Impact of Culture on Resident Centered Care and Meal Satisfaction in Long Term Care

By

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Abstract

Introduction: As the population of senior and elderly immigrants increases, those living with health difficulties and functional impairments may require long-term care (LTC). Research shows that culture and cultural preferences during mealtime are an important resident-centred care concept. Unmet cultural food and dining preferences are one of the risk factors for weight loss and poor food and fluid intake in seniors and elderly living in LTC. Individual cultural preferences are likely linked to familiarity and sensory acceptance of foods, yet limited research has been conducted in this area. The purpose of this study is to explore the experiences and what they mean to senior and elderly immigrants about food and mealtime practices in LTC, assisted living and retirement living.

Methods: This was a qualitative research study using an interpretive phenomenological approach. Purposive sampling was used to recruit six older first-generation immigrant residents (ages 65 years and older) who are living in LTC, assisted living and retirement living in Halifax Regional Municipality (HRM). Data was collected through semi-structured interviews.

Results: Thematic analysis was utilized to analyze data. Three major themes emerged through the data analysis of 6 interviews on the experiences on food and mealtime practices and what they mean to senior and elderly immigrants residing in LTC: (1) Experiencing cultural assimilation, (2) Acceptance of cultural assimilation by residents, and (3) Importance of social support in maintaining a connection with culture. The themes were further categorized into two categories: and *a connection with culture.*

Conclusion: With the growing ethnoculturally diverse aging population, there is a need for attention to cultural diversity in ongoing research and in the provision of health and LTC care services to promote well-being for ethnocultural diverse residents.

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Chapter 1 - Introduction

Research shows cultural preferences during mealtime are an important resident-centred concept (RCC) (Chaudhury et al., 2013; Tolson et al., 2012; Ducak & Keller, 2011). Unmet preferences for cultural foods and mealtime practices are risk factors for inadequate intake of foods and fluids by senior and elderly persons living in long-term care (LTC) (Soenen, & Chapman, 2013; Tamura et al., 2013). Cultural preferences that influence familiarity and acceptance of foods may become more pronounced with aging (Keller et al., 2015). Food is an important aspect of individuals religious, personal taste that is part of their culture (Evans et al., 2005). Seniors who are immigrants make up 30% of the aging population in Canada (Ng et al., 2012). As the population of senior immigrants increases due to a small proportion of seniors arriving as immigrants and earlier cohorts of immigrants aging, those with health difficulties and functional impairments may require LTC placement (Statistics Canada, 2016; Ng et al. 2012; Starr et al., 2015). Based on the evidence, sensory properties of food (i.e. taste), the familiarity of food and food variety were identified as priority factors affecting food intake in LTC (Keller, et al., 2015). Cultural preference was identified as an important RCC concept that is linked to the factors that influence meal satisfaction mentioned above, but there has been limited research conducted in this area (Keller, et al., 2015). Therefore, using interpretive phenomenological analysis, the purpose of this study is to explore

with food and mealtime practices in LTC settings and the meanings embodied in those experiences. What are the lived experiences and what do they mean to elderly first-generation immigrants and their families about food and mealtime practices in LTC?

Chapter 2 - Literature Review

Immigration and Aging

are aged 65 and above (Statistics Canada, 2017). This number is projected to increase to ten million by the year 2036 (Statistics Canada, 2017). Immigration is one of the contributing factors to the growth of this population in Canada (Laher, 2017). As a result, the overall population, as well as the growing aging population in Canada, is becoming more ethnoculturally diverse (Laher, 2017). Immigration is the driving force behind a more ethnoculturally diverse older population since approximately 3% of recent immigrants are older adults and earlier cohorts of immigrants are aging (CIHI, 2011). As the population of senior immigrants increases, those with health difficulties and functional impairments may require LTC placement (Starr et al., 2015).

Immigrant seniors tend to have more disabilities and functional limitations compared to Canadian-born seniors (Vang et al., 2015). These disabilities and limitations tend to occur years after immigrating (Vang et al., 2015). Several studies have found that immigrants arrive in a country in better health than the population of the host country, which is labelled

et al., 2011; Kennedy et al., 2015; McDonald, & Kennedy, 2004). However, there is evidence that their health declines with additional years in the new country (Gushulak et al., 2011). This declining health may be attributed to post-migration stressors and lack of individual and social resources due to resettlement (Beiser, 2005).

This study will focus on experiences with mealtime practices in LTC facilities and their meanings from individuals and families who are first-generation immigrants. Statistics Canada defines the first generation as people who were born outside of Canada (Statistics Canada, 2011). This study will exclude second or third-generation immigrants. The second generation includes

individuals who were born in Canada and have at least one parent born outside of Canada and the third generation refers to people who are born in Canada with both parents born in Canada (Statistics Canada, 2011). Second and third-generation immigrants tend to lose connection to traditional practices from their culture of origin while retaining the cultural practices of the country they perceive as home (Schwatrz et al., 2006). This cultural assimilation increased as individuals spend more years in this country (Schwatrz et al., 2006). Cultural assimilation has been defined as

ethnic distinction and the social and cultural diff

Nee, 2003, pp. 2). By the end of this process, distinguishable ethnocultural groups become effectively blended into one (Rumbaut, 2015).

Social Determinants of Health

The primary factors that shape the health of Canadians are the living conditions they experience (i.e. social isolation, income insecurity, diet acculturation, access to healthcare, discrimination, etc.), which are known as the social determinants of health (Mikkonen, & Raphael, 2010). The social determinants of health have a significant impact on the predisposition of individuals to illness, as well as on the way they experience and recover from illness (Solar & Irwin, 2010). There is evidence that the differential access to the social determinants of health people experience helps explain the wide health inequities that exist (Mikkonen, & Raphael, 2010). How long people can expect to live and whether they will experience disease or disabilities is dependent on their living conditions (Mikkonen, & Raphael, 2010). For example, poor quality social determinants create living conditions and personal experiences that endanger health (Mikkonen, & Raphael, 2010). Due to its impact on health, inequities that may result from immigration can be considered a social determinant of health (Castaneda et al., 2015). Immigration

can contribute to the deterioration of health and increased incidence of disease due to various social determinants that include social isolation, income insecurity, diet acculturation, access to healthcare, discrimination, etc. (Mikkonen & Raphael, 2010; De Maio & Kemp, 2010; Lear et al., 2009; Guruge et al., 2015). Deterioration of health due to these factors may lead to increased LTC admissions in seniors within this population (Starr, et al., 2015).

Social isolation and Income Insecurity

Social isolation and income insecurity are shown to contribute to immigration-related stress that can affect health. Continuous stress can weaken the resistance to diseases (Brunner & Marmot, 2006). Psychological stress is a significant predictor of hypertension among Asian immigrants and this risk factor rises with the increased number of years since immigration (Kaplan et al., 2002). Physiological tensions provoked by stress can make individuals more vulnerable to illnesses such as cardiovascular and immune system diseases (Brunner & Marmot, 2006). People who experience high levels of stress can often adopt unhealthy behaviours such as excessive use of alcohol, smoking, and inadequate diets that can worsen health in the long run (Raphael, 2009). Support from families, friends and communities is associated with better health because of its role in alleviating stress (Public Health Agency of Canada, 2011). Perceived social support is also associated with positive mental health outcomes (Brown et al., 2009).

Recent immigrants can have difficulty finding employment relative to the level of education and having their diploma recognized which can contribute to a low income (Frank, 2013; Fuller, 2015; Phythian et al., 2011). Having a low-income places individuals at risk for material and social deprivation. The greater the deprivation, the less likely individuals can afford the basic prerequisites for good health such as food, clothing, and housing (Mikkonen, & Raphael, 2010; Auger & Alix, 2009). It also contributes to social exclusion by making it harder to participate in

cultural, educational, and recreational activities (Mikkonen, & Raphael, 2010; Auger & Alix, 2009).

Diet Acculturation

Communication barriers such as language differences and lack of cultural competence among health care providers may affect the care provided (Lai & Chau, 2007). Preconceived notions about cultural beliefs and stigma can influence both health care professionals and clients during appointments (Aery, 2017). Due to language barriers and lack of health care provider culture competence, ethnic groups may be reluctant to seek advice from health professionals (Kwok et al., 2009).

Discrimination

Immigrants of colour can be racialized, which can contribute to adverse living conditions that can threaten their health (Mikkonen, & Raphael, 2010). People of colour in every province experience higher unemployment and under-employment rates, and lower incomes compared to the white population (Galabuzi, 2005). There is growing evidence that perceived discrimination is associated with lower levels of physical and mental health; poor access to quality health care; and adoption of detrimental health behaviours (Bernstein, et al., 2011; Finch et al., 2001; Finch et al., 2000; Gee et al., 2008; Gee et al., 2006; Panchanadeswaran & Dawson, 2011; Perez et al., 2009; Potochnick & Perreira, 2010; Ryan et al., 2006; Tran et al., 2010; Yip et al., 2008).

First-generation elderly are at risk for health effects from poor-quality social determinants of health. Deterioration of health due to these factors may lead to increased LTC admissions in seniors within this population (Starr, et al., 2015). Therefore, this group is the focus of this study.

LTC Facilities

In Canada, health care is managed provincially. With respect to LTC, this had led to some regional variation related to the mix of public and private funding, facility ownership, costs to residents for basic accommodation, the proportion of out-of-pocket costs, residency requirements, etc. (Canadians Healthcare Association, 2004). Across Canadian jurisdictions, facility-based LTC

is not a publicly insured service under the Canada Health Act and LTC is not fully insured in any jurisdiction (Berta et al., 2006).

In Nova Scotia (NS), LTC facilities provide services for either a long-term basis (permanent placement) or a short-term basis (respite) (Nova Scotia Health and Wellness, 2018). There are two types of LTC facilities available, nursing homes and residential care facilities. Nursing homes are an option available for those who have difficulty performing everyday tasks and appropriate for those who are medically stable yet have nursing needs beyond home care (Nova Scotia Health and Wellness, 2018). Residential care facilities are for those who need personal care, supervision, and accommodation in a safe and supportive environment (Nova Scotia Health and Wellness, 2018). There are currently 91 nursing homes and 56 residential care facilities in Nova Scotia (Nova Scotia Health and Wellness, 2018).

There is a growing demand for LTC placement in Canada. There has been a steady increase by more than 7% in the number of residents who need extensive or complete support with everyday activities such as getting dressed or feeding themselves (Canadian Institute for Health Information, 2017). Clients that are assessed to require placement are on a waiting list for desired LTC facilities according to the date they are approved for LTC residency (Nova Scotia Health and Wellness, 2018). The resident and the provincial government share LTC cost in NS if it is a public facility (Nova Scotia Health and Wellness, 2018). The resident pays their accommodation costs and personal expenses, whereas the Department of Health and Wellness covers the healthcare costs (Nova Scotia Health and Wellness, 2018). Privately owned LTC facilities are not eligible for a government subsidy (Nova Scotia Health and Wellness, 2018).

Resident Centered Care

Resident-centred care (RCC) is widely promoted in LTC settings in Canada to improve the quality of care (Koren, 2010). RCC is a core concept that guides changes in care philosophy from a traditional medical model to a more humanistic approach to care (Li & Porock, 2014). RCC is defined as a holistic approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where individuals are empowered to be involved in their own health care decisions at any desired level (Morgan & Yoder, 2012). RCC requires a significant shift in thinking from custodial, physical task-orientated care to care that redirects the control to residents to facilitate autonomy, independence, and quality of life (QoL) (

unique needs of the individual rather than institutional and medical goals (Brooker, 2007; Gladman et al. 2007; Powers, 2005). While mentioning RCC, it is also important to acknowledge resident-directed care. An important element of RCC is resident-directed care, which includes empowering residents and their family members to play an active role in creating and directing their own care plan (Chen et al., 2016). Having residents and their families direct their care planning is important as care plans inform all aspects of life from daily routines/activities to clinical management and reinforce individualized and continuous care (Dellefield, 2006).

only associated with RCC (Morgan & Yoder, 2012). In an RCC environment, health care providers consider the unique needs and specific health concerns of the resident to provide customized intervention (McCance, 2003). Individualization cannot be achieved wi to their ability or desire to make decisions and take control of their care (Suhonen et al., 2002; Suhonen et al., 2005). These life circumstances include knowing culture, beliefs, traditions, habits, activities, and preferences (Suhonen, et al., 2005).

unique history and personality while recognizing their perceptions and beliefs, customizing care that best meets their needs (Edvardsson et al.
personal needs and preferences instead of institutional standards or routines, as one size does not fit all (Leplege, et al., 2007). Individualized care has been shown to increase resident satisfaction (Frich, 2003), has had a positive impact on outcomes (Stewart, et al., 2000; Tate et al., 2001, Frich, 2003) and increased QoL (Patti, et al., 2003). Successful transformation to RCC depends on a cultural change throughout the organization by fostering positive and trusting relationships that attend to the needs and preferences of the residents, their family, and staff (Brownie & Nancarrow, 2013). Acknowledging residents as individuals with preferences, unique differences, and diverse cultural identities that extend well beyond their medical status is the backbone of this change (Donnelly & MacEntee, 2016).

LTC facilities are adopting organizational change models that encompass RCC at their core such as the Eden Philosophy. The Eden Philosophy is a resident-centred approach to care which was pioneered by Dr. William Thomas who was a geriatrician in 1991 (Brownie & Nancarrow,

Cultural Competence

The growing cultural and ethnic diversity of minorities has strong implications for the delivery of health care. Cultural competency is an important RCC approach and is recognized for improving the delivery of health care to racial/ethnic communities with the aim of reducing health disparities in these populations health care system is defined as one that recognizes and incorporates the importance of culture, assessment of cross-cultural relations, attentiveness to the dynamics that result from cultural differences, growth of cultural knowledge, and adaptation of services to meet the culturally unique needs of (Betancourt et al., 2003, pp. 294).

As the population becomes more culturally diverse, health care providers of all ethnic backgrounds will deal with a greater proportion of residents whose perspectives are different than those taught in the mainstream health care system (Betancourt, et al., 2003). Reduced or lack of cultural competency can lead to health disparities within the minority populations (Betancourt, et al., 2005). Research has shown health care provider-resident communication is directly linked to resident satisfaction and health outcomes (Betancourt & Green, 2010). When there is a lack of cultural competency in health care environments, it can negatively affect communication between the providers and residents and lead to resident dissatisfaction in the care provided and poorer health outcomes (Betancourt, et al., 2005). Cultural competence should be utilized as an educational strategy to prepare the future health care workforce to care for diverse populations (Betancourt, et al., 2005). This can lead to more effective provider-resident communication and help the provider understand the relationship between cultural beliefs and behaviour and develop

dining experiences are enhanced when staff recognizes the important role of mealtimes through

honouring the individual (Hung & Chaudhary, 2011; Reimer & Keller, 2009). Research has shown it is important for residents to have meals on time, to know they would receive enough help, and appreciate when staff would listen to their needs (Evan et al., 2005). However, in the case of minority residents tend to be quieter and not complain about food because of embedded cultural value they have always been accustomed to (Wu & Barker, 2008). Staff should try to understand what residents are feeling and be in tune with their cultural values and beliefs to improve the mealtime experience for them.

There is a need to recognize staff will require continuing education and support from management to deliver culturally competent care through the incorporation of a flexible approach into their daily care routines (Cultural Diversity, n.d.). Achieving cultural competence in the delivery of health care is a process in which workers continuously strive to work effectively within the cultural context of the resident (Campinha-Bacote, 2009). RCC and resident-directed care focus on improving quality of life which includes meeting personal/ cultural food preferences and focusing on individualization to meet unique needs and desires. Not incorporating cultural competence in care routines negates RCC and resident-directed care. Workers must treat each person as a unique human being worthy of care. Inequality has been correlated with negative health outcomes, so it is critical healthcare workers make conscious efforts to link cultural competence with social justice (Campinha-Bacote, 2009).

Food and Mealtimes in LTC

Mealtime in LTC is an important ritual for residents that not only reinforces their identity through food but also provides an enriching social experience with other residents and staff (Wu, 2015). A significant amount of ti

getting dressed, making their way to the dining room, waiting to be served, eating, interacting, and

digesting (Gibbs- d

allow them to socially engage and strengthen relationships (Wu, 2015).

Poor food and fluid intake are common among seniors and elderly living in LTC (Bell, et al., 2013). In a systemic literature review, 47% to 62% of elderly living in LTC were found to be at risk for malnutrition (Bell, et al., 2013). Malnutrition is a state in which a deficiency of energy, protein and other nutrients causes adverse effects on tissue or body form (body shape, size, and composition), function and/or clinical outcome (Stratton, et al., 2003). Malnutrition predisposes this population to a greater risk of chronic disease (Cereda, et al., 2011). If low food intake persists, it can result in weight loss, muscle wastage, lethargy, compromised immunity, poor wound healing, pressure sores, cognitive decline, symptoms of specific nutrient deficiencies indicative of malnutrition, increased hospitalization rates, increased costs of care and high risk of mortality (Soenen & Chapman, 2013; Cereda, et al., 2011; Beck, 2015; Kostka et al., 2014).

Dissatisfaction with meals is a significant moderator of food intake in LTC (Wright et al.,

related to traditions, religion or personal taste that is a part of their cultural roots (Evan et al., 2005). A research study on plate waste and dietary prescription in LTC indicated that restrictive diets reduce the palatability of meals, leading to reduced food intake (Buckler et al., 1994), while liberalized diets, that allow relaxation of original diet prescriptions, promote greater food choice, increase enjoyment from eating, enhance the quality of life and not lead to poorer clinical outcomes (Dorner et al., 2002). In a study by Keller, et al., (2015), sensory properties of food (i.e. taste), the familiarity of food and food variety were identified as priority factors affecting food intake in LTC. Cultural preference was identified as an important RCC concept that is linked to the factors that influence meal satisfaction mentioned above, but there has been limited research conducted in this

area (Keller, et al., 2015). Food and mealtimes in LTC can affect the health and wellbeing of all residents. For first-generation immigrant seniors and elderly in LTC facilities, cultural competence is an integral part of RCC as culture may have a significant impact on satisfaction with food and care provided.

Conclusion

There are many ethnoculturally diverse immigrant seniors in Nova Scotia and based on the current aging statistics in Canada, this population is forecast to increase in the future. It is important to acknowledge that social determinants and the health of immigrant seniors are closely entwined, which makes planning for an LTC system that is culturally inclusive a high priority. Seeing as food is a bridge that connects people to their culture but also an important resource of nutrition for disease prevention, makes this an important area to study and warrants further exploration.

Chapter 3 - Methodology

The research on elderly first-generation immigrants about food and mealtime practices in LTC, retirement and assisted living was studied through a qualitative lens informed by interpretive phenomenological theory. Interpretative phenomenology analysis (IPA) seeks to examine how participants make sense of their personal and social world and to study the meanings behind their experiences (Smith & Osborn, 2007). The use of phenomenology in qualitative studies allows researchers to delve into the perceptions, perspectives, understandings, and feelings of people who have experienced or lived in the situation of interest (Green & Thorogood, 2009). In particular to this research population, understanding their lived experiences emphasizes the impact of culture, immigration and social support as determinants of health as well as RCC in LTC (Mikkonen, & Raphael, 2010). Utilizing IPA allows the researcher to identify themes that appear within

in those experiences, which is the purpose of this study (Pietkiewicz & Smith, 2012).

Participants

Participants (n= 6) were from the senior and elderly first-generation immigrant population (ages 65 years and older) who are living in LTC in Halifax Regional Municipality (HRM). Participants were selected from assisted living and residential care since these establishments include institutional dining practices. This study was conducted on a small sample size that allowed for a thorough identification of similarities and themes which would otherwise be lost when using a larger sample size (Pietkiewicz & Smith, 2012).

Participants were selected based on a purposive sampling approach. Purposive sampling is where the participants are selected based on the characteristics of the population of interest and the objective of the study (Wiersma & Jurs, 2009). Individuals experiencing cognitive impairment (i.e.

tudy due to their inability to give consent and provide answers without the assistance of a substitute decision-maker. For individuals living with cognitive impairment, the capacity to make important decisions for themselves diminishes as their condition advances (Fetherstonhaugh et al., 2017). As a result, important decisions affecting lifestyle and treatment become the responsibility of a substitute decision-maker. Second and third-generation immigrants were not included as they tend to lose connection to traditional practices from their culture of origin while retaining the cultural practices of the country they perceive as home (Schwatrz et al., 2006). Whether or not participants met the inclusion criteria was determined with the help of their health care team.

Recruitment

Participants were recruited over a six-month period through purposive sampling. Care providers (i.e. Nursing, Dietitians, etc.) at LTC, retirement and assisted living were contacted through phone or email for input into the recruitment of participants as they had an established rapport with potential participants through daily interactions that met the inclusion criteria. Facilities were identified using the *Nursing Homes and Residential Care Facilities Directory* by the Department of Health and Wellness in Nova Scotia. Community organizations such as the Immigrant Services Association of Nova Scotia were contacted for potential participants. Recruitment flyers (See Appendix A) were placed in community settings, such as universities, libraries, churches, mosques, synagogues and temples located around the city. The participants were selected based on if they meet the inclusion criteria and a first come first served policy. The COVID-19 pandemic proved to be a barrier for further recruitment as access to LTC, retirement and assisted living establishments were denied. Interviews were conducted as soon as participants were recruited for this study. An honorarium was not offered for participation.

Data Collection

Data was collected through interactive, in-person interviews with participants about LTC, retirement, assistive living experiences and their meaning on food and mealtime in relation to their cultural backgrounds. Participants were primarily asked semi-structured open-ended questions in a consistent sequence with probes (See Appendix B) (Patton, 1990). According to Giorgi (1997), a phenomenological researcher, questions for research studies when using a phenomenological approach are generally broad and open-ended so the participants have an adequate opportunity to express their points extensively. This allows
daily experiences that form their world (Neubauer et al., 2019). There is space and flexibility for original or unexpected information to emerge, which the researcher can investigate in detail with further questions (Pietkiewicz & Smith, 2012). The interviews were approximately an hour in length to ensure a collection of rich narrative data. The interviews took place in a private setting and at a time agreed upon by the interviewer and participant(s). An example of the interview questions with prompts is found in Appendix B. The interviewer used a digital audio recorder to record the interviews. The audio files were saved on the laptop using VeraCrypt - (IDRIX, 2018) so content is encrypted and password protected. Field notes were made during the interviews by the researcher which included notes on observations on what occurred, reflection on experiences, and end-of-a-day summary or progress reviews (Groenewald, 2004). Memos and logs were used to keep track of progress and insights (Conroy, 2003).

Interviewers working with IPA need interviewing skills that include active listening and the ability to build rapport with the participant (Pietkiewicz & Smith, 2012). In addition, the interviewer needs to frequently assess the effect of the interview process on the participant (Pietkiewicz & Smith, 2012). The researcher met these criteria as she has previous research

experience that required conducting interviews with participants. The researcher also has experience working in LTC Nutrition and Food Service department with elderly populations.

Data Analysis

The researcher anticipated that six to eight participants in this study would achieve data saturation though it is always possible that additional interviews could produce new data, themes and coding (Brocki & Wearden, 2006). In this case, six participants are believed to be adequate as they provided rich and meaningful data that allowed for saturated themes. Interview data was analyzed using thematic analysis (Braun & Clark, 2006). This method was utilized to identify themes and patterns of living and/or behaviour experiences (Aronson, 1994; Conroy, 2003). MAXQDA (VERBI Software, 2017) was used to help organize and code the data (Wiersma & Jurs, 2009). The researcher purchased a 24-month student license

personal laptop and data files were backed up and stored on a password-protected USB stick. Data files on the software were also password protected and were only accessible to the researcher and supervisor. In-depth interviews were conducted and the audio recording will be transcribed

software labelled with a pseudonym.

The first stage of the analysis was to read and re-read the transcript closely to become as familiar as possible with the content (Smith & Osborn, 2007). Each reading has the potential to discover new insights and these insights were recorded as comments (Smith & Osborn, 2007). This protocol is consistent with IPA Smith & Osborn, 2007. Statements from each interview were coded using line-by-line open coding (Lin, 2013). To do this researcher needed to consider the literal content of the statements, the number of times it was mentioned and how it was stated

(Hycner, 1999, p. 154). The next stage was to look for connections between these statements to form themes (Smith & Osborn, 2007). Axial coding, which is a process of creating links between data, was utilized where codes were grouped based on similarity to form a cluster of categories and the researcher identified significant themes (Sadala & Adorno, 2001). A table was created that incorporated all the themes drawn from the data (Groenewald, 2004). The final step was to look for the themes that were common in most or all the interviews and to write a summary that must reflect the context from which these themes emerged (Hycner, 1999, p. 154; Moustakas, 1994).

It is important to keep the

their meaning (Sadala & Adorno, 2001; Miller & Crabtree, 1992). The researcher kept a reflective journal as reflexivity is considered essential and assists with the research process by facilitating understanding of the phenomenon under study (Watt, 2007). By engaging in ongoing dialogue with themselves through journal writing, researchers may become self-aware of what allows them to see, as well as what barriers may be present that inhibits them from seeing patterns in their research (Russell & Kelly, 2002). Reflection entails careful conside

behaviour can impact the study (Watt, 2007). It allows the researcher to take into account their own biases, feelings and thoughts that could be potentially impacting the research (Watt, 2007). Overall, following reflexive practices allows minimizing the risk of bias while deepening the understanding of data.

Ethical Considerations

An ethics application was submitted upon completion of the thesis proposal presentation and this research study was approved by the MSVU Research Ethics Board. The researcher read out the consent information to the participants for participating in this research study and for audio

recording their interview (See Appendix C). Their obtained verbal consent was recorded. There was minimal risk to the participants in this study as defined by the TCPS2 and the REB.FORM.001 addressed all ethical issues as per the MSVU UREB Tri-Council. Participants had the option to opt-out anytime during the interview and did not have to answer any questions they did not feel comfortable with. The participants were not anonymous to the researcher but their responses were kept confidential and were not be linked to the participants. Phrases, words, quotes from the interview were used as part of the data analysis. Any identifiers to the participants were not named but discussed in the paper and names of the participants were replaced. Data collected was stored in password-protected computer files during the study. Non-digital sources of data were kept in a locked drawer of a desk. The research was shared with the participants upon request. The research will be disseminated to stakeholders, the public and the academic community through presentations of the executive summary. Data collected for the study will be conserved for a minimum of 5 years as per ethics guidelines. The data will be stored in a password-protected folder

bin following the conservation period.

Chapter 4 Results

Table 1: Participant Characteristics

Name	*Ethnicity*	*Age*
Mariam	Lebanese	82
Lian	Chinese	95
Maria	Brazilian	67
Mei	Chinese	80
Catherine	Norwegian	78
Camila	Latin American	85

Through completing thematic analysis of the data obtained from 6 participant interviews on the experiences on food and mealtime practices, three emerging themes were noted: (1) Experiencing cultural assimilation, (2) Acceptance of cultural assimilation by residents, and (3) Importance of social support in maintaining a connection with culture. The themes were further categorized into two categories: and *Instrumental in* The names of participants are presented in pseudonyms to protect their identity.

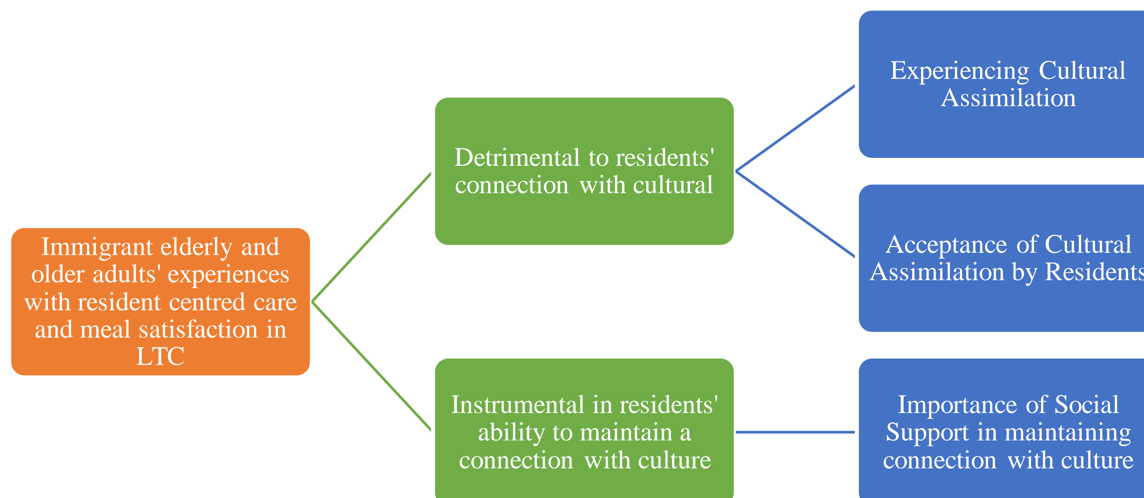

Figure 1: Categorization of Themes

Experiencing Cultural Assimilation

There appears to be a process of cultural assimilation experienced by participants in this study, which first started when they immigrated to Canada and was completed once they moved into their current care facilities. Participants noticed their assimilation went beyond just food and found changes in their mannerisms as well. This seen in a quote by Lian:

> *I myself have changed with the culture. I have left my own country 70... more than 70 years ago. So I had to adapt to other cultures. First of all, I have been exposed in Korean culture, which is similar to the Chinese. However, there are major differences. I have been living within Japanese culture for many years on and off. There again is quite different. Not only food but the way you greet each other, the way you understand each other. There are very subtle differences. Then coming to the West is again, a major difference. For example, in China, we don't touch each other but here people talk to you and touching you on the shoulder, on the back, pat you and that I resent very much, I dislike very much but I find myself doing the same*

thing to others. So it's a process of acculturation. I began to do thing I don't like originally but you can't help, it just comes on. I think it's an aspect of acculturatio

Most participants had left their home countries and immigrated to their new home country, Canada, decades before moving into their current care facilities. While living independently in Canada, many participants found it difficult to maintain traditional diets due to barriers in accessing traditional ingredients, which led to consuming a more North American diet. This was experience can be seen in a quote by Mei:

When I come to Canada as I told you, I eat Western food because Western food can easily find and is cheaper. But I choose Chinese food it's not so much Chinese restaurant but its a little bit expensive than Western food so when I come here and when I go out I eat Western food.

Some participants with access to ingredients for traditional foods would shop and prepare meals as a way to stay connected to their culture while living independently in the community. This was conveyed in this quote by Camila:

When I was in Edmonton, in Alberta yes... I was living singly in an apartment, I prepared my

much like home and I got used to having smoothies, which I love. Lots of fruit in it and very healthy. Here it's very different.

Once moving into their care facilities, participants found their traditional food practices altered significantly from when they lived independently. This included the loss in cultural food preparation techniques and consuming traditional foods, which can be seen in this quote by Mariam:

and...when I was living on my own in my condo but of course that changed living in assisted

.

Almost all participants experienced being cut off from their traditional foods, which was considered the last link to their culture, after moving into the care facilities. This was expressed in this quote by Mei:

to this facility, I eat the Western food and I get used to it

The foods provided at the facilities and the times they were provided at did not meet their personal preferences that were related to their culture. Participants found there to be a variety of food options offered at their facilities but none that met their taste preferences. According to the participants, bland foods impacted their ability to eat well. This was aptly described by Camila:

> *The foods I would say are flat, Canadian foods are flat. That's the way I feel, they don't have that much taste. There are abundant and abundant of variety but there is always something like light salt and places like this they'll put salt in any food because of the different needs. So I put lots of salt, not pepper, but lots of salt and lots of butter.*

Mealtimes were also seen to be restrictive, where breakfast was offered too early in the day and subsequent meals were spaced close to each other, which affected their food intake.

> *The meal times are so arranged that between breakfast and dinner.. mid-day dinner... 7:30 breakfast, dinner at 11:30 so that is only 4 hours. I don't have time to get hungry and between dinner and supper that I finish dinner around before 1'o clock so 1 to 4:30... that is almost 4 hours give and take so really 4 hours in between meals, it's plenty of.. you know... I really... I never felt hungry ever since I come here..*

Some care facilities would offer cultural foods in their menu, but participants felt the meals lacked authenticity - adapted for a North American diet and would not be offered frequently (i.e. exclusive to cultural holidays).

Acceptance of Cultural Assimilation by Residents

Participants seemed to accept moving away from their native culture and adopting a more North American way of living when shifting into a care facility. They knew they had unique preferences because of their culture but felt it was unreasonable for care facilities to change their practices for them. Care facilities adapting to cultural preferences were seen as unnecessary by

communicated in this quote by Camilla:

Coming from Edmonton, Alberta - where I was living singly there with lots of Canadian friends, there were no Spanish or Latino friends there. Coming here, I am a minority here.. again, minority...not only because of the language but the food and the customs...after these many years, I still feel like a minority.

Due to this belief of being a minority within the care facilities, participants felt it was their responsibility to adapt to a more North American way of living. This is seen in this quote by Lian:

But you see, I have personal needs because I come from a different culture I cannot expect people to cater to my need because I am a tiny little minority within this huge country right? I have chosen to come to Canada, it's up to me to adapt myself to this culture. I don't want to be unreasonable. So on the rare occasions, I'll go out to Chinese restaurant and I'm very happy.

Participants felt that care facilities are unfit to meet the cultural needs of different ethnic populations based on food offerings. According to them, the menus were designed to meet the needs of those who prefer a North American diet. This was evident in this quote by Maria:

I have friends from other countries which say they can't move to a place like this because they are used to curries and that kind of stuff and of course because of the different spices they wouldn't have it here.

For some participants, adapting to a more North American way of living while residing in care facilities was a way of self-preservation. They felt the need to assimilate in order to survive. This is clear from this quote by Catherine:

Well...you just have to accept these things... at this age and not getting current again...even

what it is...this is what I have to do.

Importance of social support in maintaining a connection with culture

While living in care facilities, participates expressed their strong desire to maintain a connection with their culture as they age. When discussing preparing and consuming traditional foods, participants would often relate it to their childhood memories and cultural heritage. This was articulated in a quote by Mei:

to the Chinese restaurant and choose the food that bring me back memory of China also the thing that I like to eat from many years ago.

Visiting restaurants that served cultural foods with family and friends was a popular activity amongst participants to stay connected to their culture. Participants found opportunities to maintain a connection with their culture through traditional foods by attending social gatherings with families and friends. This was apparent in this quote by Mariam:

Social gatherings with family and friends allowed residents to upkeep some of the traditions from when they were living independently. This was evident in this quote by Maria:

> *Once in every two weeks on a Sunday we have a brunch. Brunch is a self-serve and provides a variety of food that you help yourself. I enjoy that and I even bring my family to enjoy that because I used to have them over at home to eat on the weekends.*

These opportunities for social gatherings also came about when new immigrants from their cultural community would settle in Halifax or if participants had the means to visit the country they migrated from. Having these gatherings allowed participants to connect with others from their cultural community and enjoy home-cooked traditional foods. This can be seen in a quote by Maria:

> *So I try to visit once a year, that's when I really get my satisfaction but now as I said there is some Brazilians living here and sometimes they do potluck so that's the way....they are here for much less time so they are still really missing it so that's an advantage to get the right stuff...home-cooked meals..*

Overall, having opportunities for social gatherings with family and friends was protective in maintaining a connection with their traditions and culture. However, this was not the case for all participants. Those who were experiencing ill health, poor mobility and lacking social support within the community could not participate in various social gatherings within or outside their care facilities.

Summary

The interviews with participants showcase a process of cultural assimilation that started from when they immigrated to Canada and was completed when they moved into their care facilities. Social support from family and community members was seen as a protective factor in maintaining a connection with culture and a deterrent to cultural assimilation. Overall, these interviews highlight the significant role cultural foods and preferences continue to play in

despite being unable to access these foods frequently. This reinforces the unique relationship between food, culture, and identity that needs to be at the forefront of food and mealtime practices in LTC.

Chapter 5 - Discussion

Cultural Assimilation

At an individual level, assimilation stands for the overall changes that make individuals of one ethnic group more acculturated, integrated and identified with the members of another (Rumbaut, 2015). The participants in this study started experiencing cultural assimilation from the moment they moved to Canada, which continued till they moved into a care facility. According to literature, assimilation is an adaptive response to create a sense of belonging for new immigrant populations in society as many are faced with intolerance and xenophobia by those already living in that society (Rumbaut, 2015). Xenophobia is defined as an attitude or behaviour by others that is characterized by fear, dislike, mistrust, hate and violence towards individuals from a different culture (Porta & Last, 2018). This may have initiated the process of assimilation for participants in this study as most of them arrived in Canada several years ago, at a time where there were not as many ethnically diverse populations and a subsequent lack of exposure for other populations residing in Canada. Behaviour changes associated with assimilation result in an increased risk of morbidity and mortality (Riosmena et al., 2018). This is known as the negative acculturation theory, which assumes that health declines the longer an individual who has immigrated resides in North America because of poorer health behaviours and risks that reflect a North American lifestyle (Ro, 2014). This relates back to the healthy immigrant effect, where immigrants arrive in better health than the native-born population in the host country, but the negative acculturation theory leads to the loss of this effect (Vang et al., 2017; Sanou et al., 2014).

Lack of ethnically diverse populations could call into question if there was a community for these individuals. The presence of a community plays an essential role in helping migrating individuals adjust to their new environment. When immigrant families maintain a connection with

their respective ethnic communities, they have more opportunities for education and economic advancement through access to the resources that are available through their community (Couton, 2014; Portes, 1995). Maintaining a connection with their community can allow individuals to have social support and help maintain cultural practices, thereby slowing down the assimilation process (Couton, 2014). Participants in this study spoke about finding communities belonging to the same cultural background after immigrating to Canada that provided support and helped stay connected to their culture (i.e., cooking together, sharing meals and providing information about grocery stores that sold traditional ingredients). Social support includes functional support and structural support (Barth, Schneider, & von Kanel, 2010). Functional support pertains to the aid and encouragement provided by their social network such as financial, informational, appraisal and emotional (Barth, Schneider, & von Kanel, 2010). Structural support is how many individuals the person interacts with and how big their social network is (Barth, Schneider, & von Kanel, 2010). Lack of support related to immigrant status can lead to stress, resulting in the uptake of unhealthy habits (i.e. smoking, alcohol use, overeating, etc.) and subsequent disease (Raphael et al., 2020).

Some participants spoke about experiencing food insecurity after immigrating to Canada. Food insecurity is defined as limited or uncertain availability or access to nutritionally adequate, culturally relevant and safe foods (Anderson, 1990). Food insecurity can result in poor nutrition status, which is associated with decreased quality of life, functional ability and increased risk of mortality (Wei et al. 2019). Lack of availability of cultural foods and lack of access due to higher food prices were identified as deterrents to consuming culturally appropriate meals. In which case, they started incorporating western foods into their diet as these were readily available and relatively inexpensive. Research shows immigrants experiencing food insecurity consume fewer fruits and vegetables and have an intake of lower quantities and quality of foods (Girard & Sercia,

2013). A diet with low fruit and vegetable intake can lead to an increased incidence of chronic disease including cardiovascular disease, cancer, diabetes etc. (Aune et al., 2018; Nicklett & Kadell, 2013). Food insecurity can impact the trajectory of aging in individuals. Increased severity of food insecurity experienced is associated with a higher incidence of frailty in older adults compared to those who are food secure (Pérez-Zepeda et al., 2016). Research also shows loss of lean muscle mass in community-dwelling older adults experiencing food insecurity (Dassie et al., 2016). This can be attributed to inadequate calorie consumption, low intake of nutrient-dense foods and decreased number of meals throughout the day while experiencing food insecurity (Lee, Fischer, & Johnson, 2010).

Those who had access to cultural ingredients and foods would regularly consume them while living independently to stay connected with their culture. Many would utilize food preparation techniques passed down to them from their family members and ancestors. Research shows immigrant communities want to preserve and continue with their food culture after immigration (Garnweidner et al., 2012). Food is a symbol of individual identity, ethnicity and cultural belonging among immigrant populations (Garnweidner et al., 2012; Weller & Turkon, 2015). Immigrant communities use food to practice their culture, which can deter assimilation, and food preparation techniques are often passed down to children to maintain cultural identity (Cook, 2008). The process of preparing and consuming foods associated with their culture allows individuals to revisit memories and recall family, friends and places they left behind to start a new life (Weller & Turkon, 2015). So, food can act as a connection to the countries they immigrated from despite the physical separation (Cook, 2008). Therefore, the inability to consume cultural foods results in the loss of cultural identity (Gabaccia, 1998).

Once moving into a care facility almost all participants were no longer able to consume cultural foods regularly. The types of foods provided at the care facilities and the timings the foods were provided were found to not meet the preferences of the participants. Food is an important aspect of lives and food choices are based on traditional, religious, personal taste that is part of their culture (Evans et al., 2005). Having continuity of familiar cultural practices (i.e. cultural foods) can decrease the stress that can result from institutional living (Durst & Barrass, 2014). It is also established that unmet preferences for cultural foods and mealtime practices are risk factors for inadequate intake of foods and fluids by senior and elderly persons living in long-term care (LTC) (Soenen, & Chapman, 2013; Tamura et al., 2013). Thus, when cultural needs are not met in care facilities, it can lead to poor food and fluid intake resulting in malnutrition (Soenen & Chapman, 2013; Tamura et al., 2013). Malnutrition can lead to weight loss, muscle wastage, lethargy, compromised immunity, poor wound healing, cognitive decline, nutrient deficiencies, increased hospitalization rates, increased costs of care and a higher risk of mortality (Soenen & Chapman, 2013). Overall, the meal and mealtime experiences of the participants in LTC may make them more susceptible to frailty as they may lead to unintentional weight loss. An individual is categorized as frail when they meet the phenotypic criteria which include low grip strength, low energy, slowed walking speed, low physical activity and unintentional weight loss (Fried et al, 2001). Frailty in older immigrant adults makes this population more vulnerable to stressful events and susceptible to negative health outcomes such as acute illness, a decline in physiological reserve, and increased risk for adverse outcomes including loss of independence, reduced quality of life, disability, delirium, falls, hospitalization, and death (Collard et al., 2012; Clegg et al., 2013; Cheng & Chang, 2017; Persico et al., 2018; Kojima, 2018; Kojima, 2017; Kojima, Ilffe & Walters, 2018; Lin et al., 2016).

Acceptance of Cultural Assimilation by Resident

Participants felt they had to change and adjust in the care facilities since they were a minority within the majority. A minority group is a subgroup of the population with distinctive social, religious, ethnic, and racial characteristics that are different from those of a majority group (Perkins & Wiley, 2014). The minority group typically holds less power than the majority, dominant group (Perkins & Wiley, 2014). Historically, immigration to Canada was fueled by migrants from European countries, which has played an important part in influencing the cultural traditions and care practices that are currently present in LTC facilities.

immigration policy from an ethnicity-based criterion that favoured European migrants, to a points system promoted and led to an increase in migrants from places such as Asia, South Asia and Africa (Statistics Canada, 2007; Green & Green, 2004). This shift is now contributing to the growing ethnocultural diversity in Canada, especially within the aging population. Despite these changes within the aging demographics in Canada, the health care services in the LTC sector are still being delivered and are adapted from the cultural norms of the dominant, Eurocentric group (Durst & Barrass, 2014). There is a need to adapt health care services to accommodate the growing ethnoculturally diverse population. Based on this research study examining the perspectives of senior and elderly immigrants residing in care facilities around resident-centred care and meal satisfaction, it is indicated LTC facilities have been falling behind on adapting for a growing ethnoculturally diverse population. As a result, residents from ethnoculturally diverse populations are being forced to assimilate and adopt a more North American way of living when moving into care facilities. Having this perception of being a minority within the majority, ethnoculturally diverse residents felt they needed to adapt to the care facilities rather than these facilities adapting their services to accommodate for cultural differences. Participants also felt it was unreasonable

to ask for services (i.e. food and mealtimes) to accommodate for cultural differences as they chose to leave their home countries and immigrate to Canada.

The results of this study showcase how residents from ethnoculturally diverse populations have to adapt to a more North American way of living due to care facilities not being able to incorporate cultural preferences within the essential services like meals and mealtime. The LTC settings in Canada claim to promote RCC to improve the quality of life of residents. Cultivating RCC in facilities means that care being delivered is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where residents are empowered to be involved in health decisions at whatever level they desire (Morgan & Yoder, 2012). Individualization is integral when delivering RCC. Having knowledge about culture, beliefs, traditions, habits, activities, and preferences is essential when individualizing services to promote RCC (Suhonen, et al., 2005). LTC facilities not adapting their care practices to the culturally diverse needs of residents, as seen in this study, can be a barrier in providing individualized care that is a contradiction to resident-centred and resident-directed care.

Residents living with chronic conditions and diseases (i.e. cancer) felt they needed to assimilate to survive. One participant, in particular, spoke about living with cancer and how she viewed meals at the care facility as a source of nourishment rather than enjoyment, so she can gain strength to survive through her ongoing cancer treatment. There is a growing body of research that has looked at the effect of minimal cultural support in care facilities on residents from ethnoculturally diverse populations. Lack of cultural support in care facilities can be a barrier to communication, leads to resident dissatisfaction, negatively impacts resiliency of residents, mental health, ability to thrive, quality of life, nutrition and increases the risk for falls, hospitalizations, the need for pain management and medication use (Ihara, 2004; Durst & Barrass, 2014; CLRI,

2017; Mclvor, Napoleon & Dickie, 2009; Um, 2016). In contrast, acknowledging and accommodating cultural differences can result in reduced social isolation, improved mental health outcomes, lived based on their values, beliefs and practice tradition building resiliency and ability to survive (Um, 2016; Cheng, 2005). Support of culture in LTC is noted to be crucial during end-of-life for residents as it can the one source of comfort at an otherwise difficult time (CLRI, 2017). Based on this evidence, assimilation may be an instinct to survive but may be detrimental to the health of older adults from ethnoculturally diverse populations.

The lack of emphasis on cultural adaptation and accommodation in care facilities can be seen to complete the process of assimilation that started when participants first immigrated to Canada. The social determinants of health experienced by participants may play a role in how they have aged and continue to impact how they are aging in care facilities. There is a need for further research to identify how the current care practices in relation to cultural diversity and mealtimes in LTC may shape the overall health and well-being of ethnoculturally diverse residents.

Importance of social support in maintaining a connection with culture

The desire to maintain a connection to culture was evident in participant interviews. While discussing favourite foods, participants would talk about preparing and eating traditional foods and relate them to their childhood memories and cultural heritage. One participant spoke about her need to continue eating traditional foods as it brought back memories of her time in China and she wanted to hold on to these memories as she grew older. Food is an integral component of culture. In cultural groups, the way people eat is based on shared knowledge, beliefs, values and customs (Burns, 2009). These food habits are formed and internalized early in life to become part of an indiv within a cultural group (Burns, 2009). Due to this unique relationship of food

with culture and identity, it is only natural that participants longed to access traditional foods to maintain a link with their culture.

Social support from family and community members was found to be a protective factor in maintaining a connection with culture by increasing access to traditional foods. Social gatherings outside the care facilities with family and friends allowed participants to take part in traditions they used to maintain while living independently. This presented as an opportunity to enjoy home-cooked traditional foods. Some participants, like Mariam, would often cook traditional dishes for their family members during these gatherings. Presence of a community from similar cultural background allowed for social gatherings that usually revolved around cultural foods that individuals from the community would prepare and enjoy together. Participants who could do so would occasionally visit the countries they migrated from to visit family and maintain their connection with culture. Participants who identified as Chinese would often visit different restaurants with friends in the city that serve Chinese cuisine when they felt the need to eat cultural foods. In contrast, participants that were experiencing ill health, poor mobility, financial constraints and lack of social support within the community could not participate in various social gatherings outside their care facilities.

Social cohesion and relationships within the community can improve quality of life and protect the health of older adults (Rapacciuolo et al., 2016). However, lack of social support can lead to social isolation and exclusion, which are social determinants of health associated with poor physical and mental health status, decreased quality of life and an increased risk of mortality (Rapacciuolo et al., 2016). Social isolation is also an important predictor for nutrition inadequacy in older adults (Locher et al., 2005; Boulos et al., 2017). Recent evidence suggests a sense of social isolation and exclusion in ethnoculturally diverse older adults residing in LTC increases when the

food, mealtimes and recreational activities are adapted for a Eurocentric population (Mullings & Gien, 2013). The absence of foods that align personal preferences can hinder the adjustment of ethnoculturally diverse residents in care facilities, furthering feelings of isolation (Hutchinson et al., 2011; Runci et al., 2014). When menu offerings are not based on preferences, it can lead to dissatisfaction with meals - a significant moderator of food intake (Wright et al., 2011).

Residents from ethnoculturally diverse communities often depend on family and community members to access traditional foods based on preferences that are otherwise not served in care facilities, which was evident in this study. A study by Xiao et al. (2017) identified that family and members from a cultural community played an integral role in meeting the diet needs of ethnoculturally diverse residents. Having social support may help increase food intake and can be protective against malnutrition in ethnoculturally diverse residents. Based on a study by Keller, et al., (2015), sensory properties of food (i.e. taste), the familiarity of food and food variety were identified as priority factors affecting food intake in LTC. In this study, social gatherings with family and friends were a source of social support and helped connect participants to their culture by providing a variety of traditional foods that are familiar and meet taste preferences.

Limitations of the Study

A limitation of this study is related to participant recruitment. The sample size for this study was small. This is due to the lower density of ethnoculturally diverse older adults residing in retirement, assisted living and LTC homes in the HRM. Many individuals from ethnoculturally diverse communities residing in facilities were living with advanced stage dementia, automatically excluding them from this study. Some potential participants relocated to facilities in Ontario that they cited could meet their cultural needs because of a higher density of ethnocultural diversity.

The recruitment period was also cut short due to the Covid-19 pandemic as access to facilities was denied to prevent the spread of the virus.

Bias can be a concern when interpreting the data in any qualitative study. For this study, the researcher id

To diminish the bias in this study, the researcher went through a rigorous coding process and constant self-reflection. Journaling was used as a technique to practice reflexivity. This allowed the researcher to organize her reflections around feelings and thoughts about immigrating to Canada to check in with them throughout the research process.

Implications for Future Study

Within the field of nutrition and dietetics, it is necessary to further explore the impact of a Eurocentric menu and mealtime practices in LTC facilities on meal satisfaction and food intake of ethnoculturally diverse residents. More specifically, it may be beneficial to look at the effect on nutritional markers to identify the risk for malnutrition. As cultural food preference is liked with meal satisfaction and intake, it may be important to assess the intake of key macro and micronutrients of ethnoculturally diverse residents that can help measure nutrition risk. This may allow health care practitioners and policymakers to understand and gain insight into the negative consequences of Eurocentric care practices on an ethnoculturally diverse population.

In addition, further exploration is warranted to understand management and staff perspectives on supports and barriers to providing culturally competent care concerning food and mealtime practices. The growing demand for the inclusion of culturally competent care directly affects policy and procedure within LTC facilities as well as the care provided by staff (Parker, 2010). Collaborating with management and staff is critical in creating sustainable interventions

and improving access to resident-centred care (Cranley et al., 2020). It is also essential to investigate how government funding and regulation may pose a barrier to providing culturally competent care in LTC facilities. Limited funding for LTC is a commonly cited obstacle for meeting dietary preferences for residents (Barrass, 2006). The nature of LTC regulations can limit how resources can be utilized to meet the cultural needs of residents (Barrass, 2006).

Study Recommendations

There are a few recommendations that can be derived from the findings of this study. The first would be for dietitians and food service managers to understand the demographics of the residents in the LTC facilities and including their perspectives when planning the menu. Based on the experiences of immigrant residents explored in this study, it is apparent each individual has unique lived experiences and routines before living in care facilities. Adapting the menu to incorporate some cultural foods based on the demographics of the care facility during meal and snack times may be a way to meet cultural needs.

The second suggestion would be to re-think how meal satisfaction evaluations are conducted within LTC. This study identified that ethnoculturally diverse residents may not be forthcoming with suggestions on improving mealtime practices to meet their cultural needs as they feel they have to adapt. Previous research has also established that residents are wary of completing meal satisfaction evaluations as many felt providing negative feedback may impact the delivery of care (Crogan, 2004). Therefore, it is important to evaluate how meal satisfaction evaluations are designed and distributed to accurately capture feedback that will be used to improve food and mealtime practices. Revising the process of meal satisfaction evaluation may allow management and staff to capture existing gaps in care practices for ethnoculturally diverse residents in relation to food and mealtime.

The third suggestion would be to create flexible mealtimes. Participants in this study found mealtimes restrictive compared to when they lived independently. They noticed that the strict schedules left very little time between meals, which made it hard for them to build up an appetite. Restriction in mealtimes can impact the social experience of eating and add a burden on staff that assist residents with feeding (Lowndes et al., 2015). The social experience of eating is integral to the quality of life and can improve food intake (Lowndes et al., 2015). Dining room interactions during mealtimes present as an opportunity for residents to establish and maintain relationships with other residents and staff (Watkins et al., 2017). Therefore, mealtimes create a sense of community that facilitates emotional and psychological connections between residents (Watkins et al., 2017). A social environment created during mealtimes promotes improved quality of life, food intake, physical functioning and body weight (Nijs et al., 2006). Thus, creating flexible mealtimes may enhance the dining experience and overall quality of life of residents.

The final suggestion would be to capture the perspectives of the LTC institution management, staff and resident families on supporting ethnoculturally diverse residents. Including these perspectives will allow insight into the barriers to providing culturally competent care for residents within the LTC. This knowledge can aid in creating high-quality interventions to better support ethnoculturally diverse residents and improve resident, family and staff satisfaction (Legare et al., 2018).

Conclusion

Thus far, there has been very little attention that has been paid to the role of culture in resident-centred and resident-directed care as it applies to meal satisfaction the in LTC system. There is also limited research published that explores the perspectives of immigrant senior and elderly individuals residing in care facilities. The barriers to achieving adequate nutrition for older

adults are well documented. This research shows how social determinants of health along with factors such as aging and an immigrant identity work together to increase the risk for malnutrition in ethnoculturally diverse older adults from the community to LTC. With the growing ethnoculturally diverse aging population, there is a need for attention to culture in ongoing research and in the provision of health and LTC care services to promote well-being. Not doing so can lead to greater health disparities that directly impact ethnoculturally diverse populations.

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Appendices

Appendix A: Recruitment Flyer

Appendix B: Interview Questions

1. What are some of your favourite foods from your culture?
2. What foods do you eat more often?
3. What role does your culture play in what you eat?
    - o How do you maintain your culture in your day-to-day life?
    - o How has moving to long-term care/assisted living/ retirement living impacted this?
4. Describe your mealtime experience?
    - o Do they meet your individual liking?
    - o Do you look forward to meals at your residence?
5. What do you think about the choices of meals available to you?
6. Can you describe the mealtime practices at your residence?
    - o What do you think about the quality food and service provided?
7. What role does staff play during meal services at your residence?
    - o Describe your relationship and interactions.
8. Can you tell me about eating habits in long-term care?
    - o How has it changed?
9. Do you have any suggestions for improvements?

Appendix C: Consent Form

Informed Consent

Thesis Topic: Impact of Culture on Resident Care and Meal Satisfaction in Long Term Care.

Thank you for your interest in participating in my study. I will read the following details about the study and your involvement. If you agree to the terms, please say yes.

Food carries a deep significance in our lives. The meaning behind our choices for food is related to traditions, religion or personal taste that is a part of our cultural roots. The purpose of this study is to explore the experiences of first-generation immigrant senior, elderly persons and their families about food and mealtime practices in long-term care, assisted living and retirement facilities located in Halifax, Nova Scotia. This study will be carried out in Halifax, Nova Scotia under the supervision of Professors Linda Mann, Department of Applied Human Nutrition and Dr. Deborah Norris, Department of Family Studies and Gerontology, at Mount Saint Vincent University. The data is collected for the purposes of a MSc. Thesis and perhaps for subsequent research articles.

I am seeking eight to ten participants who have immigrated to Canada, are 65 years of age or older and who are living in long-term care, assisted living and retirement facilities in Halifax Regional Municipality.

With your consent, I will conduct a face-to-face interview for about 1-1.5 hours. The interviews will be audio recorded by me. During the interview, you will be asked questions about your background and then more general questions about your perspectives and experiences on food and mealtime practices in long-term care/ assisted living/ retirement facilities. Throughout the interview, I may ask questions to clarify your answers but my part will be mainly to listen to you speak about your views and experiences. During the interview, I may write brief notes that will be used to assist me in asking the questions that follow.

Each interview will be audio taped and later typed and saved on my computer. The typed version will be identified by a number, not your name. The information obtained in the interview will be kept in strict confidence and stored at a secure location. All information will be reported in such a way that participants cannot be identified. All raw data (i.e. transcripts, field notes) will be destroyed five years after the completion of the study. During this time period, the data may be used as supplementary data for future studies.

You may at any time refuse to answer a question, withdraw from the interview process, or withdraw from the study itself. You may request that any information, whether in written form or audiotape, be removed from the study. Finally, you are free to ask any questions about the research and your involvement with it and may request a summary of the findings of the study.

Consent for Audio Recording

As a participant in this research study, you agree to be audio recorded for the purpose of data collection. What you share about your experiences on food and mealtime practices in long-term care/assisted living/retirement facilities will inform future practice through my MSc. Thesis. You have the choice to withdraw this consent at any time without penalty or consequence, at which time the recordings will be completely erased and destroyed.

You understand that the recordings will be kept confidential and that no information about you, including these recordings, will be given to anyone.

You consent to excerpts of these recordings, or descriptions of them, being used by the researcher for the purpose of research or the presentation of research. You understand that the researcher will edit out from these recordings, or from descriptions of the recordings, any information that may identify you.

You understand that you will be given the opportunity to provide or withdraw your permission for the use of the recordings for purposes other than the current MSc. thesis project and supplementary data for future research studies.