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Navigating Mealtimes to Meet Public Health Mandates in Long-Term Care During COVID-19: Staff Perspectives

RESEARCH

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ABSTRACT

Context: Mealtimes in long-term care (LTC) settings play a pivotal role in the daily lives of residents. The COVID-19 pandemic and the required precautionary infection control mandates influenced many aspects of resident care within LTC homes, including mealtimes. Limited research has been conducted on how mealtimes in LTC were affected during the pandemic from staff perspectives.

Objective: To understand the experiences of LTC staff on providing mealtimes during the pandemic.

Methods: Semi-structured telephone interviews were conducted with 22 staff involved with mealtimes between February and April 2021. Transcripts were analysed using interpretive description.

Findings: Three themes emerged from the analysis: (1) *recognizing the influence of homes' contextual factors*. Home size, availability of resources, staffing levels and resident care needs influenced mealtime practices during the pandemic; (2) *perceiving a compromised mealtime experience for residents and staff*. Staff were frustrated and described residents as being dissatisfied with mealtime and pandemic-initiated practices as they were task-focused and socially isolating and (3) *prioritizing mealtimes while trying to stay afloat*. An 'all hands-on deck' approach, maintaining connections and being adaptive were strategies identified to mitigate the negative impact of the mandates on mealtimes during the pandemic.

Limitations: Perspectives were primarily from nutrition and food service personnel.

Implications: Overly restrictive public health measures resulted in mealtime practices that prioritized tasks and safety over residents' quality of life. Learning from this pandemic experience, homes can protect the relational mealtime experience for residents by fostering teamwork, open and frequent communication and being flexible and adaptive.

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INTRODUCTION

Mealtimes in long-term care (LTC) homes are fundamental aspects of residents' day-to-day life and stretch far beyond simply nutrition (Watkins et al., 2017). Eating with others provides residents with a sense of structure and autonomy, and importantly, an opportunity for building relationships and making social connections (Trinca et al., 2020a). Older adults living in LTC were disproportionately impacted by the COVID-19 pandemic (Thompson et al., 2020). In Canada, over 80% of reported COVID-19-related deaths were among this population (CIHI, 2020). The LTC sector underwent many changes in response to mandated precautions outlined by local public health agencies in efforts to protect residents from the virus, including restricting communal activities like dining or recreational events (Chu, Yee & Stamatopoulos, 2022) and limiting the access of families, volunteers and visitors into homes (Vilches et al., 2021). Furthermore, 30% of those LTC staff who were employed part-time in multiple LTC homes were required to limit their work to a single home so as to reduce the spread of the virus in most Canadian provinces (Estabrooks et al., 2020); this in turn further aggravated staffing shortages (Bethell et al., 2021; Jones et al., 2021). Reduced workforce, in combination with an increased workload and restricted support from family caregivers, resulted in staff feeling burnt-out, stressed and anxious throughout the pandemic (Hung et al., 2022; White et al., 2021). Restrictive pandemic public health orders, while perceived as necessary at the time to save lives, negatively impacted the ability of homes to provide social care to residents, particularly at mealtimes (Cooke et al., 2023; Keller et al., 2021; Montgomery, Slocum & Stanik, 2020).

Mealtimes have been identified as an opportunity to exercise social models of care, such as relationship-centred care – a philosophy of care that promotes reciprocity and the quality of relationships between residents, home staff and families (Adams & Gardiner, 2005). Within the context of mealtimes, this care philosophy recognizes the essential role eating with others plays in residents' lives (Nolan et al., 2004; Trinca et al., 2020a; Wu et al., 2020). An example of relationship-centred care practice during mealtimes is reinforcing meaningful relationships through engaging residents in social conversation. However, more often than not, mealtimes can become task-focused where priority is placed on task completion and efficiency (Liu, Perkhounkova & Hein, 2022; Wu et al., 2023), such as rushing residents out of the dining room in order to begin mealtime clean-up. Despite the vital role mealtimes play within LTC home communities, public health orders promoted task-focused care that emphasized keeping residents safe from COVID-19, resulting in missed opportunities for meeting residents' relational needs with other residents, family members and staff (Ickert, Stefaniuk & Leask, 2021). Staff often perceived these mandates as unclear (White et al., 2021), which included vague physical distancing mandates without clear direction on how homes could achieve them. They were also required to complete additional tasks such as implementing new policies and procedures, and communicating changing policies with residents, staff and families (Snyder et al., 2021). The mandated changes and their timing for implementation were outside of the control of homes, which helps to explain why there was considerable variability in the adoption of these policies among homes (Estabrooks et al., 2020). Mealtime practices during the COVID-19 pandemic were also impacted by these mandates. For instance, distancing requirements between dining tables necessitated restricting the number of residents in the dining rooms, and in some instances, required residents to eat in their rooms for extended periods of time (Keller et al., 2021). Restricting family and volunteer access into homes also impacted the dining experience, as these caregivers play a critical role in supporting mealtimes, including reinforcing identity by bringing in favourite foods and providing the resident with careful eating assistance (Stall et al., 2020; Wu et al., 2020). Such restrictions further contributed to social isolation and feelings of loneliness during this unprecedented time (Smith et al., 2022).

While pandemic-focused research has examined the impact of public health restrictions in LTC from a variety of perspectives (Thompson et al., 2020; Ickert, Stefaniuk & Leask, 2021; Palacios-Ceña et al., 2021; Vellani et al., 2022), there remains a limited understanding of how mealtimes were managed by staff during the first waves of the pandemic. Given that mealtimes are a vital component to supporting LTC communities, and the social, physical health and well-being of residents, focusing on the impact of pandemic precautions on staff mealtime practices can further guide how we manage similar crises in the future including infectious disease outbreaks. The aim of this study was to examine the experiences of Canadian LTC staff involved in mealtime care during the COVID-19 pandemic. Specifically, we sought to identify mealtime changes and challenges, and understand how they were managed during the pandemic, to learn from this experience and improve future practice.

METHODS

RECRUITMENT AND PARTICIPANTS

This qualitative study was completed in conjunction with a larger online survey study (July to September 2020) that investigated the perspectives of healthcare professionals on mealtime practices in LTC after the first wave of the pandemic, including changes that resulted from COVID-19 precautions put into place, and specifically these effects on relational mealtimes that focus on social and relationship building activities (Keller et al., 2021). At

the end of this survey, participants could volunteer their contact information to be invited to participate in an interview to gain a more in-depth understanding about their experiences managing mealtime practices during the pandemic and impact on relational dining.

Interview participants were recruited at the beginning of 2021. Inclusion criteria included (1) currently working in a Canadian LTC home and not performing work remotely; (2) employed at least 0.5 full-time equivalent hours and (3) directly involved with food and/or mealtime service, such as menu planning, food service and/or providing resident eating assistance. A study information letter was sent to the participants via email. Verbal consent was obtained from participants prior to the start of the interview. Ethics approval was obtained from the University of Waterloo (ORE#42335) and the University of Alberta (Pro00113653).

DATA COLLECTION

A semi-structured interview guide was created and reviewed by members of the research team focusing on relationship-centred mealtime care before the pandemic and changes during the pandemic (Table 1). Interview questions used in this analysis focused on understanding participants' role within the LTC home; dining changes made during the COVID-19 pandemic; challenges that accompanied COVID-19 precautions and their perceived impact on residents, families, and staff; efforts to promote relational mealtimes despite restrictions and strategies used to balance the increased safety precautions with resident quality of life. Participant demographic data were captured in the initial online survey.

Of the original survey sample ($n = 1138$), approximately 16% indicated interest in completing an interview and met the inclusion criteria ($n = 162$). Purposive sampling was used to select participants with diverse experiences (e.g., geographical representation, staff role) from this subset of our original survey respondents, based on their reported demographic characteristics. We over-recruited by emailing approximately a third of this group in three waves beginning in January 2021, recognizing that some may have left their organization, may no longer have interest in participating and/or may be inundated with their current work duties and unable to participate. Only those participants who responded to this email were interviewed. Semi-structured interviews were conducted by author HD with 22 home staff via telephone between February and April 2021. Interviews were audio recorded and transcribed verbatim. Interview length ranged from 18 to 48 min in length (average ~30 min). Participants were de-identified prior to analysis.

DATA ANALYSIS

Interpretive description is a qualitative research methodology based on a naturalistic and contextual approach aiming to produce meaningful knowledge that can be directly applied in healthcare settings and to inform practice (Moisey et al., 2022; Thorne, 2016). This methodological approach was the best fit to answer our research question and to examine the experiences of staff managing mealtimes during the pandemic, and was used as described by Thorne (2016). The first author, a registered dietitian with experience working in LTC, collected and analysed the data.

Initial analysis was completed by HD using five transcripts to create an initial inductive coding scheme, with a preliminary definition and example data (i.e., quotes) to represent the code. Remaining transcripts were coded using these broad coding categories and by answering 'What is going on here?' (Hunt, 2009); where new codes were identified, they were similarly defined and described. Codes were used to make connections

INTERVIEW QUESTIONS
1. Can you tell me what your role is and how long you have been working in this home?
2. What dining changes were made in your home during the COVID-19 pandemic?
3. What were some of the challenges you noticed with these precautions? How did it affect residents? How did it affect team members? How did it affect family members?
4. What sorts of things did your home attempt to do to bring fun and interest to mealtimes and make them as social as possible during the time when precautions were in place? What was helpful to support putting these into place?
5. Tell me about how your home balanced the increased safety precautions due to COVID-19 with resident quality of life. Any key lessons learned?
6. Now think back to before COVID-19. On a scale of 1 to 5 where 5 is fully relationship-centered and 1 is not relationship-centered at all, how would you rate your home pre-COVID-19 on relationship-centred care? Can you tell me about why you chose that rating?
7. How has your home tried to incorporate resident- and relationship-centred care at mealtimes before the pandemic? During the pandemic?
8. How do you know whether relationship-centered care is happening during mealtimes in your care home?
9. Aside from the challenges during the pandemic, what have been your challenges with relationship-centred mealtimes?
10. What do you see as the future for dining in long-term care?

Table 1 Semi-Structured Interview Guide.

and recognize patterns among the data (Moisey et al., 2022). Codes were discussed by HD and HK to determine emerging themes, and subsequently used to create an initial thematic document to share with co-authors. This thematic document summarized key concepts and data examples into initial thematic groupings. Transcripts were reviewed by HD throughout the analysis to support the development of themes. These initial themes were examined and discussed by HD, HK, SW and AC, to continue and extend the analysis and support interpretation. Themes were discussed and finalized with all authors using a later version of the thematic document. Analysis continued through the writing of the first drafts of the findings. Credibility of the findings was enhanced by documenting the analytic decision-making process and practising reflexivity (Thorne, 2016). Confirmability was supported through transparency of recruitment strategies, presentation of study methods, data collection and analysis and rich description alongside verbatim data excerpts (Thorne, Kirkham & O'Flynn-Magee, 2004).

RESULTS

PARTICIPANT CHARACTERISTICS

Twenty-two staff participated, the majority of whom were female (81.8%), over half between 40 and 55 years of age (52.4%) and 60% had been working for ≥5 years in LTC. The largest group were dietitians (41.0%), food service managers (27.3%) or both (i.e., dietitian/food service manager: 9.10%). Half worked in Ontario LTC homes (50.0%), with almost three-quarters working in non-profit and/or independent homes (73.0%). Table 2 summarizes participants and home demographics.

Three overarching themes underpinned participants' perceptions and experiences with mealtimes during the pandemic. The first, *recognizing the influence of the home's contextual factors*, highlights the effect of home size, resource availability, staffing levels and resident care needs on mealtime practices. The second, *perceiving a compromised mealtime experience for residents and staff*, describes the negative impact of the pandemic on mealtimes. The third, *prioritizing mealtimes while trying to stay afloat*, captures strategies employed by the home to uphold the mealtime experience during the pandemic.

RECOGNIZING THE INFLUENCE OF THE HOMES' CONTEXTUAL FACTORS

The ways in which LTC homes modified mealtime practices in response to public health orders in the first two waves of the pandemic (i.e., February 2020–February 2021) were impacted by contextual factors in each home, including home size (i.e., number of beds and size of the facility), availability of resources (e.g., food carts, tables),

PARTICIPANT CHARACTERISTICS	% (n)
Sex (n = 22)	
Female	81.8% (18)
Male	18.2% (4)
Age (n = 21)	
18–25	9.5% (2)
26–39	14.3% (3)
40–55	52.4 % (11)
56+	23.8% (5)
Job Category (n = 22)	
Dietitian	41.0 % (9)
Foodservice manager	27.3% (6)
Dietitian/Foodservice manager	9.1% (2)
Director of Care	9.1% (2)
General manager	4.6% (1)
Recreational therapist	4.6% (1)
Foodservice worker	4.6% (1)
HOME CHARACTERISTICS	
Home Location (n = 22)	
Ontario	50.0% (11)
Alberta	23.0% (5)
New Brunswick	9.0% (2)
Manitoba	4.5% (1)
Nova scotia	4.5% (1)
Saskatchewan	4.5% (1)
British Colombia	4.5% (1)
Profit status (n = 22)	
For Profit	27.0% (6)
Not for Profit	73.0% (16)
Continuum of Care	41.0% (9)
Chain status (n = 22)	
Part of a Chain	27.0 % (6)
Independent	73.0 % (16)
Age of the building (n = 22)	
<5 years	9.1 % (2)
5–10 years	13.6% (3)
11–20 years	9.1% (2)
21+ years	68.2% (15)
Number of beds (n = 22)	
Small (20–49 beds)	4.6% (1)
Medium (50–99 beds)	9.1% (2)
Large (≥100)	86.3% (19)

Table 2 Participants and Home Demographics.

staffing levels and resident care needs. Participants reported that physical space was a factor influencing mealtime practices during the COVID-19 pandemic. The precautionary requirement for physical distancing meant that residents were spread out throughout the home during mealtimes which resulted in isolating dining as opposed to shared mealtimes. Residents living in smaller homes were at an even greater disadvantage due to limited space availability; this requirement often resulted in confining residents to their rooms and then using unusual spaces such as hallways or TV lounges that were not intended to be used for meals in order to maintain physical distancing. Some homes were unable to maintain physical distancing between residents throughout the pandemic because of these spacing issues and instead elected to move residents back to the dining room to support their mental well-being, rather than isolating residents in their rooms. Other adaptations such as plastic dividers were sometimes used in the dining room, with variable success. While this allowed residents to gather at meals, it created another barrier by reducing the opportunity for residents to connect with others in the dining room due to challenges with speaking loud enough to be heard. Regardless of the strategies put into place to support physical distancing, it was recognized that these alterations resulted in less desirable practices: ‘We can’t have all the residents in the dining room… So, it’s all task-focused, which is unfortunate.’ (P18, Food Service Manager). The additional time and distance it took for staff to deliver meals limited their opportunities to facilitate interactions with the residents and create a positive mealtime environment where the focus was beyond food provision.

Availability of food service resources was another key factor that influenced meal delivery and adaptations made during the pandemic. Participants described having limited resources to implement some of the modified mealtime procedures, especially around the logistics of alternative meal delivery for residents to eat in their rooms. This included food delivery equipment, food trays or personal tables required to serve residents their meals, in addition to disposable dishes and ways of keeping the food warm. Participants described using the resources they had available at the home to serve meals despite their lack of fit. For instance, a registered dietitian described using folding tables at meals to maintain physical distancing, however, these tables were not suitable for residents with wheelchairs or those who required positioning support. Resource availability could depend on the budget for new equipment, but also availability of these materials considering accessibility and supply chain issues due to the global impact of the pandemic. Additionally, participants described challenges during periods of active outbreak and having to rapidly adopt different food service operations related to meal ordering and delivery.

> I know with the ordering and purchasing of food, the dietary manager finds it really frustrating … because when we’re in outbreak we have the outbreak menu put out by the corporate level. So, she already pre-orders her food for the next two days and then we go into outbreak … So, they don’t have any of the food in stock and the food that we have we’re not supposed to be using according to this outbreak menu. (P3, Dietitian).

Staffing levels also influenced care quality during the pandemic. Homes faced challenges with maintaining adequate staffing as they were required to follow additional precautions through contact tracing and prolonged isolation protocols (e.g., isolating for 14 days regardless of infection status). As a result, reduced staffing levels impacted meal delivery and mealtime care quality. Staffing shortages among direct care providers (e.g., registered nurses) were common before the pandemic, but now all departments were impacted, and the issue exacerbated. ‘When we’re short staffed…. Maybe the person that would only feed one person during lunch is feeding two people during lunch, plus running plates. So that workload definitely affects mealtime.’ (P3, Dietitian).

Participants recognized individual residents’ care needs (e.g., eating assistance and management of personal expressions) as one of the factors impacting mealtime delivery and adaptations that were put in place during the pandemic. Participants discussed the rapid changes in residents’ needs, partially attributed to isolation affecting their physical and mental well-being. For example, ‘challenge is feeding everybody because all of the sudden…you’ve got people that may not have needed to be fed before, but when they’re in the room and isolating…so more people need more 1-on-1.’ (P1, Dietitian). An increase in personal expressions and behaviours among residents (e.g., agitation, confusion, meal refusal) was also noted during the pandemic as compared to pre-COVID-19, which sometimes resulted in decreased food intake. This was attributed by participants to the inconsistencies in mealtime delivery practices, resident needs not being met in a timely way, and also due to an overall decline in residents’ health.

PERCEIVING A COMPROMISED MEALTIME EXPERIENCE FOR RESIDENTS AND STAFF

The pandemic was perceived as a barrier to relationship-centred care by participants. For instance, they reported low staffing levels limiting social interaction time and requirements for distancing affected what they could do to develop relationships with residents, while mask-wearing made communication difficult: ‘all the

restrictions that we have were barriers to relationship-centred care. We need to maintain this distance.' (P6, General manager).

Needing to continually adapt to changing mealtime practices translated into a negative mealtime experience for both staff and residents. Participants expressed frustration about the constant change due to pandemic mandates and the resulting uncertainty related to their job conditions and the tasks to be completed as part of their role. Staff stress negatively impacted residents' mealtime experiences:

> When we're short staffed, … the workload is increased. They're [staff] stressed and everyone else can kind of feel that stress, especially the residents…they can see their caregiver stress and they kind of feel the stress too, so that impedes on things. (P3, Dietitian).

The pandemic also influenced the capacity for staff to complete direct care tasks, such as supportive eating assistance due to an increasing need for assistance and altered food service and delivery practices. A food service manager (P13) reported:

> There's a lot more work for the team members… specifically the ones that feed the patients because they're not all close… with the six feet social distancing rules and things like that, we need more staff members to feed the residents. (P13, Food Service Manager)

This distancing requirement not only meant that more staff were required, but potentially residents had to wait until a staff member was available to deliver their meals and/or provide assistance. Residents eating in their rooms or in various locations spread in the home, was especially challenging for staff because they needed to travel throughout the building during mealtimes to ensure residents' safety and needs were met, further increasing their workload and mealtime duration.

Some residents were unable to understand why they were not seeing their families and loved ones and why they needed to isolate from other residents during meals. Consequently, participants described residents having difficulty adjusting to the changes, combined with the lack of social interaction leading to a decline in their mental health, 'oh my goodness, the residents were so depressed, they were crying, they were scared.' (P11, dietitian).

Specific to the modified meal delivery practices (e.g., physical distancing in the dining room, tray service in residents' rooms), participants described residents having a poor appetite and intake at meals, in addition to more frequent meal refusal, as noted by a Dietitian and Food Service Manager (P4): 'I've observed people actually refusing to eat a meal because they would be upset that they couldn't come into the dining room…so they'll go off and refuse to eat.' The precautionary removal of commonly shared mealtimes represented the loss of this central socialization event of the day and staff noted that this loss directly impacted residents' overall emotional and mental well-being:

> I saw people that weren't affected by COVID but, because they couldn't go to dining rooms… it really affected their mental or emotional, their physical, and spiritual health. You'd have more falls, you'd have more delirium, you'd have more- Just their whole mental physical status deteriorated. (P6, General Manager)

Poorer food quality and sensory traits (e.g., tepid servings and dull appearance) in addition to limited food choices also negatively impacted the mealtime experience. Participants reported challenges maintaining the temperature and the consistency of food due to lack of equipment (e.g., temperature-controlled food carts and plate lids) that allowed for hot food delivery throughout the home which was particularly a challenge for maintaining the texture of modified foods. Furthermore, modified mealtime practices included using disposable cutlery and dishware, implementing menus with shorter cycles (7 days instead of 21 or 28 days), and limiting choice to one option per meal to simplify menus and overcome challenges related to meal delivery; all of which are examples of task-focused care. Participants discussed the prevalence of task-focused practices before COVID-19, and how those practices were exacerbated during the pandemic. Additionally, with a growing number of residents from different cultures, their needs were typically unmet before and certainly during the pandemic: 'I find like we have a lot of multicultural residents, but the dining and the menu options don't always meet their needs and then they try, to find alternatives.' (P2, Recreational Therapist).

PRIORITIZING MEALTIMES WHILE TRYING TO STAY AFLOAT

Numerous strategies were employed to uphold quality mealtime care in the face of challenges experienced due to the pandemic. Strategies included using an 'all hands-on deck' approach, maintaining connection and emphasizing flexibility in adapting to the constant change that was required by public health mandates.

Many LTC homes used an 'all hands-on deck' approach where all staff helped during meals to improve the residents' experience and promote food intake.

> Having more hands-on deck, and everyone really...., and I think because the staff really know the residents, because a lot of them have worked with them for a long time, I think that was helpful. (P5, Food Service Manager).

Redeployment of managers and staff from other departments, like recreational aides, mitigated some challenges such as staff shortages that worsened during the pandemic. Staff redeployed from other areas delivered meals to residents, picked up trays and provided eating assistance. This strategy was helpful as these staff were already familiar with the residents and had a pre-existing relationship developed through their interactions outside of mealtimes. Consequently, their involvement during mealtimes was welcomed by residents and helped improve their mealtime experience.

Redeployed staff were also trained on mealtime-related tasks such as safe and effective eating assistance practices. Training was typically delivered through online platforms (e.g., surge learning) since in-person training was not feasible during the pandemic. Training was also required for using pre-existing (e.g., menu-planning software) and new tools (e.g., Point of Service dining tool) utilized at mealtimes to communicate residents' diet orders, likes and dislikes and mealtime interventions. With the evolving and changing work staff, training of redeployed staff was ongoing in homes in efforts to deliver better and consistent care.

With the frequently changing mandates during the pandemic, communication with staff, residents and family fell through while prioritizing other care tasks. Improving and increasing communication was a fundamental approach to improving mealtime care to understand the needs of staff and residents while maintaining relationships and connections amongst those in the homes 'communication was the biggest thing... making those relationships and connections with them. Making sure that they felt safe and comfortable and knew what was going on with the pandemic' (P10, Dietitian). Homes recognized the value of resident engagement through enhanced communication which facilitated the best care possible during this period. To foster increased communication within the home, residents and staff were provided with information letters and families received emails to keep them informed about upcoming changes taking place in the home, while other homes utilized social media platforms for communication:

> A lot of communication with staff [supported improving mealtimes] ... Just talking more to staff and making sure everyone's on same page, we would point that out through like Facebook or through like our email lists. (P10, Dietitian).

Some participants conducted internal surveys within the home to learn about staff and residents' experiences, what they thought was missing around mealtimes and areas for possible improvements. Homes recognized the significance of maintaining connections between staff, residents and families and reprioritized their efforts to fill an existing gap that was further aggravated during the pandemic.

The COVID-19 pandemic presented significant uncertainty and LTC homes recognized that flexibility and their ability to adapt quickly to mandated changes were necessary for problem-solving. Homes adopted alternative food service operations and mealtime practices to overcome outbreak-related concerns during the pandemic. For example,

> We've gotten super creative over different strategies to problem solve...because we could be fine today and then by dinnertime, they were in outbreak...so just being flexible with our product, flexible with meal prepping, and menu planning (P3, Dietitian).

Another example of flexibility is having staff working across multiple departments and assisting where necessary to overcome challenges with staffing and to also support the overall mealtime experience. Homes attempted to identify ways to make mealtimes special by planning different activities like theme days to engage staff and residents and to uplift the homes' atmosphere during the pandemic. For instance:

> Entertainment was not brought in... it was from within. For instance, we had talent on our team, people could play the guitar, people can sing, so people who are working here were entertaining residents during meals. (P1, Dietitian).

Participants explained lessons learned from their experience managing mealtimes during COVID-19 which were centred around creativity and innovation to adapt to ever-changing circumstances while supporting resident social connection and a quality mealtime experience.

DISCUSSION

The findings of the current study highlighted the impact of contextual factors on homes' response to COVID-19 during mealtimes, the compromised mealtime experience for residents and staff, and strategies used by staff to make the best out of a difficult situation during the pandemic. Everchanging infection control mandates during the COVID-19 pandemic required homes to take quick actions and modify their day-to-day operations to reduce the spread of the virus and protect residents

(Ickert, Stefaniuk & Leask, 2021). This study identified how LTC home staff responses depended on contextual factors and that negative experiences for residents and staff were widespread. Yet, staff described adapting to their changing situation, being creative and learning from this experience – knowledge that can be translated to reinforce the importance of mealtimes and how the goals of quality food and social connection can be upheld.

Our findings demonstrate that frequent and rapid public health mandates during the pandemic resulted in disruptive and sometimes chaotic meal service and variable practices across homes. Although homes received a large amount of information from a variety of sources, including the Ministry of Health and local public health authorities (Siu et al., 2020), prior research has noted that these communications were unclear and confusing (Giebel et al., 2022; Snyder et al., 2021; White et al., 2021), requiring those responsible for implementation to conduct their own research and modify policies and procedures (D'Adamo, Yoshikawa & Ouslander, 2020). Despite the vulnerability of the population residing in LTC, homes were ill-prepared to deal with pandemics (Giovenco, 2021) and did not have emergency plans (Havaei et al., 2021), which was evident by the responses of our study participants. Literature suggests lack of pandemic preparedness was a key contributor to the challenges experienced by healthcare facilities during the COVID-19 pandemic (Kaye et al., 2021; Siu et al., 2020; Usher et al., 2021). Based on our findings, homes should consider developing contingency and emergency operation plans that consider their specific context to enhance their pandemic preparedness. In addition, public health officials need to make feasible recommendations recognizing the differences within homes and their available resources, while also considering the timeliness and the appropriateness of their directions to improve home preparedness (Siu et al., 2020).

Public health mandates during COVID-19 adopted a biomedical approach, placing emphasis on keeping residents physically safe at the expense of neglecting their mental and psychosocial needs (Iyamu et al., 2022; Smith et al., 2022; Stefanacci & Riddle, 2020). The negative impact of socially distanced meals and the exclusion of family, friends and volunteers from meals not only resulted in poor food intake but was also detrimental to the well-being of residents as participants reported residents feeling depressed and isolated. Other studies have also noted loneliness, social isolation, depression and poor quality of life resulting from pandemic procedures (Hwang et al., 2020; Low et al., 2021; Smith, Steinman & Casey, 2020), although they do not point to mealtimes as a specific social activity that was lost as a result of initial precautionary measures. Smith et al. (2022) communicated similar results as LTC staff reported residents would stop eating as a result of social isolation, which negatively impacted their physical and mental health (Smith et al., 2022). After the initial waves of the pandemic, staff realized the importance of shared activities such as mealtimes and have since reinstituted dining room meal delivery. These findings reinforce the importance of meals and the 'slippery slope' isolation procedures may have on residents physical health, well-being and quality of life. Our findings indicate that it is important to find ways to maintain essential aspects regardless of pandemic status, and that staff are up to the challenge of finding creative ways to accomplish this. Policy directives need to allow for and even promote staff creativity to enact public health measures, while supporting the quality of life of care home residents.

Despite ongoing efforts to facilitate culture change in LTC pre-pandemic, mandated precautions facilitated a regression to task-focused care to limit the spread of COVID-19, rather than maintaining meaningful connections to mitigate the risk of isolation (Iyamu et al., 2022; Smith et al., 2022). The increased prevalence of task-focused care practices and lack of relationship-centred care practices reported by participants contributed to negative mealtime experiences and poor food intake and physical health. Yen et al. discussed that non-COVID-related death rates among residents increased due to isolation, poor nutrition and lack of physical activity (Yen, Schwartz & Hsueh, 2022). Although meal service may have returned to dining rooms for most residents (Government of Canada, 2020), the quality of the interactions at mealtimes continues to be an area that requires education and support. Inclusion of family and volunteers during mealtimes in the dining room has shown to support more relationship building at mealtimes, food intake and certainly providing assistance where needed (Green et al., 2011; Low et al., 2021; Trinca et al., 2020b; Wu et al., 2020). As of now, family caregivers have returned to homes, but their involvement in mealtime activities in the dining room is unknown. Considering how families and volunteers can maintain access to communal dining during outbreaks is needed to ensure a positive mealtime experience for residents. Policies that impact social interactions and dining experiences in LTC should aim to balance physical safety with meaningful mealtime experiences and resident well-being. In fact, social isolation and loneliness are recognized by many as critical public health issues (Ding, Eres & Surkalim, 2022), which should not be ignored in the face of another public health crisis, such as a pandemic. Safe visitation policies to facilitate family involvement at mealtimes during future pandemics or outbreaks is one area of policy that should be further developed (Low et al., 2021).

Participants did their best to balance safety and socialization during the pandemic, as they recognized the detrimental effect of social isolation and the value of mealtimes. However, their ability to do so was constrained by home capacity and influenced by staffing shortages and increased resident needs, which aligns

with extant literature (Estabrooks et al., 2020; Giovenco, 2021; Inzitari et al., 2020). Staffing shortages and increased workloads during the pandemic hindered staff from maintaining social connections with residents due to time constraints (Iyamu et al., 2022; Yen, Schwartz & Hsueh, 2022). Moreover, one study reported staff stress during the pandemic due to high staff turnover, lack of activity with the homes and having to follow procedures that they perceived harmful to residents (Haslam-Larmer et al., 2022). Going forward, public health units and/or governing bodies must consider how continual change affects working conditions and staff in older adult care. As staffing challenges are and will be an ongoing challenge within LTC (Hsu et al., 2020), healthcare systems must invest in supporting this sector since adequate staffing is a prerequisite for implementing best practices to control an outbreak (Hwang et al., 2020), as well as a positive mealtime experience (Low et al., 2021). This recommendation is supported by the findings of Hung and colleagues in a Canadian LTC home, as staff were able to meet the psychological and physical needs of residents when the home had adequate staffing levels which supported relationship building (Hung et al., 2022).

Available literature and current findings demonstrate a discrepancy between the goal of governing bodies/policy makers and the needs of those who work and live in LTC; failing to understand the consequences of their mandates and if homes were unequipped to manage the pandemic (Iyamu et al., 2022). In a study examining the preparedness of LTC during the COVID-19 pandemic in Canadian LTC homes, ~46% of staff perceived recommendations as unfeasible (Siu et al., 2020). Therefore, policymakers should engage LTC personnel (leadership, staff and residents) to better understand their needs and create policies that are feasible and supportive of resident health and well-being (Laxton, Nace & Nazir, 2020; Siu et al., 2020). In addition, mandates should allow for flexible implementation to consider variability in homes' capacity while maintaining the quality of care and life for residents (Armstrong et al., 2019).

This study can inform the mandates of health authorities and the LTC responses to these requirements during outbreaks. Overall, this study demonstrates the critical role of mealtimes in LTC in supporting residents' social connectedness, well-being and quality of life. The system must be strengthened by building resiliency and enhancing preparedness to deliver high-quality care, despite the challenges of pandemics or other unforeseen occurrences. Based on our findings, we have developed two primary implications for practice and policy:

1. Mealtimes in LTC are complex activities that provide functions beyond food provision. Mealtimes foster an environment for building relationships and meaningful connections supporting residents' physical and mental well-being. Safety precautions to prevent infectious diseases that limit social interaction and eating together need to be balanced with the need to maintain residents' relationships and quality of life.
2. Establishing emergency plans for food service and other departments that consider homes' contextual factors can serve as an essential safeguard to the vulnerable population in LTC. These protocols should include quality of care requirements such as staffing levels and resources (Giovenco, 2021).

Furthermore, it is critical to engage the LTC sector when planning and establishing policies that impact residents. Collaborative planning would identify potential negative implications and support a better understanding of the needs of residents beyond preventing infections and deaths. Flexible policies should be implemented, as opposed to a 'one size fits all' approach given the variability in home capacity and characteristics (Armstrong et al., 2019).

STRENGTHS AND LIMITATIONS

The findings in our study address a gap in the literature related to mealtime practices in LTC homes during the initial months of the pandemic. In addition, the study captures the perspectives of staff from across Canada, which is a strength considering the variability in provincial public health responses to the pandemic (Cyr, Mondal & Hansen, 2021). However, the current study is not without limitations. Perspectives were primarily from nutrition and food service personnel and lacks representation from staff from other disciplines that are often involved during mealtimes. For instance, personal support workers and healthcare aides who often provide mealtime assistance and play a significant role during mealtimes were underrepresented. The sample was also limited to those who expressed interest after completing the survey targeted towards staff working in LTC (Keller et al., 2021). Three rounds of email invitations were required to reach our sample and theoretical saturation. The challenges surrounding recruitment and sampling diversity in qualitative research during this time period have been found to be a common limitation (Chu, Donato-Woodger & Dainton, 2020; Dupuis-Blanchard et al., 2021). Future studies should aim for a more diverse sample to capture the different perspectives of staff involved during mealtimes.

CONCLUSION

This study explored the perspectives and experiences of LTC staff in managing mealtimes during the COVID-19 pandemic. Staff across Canada provided insight into how

constant changes required as a result of public health mandates, negatively influenced mealtimes in LTC. Staff's ability to implement requirements was related to their contextual factors, often with a negative impact on residents' physical health and well-being. Findings emphasize how infection control mandates promoting social isolation come at a cost to residents and staff, emphasizing safety and task completion and neglecting relational care. The value of mealtimes in supporting resident well-being was reinforced when commensal dining was lost as a result of isolation procedures. Thus, future pandemic responses should strive to balance residents' safety with their well-being and quality of life by establishing emergency protocols that consider the residents' physical and psychosocial needs and take into consideration homes' contextual factors.

TRANSPARENCY DECLARATION

The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported. The lead author affirms that no important aspects of the study have been omitted and that any discrepancies from the study as planned have been explained.

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

Conceptualization all authors; data Collection HD; methodology all authors; formal analysis HD; writing – original draft preparation HD, HK, SAW, VT and AC; writing – review and editing all authors; funding acquisition HK, AC, NC, CL, HMO and SES. All authors have read and agreed to the published version of the manuscript.

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