Canadian Journal on Aging / La Revue canadienne du vieillissement

www.cambridge.org/cjg

Employee Experiences Providing Nutritional Care during the COVID-19 Pandemic

Heather Alford[1], Paulette Hunter[2] and Allison Cammer[1]

[1]College of Pharmacy and Nutrition, University of Saskatchewan, Saskatoon, SK, Canada and [2]Department of Psychology and Health Studies, University of Saskatchewan, Saskatoon, SK, Canada

Article

Cite this article: Alford, H., Hunter, P., & Cammer, A. (2024). Employee Experiences Providing Nutritional Care during the COVID-19 Pandemic. *Canadian Journal on Aging / La Revue canadienne du vieillissement* https://doi.org/10.1017/S0714980823000764

Received: 26 October 2022
Accepted: 03 November 2023

Mots-clés:
vieillissement; COVID-19; repas relationnel; soins de longue dur; ée; heures des repas; soins centr; és sur la personne; qualitatif

Keywords:
aging; COVID-19; relationship-centered dining; long-term care; mealtimes; person-centered care; qualitative

Corresponding author:
La correspondance et les demandes de tirésàpart doivent être adressées à : / Correspondence and requests for offprints should be sent to: Allison Cammer, University of Saskatchewan, Saskatoon, SK, Canada (allison.cammer@usask.ca).

Résumé

Les soins nutritionnels sont un élément essentiel de la prestation de soins dans les centres de soins de longue durée (CSLD). Liés au bien-être psychologique et physiologique des résidents ainsi qu'à la culture et la socialisation, ces soins sont toutefois souvent négligés. Plusieurs protocoles de contrôle des infections COVID-19 ayant perturbé les soins nutritionnels, cette étude visait à comprendre les expériences des employés face à ces changements et leurs répercussions. Sept entrevues semi-structurées ont été menées auprès d'employés de la santé de la Saskatchewan spécialisés dans diverses disciplines, qui ont tous joué un rôle dans le soutien des soins nutritionnels en CSLD. Les transcriptions de ces entrevues ont fait l'objet d'une analyse thématique réflexive. Trois thèmes principaux caractérisent les réflexions des personnes interrogées : la régression vers un environnement de repas institutionnel, des attentes irréalistes et de l'inquiétude pour les résidents. Compte tenu du rôle central des soins nutritionnels dans la qualité de vie des résidents, les stratégies visant à aider le personnel à fournir des soins nutritionnels centrés sur la personne doivent être mieux formulées afin de maintenir les normes de soins pour les résidents des CSLD au cours de futures propagations de virus et épidémies.

Abstract

Nutritional care is a critical, yet often overlooked component of quality care in long-term care (LTC) that is linked to culture, socialization, and residents' psychological and physiological well-being. Given that several COVID-19 infection control protocols affected nutritional care, this study aimed to understand employees' experiences of these changes. Seven semi-structured interviews were conducted with Saskatchewan healthcare employees from several disciplines, all of whom had a role in supporting nutritional care in LTC. The resulting interview transcripts were analyzed using reflexive thematic analysis. Three main themes characterized the interviewees' reflections: regression to an institutional mealtime environment, unrealistic expectations, and concern for residents. Given the centrality of nutritional care to quality of life, strategies tailored to support staff in providing relationship-centered nutritional care must be further articulated to maintain standards of care for LTC residents in future outbreaks and epidemics.

Overview

The COVID-19 pandemic disproportionately impacted Canada's long-term care (LTC) sector, with residents of LTC and seniors' homes accounting for more than 80 per cent of all reported COVID-19 deaths during the first wave of the pandemic (Canadian Institute for Health Information, 2021; Clarke, 2021). At the end of the second wave in March 2021, LTC and seniors' homes remained the population with the greatest proportion of outbreak-related cases and deaths, accounting for 50 per cent of all reported COVID-19 deaths in Canada (Clarke, 2021). A lack of well-established safety protocols and chronic under-resourcing in this sector had a devastating impact on LTC residents and their families and also had adverse consequences for employees (Chu et al., 2020; Clarke, 2021; Ickert et al., 2021; Saskatchewan, 2021).

The shortcomings of Canada's LTC sector have been widely reported during the COVID-19 pandemic, triggering responses from government and public health agencies aimed at establishing national standards for quality LTC. For instance, the Canadian government announced a billion-dollar Safe Long-Term Care Fund in support of new national standards in LTC along with $9.8 million for initiatives related to infection prevention and control. Alongside concern for safety, there has been recognition of several practical and ethical issues related to the conceptualization and implementation of safety measures in Canada's LTC facilities. In particular, the prevention of COVID-19 transmission has been prioritized, but the increase in safety protocols and infectious disease prevention practices has had unforeseen impacts on other areas

of quality care, including issues related to living conditions, resident autonomy, isolation, and reduced staffing (Rochon et al., 2022). Additionally, in contrast to some other nations, Canada emphasized infection prevention policies that limited social activities and restricted the presence of family and visitors, alongside more traditional policies such as symptom screening, the use of personal protective equipment, redeployment of staff, and strong hand hygiene practices (Government of Canada, 2021).

Infection prevention strategies are particularly important during mealtimes. One of the predominant settings for COVID-19 transmission is at restaurants, cafes, and other social gatherings where people often relax barrier gestures and interact without masks on (York, 2021). Mealtimes are inherently social in LTC homes, and many residents consider the dining experience essential to their quality of life (Chaudhury et al., 2017; Keller et al., 2021; Lam & Keller, 2012). For example, mealtimes offer residents the opportunity to enjoy a ritual of socialization linked to lifelong memories of special events and traditions that offer a source of comfort, familiarity, and security, making mealtimes socially, culturally, and psychologically significant (Chaudhury et al., 2013; Evans et al., 2005). Moreover, traditions around food preparation and consumption are linked to family origins, providing a powerful connection to one's identity that reinforces a positive sense of self (Evans et al., 2005; Lam & Keller, 2012). Nutritional care encompasses the supportive and therapeutic aspects of food of fluid intake that support basic biological and physiological functions, and which are accentuated by rich social connections to create a pleasurable mealtime experience and achieve standards of relationship-centered nutritional care (Keller et al., 2022; Sloane et al., 2008; ten Cate et al., 2021). Yet mealtime has also been a focus of COVID-19 precautions in LTC, with many homes implementing co-resident distancing requirements at mealtimes that included the isolation of residents exposed to COVID-19 (Government of Canada, 2021).

Previous research highlights the need for an improved understanding of multilevel (government, home, staff, resident, and family) barriers that healthcare employees face in providing quality relationship-centered nutritional care that supports not only increased quality of life for residents of LTC, but also represents the standards of care expected by stakeholders of the LTC sector in Canada (Brauer et al., 2022; Keller et al., 2022; Wu et al., 2020). In contrast, while the media has widely reported on the shortcomings of the LTC sector during the COVID-19 pandemic, meal service and nutritional care have been overlooked and underrepresented (Keller et al., 2021, 2022). The purpose of this study is to describe employees' experiences of providing meal service and nutritional care during the COVID-19 pandemic; particularly, the challenges faced by employees in balancing increased safety protocols and ideals of quality care throughout prolonged states of outbreak.

Method

This study followed a generic qualitative research methodology (Caelli et al., 2003; Kalke, 2014) and is positioned within a critical realist ontology and a constructionist epistemology, allowing for the interplay of the experience and subjectivity of the researcher with the expressions of the participants (Moon & Blackman, 2014). This study received approval through the University of Saskatchewan Behavioural Research Ethics Board (2021-2022-472-015).

Procedure

Recruitment

LTC employees involved in nutritional care were invited to participate in individual interviews from January to mid-February 2022. Since food service operations depend on the collaboration of team members from a range of departments, employees who participated in aspects of planning, execution, and/or evaluation of pandemic nutritional care in LTC were welcomed to participate. Out of respect for the workload of healthcare employees during the fourth wave of the COVID-19 pandemic, this study was completed outside of work hours. LTC employees were recruited through snowball sampling and invited to participate by volunteering time outside of work. The researchers began the snowball sampling process within their LTC networks through word of mouth and/or by e-mailing a recruitment poster. Interested participants were invited to connect with the researcher by email to schedule their interview and obtain a copy of the study information form.

Sample

Seven participants employed at five different LTC homes in Saskatchewan participated in the study. Six participants identified as women and one participant identified as a man, with an average age of 45 years. Participants' roles in LTC included a continuing care assistant, a registered nurse, a director of care and a director of nutrition support, a dietitian, a head cook, and a chief executive officer. On average, participants had been in their roles for six years, with previous healthcare experience ranging from two years to 22 years, working primarily in direct care roles. Participant characteristics are provided in Table 1.

Interview setting

Individual semi-structured interviews were conducted by the first author, a student researcher with professional training in psychology and culinary arts, who worked under the co-supervision of authors two and three. Because of COVID-19 pandemic restrictions in LTC, interviews were conducted virtually in a password-protected meeting on the University of Saskatchewan's secure Cisco WebEx video conferencing portal.

Data generation

All participants provided verbal consent prior to the interview. Interviews began with closed-ended demographic questions to characterize participants' positions in LTC. Then, interviews followed a guide designed by the research team to inquire about employee experiences of changes to workflow in meal service and nutritional care as a result of pandemic policies (Table 2). The interview guide relied on the laddered question technique, or Socratic dialogue (Price, 2002), to generate rich descriptions of employees' actions, thoughts, and beliefs, and how these intersect. Interviews lasted an average of 39 minutes, ranging from 25 to 50 minutes.

The interviews began with gaining a general understanding of the workings of the associated LTC home, including the layout, the number of individuals residing at the home, and volunteer and family member involvement prior to the pandemic. For additional context, the interview sought to understand meal service prior to the pandemic. This included understanding how meals were served, who was involved in coordinating meal service, and the role that volunteers and family members historically played in supporting meal service. Next, the focus shifted to understanding

https://doi.org/10.1017/S0714980823000764 Published online by Cambridge University Press

Table 1. Participant characteristics

Participant (n = 7)	Gender	Age	Role	Years in role	Location	Size of home(s)
1	Female	41	Dietitian	11	Multiple; Rural/Urban	Ranging from 30–240 residents
2	Female	58	Director of nutrition services	5	Urban	60 residents
3	Male	40	Registered nurse	2	Urban	230–260 residents
4	Female	53	Continuing care assistant	2	Urban	80 residents
5	Female	32	Director of care	6	Urban	60 residents
6	Female	62	Chief executive officer	4.5	Urban	60 residents
7	Female	31	Head cook	9	Rural	42 residents

Table 2. Semi-structured interview guide

1. I would like to start by learning a little about you
   a. If you are comfortable doing so, can you please tell me your gender identity and your current age?
   b. What do you do at [home name]? And what does that involve?
   c. How long have you worked for [home name] as a [role]? Did you work for any other healthcare settings or in any other roles before this job?
   d. Can you give me some sense of case counts among staff members, and the number of outbreaks at [home]?
2. I would like to learn a little more about [home name]
   a. Tell me about the layout of the home (Is it set up as floors, or wings, or cottages?)
   b. How many people live in each [floor, wing, or cottage]? And what about in the home overall?
   c. I am interested in learning about how volunteers were engaged in your home before the pandemic. (What did they do? Where do you notice changes in their involvement the most?)
   d. How involved were the residents' families? Where do you notice changes in their involvement the most?
3. Tell me about how meal service was traditionally coordinated at [home name] before the pandemic. How are meals served?
   a. Which staff roles are involved in coordinating meal service?
   b. What is your own role in meal service?
   c. Were people who are not on the staff, like families or volunteers, involved in any way? Tell me more
4. What was the biggest change your home was asked to make to meal service during the pandemic?
   a. What policies resulted in that change?
   b. How was work reorganized to accommodate this change? Can you walk me through it?
   c. How did this affect your own workload or how you balanced your day?
   d. What did you notice about how it affected other staff?
   e. Overall, what was the effect on the home? (e.g., general climate, social environment, sense of community)?
   f. What effects did this have on residents? (What type of feedback did you hear from residents? Did the changes affect the amount they ate or drank? How they felt
   g. Did you ever notice people trying to make mealtimes better for residents? What did they do?
   h. Did you do this before?
5. Were there other times of significant change?
6. Overall, compared to the beginning of the pandemic, how has meal service changed over the year?
   a. How has work been reorganized?
   b. How does this affect your own workload or how you balanced your day?
   c. What do you notice about the effect on other staff?
   d. Overall, what is the effect on the home?
   e. Overall, what is the effect on residents? (What type of feedback do you hear? Is there a change to the amount they eat or drink? Or how they feel?)
   f. Is there anything that is going better now than it was before? Tell me more about that
   g. Did you ever notice people trying to make mealtimes better for residents? What do they do? How did that go?
7. Thinking about the roles of family and volunteers at mealtime, overall, how has that changed during the pandemic?
   a. How was work reorganized to accommodate this change?
   b. How did this affect your own workload or how you balanced your day?
   c. What did you notice about how it affected other staff?
   d. Overall, what was the effect on the home?
   e. What effects did this have on residents?
8. To what extent does meal service factor into how you think about your work?
9. Let us say you were invited to a consultation meeting about the future of long-term care in Canada. If you were asked how meals should be planned in the future, what kinds of things might you say?
10. Let us say you happened to be in an elevator with a public health representative, and that person said to you, 'What is the most important thing for me to take into account in order to design a good meal service policy for outbreaks, epidemics, or pandemics that affect long-term care?' What would you say?

what changes occurred as a result of the pandemic and the associated infection control protocols. Finally, participants were asked how they experienced these changes. Employees were also asked to reflect on strategies to mitigate the effects of the pandemic on the quality of care provided in LTC. All interviews were recorded and transcribed verbatim by the first author. Additionally, the interviewer generated field notes after each interview to capture gestalt impressions, the tone and context of the interview, and non-verbal cues.

Analysis

Using NVivo v.12, an inductive qualitative approach to analysis, *reflexive thematic analysis,* was used to represent employee

https://doi.org/10.1017/S0714980823000764 Published online by Cambridge University Press

experiences in a way that can be shared, understood, and utilized by LTC stakeholders (Braun & Clarke, 2022; Campbell et al., 2021). The analysis involved iterative application of the six steps of thematic analysis while diligently reflecting on the research team's personal experiences within food service and LTC systems to produce descriptions of employees' experiences relevant to LTC policy and decision-makers (Braun & Clarke, 2022). Namely, analysis consisted of recursive immersion into the data, organization of meaningful groups of codes exemplifying overarching themes, and theme generation through discussion and deliberation amongst the research team (Braun & Clarke, 2022; Campbell et al., 2021).

Under the supervision of authors two and three, the first author used line-by-line coding to generate initial codes. The research team met weekly to discuss and reflect on findings and to focus subsequent data collection toward a greater understanding of emergent themes. As data were generated, codes were refined, and together, the research team identified overarching themes that encompassed and unified participants' shared experiences. Data generation concluded when the research team determined that interviews ceased to yield new information or expand additional themes. During the analysis, attention was given to previously published criteria for establishing trustworthiness in qualitative research, including credibility, transferability, dependability, and confirmability (Korstjens & Moser, 2018). For the purposes of this study, *credibility* means that the research will accurately reflect the social reality of LTC employees, and we attended to credibility by ensuring that each theme connected well to the experiences of most participants. Additionally, as the third author worked in LTC during this time, and the second author maintained a formal network of registered dietitian colleagues working in LTC, we were able to consider our interpretations against direct experience and ongoing disciplinary dialogue as the analysis unfolded. To maximize *transferability*, we inquired about relevant contextual details during the interviews in order to be able to more precisely describe not only the LTC context, but also the nature of the responsibilities and roles carried out by participants in their respective LTC facilities. *Dependability,* or the likelihood that others would find the results to be a reasonable translation of the interview data, was supported with the construction of a thematic map that represents the analytic narrative (Campbell et al., 2021), and detailed descriptions of the analysis process of generating findings (Korstjens & Moser, 2018). Finally, acknowledging the 'reflexivity' in reflexive thematic analysis, the research team met regularly to check assumptions, discuss the research findings, and reflect on how to employ these reactions in research, continually integrating the results of these discussions into the research process (Campbell et al., 2021).

Findings

Three main themes were identified in analyzing participants' descriptions of their experiences and interpretations of changes to meal service and nutritional care during the COVID-19 pandemic: *regression to an institutional mealtime environment (*characterized by ***s****tringent safety protocols strained relationships* and *fewer opportunities to enjoy the dining experience), unrealistic expectations (disparities between tasks and time* and *a depleted workforce),* and *concern for residents (moral distress about resident neglect).*

Regression to an institutional mealtime environment

Participants described pre-pandemic mealtimes in LTC as a place where residents, staff, family, volunteers, and other visitors gathered like a small community to share food, culture, and conversation, while collectively caring for residents. Participants primarily described two types of mealtime settings, one where a central dining room connected to the main kitchen and residents from all areas of the home gathered, and smaller, more intimate kitchenette settings where residents gathered in a more homelike fashion with those residing in a specific neighborhood of the home. In most cases, food service staff and continuing care assistants served and assisted residents, and family members were highly involved in assisting residents and socializing. For staff, mealtime served as an opportunity to build relationships and rapport with residents, and to interact with those whom they might otherwise not see throughout the day. Mealtimes offered a congregate setting for socialization and relational care that created the conditions conducive to a homelike feeling.

During the pandemic, the sense of community in LTC deteriorated. Participants explained that initial infection control precautions and restrictions required LTC homes to abruptly enforce lockdown policies, restricting family members, volunteers, and other visitors from entering the homes. Pandemic policies resulted in a sudden upheaval of familiar practices that disrupted meal service and particularly, the homelike dining environment. These changes are explained further in two subthemes: *stringent safety protocols strained relationships* and *fewer opportunities to enjoy the dining environment.*

Stringent safety protocols strained relationships

Each participant highlighted the impact that pandemic safety protocols had on the relational aspect of mealtimes. As the Saskatchewan Ministry of Health and Infection Prevention and Control Canada introduced policies and guidelines specific to in-person dining in LTC, it was required that wall dividers were set up and tables were spread out, and everyone was encouraged to stay six feet apart from one another. Physical distancing measures created barriers to communication and socialization during mealtimes, and also hindered staff members' ability to convey compassion to residents through gentle touch.

> You're serving from a distance and it is not the same as going up to the table, you don't have that same interaction… I want to keep that human touch with residents… When on isolation or outbreak, you don't have that same time or same interaction because they're in their room and you're talking from the door… Before, it was like family. You were talking to them up close and personal. Now, it's all from a distance and they're like, 'I can't hear you!' (Participant 2, Director of Nutrition Services)

Fostering meaningful relationships with and for residents became increasingly difficult as staff were required to enforce inherently isolating safety protocols, meaning formerly familial interactions between staff and residents at mealtimes became increasingly contrived.

Participants also talked about the ways in which visitor restrictions changed the dynamics at mealtimes. For instance, one participant explained that without the family members who were typically present and involved with assisting residents at mealtime, staff had to reorganize their work to accommodate assisting those residents. Meanwhile, because of physical distancing requirements,

https://doi.org/10.1017/S0714980823000764 Published online by Cambridge University Press

attending to several residents at one time became increasingly difficult. This resulted in reduced time spent with residents, less meaningful interactions, and a more task-based approach to mealtimes. Moreover, participants mentioned that staff consolidated tasks to increase efficiency and eliminate nonessential interactions with residents who were placed on isolation in their rooms throughout the day, including during nutritional care. Fewer, and less meaningful interactions between staff and residents coupled with the loss of family and volunteer presence severely impacted relationship-centered mealtime practices.

Fewer opportunities to enjoy the dining experience

Prior to the pandemic, mealtimes were, 'one of the few pleasures for residents living in long-term care' (Participant 1, Dietitian). However, because of the changes to nutritional care practices in LTC during the pandemic, participants described a shift in the atmosphere, explaining the impact that physical distancing requirements and visitor restrictions had on the social aspect of mealtimes.

> [Mealtimes] used to be buzzing, busy. It's still busy, but the life is not in the building like it was before, the joy. (Participant 2, Director of Nutrition Services)

> They're not eating as much because the eating is the social part of their day. So before, I would see more people more engaging, sitting longer, visiting. And if you're sitting and picking at food, not rushing, not sitting by yourself, you tend to pack a little more nutritional intake. (Participant 2, Director of Nutrition Services)

Special events that once brought people together came to a halt, and there was a loss of the shared dining experience that participants described as important to fostering relationships and helping residents feel at home in LTC pre-pandemic. Participants explained that special events offered staff the opportunity to contribute to residents' enjoyment and sense of belonging in their home as they unified residents, staff, and family as a community.

> Before, I would have more time to do special things for them, different treats. Now, I don't have time to do that. We did a cheese party or a tea party. I took joy in being able to do that for them, and my staff as well. Those little things we don't have time to do, everybody misses. Because you see the joy that it gives to them. When food's involved, everyone's around. More staff, more family, more visitors. Everybody loves food. (Participant 2, Director of Nutrition Services)

Participants reported that pandemic safety protocols confined staff to work within the most rote interpretations of their roles and responsibilities regarding nutritional care. An element of freedom was lost, which participants had previously used intentionally to provide experiences for the residents that they felt elevated the quality of nutritional care provided to residents. The shared experience of mealtimes was taken for granted pre-pandemic and began to feel like a luxury to participants in its absence during the pandemic.

> It just kind of changed the whole feeling at home while you're eating a meal. Cause you're far apart, you can't talk as well, you can't have as many residents sit at a table as they used to… we strive to say that this is their home and we do everything as much as possible to make it feel homey…when everything happened with COVID, it turned back into almost an institutional way of doing things because of all the things we had to switch. (Participant 5, Director of Care)

Pandemic infection control precautions and restrictions confined staff to strict task-based meal service, reducing opportunities to foster mealtime enjoyment for residents and their families. In addition to diminishing residents' experience of mealtime as an opportunity for socialization, participants also reported that the change in atmosphere compromised their feelings of fulfillment in their nutritional care roles as they perceived mealtimes as less opportune for enhancing residents' quality of life, and increasingly onerous.

Unrealistic expectations

Many participants discussed how the work associated with accommodating multiple dining areas that were adequately spaced never developed beyond stressful and chaotic, to become systematized and manageable. Participants described an initial panic as they were left to their own devices to find solutions when their regular practices were upset by new infection control protocols. For the most part, homes were quick to purchase protective equipment and supplies, but neglected to provide staff with other important resources or support, like additional human resources or strategies for coordinating changes to workflow. A lack of strategic food service pandemic planning left food service staff working to achieve unreasonably high expectations yet responsible to fulfill the basic need for food and hydration. Two subthemes, *disparities between tasks and time*, and *a depleted workforce* further describe participants' challenges in meeting expectations of pandemic nutritional care.

Disparities between tasks and time

Each participant discussed the increased time that it took to accommodate residents isolated to their rooms, either by choice or because of positive or suspected COVID cases. Specifically, changing protective equipment between each residents' room added a significant amount of time to meal service, and greatly reduced staff's ability to efficiently assist multiple residents at a time.

> It was so stressful. Having to put on that gown, having to put on a new glove to go in, come out, remove again, go to this person, put on. I mean, it took all of our strength. It was *exhausting.* It was exhausting. (Participant 4, Continuing Care Assistant)

> It's just another thing to add to the plate when you're already busy and stressed enough as it was prior to COVID. And just more and more that gets piled on. (Participant 5, Director of Care)

The added pressure of attending to residents individually created moral distress for participants, leaving them feeling guilty when regular tasks seemed impossible to complete day after day.

> Everyone just did what they had to do, and put in the time, put in the work… People were tired. People are tired… It's been a long time… It's two years in, people are exhausted. I would say the climate is probably a bit harder *now* than right when things started. (Participant 1, Dietitian)

Two years into the pandemic, participants explained that the initial intensity around their pandemic response to food service developed into frustration, mental and physical exhaustion, and burnout.

https://doi.org/10.1017/S0714980823000764 Published online by Cambridge University Press

A depleted workforce

Most participants mentioned the benefits of interdepartmental collaboration in mealtimes during the pandemic. However, each participant acknowledged the 'burnout and exhaustion and frustration' (Participant 5, Director of Care) attributed to the unreasonably high expectations and responsibility placed on LTC staff to maintain food service operations within the constraints of pandemic protocols and without additional resources.

> We still struggle with it every day. It's a struggle because we don't have more staff on than we did before. (Participant 7, Head Cook)

> We had anybody. We had housekeepers helping to serve meals just because we needed that extra help. (Participant 5, Director of Care)

Participants described many detriments associated with the loss of family support at mealtimes. The level of support previously provided by family caregivers at mealtimes was more noticeable in their absence during the pandemic, as staff undertook the added responsibility to care for residents and attend to their nutritional and social needs.

> It affects the staff because as much as it's great for the residents, it also was helpful to the staff to have the extra hands in the dining room. Because generally speaking, there are just never enough people to assist… to not have that all of a sudden and have your dining room all switched up as well, it creates stress for sure. (Participant 1, Dietitian)

Participants explained the dilemma they have faced throughout the pandemic in understanding the importance of mealtimes for residents in LTC while they carried mental and physical stress about attempting, yet often failing, to meet residents' nutritional care needs. Specifically, participants described that their mental and physical exhaustion worsened as the pandemic persisted and they perceived their best efforts at short-term fixes as failing to sustain residents' well-being and nutritional status.

Concern for the residents

Participants tied their interpretations of residents' experiences of the pandemic closely to their own. They empathized with the residents, knowing they were abruptly isolated from family and the outside world and stripped of the familiar patterns fundamental to their experience of LTC as home. For example, with evident distress, one participant described that most residents previously enjoyed meals with the same tablemates every day, then were suddenly seated alone and with barriers around them. Particularly for residents with dementia, participants lamented for residents' loss of familiarity and social care.

> They kept going to the doors and keep asking you to open the door. They want to go out. And many of them will say, 'Is my mom not coming?' Their mom or their dad or their brother… And you could see some of them really crying, like, 'I want to go home. I want to go home.' (Participant 4, Continuing Care Assistant)

Participants perceived isolation and loneliness as detriments to the aging experience in LTC during the pandemic.

> When you're part of a community and you don't get to see your friends and your mates next door, it becomes very lonely. The plagues of being older and boredom and loneliness. And we want to not have that for residents. We want them to feel accepted and loved and part of a community. (Participant 6, Chief Executive Officer)

Each participant recommended that LTC homes incorporate greater opportunities to empower residents to participate in their care planning in the future. Specifically, participants perceived involvement in nutritional care planning as beneficial to both staff and residents as it contributes to food service staff's ability to maximize resident's enjoyment of their mealtime experience, while presenting residents with the opportunity to establish connection and a sense of belonging within their community.

Moral distress about resident neglect

Participants described the pressure they felt in carrying an increased responsibility for residents' health and well-being in the absence of family presence. For nutritional care in particular, most participants acknowledged that there simply weren't enough resources to provide each resident with the care they needed.

> There's some who can take one hour to eat. And there's actually no time… It's a lot of pressure… I know that also their dental health needs to be taken care of. Most of the time, there's actually no time for every one of them. (Participant 4, Continuing Care Assistant)

A lack of family presence combined with the barriers staff faced in providing relational care left residents neglected.

> I don't think a lot of considerations have been given to the people who fall through the cracks and stop eating… We're not used to being in that position… They're lonely and they don't have an appetite. You don't have time to give time to that. Before, there was more time to sit with them and encourage them. Now, they're in a room by themselves or spending time alone, and who's noticing? (Participant 2, Director of Nutrition Services)

In the absence of family caregiver presence, staff became the primary witnesses of residents' experiences during the pandemic, which contributed to their moral distress and exhaustion. Participants warned that isolation and a lack of family and resident involvement in the pandemic responses in LTC were detrimental to residents' health and well-being, which 'lead to a lot of neglect and that lead to a lot of problems' (Participant 3, Registered Nurse).

Participants suggested that innovative collaboration and strategic planning need to be undertaken in order to ensure that policies and safety protocols protect and serve residents' holistic care needs. In particular, participants highlighted the urgent need for increased staffing levels to ensure LTC homes are appropriately equipped to provide the relational and social aspects of nutritional care that are vitally important to residents' nutritional outcomes and overall well-being.

Discussion

Nutrition and food service are critical components of quality care and quality of life in LTC and need to be treated as such. Participants described in rich detail their interpretations of mealtimes as essential to supporting and enhancing LTC residents' health and quality of life. However, throughout the COVID-19 pandemic, nutritional care remained an overlooked component of quality care which received scant institutional support. In the absence of family caregiver presence, LTC employees became the primary witnesses

https://doi.org/10.1017/S0714980823000764 Published online by Cambridge University Press

of changes to residents' health and well-being. Their observations about the deleterious outcomes of the LTC sector's nutrition care response on staff and resident well-being during the COVID-19 pandemic are fundamental to informing the conditions necessary to re-establish sustainable standards of quality nutritional care in LTC. These included observations of a *regression to an institutional mealtime environment, unrealistic expectations*, and *concern for residents*. Overall, a lack of pandemic preparedness and persistently deficient resources left staff burdened with unsustainable responsibilities and concerned about the inadequacy of nutritional care throughout the pandemic.

A fundamental issue with the COVID-19 pandemic response in LTC is that despite staff's best efforts, it negated these facilities as residents' homes. Wide-ranging restrictions devoid of consideration for residents' unique care needs diminished residents' personhood and agency within their homes, reinstating an oppressive culture of institutionalism in LTC (Baumann & Crea-Arsenio, 2022; McAiney et al., 2021). Relationship-centered care is widely recognized as the appropriate standard of care in LTC settings, and it has been recognized for several decades that 'quality of care and quality of life' are inseparable in LTC (Chaudhury et al., 2017; Law et al., 2017; Terkelsen et al., 2020; Zimmerman et al., 2014, p. S2). Yet some of the well-known, consistently reported challenges of implementing individualized, resident-focused care in LTC include insufficient staffing levels with high turnover rates, chronic underfunding and an overall lack of resources, outdated infrastructure that promotes assembly line work, and traditional organizational structures that are inconducive to implementing change (Berta et al., 2022; Zimmerman et al., 2014). This study provides evidence that the COVID-19 pandemic has accentuated to an inexcusable extent the difficulties that staff face in providing relationship-centered nutritional care in LTC during periods that require higher attention to infection control, underscoring the need for systemic changes in LTC.

Because mealtimes position staff as working with and for relationships with residents, mealtimes are a hub for relational work and contribute positively to staff's enjoyment of work and feelings of having contributed to residents' experience of LTC as home. However, hastily implemented pandemic policies impeded staff's ability to epitomize relational values in their nutritional care practices, which had severe implications on staff and residents' well-being. In fact, Byrd et al. (2021) found that existing evidence for the efficacy of some of the most widely adopted infection prevention and control measures aimed at preventing or managing the spread of COVID-19 in institutional care settings, including visitor restrictions and resident isolation, is of very low certainty. Others have reported that some of these pandemic response measures severely impacted the well-being of residents and their care providers (Ickert et al., 2021; Keller et al., 2021; Low et al., 2021; McAiney et al., 2021). The misgivings of LTC sector's pandemic response have been widely reported (Fisman et al., 2020; Titley et al., 2022; Vellani et al., 2022) and are likely due to the dearth of data on residents' experiences and quality of life, quality of care, and staff's quality of work life (Byrd et al., 2021; McAiney et al., 2021).

Supporting LTC employees' autonomy, choice, and collaboration in their practices are well-documented ways in which leadership and decision-makers create humanistic work environments in LTC (Armstrong et al., 2009). Similarly, participants in the present study expressed an appetency to prioritize collaborative approaches to nutritional care practices in LTC, including for improved pandemic response strategies. These findings reflect an attitudinal and cultural shift in favor of co-designed care models, offering hope that relationship-centered nutritional care in LTC is not only attainable, but probable with the appropriate supports set in place. Engaging employees directly involved in food service operations and mealtime supports when making decisions which affect their work and ability to provide relationship-centered care is key to ameliorating work conditions for LTC staff, supporting their optimal performance, and meeting the collective goal of nourishing residents' care needs. Particularly during periods of outbreak, when decisions regarding the essentiality and boundaries of employees' roles have implications on staff mix and ratios, work environment, and quality of care, encouraging employee participation as well as employee-leadership collaboration is critical for prioritizing goals of care and developing strategies to mitigate the negative impacts of employee burnout and resource scarcity (Berta et al., 2022; Vellani et al., 2022).

As reported by Keller et al. (2017), undernutrition in LTC is common but preventable with increased description and understanding of its detriments. This study advances our understanding of multi-level (resident, staff, facility, and system) interactions that contributed to issues of food and fluid intake in LTC throughout the pandemic (Keller et al., 2021, 2022). Pandemic policies inclusive of visitor restrictions and physical distancing requirements depleted an already scarce workforce, resulting in what staff perceived as inadequate nutritional care and intake for residents. Consistent with others (Ickert et al., 2021; Keller et al., 2021), these findings affirm that already-present issues of understaffing were exaggerated within the constraints of pandemic restrictions, meaning staff faced inordinately persistent ethical dilemmas in failing to meet residents' nutritional care needs.

According to Lowndes et al. (2018), funding restrictions that control food provision, acquisition of dietary staff, and hours allotted to mealtimes negatively impact the quality of nutritional care in LTC. Prior to the COVID-19 pandemic, deficient resource allocation to food service departments impeded LTC staff's ability to meet experts' recommendations of providing a minimum of 20 minutes of individualized nutritional care per meal for residents requiring eating assistance (Lowndes et al., 2018). Continued issues of understaffing throughout the pandemic, particularly in food service departments where staff rely heavily on unpaid caregivers to supplement care provisions, meant staff were sorely underequipped to meet residents' individual care needs. Issues of inadequate funding for food service operations existed pre-pandemic and were heightened to ethically burdensome extremes for LTC employees during the pandemic. It is essential to the integrity of Canada's LTC system that the adversities LTC staff and residents faced are not overlooked as issues unique to the COVID-19 pandemic, but rather serve as evidence of the dire fragility of our aged care system, including obvious limitations in its capacity to care for Canada's aging population in its current state.

Staff's ability to meet standards of relationship-centered nutritional care depends on the adequacy of multilevel systems and supports, including policies considerate of LTC residents' needs and goals, the role of family caregivers in supporting improved psychosocial outcomes for residents and staff, and appropriate resource allocation to food service departments that preserve staff's ability to perform optimally in their roles or be resilient to shocks, including epidemics and pandemics (Brauer et al., 2022; Ickert et al., 2021; Keller et al., 2021, 2022; Wu et al., 2020). As such, it is critical that reimagined and re-established standards of nutritional care in LTC are humanistic and sustainable for staff, so that these standards are ultimately conducive to humanistic, nourishing, and life-enhancing care for residents.

https://doi.org/10.1017/S0714980823000764 Published online by Cambridge University Press

Limitations

There are limitations to this study that should be considered. First, participants noted a recent rise in COVID-19 outbreaks within their respective homes at the time of interview, as well as an increase in staff illnesses which were particularly taxing for already scarcely staffed facilities. This reduced the potential sample size and diversity of represented homes and may have influenced participants' impressions of global capacity limitations during the pandemic. Next, the research question for this study focused on understanding the staff experience, yet participants tied a great deal of their ideas of pandemic nutritional care to their interpretations of residents' experiences. Further investigation into residents' experiences is needed to explicate how employees' experiences and quality of nutritional care relate to residents' quality of life. Infection control procedures made it very difficult for researchers to engage directly with residents during the pandemic, yet the only way to understand their experience directly is to observe and inquire about it directly.

Conclusion

The COVID-19 pandemic has underscored the fragility of the LTC sector in Canada, highlighting a need for changes that support standards of quality care that Canadians can rely on to support our aging population. During this study, the importance of nutritional care as foundational to quality of life for LTC residents was emphasized by staff who became the primary witnesses of residents' health and well-being in the absence of family caregiver presence. Toward upholding standards of relationship-centered nutritional care in future pandemic, epidemic, and outbreak situations, participants called for collaborative innovation inclusive of LTC residents, families, staff, leaders, and decision-makers.

Acknowledgments. The authors would like to thank the healthcare professionals working throughout the COVID-19 pandemic, with special appreciation for the time and contributions of those participating in long-term care research.

References

Armstrong, P., Banerjee, A., Szebehely, M., Armstrong, H., Daly, T., & Lafrance, S. (2009). *They deserve better: The long-term care experience in Canada and Scandinavia*. Canadian Centre for Policy Alternatives.

Baumann, A., & Crea-Arsenio, M. (2022). Rights versus risks: The impact of isolation on residents and families in long-term care. *Healthcare Policy*, **17**, 133–144. http://doi.org/10.12927/hcpol.2022.26849

Berta, W. B., Stewart, C., & Baumann, A. (2022). What is old is new again: Global issues influencing workers and their work in long-term care. *Healthcare Policy*, **17**, 66–90. http://doi.org/10.12927/hcpol.2022.26853

Brauer, P., Mardlin-Vandewalle, L., & Whittington-Carter, L. (2022). National long term care standards project: Recommended food & nutrition standards. *Dietitian of Canada.* https://www.dietitians.ca/DietitiansOfCanada/media/Documents/Resources/GN-National-Long-Term-Care-Food-and-Nutrition-Standards-Project-Background-2022.pdf

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage Publications.

Byrd, W., Salcher-Konrad, M., Smith, S., & Comas-Herrera, A. (2021). What long-term care interventions and policy measures have been studied during the COVID-19 pandemic? Findings from a rapid mapping review of the scientific evidence published during 2020. *Journal of Long-term Care*, 423–437. https://doi.org/10.31389/jltc.97

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as Mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods*, **2** (2), 1–13. https://doi.org/10.1177/160940690300200201

Campbell, K. A., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., et al. (2021). Reflexive thematic analysis for applied qualitative health research. *The Qualitative Report*, **26**(6), 2011–2028. https://doi.org/10.46743/2160-3715/2021.5010

Canadian Institute for Health Information. (2021, March 30). *The impact of COVID-19 on long-term care in Canada: Focus on the first 6 months.* https://www.cihi.ca/sites/default/files/document/impact-covid-19-long-term-care-canada-first-6-months-report-en.pdf

Chaudhury, H., Hung, L., & Badger, M. (2013). The role of physical environment in supporting person-centered dining in long-term care: A review of the literature. *American Journal of Alzheimer's Disease & Other Dementias*, **28**(5), 491–500. https://doi.org/10.1177/1533317513488923

Chaudhury, H., Hung, L., Rust, T., & Wu, S. (2017). Do physical environmental changes make a difference? Supporting person-centered care at mealtimes in nursing homes. *Dementia*, **16**(7), 878–896. https://doi.org/10.1177/1471301215622839

Chu, C., Donato-Woodger, S., & Dainton, C. (2020). Competing crises: COVID-19 countermeasures and social isolation among older adults in long-term care. *Journal of Advanced Nursing*, **76**(10), 2456-2459. https://doi.org/10.1111/jan.14467

Clarke, J. (2021, June 10). *Impacts of the COVID-19 pandemic in nursing and residential care facilities in Canada*. Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/45-28-0001/2021001/article/00025-eng.pdf?st=p4uiIMla

Evans, B. C., Crogan, N. L., & Shultz, J. A. (2005). The meaning of mealtime: Connection to the social world of the nursing home. *Journal of Gerontological Nursing*, **31**(2), 11–17. http://cyber.usask.ca/login?url=https://www.proquest.com/scholarly-journals/meaning-mealtimes-connection-social-world-nursing/docview/204149931/se-2?accountid=14739

Fisman, D. N., Bogoch, I., Lapointe-Shaw, L., McCready, J., & Tuite, A. R. (2020). Risk factors associated with mortality among residents with coronavirus disease 2019 (COVID-19) in long-term care facilities in Ontario, Canada. *JAMA Network Open*, **3**(7), e2015957. https://doi.org/10.1001/jamanetworkopen.2020.15957

Government of Canada. (2021, November 2). *Infection prevention and control for COVID-19: Interim guidance for long-term care homes.* https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevent-control-covid-19-long-term-care-homes.html

Ickert, C., Stefaniuk, R., & Leask, J. (2021). Experiences of long-term care and supportive living residents and families during the COVID-19 pandemic: "It's a lot different for us than it is for the average Joe". *Geriatric Nursing*, **42** (6), 1547–1555. http://doi.org/10.1016/J.GERINURSE.2021.10.012

Kalke, R. M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods*, **13** (1), 37–52. https://doi.org/10.1177/160940691401300119

Keller, H., Trinca, V., Dakkak, H., Wu, S., Bovee, S., Carrier, N., et al. (2021). Impact of COVID-19 on relationship-centred residential dining practices. *Canadian Journal on Aging*, **40**(4), 604–618. https://doi.org/10.1017/S0714980821000568

Keller, H. H., Carrier, N., Slaughter, S., Lengyel, C., Steele, C. M., Duizer, L., et al. (2017). Making the most of mealtimes (m3): Protocol of a multi-centre cross-sectional study of food intake and its determinants in older adults living in long term care homes. *BMC Geriatrics*, **17**(1), 1–15. https://doi.org/10.1186/s12877-016-0401-4

Keller, H. H., Syed, S., Dakkak, H., Wu, S. A., & Volkert, D. (2022). Reimagining nutrition care and mealtimes in long-term care. *JAMDA*, **23**, 253–260. http://doi.org/10.1016/j.jamda.2021.12.021

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, **24**(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Lam, I. T. Y., & Keller, H. H. (2012). Honoring identity through mealtimes in Chinese Canadian immigrants. *American Journal of Alzheimer's Disease & Other Dementias*, **30**(7), 662–671. https://doi.org/10.1177/1533317512449727

Law, K., Patterson, T. G., & Muers, J. (2017). Staff factors contributing to family satisfaction with long-term dementia care: A systematic review of the

literature. *Clinical Gerontologist*, **40**(5), 326–351. https://doi.org/10.1080/07317115.2016.1260082

Low, L.-F., Hinsliff-Smith, K., Sinha, S. K., Stall, N. M., Verbeek, H., Siette, J., et al. (2021). Safe visiting is essential for nursing home residents during the COVID-19 pandemic: An international perspective. *The Journal of Post-Acute and Long-Term Care Medicine*, **22**(5), P977–P978. https://doi.org/10.1016/j.jamda.2021.02.020

Lowndes, R., Daly, T., & Armstrong, P. (2018). "Leisurely dining": Exploring how work organization, informal care, and dining spaces shape residents' experiences of eating in long-term residential care. *Qualitative Health Research*, **28**(1), 126–144. https://doi.org/10.1177/1049732317737979

McAiney, C., Conway, E., Koch, M., Middleton, L., Dupuis, S., Keller, H., et al. (2021). In their own words: How COVID-19 has impacted the well-being of persons living with dementia in the community. *Canadian Journal on Aging / La Revue Canadienne Du Vieillissement*, **40**(4), 543–553. https://doi.org/10.1017/S0714980821000441

Moon, K., & Blackman, D. (2014). A guide to understanding social science research for natural scientists. *Conservation Biology*, **28**(5), 1167–1177. https://doi.org/10.1111/cobi.12326

Price, B. (2002). Laddered questions and qualitative data research interviews. *Journal of Advanced Nursing*, **37**(3), 273–281. https://doi.org/10.1046/j.1365-2648.2002.02086.x

Rochon, P. A., Li, J. M., Johnstone, J., Brown, K. A., Armstrong, P., Tanuseputro, P., et al. (2022). The COVID-19 pandemic's impact on long-term care home: Five lessons learned. *Science Briefs of the Ontario COVID-19 Science Advisory Table*, **3**(60), 1–14. https://doi.org/10.47326/ocsat.2022.03.60.1.0

Saskatchewan, O. (2021, August). *Caring in crisis: An investigation into the response to the COVID-19 outbreak at Extendicare Parkside.* https://ombudsman.sk.ca/app/uploads/2021/08/Caring-in-Crisis-Full-Report.pdf

Sloane, P. D., Ivey, J., Helton, M., Barrick, A. L., & Cerna, A. (2008). Nutritional issues in long-term care. *Journal of the American Medical Directors Association*, **9**(7), 476–485. https://doi.org/10.1016/j.jamda.2008.03.005

ten Cate, D., Schoonhoven, L., Huisman-de Waal, G., Schuurmans, M. J., & Ettema, R. G. A. (2021). Hospital and home care nurses' experiences and perceptions regarding nutritional care for older adults to prevent and treat malnutrition: A cross-sectional study. *Journal of Clinical Nursing*, **30**(13–14), 2079–2092. https://doi.org/10.1111/jocn.15764

Terkelsen, A. S., Petersen, J. V., & Kristensen, H. K. (2020). Mapping empirical experiences of Tom Kitwood's framework of person-centred care for persons with dementia in institutional settings. A scoping review. *Scandinavian Journal of Caring Sciences*, **34**, 6–22. https://doi.org/10.1111/scs.12709

Titley, H. K., Young, S., Savage, A., Thorne, T., Spiers, J., & Estabrooks, C. A. (2022). Cracks in the foundation: The experience of care aides in long-term care homes during the COVID-19 pandemic. *Journal of the American Geriatrics Society*, **71**, 198–205. https://doi.org/10.1111/jgs.18024

Vellani, S., Zuniga, F., Spilsbury, K., Backman, A., Kusmaul, N., Scales, K., et al. (2022). Who's in the house? Staffing in long-term care homes before and during COVID-19 pandemic. *Gerontology and Geriatric Medicine*, **8**, 23337214221090803. https://doi.org/10.1177/23337214221090803

Wu, S. A., Morrison-Koechl, J., Slaughter, S. E., Middleton, L. E., Carrier, N., McAiney, C., et al. (2020). Family member eating assistance and food intake in long-term care: A secondary data analysis of the M3 study. *Journal of Advanced Nursing*, **76**(11), 2933–2944. http://doi.org/10.1111/jan.14480

York, J. (2021, February 8). *Eating together spreads COVID, third French study confirms.* The Connexion: French news and views. https://www.connexionfrance.com/French-news/French-study-finds-social-meals-increase-Covid-contamination

Zimmerman, S., Shier, V., & Saliba, D. (2014). Transforming nursing home culture: Evidence for practice and policy. *The Gerontologist*, **54**(S1), S1–S5. https://doi.org/10.1093/geront/gnt161