. Team work
  13. Work competently and responsibly
  14. Effective problem-solving
  15. Dealing with users respectfully

RESULTS AND DISCUSSION

The anthropological concept of "old age" does not differ significantly among the groups interviewed, although there are important nuances related to the origin of the respondent (local or immigrant).

- **Auxiliary staff:** it is the group with the most negative vision of the term "old age", probably due to the type of work they do. The locals use more neutral adjectives, related to the physical and mental condition of the users, such as*: vulnerable, appreciative, pleasant, defenceles*s... Immigrants, on the other hand, use a type of language that tends to highlight the users' weakness more: *weak, dependent, fragile, sensitive*... One point where there are coincidences between both groups is in defining the seniors as *complicate*d, that they *require a great deal of work* and *are not always easy to handle*. Nevertheless, immigrant auxiliary nurses are more prudent in describing the more controversial details pertaining to the character of seniors, but it is also clear that the fact that they are not from this country means that their relationship is not always optimal and they have to work hard to win over the user in order to gain the same level of trust that exists between residents and local staff. However, both locals and foreigners agree that the hardest part of their job is not that that users evince a deliberately negative attitude towards

immigrant staff, but rather that the users' physical and mental condition colours their perception of reality.

- **Users:** For the residents, the concept of old age varies significantly depending on a cognitive perspective. They think that it is essential to feel that they have enough autonomy to do certain things and be able to negotiate specific aspects with their caregivers (such as when they go to bed, what they eat...) This is why seniors whose cognitive condition is better shy more away from defining themselves as *elderly* or *senior* than other residents who have more intellectual difficulties. The most common adjectives are ones that refer to their *goodness*, their *pleasant* nature and their *experience*. Some residents feel that they are a nuisance, and for this very reason attach so much importance to being in good physical and psychological condition so as not to have to be asking for help all the time, and for them it is very important to feel valid and self-sufficient in everyday aspects. The *respect* concept is very important for them in being treated as seniors, because they are sensitive and delicate, and realise that they have lost many things in the course of their lives, such as health, memory or their loved ones. This is why they need to maintain certain daily routines that afford them security or certainty and help them to find their place in this new stage of their life.
- **Management and professionals**: The more protective and paternalistic vision is mirrored in the answers of the social and healthcare professionals and in the managers of the centres. This group highlights the *fragility* and physical and psychological *vulnerability* of the seniors. This is why they consider that it is very important to deliver all-encompassing care in order to perform the basic functions (eat, get dressed...) and transmit the affection and the security they need. They know that physical, emotional and mental care are all equally important to the seniors. The people who are the most protective and have a more compassionate vision of the seniors are immigrant professionals, who define them as *handicapped*, *isolated, special* and *obedient*. These professionals warn particularly about residents' problems in leading a normal life a due to their limitations in their day to day life. While the local professionals' vision of the seniors is not all that different to that of the immigrant caregivers, they underline other aspects such as *experience*, *affection*, their *gratefulness,* even although they also define them as *stubborn*

and impatient. For the locals, it is more important to create bonds of affection with the residents so that they will feel safer or more secure in facing the changes they encounter on leaving their own home. As was implied by the residents' vision of old age, the professionals underline the importance of the routines the users need to feel safe or secure, even although they also try to get the residents be open to change. To them, the routine established by the centre and the protocol is fundamental, since the seniors shun the unknown and find it difficult, in some cases, to adapt to a new environment. This transition has to be carried out gradually to make it as trauma-free as possible.

The most significant variables that can determine and condition coexistence in a Residence for Seniors, beyond those related to physical, psychological and affective circumstances (as we saw in the previous point), lie in the distortions caused by the cultural differences between the locals (users, auxiliary staff or professionals and management) and immigrant staff (auxiliary staff and professionals). These differences may generate conflicts of coexistence in areas such as:

- **Capacity to accept user self-determination:**
  - **Auxiliary nurses:** According to the local staff, the residents' preferences and opinions are always listened to, but it is not always possible to act upon them due to the workload and the way the centre operates. Immigrant staff also feel they take the residents' preferences and opinions into account, but also admit that the seniors do not ultimately have the last word in these matters. They are listened to but their requests are not always heeded. While protocols also count, aspects such as when or the way they dress or when they go to bed will depend on the resident's physical conditions, since, due to questions of speed and efficacy, it is often the auxiliary staff who choose their clothes and dress them. Bedtimes and time spent outside the centre are the most restrictive aspects upon which local and immigrant staff agree most: procedures and protocols must be followed, although sometimes flexibility has to be exercised.
  - **The residents:** The perception of this group differs from that of the other groups involved in coexistence at the residence. While the staff admit that in many cases they have to go about their

daily work in a very direct way and do not have too much time to give pedagogical explanations, the users feel listened to and cared for, and their opinions are always or often taken into account as far as possible. The residents are aware of the existence of a timetable for going to bed and for going outside the centre that may be changed sporadically if so requested by them or by their relatives. The seniors do not have a feeling of lack of self-determination, largely because they adapt to the facilities offered by the professionals and auxiliary staff with regard to their daily work, which means that many of them adapt to this because they have never had alternatives. In this section of the survey, the residents make no explicit distinction between the way they are treated by local or immigrant staff.

- **Health/social professionals and management**: Practically all the interviewees from this group believe that the residents' preferences are always or often taken into account. Most of them acknowledge that due to operating, organisational, timetable or practical reasons, these preferences are not always observed, although they admit that on many occasions the seniors have sufficient capacity to decide for themselves or to do a given thing with a minimum level of supervision. This aspect is more easily detectable among local professionals than among immigrant staff, who are more reluctant to grant greater levels of autonomy to the residents, and they agree that preferences, ideas and opinions must be given due consideration, albeit with certain limitations, and always after the user's level of autonomy has been assessed. With regard to going to bed and outings from the centre, they agree with the other groups of interviewees in stating that there is a timetable to be observed, although exceptions may be made at the request of the user and their relatives.

- ***Interpersonal relationships***

  This section analyses aspects such as kindness in the handling of users, pedagogy in the performance of routine actions so that the user knows exactly what they have to do, or worker-user levels of trust. The users are also asked directly whether they prefer to be handled by local or immigrant personnel, as well as the degree of communication with the staff. The answers show that each group has a different perception of the situation and convey this in differ-

ent ways, although it is not expressed tacitly, but rather through insinuations.

- **Auxiliary nurses:** As was explained in the preceding paragraph, the local staff state that while they try to take residents' needs and preferences into account, for questions of workload they are not always able to explain this to the users and be as kind and as attentive as they would like. In any event, a broad majority of interviewees agree that immigrant staff handle users differently. According to them, while they try to forge bonds of trust, take great care and explain their work as best as possible, foreign staff take this aspect more lightly, act more mechanically and do their job without creating bonds with the residents since, as far they are concerned, it is just a job, and sometimes only a temporary or passing one. In terms of user care, the local staff also state that there may be a certain degree of xenophobia among residents and that most of them would rather communicate with and be cared for by local personnel. The reasons given are related to language difficulties (the resident would rather be attended to in Catalan) and to the cultural difference that would affect customs and behaviours. This preference and better communication is also applicable in many cases to the users' relatives, who would also rather be attended to by local people. On the other hand, immigrant staff and local staff see interpersonal relationships in a different light. Indeed, most immigrant staff think they are pleasant and pedagogical and that they generate trust with the residents, they do not in principle perceive major differences although they do detect a certain initial hostility due to their being foreign. In their opinion, this initial reserve is largely due to language, which is therefore relatively easy to overcome through an affectionate relationship with the resident.
- **The residents:** Most of them say that their caregivers (without making any distinction of origin) are kind and affectionate with them, and that generally speaking everything that is done in the residence is explained to them. When questioned directly about relationships with immigrant staff, they evince a certain degree of mistrust, they say they feel more at home with local staff, due to their way of thinking, the language or customs. As occurs with the local auxiliary personnel, residents also consider that foreign caregivers see their work solely as a way of earning a living and

that they lack true commitment. Approximately 40% of residents are indifferent to the origin of their auxiliary nurses, and 60% openly state their reluctance to be looked after by an immigrant worker. The same percentages apply to the communication dimension: 40% say they have no communication problem with any of their auxiliary nurses and 60% admit that they would rather communicate with local staff mainly for reasons of language.

- **Health/social professionals and management**: Local managers and staff consider that although foreign staff are always kind and affectionate, they tend to be more abrupt and verbal, which some residents might find rather aggressive. Local staff admit that while they always try to explain all their actions to the residents, sometimes they act mechanically without attaching due importance to the explanation to guide the user and to promote their autonomy. They acknowledge that staff often go faster if some of these recommendable guidelines are not applied. Eighty per cent (80%) of the local staff believe that immigrant staff are too mechanical and direct to be able to create the bonds needed to generate the necessary trust in the resident. Barring one case, they all agree that residents feel more comfortable dealing with local personnel; they say that many residents feel uncomfortable with immigrant staff and are reluctant to have them as caregivers. With regard to communication, most of them consider that while there is no actual conflict, the language barrier may often hinder better relationships. Nevertheless, foreign staff have an altogether different perception: they believe that staff and residents get on well although they are not always pedagogical enough towards the users and they consider that all staff try to strike up bonds of trust with the users, although this is not always possible due to the residents' personality. They do not in principle detect problems or differences in the way local or immigrant personnel handle residents, and think that the users have no clear preference for either group. However, all of them voice the conflicts derived from their lack of fluency in Catalan, since most of the residents would rather communicate in this language.

- **Appraisal of responsibility at work.**
  - **Auxiliary nurses:** Local staff feel there are differences in terms of time organisation and management, teamwork and the com-

petent performance of work duties. They feel there is a lack of commitment or involvement among immigrant staff, and consider that they are not very well trained, lack interest or experience in team work and have no desire to go beyond the functions established in their contracts of employment. They therefore understand that they are not personally committed to their work or to the people they look after. Foreign staff are aware of these criticisms, but say that they merely stick to the centre's procedures and protocols and that each one operates on the basis of their own way of working. Their answers seem to suggest that they mainly attach a great deal of importance to rules or procedures and relegate teamwork to a secondary position.

– **Social/health professionals and management**: Local personnel have the perception that they are better organised and that foreign staff operate more chaotically. They only bring rivalries and the difficulties in working together to light as a last resort. There are also differences in time management: whereas local personnel see themselves as operational, they feel that staff from abroad commit to doing things but only actually comply when supervised by management. The staff and management teams have the sensation that immigrant staff prefer to take on less responsibility, do more mechanical jobs and those that require less teamwork. Most of the interviewees detect teamwork issues: they consider that staff from abroad lack the self-confidence to take certain decisions and take the initiative, and that greater dialogue is called for among all personnel. As in the previous sections, immigrant staff have a different perception in this regard too: they emphasise the fact that the residence establishes organisational and management aspects and that there are no particular problems in observing these rules. Here, foreign health and social professionals view teamwork more as a question of mutual aid and not as a chance to learn how to improve organisation and cooperate.

FINAL CONSIDERATIONS

The results of the surveys with the management teams, staff and users of Residences for Seniors show that in a matter of years the change in

demographics in Catalonia has also had an impact. Thus, besides the period of adaptation that all the groups need to take new routines on board, the issue of interacting with people from other countries must also be considered, which hitherto was perhaps not the case for some residents and staff.

As was said in the introduction, in this project we have sought to analyse whether, beyond the factors related strictly to individual psychology, the intercultural variable can also be seen in aspects related to coexistence and/or conflicts that might affect the quality of life of everyone involved in the Residences for Seniors setting. The data obtained from the field work are also conducive to stating that the intercultural dimension does indeed play a important, but understudied, role. It may thus be asserted, more specifically, that quality of life is closely linked to the different cultural appraisal of seniors and the incidence of the intercultural variable on day-to-day management of a residence through teamwork.

Increased longevity and quality of life-related expectations pose the challenge of responsible healthcare that is visible, for example, in the terminological evolution of recent decades: grandparents, old people, OAPs, the elderly, seniors, the third age, the fourth age and seniors.[34] We are therefore in the midst of an ethical dimension which, as explained in the quality of life construct, proposes an active approach to the phenomenon from the standpoint of humanising action; this is made quite clear through the evolution that has taken place in terms of talking about "Residences for Seniors" rather than "Old People's/Geriatric Homes". However, this ethical approach has to be addressed from an intercultural perspective, which calls for a careful consideration of elements such as:[35]

[34] Sánchez Granjel, L. (1991) *Historia de la vejez*. Salamanca: Ediciones Universidad de Salamanca; Torrallba, F. and Giménez-Salinas, J.C. (coords). (2009) *La ancianidad en nuestro mundo. Más allá de los tópicos*. Barcelona: Prohom Edicions.

[35] Nello, A. (2001) La quadratura circumscrita de l'ètica professional. *Ars Brevis. Anuari de la Càtedra RamonLlull-Blanquerna, 7,* pp. 289-309; Nello, A. (coord.) (2008) *Atenció a la gent gran: disseny d'un projecte d'intervenció al Poble Sec de Barcelona i elaboració d'una proposta de codi ètic específic*, Barcelona: Ethos Ramon Llull (retrieved May 13, 2013, http://ethos.url.edu/categories/Biblioteca/); Nello, A. (2011) La corresponsabilidad social en la atención a las personas mayores: un reto ético. In Bruna O., Roig T., Puyuelo M., Junqué C. and Ruano A. *Rehabilitación neuropsicológica: intervención y práctica clínica*. Barcelona: Elsevier-Masson, pp. 461-476; Nello, A. (coord.) (2011) *Vers una guia de bones pràctiques ètiques del cuidador no professional*. Barcelona: Ethos Ramon Llull (retrieved May 13, 2013, http://

1. We come from a tradition which, over the centuries, has been formulated through two great models on seniors: the Jewish root (which advocates respect for the elderly as a symbol of knowledge and accumulated experience) and the Greek root (which encourages people to stoically accept the chakras of age). Besides these two great models, there are other models which, given the intercultural perspective promoted by globalisation, reflect the new population composition of our society with even greater nuances.
2. The new social services outlook considers that the ethical approach surpasses the strictly professional dimension and straddles all citizens. The emphasis is placed more on the service to be rendered rather than on the professional rendering it. This means recognising that the code of conduct is insufficient, as it cannot go beyond conventional understanding, according to which we would be dealing with an asymmetric relationship: the power of the health professional over the seniors, reduced to the condition of service user. Here we are dealing with the revitalisation of the joint responsibility of the different actors involved in the quality of life of seniors, particularly non-professional caregivers.
3. In practice, this means that the general principles of professional ethics (principle of welfare, autonomy and justice) and the rules of good ethical practice (truth, confidentiality and loyalty) must be studied, also from the intercultural perspective.[36] It will thus be possible to ascertain if these guidelines have to be resized when taking into account the varying world view of the culture of the different groups involved: how the different ways that each culture has of understanding what is good for a person, their self-determination capacity and the respect due to them, transparency in communication, respect for confidential information and loyalty to the commitments taken on, affect quality of life. Here, it is undeniable that there is a huge amount of research yet to be done, which will help to optimise the service rendered to seniors, and therefore their quality of life.[37]

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ethos.url.edu/categories/Biblioteca/); Nello, A. (2012) Reptes ètics de l'atenció a la gent gran. *Aloma*, 30 (1), pp. 17-25.

[36] Beauchamp, T.L., Childress, J.F. (2001) *Principles of Biomedical Ethics*. 5th ed. New York: Oxford University Press.

[37] Ayalong, L. (2004) Cultural variants for caregiving or the culture or caregiving. *J Cult Divers*, 11 (4), pp. 131-138; Jones, P.S., Zhang, X.E., Jacelgo-Siegl, K., Meleis, A.I. (2002) Caregiving between two cultures: an integrative experience. *J Transcult*

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