

Meal context and food offering in Quebec public nursing homes: the perspectives of first-generation immigrant residents, family members, and frontline care aides

Alain Girard and Asma El Mabchour

Alain Girard is based at GastronomiQc Lab, Joint Research Unit, Institut de tourisme et d'hôtellerie du Québec, Montreal, Canada. Asma El Mabchour is based at Nutrition Department, Université de Montréal, Montreal, Canada.

Abstract

Purpose – *The purpose of this paper is to gain a better understanding of the meal context and the food offering in Quebec public nursing homes for non-autonomous seniors, particularly with respect to first-generation immigrants.*

Design/methodology/approach – *A focused ethnography approach was used. Semi-structured interviews were conducted with three distinct groups: non-Quebec-born residents (n = 26), their families (n = 24) and frontline care staff (n = 51). Structured non-participative observations were made in facilities.*

Findings – *First-generation immigrants, however, long ago they arrived in Quebec, adapted with difficulty and often not at all to the food offering. Resident's appetite for food offer was a problem for reasons related primarily to food quality, mealtime schedules, medication intake, physical and mental condition, and adaptation to institutional life. Family/friends often brought in food. Care staff tasks were becoming increasingly tedious and routinized, impacting quality of care.*

Practical implications – *Institutions should render procedures and processes more flexible and adapt their food offering to the growing diversity of their client groups. For residents, the meal experience is profoundly transformed in nursing homes in terms of form, conditions, rituals and meaning. A better understanding of lived situations shaped by a more refined cultural sensitivity would go a long way toward achieving a better quality of life not only for residents but also for their families and friends. Care aides, on whose shoulders rests the responsibility of ensuring that meals are safe and pleasant moments for socializing and maintaining social dispositions, are ambivalent about their work.*

Originality/value – *The paper is based on an original study. To the authors' knowledge, the literature on the meal context and food offering in Quebec public nursing homes, regardless of population type, was non-existent. Analyzing and interpreting the results by crossing the discourses of immigrant residents, their family and friends, and frontline care staff made it possible to reveal different aspects of the phenomenon, which, if considered together, shed light on the meal context in public nursing homes.*

Keywords *Immigrants, Food, Culture, Nursing home residents*

Paper type *Research paper*

1. Issue and social context

1.1 Senior population growth, population diversification, and diversification of culinary tastes and expectations in Quebec

With the growing number of people in the 80s and over age group and the lengthening of life expectancy in Canada, how to care for non-autonomous seniors and, more specifically, how to feed them in institutional facilities, is becoming a mounting concern. According to a report published by the Quebec federation of seniors, FADOQ (2017), based on data from the Institut de la statistique du Québec (ISQ; Quebec statistics institute), demographic projections show that, by 2021, the over-80 population in Quebec will increase by 75 percent over the benchmark

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year of 2011. Moreover, it will increase by 110 percent by 2031 and reach nearly 703,000 persons, compared with 329,000 in 2011 (ISQ, 2014).

Most of the current residents in Quebec's public nursing homes[1] are of French-Canadian descent. They were socialized in the dietary models (mostly rural) prevailing in French-speaking Quebec more or less in the period from 1945 to 1965. In these dietary models and in this population that constituted the vast majority in the province, foodstuffs, cooking techniques and seasonings were of relatively limited diversity on a local basis. This was due in large part to the fact that geographic mobility of the population and of foodstuffs and recipes alike was much more limited compared to today (Coulombe, 2002; Lambert, 2011).

However, these dietary models began to undergo major changes in Quebec in the 1970s. The diversification of culinary tastes, foodstuffs, culinary cultures and populations in Quebec, particularly in Montreal, the province's metropolis, completely transformed the province's dietary landscape (Laurence and Perreault, 2010; Jourdan and Riley, 2013; Lambert, 2013). Today, nursing homes and other public care facilities are at the dawn of a dietary paradigm shift. These institutions will soon be receiving populations with tastes and expectations far different from those of current residents in terms of food. The first cohorts of baby boomers, for instance, will be arriving in nursing homes around 2025.

The presence of immigrant groups has grown steadily in Quebec's population since the Second World War. Today, these total some 1,155,000 people or 13 percent of the overall population (MIDI, 2017). It is important to point out, also, that 74 percent of Quebec's immigrant population lives in the greater Montreal area (Ville de Montréal, 2018). As we will see later, a certain number of immigrants are already in nursing homes, particularly in those that our research focused on.

1.2 The meaning of food and foodways and first-generation immigrants' relation to food

Eating and mealtime extend well beyond the mere intake of nutrients required for the body to survive and function properly. They are experiences with a strong social, identity, symbolic, emotional, memory and hedonistic dimension. This is why sociocultural and anthropological approaches are required to understand food holistically (Fischler, 1990; Poulain, 2002; Counihan and Van Esterik, 2008; Le Breton, 2012).

The powerful ties that first-generation immigration populations entertain with their pre-migration dietary models are well documented (Diner, 2001; Ray, 2004; Duruz, 2010; Chapman *et al.*, 2011; Girard, 2013), as is the persistence over time of food socialization (Chiva, 2002; Dupuy and Poulain, 2008; Dupuy and Watiez, 2012; Diasio, 2014). We are referring here to more than just phenomena of continuity given that dietary practices and cuisine are subject to change owing, if for nothing else, to changes in the food offering, exposure to other dietary models, the food socialization of children in their new social space and lifestyle changes (Harbottle; 1996, Foner, 1997; Koç and Welsh, 2001; Burns, 2004; Renzaho and Burns, 2006). Nor is it merely a question of breaking with the past, given that how other foods (tastes, techniques, foodstuffs and discourse) are appropriated and how practices are reconstructed depends in part on people's pre-migration culinary knowledge and practices and their food socialization.

This attachment is not purely a matter of nostalgia for one's native land. Actually, it has little to do with nostalgia, as we demonstrated in a rather large-scale study carried out from 2008 to 2013 involving various immigrant groups (all non-native French or English speakers) from a wide range of sociocultural and geographic horizons (Girard, 2013). It emerged that food has much more to do with sensoriality or, more precisely, with one's relationship to the world via a sensorial and sensual dimension (which encompasses pleasure) mediated by flavors, odors, emotions, memory and intimacy (Choo, 2004; Thomas, 2004; Dennis and Warin, 2007; Chau, 2008; Oyangen, 2009; Sutton, 2010), all of which are building blocks in the construction of what people call home, that is, their subjective appropriation of space (Hage, 1997; Serfaty-Garzon, 2003; Ore, 2014), as they are in the construction of family, gender, and individual and collective identities (Murcott, 1982; DeVault, 1991; Devine *et al.*, 1999; Harbottle, 2000; Devasahayam, 2005; Girard, 2013). It is because it sets off numerous dimensions of existence, often some of the most critical, that one's attachment to food and culinary practices is so powerful. This takes on a most particular dimension for first-generation immigrants.

Meals are opportunities for socialization and interaction, which are important for the generativity and integrity of the ego, particularly in the case of seniors in institutional facilities (Crogan *et al.*, 2004; Nugent, 2013). When food is familiar it is also a source of comfort, an element that takes on a singular dimension at the end of life (Bundgaard, 2005; Evans *et al.*, 2005). Though the meaning of food, eating habits and food preferences evolves across the stages of the life cycle, eating is, until death, a major, if not central, experience in an individual's personal, social and cultural life.

1.3 Institutional feeding, perspective of nutrition sciences and working conditions of care aides

Research on the institutional feeding of the elderly has, in Quebec and elsewhere in the world, focused primarily on strictly nutritional concerns. Undernutrition is a widespread phenomenon among seniors living in nursing homes and, more broadly, among seniors living alone. The issue is well known to practitioners and researchers (Sidenvall *et al.*, 2000; Donini *et al.*, 2003; Ferry, 2007; Cardon, 2010; Pouyet *et al.*, 2015). The purpose of the research in those cases is to understand the phenomenon of undernutrition observed in these populations in order to provide adequate nutritional intake and to adapt diets to the specific nutritional needs of seniors (Donini *et al.*, 2003; Divert *et al.*, 2015; Cichero, 2016; Guérin, 2016a). The literature on the subject is extensive. Though it is fundamental, this clinical approach to nutrition overlooks other key dimensions of food and eating, such as food socialization and food preferences tied to sociocultural background. It also neglects the roles and perceptions of the different stakeholders involved in food production and meal service in nursing homes. The literature in this regard is rather scarce at the international level and, to our knowledge, non-existent in Quebec.

Though the literature has focused considerable attention on issues regarding care delivery by, work organization for, and working conditions of nursing home care aides (CA), meal services in these settings have never been examined in and of themselves. Two things in particular have emerged from this line of research: in recent years, the working conditions of CA have deteriorated and the care acuity of nursing home residents has increased. This has a profound impact on the overall quality of care provided by care staff and on their wellbeing (Bourassa, 2015; Aubry, 2016; Tremblay, 2017; Angers and Vézina, 2018). It also has a significant impact on their capacity to provide effective and compassionate service, as we will see later on.

1.4 Food offering and mealtime in institutional facilities for non-autonomous seniors

The European and American literature on the institutional feeding of non-autonomous seniors has shown that, for nursing home residents, meals should be authentic and as close as possible to home-cooked fare and that they should promote independence and satisfy the preferences of residents in terms of food and service quality (Sidenvall *et al.*, 1996; Evans *et al.*, 2005).

This literature has also demonstrated that, where the food intake of nursing home residents is concerned, work organization, meal routines and ritualization, food quality, living conditions, and CA attitude toward work and residents play a role as important as do food preferences, socialization and health conditions (often chronic) of residents, if not more so (Sidenvall and Fjellstrom, 1994; Sidenvall *et al.*, 1996; Kayser-Jones and Schell, 1997; Crogan and Evans, 2001, Allison, 2002; Evans *et al.*, 2005). Generally speaking, it has been shown that CA are not always mindful of the needs of residents, that they focus more on executing the tasks at hand than on nurturing relationships with residents, that they do not spend enough time assisting residents during mealtime, and that they are stressed out by the rapid pace at which basic tasks must be executed as instructed by management.

Moreover, some researchers have emphasized the psycho-affective dimensions of food intake and mealtime and pointed out the effects of meal context in nursing homes on residents' appetite (willingness to eat) and food intake (Wikby and Fägerskiöld, 2004; Nijis *et al.*, 2009; Divert *et al.*, 2015).

In France, Pouyet investigated food attractiveness and consumption in public residential facilities for dependent seniors (more commonly referred to by their acronym, EHPAD), which cater particularly to people with cognitive impairments. She demonstrated that attractiveness and consumption depended on sensorial factors (visual aspect, flavor, texture and temperature),

cognitive factors (familiarity, sociocultural identity, reminiscence and ease of digestion), and food plating (aspect and quantity) (Pouyet, 2015, 2018). She also showed that cognitive impairment played a large role in the amount of food consumed (e.g. difficulty eating) but that mealtime assistance, level of dependence and resident's social network played a huge role as well.

Guérin (2016a, b), for her part, showed that maintaining the social and symbolic dimensions of meals in EHPADs was problematic. These facilities were expected to meet a social requirement whereby meals are considered an integral part of care and a time for socializing. Instead, they constituted a daily ordeal for care teams on account of the arduousness of the task and the residents' many physical and, more importantly, mental conditions.

Finally, Sydner and Fjellström (2005) and Crogan *et al.* (2004) noted that the various players in nursing homes (managers, nutritionists, nurses, CA) did not consult residents enough to find out their preferences and needs in terms of food and meal context and did not recognize the sociocultural meanings that food had for them. However, a significant proportion of nursing home residents did not communicate their needs even when efforts were made to consult them. Consequently, residents were neither the ones making decisions, nor were they even participating in decision making. Instead, decisions were part of an organizational context that contributed to turn residents into passive, dependent care recipients rather than treating them as citizens capable of agency (Sydner and Fjellström, 2005, p. 51).

2. Purpose of paper and scope, strengths and limitations of study

The purpose of this paper is to gain a better understanding of the meal context and food offering in nursing homes and to take stock of the situation. There is a pressing need to develop knowledge that will allow gaining a better grasp of the act of eating and the meal context as a whole in institutional facilities and, more particularly, with respect to immigrant populations.

The paper is based on an original study that sought to examine the meal context in Quebec public nursing homes, specifically with respect to residents' groups that are first-generation immigrants, many of whom had arrived in the province a very long time ago. To our knowledge, the literature on the meal context and food offering in Quebec nursing homes, regardless of population type, was non-existent. Analyzing and interpreting the study's results by crossing the discourses of immigrant residents, of their family and friends, and of frontline care staff made it possible to reveal different aspects of the phenomenon, which, if considered together, shed fresh light on the meal context in nursing homes.

One of the limitations of the research might be a certain degree of heterogeneousness in the focus groups with staff. Also, the presence in a few cases of a hierarchical superior might have influenced the discourse of the CA or of the nurses in these groups. However, the reasons for their presence were not for them to spy on what team members had to say but rather to have them express, like the others, their point of view on the issues under study.

Two more limitations need to be underlined. Given the focus groups strategy and the study's focus (and, by that token, that of the interview guide) on meal context and food served, we did not seek to explore the circumstances of immigration and the life story of long-standing immigrants in the Quebec context and, more specifically, their food experience in the years preceding admission to a nursing home. Though this would have been interesting, it would have led participants too far astray of our paper's purpose and those results, in any event, would have warranted one or more separate papers. This might explain why our sample of residents comes across as monolithic. The fact of the matter is that they all commented on the same (current) context and the results show that there was a great deal of similarity in how they read that context.

Finally, we underscore at various times in this paper the fact that the frontline care staff (CA) operated under challenging work conditions, that they stood at the bottom of the institutional hierarchy, and that this situation had grown worse in recent years instead of getting better. However, their work conditions, their subordination and the fact that they have little say within the organization could not be directly part of this paper's subject and analyses. Here, too, it would be worthwhile to investigate these issues more specifically, but that would have driven us to cover

more research questions than methodologically possible. We kept the focus on their role and their reading of the meal context in the facility where they worked, highlighting the central but demanding role they play in this context.

3. Profile of resident population in CIUSS-NIM nursing homes

According to statistics from the Centre intégré universitaire de santé et de service sociaux du Nord-de-l'île-Montréal (CIUSSS-NIM; integrated university centre for health and social services in north-end Montreal) compiled for the purposes of this research, the total number of residents in their 12 facilities was 1,795 (total of 1,921 available beds). Their mean age was 83.2 years, up 1.6 years since the benchmark year of 2013–2014, and 65 percent of the residents were women. They had been in their facilities for 2.7 years on average. Finally, the CIUSSS-NIM admitted 1,340 new residents over the course of the 2016–2017 budget year, which represented an increase of 29.5 percent over 2013–2014.

The CIUSSS-NIM does not collect information on what proportion of its residents is not Canadian born. However, based on our own observations and conversations with managers, the percentage varied across facilities from about 3 to 10 percent and was on the rise. These percentages were far lower than those observed in the populations in the neighborhoods surrounding the CIUSSS-NIM facilities, which varied from 15 to 50 percent (Ville de Montréal, 2011).

The CIUSSS-NIM was unable to provide us with data on the proportion of residents with a cognitive impairment seriously affecting their level of autonomy. However, pan-Canadian data collected from similar facilities have shown that in the 80s and over age group, the mean incidence of dementia in its various forms was 47 percent (Wong *et al.*, 2016), with 71 percent of the residents affected being women. Given that women made up 65 percent of the resident population in CIUSSS-NIM facilities, it is not unreasonable to suppose that at least half of this population was affected by one form or other of dementia and no longer had the autonomy required to eat without assistance. This has major repercussions on the work performed by CA, as we will see later on.

4. Methodology

An inductive, ethnographic approach was used in the study (Biggerstaff and Thompson, 2008, Chan *et al.*, 2010) and a semi-structured questionnaire was used in the interviews to make participants express themselves on general topics (e.g. “tell me about [...]”). The aim was to allow their perceptions and perspectives to emerge regarding meals, service, food, recipes, meal context, and institutional food offering and feeding.

Semi-directed focus groups were held with six people on average per group. Three group categories were defined beforehand and these were met with separately using very similar questionnaires only slightly adapted according to the roles and status of each group regarding the global topic.

4.1 Residents

These had to be full-time nursing home residents born outside Canada. Decisional capacity was controlled via a brief questionnaire administered orally prior to the focus group (Jeste *et al.*, 2007, Hugonot-Diener *et al.*, 2008). A total of 26 persons participated, split evenly between genders, though this was not mandatory. Mean age of participants was about 72 years. We did not seek to explore their migration history or the socio-economic and cultural characteristics of their situation in Canada prior to being admitted to a public nursing home as the duration of interviews was limited to about one hour on account of their state of health and more broadly to their advanced age. Furthermore, the inclusion of resident's different backgrounds in data collection would have implied other research questions, other assumptions, an additional literature review and an analysis accordingly. What we can say, however, is that the participants had different profiles in terms of geographic origin and that they had all immigrated to the country more 40 years earlier.

Most resided in the care facility for more than three years. All were no longer autonomous enough to continue to live at home and required daily continuous care that their families could no longer provide.

4.2 Family and friends of residents

Inclusion criteria for this group were to have a family member or friend born outside Canada living in a public nursing home. In total, 24 persons participated. We did not investigate their socio-economic and cultural profiles for two main reasons: the profiles would have been too diversified to be correlated in the analyses and we had to remain focused on meal context and food in public nursing homes and how their family members adapted to these.

4.3 Staff

Employees with meal-related duties who expressed an interest in the issues of the food offering and meal context in their facility were eligible. Most of the participants were CA in contact with residents on a daily basis. There were 51 participants, of which 35 CA, 12 nurses, 1 nutrition technician, 1 nutritionist, 1 food department head and 1 department head. It need be underlined that nearly all of the CA were first-generation immigrants from 35 to 40 years of age. This raises the question that would be interesting to explore as to why there are no or few White, French-speaking Quebecers of European origin working in the care professions.

The focus groups were held from December 2017 to March 2018 in nine nursing homes under CIUSS-NIM jurisdiction. NVivo qualitative data analysis software was used to code themes according to an inductive approach based on the content analysis of transcriptions. The coding was validated by the main researcher.

Researchers also observed meal service at lunchtime in eight CIUSSS-NIM facilities.

5. Presentation of results

The transcript excerpts cited below are tagged as follows to indicate the source focus group: “Resident” for immigrant seniors, “Family” for family and friends of residents, and “Staff” for members of the care team (CA, nurses, etc.), bearing in mind that these were CA and nurses 90 percent of the time.

Coding of the transcripts allowed five themes to emerge at the first level of generality. Each of these contained sub-themes corresponding to various situations experienced or perceived by participants. These general themes were the following: Meal context, Meals as activities of socialization and maintenance of social disposition, Appetite, Assessment of food offering and alternative practices of family members, and Deterioration of food offering over time. We will begin by presenting the results, primarily through transcript excerpts grouped under the umbrella of five general themes, but characterizing them more specifically in a manner corresponding to a second level of classification (not numbered).

5.1 Meal context

All the nursing homes where the study was conducted had a production kitchen, except one where outside food was reheated upon arrival. Each nursing home had a certain degree of autonomy regarding how food was conveyed and distributed in dining rooms and private rooms and what services CA provided. Most of the time, regardless of where residents took their meal, the food was already on an individual tray marked with the person’s name to ensure they received their menu choices that complied with their diet and any food tailoring necessitated by specific health conditions (e.g. texture modification to facilitate chewing and swallowing). On rare occasions, food arrived on floors in bulk and was portioned out by CA sequentially.

When the study was conducted, menus were prepared on a three-week cycle. Breakfast comprised several food choices such as cereal, eggs, toast and dairy products. For lunch, there were two choices on the menu and the possibility of having a sandwich instead. For supper, the

menu offered two choices as well, but one was the same as one of the lunchtime choices. It should be noted, however, that since March 31, 2018, further to a ministerial circular (MSSS, 2017), the lunch and supper menus have had to offer four different choices.

Based on our observations in the nursing homes, most of the residents took their meals communally. Meals were served in common rooms on each floor (about 20 people on average) or in fair-sized cafeteria-style dining rooms often adjacent to the production kitchen (several dozen persons at a time, including staff and visitors). In the latter case, the residents were autonomous and, if not, they were assisted by a friend or family member or, in some rare cases, by a volunteer.

As each production unit in the kitchens was autonomous, there was in fact a rather considerable variability in the overall quality of the food offering across facilities, which seemed to depend in part on the experience and skill levels of the production team members.

At mealtime, generally, the CA turned off the television sets in the common rooms, put on some soft music, invited the more autonomous residents to take a seat, and assigned seats to and directed less autonomous and non-autonomous residents in order to feed these individually. A few minutes prior to serving the meal, staff would stimulate residents and prepare them to eat. This entailed more than just handing out trays or a meal item; it also consisted of encouraging residents and making sure and checking that they ate as much as possible safely (the risk of choking was high). The responsibility borne by CA was heavy and their task, extremely demanding and repetitive:

[...] and the residents of late have been really heavy cases, most need total assistance to eat. There are few residents who can feed themselves without assistance. Very few. And volunteers are practically useless. (Staff)

That is, you need to spur her on like a baby. You have to say, like, "here's your plate, you got to eat, it would be a waste to throw it out". And then you have to explain to her and urge her on like a baby. And then if you want her to eat, you have to take a bite as well, like [...], I don't know, like a one-year-old who's just learned to eat. Get it? (Family)

Now, there, each one has so many specific things, and then they changed the system and how we do things, so it has to be repetitive and methodical. (Staff)

On our floor, unfortunately, time is precious. So we don't have time to cut or clean. So, for us, the trays have to be prepared beforehand. Fruit has to be in pieces already when it arrives. (Staff)

However, residents could also eat in their rooms. In these cases, the decision might have been taken by a family member (or a legal guardian) or by the resident. For example, one lady with Parkinson's disease was ashamed of her condition and did not want the others to see the difficulty she had bringing food to her mouth:

[I eat] alone, alone. Because my hand isn't much good. I'm dropping stuff and picking it up all the time. I don't want anyone to [...] It's not like before, I could use a fork and knife. It falls out of my hand. My hand only moves this way. It doesn't move backward. (Resident)

Or, for example, this woman who decided for her mother, for the following reasons:

When I said that my mother eats in her room, I decided that. Because my mother, you see, when she has a need that isn't satisfied, she starts to sing. So, to avoid her bothering the others, I decided that she should eat in her room. If she does eat in the big hall, it's because I'm there looking after her. (Family)

Some residents might eat alone in their room following a transitional shock:

When she first came here, she didn't want to know anything. She used to say 'no, no, everyone's sick here, I don't want to be sick', that's the idea. She would eat in her room, it was her home. Now, she's changed a lot. Now, she'll say 'ah, they're my friends, I haven't seen you in a while' and she'll talk to them. (Family)

Some residents ate alone in their rooms for lack of appetite, at least at certain meals, or because they did not feel like socializing or they found the behavior of other residents inappropriate:

I don't like talking to the others much, bla, bla, bla. Looking at them when they can't eat right, food spilling out of their mouth. (Resident)

There are lots of patients, at breakfast they eat, but at lunch they won't eat anything at all. They'll snack a little in their rooms on their own. A little chocolate, some cookies, a little candy, in their room. A small

yoghurt, a small fruit compote, or something. They snack away in their rooms and then they don't eat anything at lunch. (Staff)

For the care staff (but first and foremost for the residents), eating alone in one's room represented a risk, because it made it harder for them to supervise that all was going well and to check whether the resident needed anything:

It's also a question of supervision for us. If we're in front of them when they eat and someone has to do the rounds in the rooms, it doesn't work. There's one less person in front if they go off to check up on the others. Consequently, there are fewer of us in front to supervise everyone. (Staff)

Meals were sometimes disrupted by the behaviors of certain residents. Most of the time, these behaviors were the expression of cognitive impairments (dementia), which were on the rise in Quebec nursing homes on the whole:

Patients can be aggressive with one another sometimes. (Staff)

Some even chuck their plates to the floor. (Staff)

There's this one man where I work, at lunchtime, he creates a commotion every time if the food isn't presentable. If it's not the way he wants it, like clockwork, he has a fit. At lunchtime, every time, same thing. And when he has his fit, it upsets everyone on the floor. (Staff)

For example, some people will get into argument and they'll yell out stupid things. Some people, because of their illness—I'm not criticizing—they make sounds, noises, when they need something. They need attention. They're pretty serious and heavy handicaps. So, for someone like my mom who's got no cognitive problems, it has an impact, it has a negative effect on their morale. (Family)

5.2 Meals as activities of socialization and maintenance of social disposition

Most of the time, meals were considered by residents, family and friends, and staff as a socialization activity that was important to maintain in nursing homes. First, staying alone was not socially desirable:

Me, I'm sociable by nature. Alone, it's not good. When I do a little cooking, I tell my neighbour: "Hey, come and eat." I don't like eating alone. (Resident)

Me, I eat together with the others. I don't like eating in my room, I like eating together with the others. (Resident)

It's like an activity where they're together. Plus they can talk to each other. They know each other. They know that the person next to me is such and such, and if there's an empty seat, they know who's missing and they ask what's wrong with her? [...] they know that now's the time to eat, I'll go over to see this person, I'll do the rounds and chat a little with everyone. (Staff)

There are some who only come out of their room to eat. They come to chat with the others. It's a special moment, an important moment. (Staff)

Food. I think that it's the biggest thing they have left. Food. (Staff)

Even if the meal context in nursing homes could often be trying on account of the behavior of certain residents with dementia, the socialization of meals at times took the form of an order from family and friends:

She doesn't have a choice. She can't just stay in her room all the time! (Family)

We make sure that she goes to the room where everyone is. Because if we leave her in her room, it means they're isolated. That I find is crucial. The residents have to come together. It changes everything instead of being like a child that's been punished, alone in their room. (Family)

In a context where food is an issue and an appetite is difficult to work up, the presence of others eating could incite one to do the same:

Me, when I come, it's always in the dining room so she can see people, the other people. It's also to encourage her, because when she's all alone, it's harder. When she's with the others, we'll say: "Oh, the others are eating, you have to eat as well, otherwise they're going to scold you." You understand. More arguments to incite her to eat. (Family)

Moreover, our observations at mealtime and a visual inspection of the plates after the meal showed that about eight out of ten were returned half full by residents who ate alone. There was a great deal of food wasted in these facilities. However, in the units where CA and family assisted residents to eat, the food on the plates was by and large eaten. These issues will be discussed later.

5.3 *Appetite*

Resident appetite (or lack thereof), be it in general or at specific meals in the day, depended on various circumstantial, social, physiological and cultural factors, and others related to the appearance, taste and smell of food.

The hours at which meals were served:

For example, I get here at nine in the morning. My mother, she's still eating. She finishes around ten. She finishes breakfast. At eleven and a half, they're serving lunch. She's not hungry, so, she might not even eat half. And at five and a half, it's supper. So, she hasn't enough time to finish [breakfast] that lunch is served, and after supper, they don't serve any snacks. After that, she doesn't eat anything until the next day. No wonder she's so hungry and eats all morning. (Family)

[...] because if they eat too much at breakfast, there's not enough time in between, they don't have lunch. (Staff)

Menus, variable appetite, time of day:

For the residents, it depends on the menu and it depends also on the days. Some might eat very well, others not at all, because they're not hungry or they don't want to. [...] You might have someone who eats well at lunch and breakfast but doesn't eat supper. (Staff)

Anyway, breakfast, I find everyone likes breakfast, have their toast and coffee. Breakfast, the residents generally like. It's when you get to lunch, some like, some don't. (Staff)

The pleasure or not of eating:

There are those that it's a pleasure for them. There are those that really have no appetite but, I can't say that we force them to eat. (Staff)

The presence of other residents with behaviors that undermine one's appetite:

I understand them, too. They're at the table, one's dribbling, the other takes out his denture, sucks on it. It's true. When you have all of your wits about you and you're surrounded at a table by people like that, it ruins your appetite. (Staff)

Physical condition, physical or mental health, and effects of medication:

"I used to like eating. Not anymore, not since my stroke. That completely changed my body, completely." Interviewer: "When you're served to eat, do you manage to finish your plate?" "No, I'm not hungry." (Resident)

The problem is that when I put that in my mouth, I feel like throwing up. Me, when I feel like throwing up, well, better stop there. Even, sometimes, my sister will bring me some food, and I'll say to her: I don't get it, it doesn't taste the same as before. And she'll say: No, no, no, it's my medication that's altering the taste. (Resident)

Like, they're giving her three different medications because she's a little agitated. But you can't just stuff someone with drugs like that. How can you feed her if she's sleeping? (Family)

Come evening, everyone's tired. Actually, they are really tired at suppertime. They might feel like eating, but they're just so tired it gets the better of them. (Staff)

Because no matter what they give her, if I'm not there, it'll go to waste. They can give her, jeez, a gastronomic dish, if me and my sister we're not there, the food'll go to waste. It's not about being hungry or not, or not wanting to eat, or not liking the food, it's just a mental thing. (Family)

Generally, the residents eat. It's just that it's their state of health that's changed. If they're sick, that's when you notice a loss of appetite and a loss of weight. (Staff)

Look, texture, temperature, taste and quantity of food:

There are no leafy greens. All we get is vegetables, they're overcooked and soggy. Too soft. That's no good. (Resident)

Sometimes, they're just not interested, but if there's something, sometimes, I'll ask the nurse if there isn't anything else. I get the impression, it's not just that the person doesn't want to eat, it's that, it's placed in front of them and: "It just doesn't appeal to me, I don't like the texture or the colour." (Staff)

But my mother, there, she's the sort that if she doesn't like what she sees [...] Her head's not always there, but in her head, she likes appearances. She likes it when a plate's pretty and well prepared. (Family)

I can attest that, in the past three years, how many people I've seen, a lot also are no longer there. They were disgusted, they didn't want to eat. (Family)

I noted, often, even if they're hungry, but they arrive and their plate is hot, they're like discouraged, and they don't eat. (Staff)

Adaptation (or lack thereof) to the food offering and, more broadly, to institutional life:

So, yeah, they adapted. They adapt their way of being to the food there. For now, it's much better that she eats here, but a year ago, no way, the fights! They adapt to the life. Me, in any event, that's what I saw, but I don't know for the others. (Family)

Cultural preferences, socialization in non-Canadian or non-Quebec culinary cultures:

I want to eat Armenian food and fajitas. There is a long-term care residential centre that serves Armenian dishes. [...] I'm not used to [the nursing home's] food. We Armenians, we prepare foods in sauce and a lot are oven baked. I've been here seven years.

Interviewer: "And you haven't got used to it yet?"

"No." (Resident)

If there are dishes I don't like, they're mostly [North American]. (Resident)

Like my mother, she doesn't need help to eat, but seeing how she's not used to Quebec dishes, if we're not there, you have to push her to eat. (Family)

Take this Haitian resident, for example. Food from here, he doesn't eat. The main course, he doesn't even touch. However, if staff order in creole food from the restaurant, he eats every last bit of it. (Staff)

We often have non-Quebec residents, for example, so, there are often residents who refuse the main courses. There are quite a few. You know this place is multi-ethnic. The main course, hardly touched. There are Italians, Greeks who refuse the main course. (Staff)

5.4 Assessment of food offering and alternative practices of family members

Residents could be split into two almost even groups. One made do with the food offering but specified that they were not picky:

If someone finds it's not good what they've prepared, they just don't eat it, that's all. Me, personally, I'm not fussy. (Resident)

It's alright, I'm not finicky. I eat whatever there is. (Resident)

Because, me, I'll take what they serve me. I'm not picky. (Resident)

Listen, my husband is from Istanbul. So, the people there, they are eating the *pasturma*, these things. But now, if they give him that purée, everything is the same for him. You know. He never says 'no, I don't want that, and I like this', no, never. He's eating [...] he's eating everything. (Family)

The other group expressed its dissatisfaction with the offering:

I'm losing my appetite here. Because of the food that I don't like. Always the same, always. It's like the people in concentration camps. They give you the same thing morning, noon and night. (Resident)

I don't much like the food in the home. It doesn't taste anything. (Resident)

I'm Hungarian. Because of that, I eat spicy. I like spices and flavour. Here, it doesn't taste anything at all. Me, I'm not used to eating stuff that doesn't taste anything. Me, I'm used to eating things that have flavour, hot, spicy. (Resident)

The dishes they serve, I never like them. Steak with a brown sauce, side of mashed potatoes. A little chicken, same thing, side of mashed potatoes. It all looks the same. (Resident)

Family members, too, divided into two groups. A small minority was rather satisfied with the food offering. It need be noted here that family and friends remained cautious and qualified what they said and seemed rather relieved that their family member or friend had got used to the food offered in the facility:

My mother doesn't complain about the food. At first, there were a few problems. She's picky and there were some things she didn't eat but with time they've managed to give her everything she likes. (Family)

We're lucky. My mother-in-law's got used some to the dishes here. (Family)

For example, my mother, I know she eats everything. The soups, she likes the soups. It's just the meat, I don't know if maybe they give her too much sauce, but if you ask me, it would be better to serve it on the side. (Family)

To be honest, I don't come often, but every time I come I like the meals. But my mother [...], she likes it when dishes are well prepared and presented. Quite often she doesn't eat enough. (Family)

The other group, however, the large majority, was dissatisfied with the offering in general:

No, I don't eat here, but I've tasted the food so I know why my mother, she won't eat it. Nothing tasted anything. (Family)

There are certain dishes that I can't eat. Just the smell. I don't know. Me, when I walk into a hospital or in places like that with plastic plates, there's this smell. So the food really has to be good to make me feel like eating. Because, otherwise, you see, the soups, they're in plastic cups. That alone, it doesn't make me feel like eating. You understand? (Family)

When residents had problems with the food offering, for example, in terms of quality of preparation and cultural acceptability, some family members brought food in from home or from a restaurant the resident appreciated:

Because my mother, she doesn't eat all of the Quebec dishes. Since she's been here, there are dishes where that sort of food is put in, but she eats very little. You understand? That's why we've always had to bring in Vietnamese food. (Family)

So, I visit my mother every day and I bring in what I've cooked at home. (Family)

Me, sometimes, I bring food for my mother [...] Like I said, we cook spicy [...], but we can't ask to make the food spicy for everyone. Because not everyone likes that. (Family)

My mother's been here a year and two months. For the past year, me and my sister, every day, what we cook at home, we bring to my mother. We give her what we prepare. Because she doesn't like it here. (Family)

However, for family members, bringing food in could be a burden:

When I can bring food from home, I bring. But it's still a lot of trouble. (Family)

These practices sometimes led to exchanges of favors and gifts between family members of different residents:

So, what happened was, I saw what the others did, I did the same, I bring food in from home. Then, between neighbours, we got to know one another and, thank god, we share food, "I cooked this, you want a taste, I brought some for your mom". (Family)

The majority of staff, particularly CA, were rather critical of the food offering. Moreover, they noted, and almost unanimously so, that the food offering had deteriorated in recent years:

Even those who are still perfectly lucid, they can say to you "that's dog food!" (Staff)

Because it's always, always the same thing. So, someone who can say it, they'll say always the same. [...], but residents, they'll say "Not again! It's unpalatable". (Staff)

It's really not appealing. Because some people eat with their eyes first, with their senses, with their nose and you see it, so then, you feel like it. (Staff)

Some meals really don't make you feel like eating and, sometimes, just how it's presented on the plate, me, I put myself in their place. (Staff)

One, it's cold. Two, it's inedible, it doesn't taste anything, so, it gets chucked. (Staff)

I want to come back to presentation. The trays, they've been there for ages. The plates are about as old as I've ever seen. They're really in bad shape. The utensils, sometimes, are really dirty or the forks are bent out of shape. Then, for the meals, most of the time, the residents say it's bland, there's no flavour. Some meat you can't even cut. It's too hard. There are residents who are not able to eat it like that. Really, even we can't cut it [...]. (Staff)

Finally, only a rare few had a positive opinion of the food offering. It might be that there was a good, skilled and steady team in the kitchen at play here. As we observed, this was becoming increasingly rare in public nursing homes:

Me, I often eat at the cafeteria here, which means that I often taste what they prepare. I like it, generally. (Staff)

5.5 Deterioration of food offering and CA work conditions over time

The overall quality of the food offering deteriorated significantly over the past three or four years. This was reported above all by staff who had worked in the facilities many years and by family members of residents living in a facility long enough for them to note the phenomenon. Organizational changes implemented by the Quebec Ministry of Health and Social Services over this period, as well as lost expertise in the kitchens, explained in part the deterioration, according to study participants. Residents who participated in the study made no comment in this regard:

Me, like I said, I experienced [...]. My mother, seven years ago, the food was very good. Sauces weren't always thickened, they were like home made. There was chicken bourguignon. The variety was incredible. There was a summer menu and a winter menu. [...] I even used to bring some home to my husband. Then, after the changes, when we became a CSSS[2], he said to me: 'you know what, it's not worth the bother', so I stopped bringing him any. (Family)

The rise in food prices was also mentioned as a factor explaining the deterioration of the food offering:

The quality has declined because costs have risen. Therefore, the people who do the purchasing, they're going to go for lower quality. (Staff)

A drop-in participation on the part of volunteers helping CA had an impact on overall service delivery:

In the old days, about three, four years ago, there were volunteers. Now, they're extremely rare. They were a big help to us and they made the CA's work easier because they played an active role at mealtime. Instead of a patient staying in bed and eating in bed, there were patients we used to group in the solarium in each section. (Staff)

Staff confided that recent organizational reforms cut the time CA could spend on meal service:

Before, we had time. It was the time of day we enjoyed most, when we ate with the residents but, now, we can't do that anymore. (Staff)

In the previous twenty years, before, we could propose choices, cut the food for residents. That's not part of our reality nowadays. (Staff)

During the day, there are a few more of us, and we're running around like mad, so you can just imagine, four people in the evening, they have their supper and then we have to put them all to bed. And, you know, old people, they want to go to bed early. They're tired come evening. They don't even have time to digest their food. (Staff)

But that's our problem. Everyone's running around left and right. We don't have time to stop and listen to a patient who wants to formulate, I wouldn't say a complaint, but not wanting a meal, not wanting that, wanting something else. For us, what we miss most, is having fun at work. (Staff)

Special treats, for example, at a resident's birthday were no more:

There'd be chicken breasts in a mushroom sauce. That I hardly ever see anymore. There also used to be for patients, on their birthday, they'd get roast beef and a glass of wine with a piece of cake with a candle to mark their birthday. We don't see that on the menu anymore. A lot's changed. (Staff)

The loss of culinary expertise (head cook or pastry chef) owing to budget cuts, too, was responsible for the drop in the overall quality of the food offering:

Before, we even had pastries here made on site. There were fresh pastries every day. The food presentation was better. It was high end or better. There was so much variety on the menu every day,

we used to like eating here. Now, it's not as appealing, there isn't much variety. Portions are smaller, plus, the pastries are frozen. They're shipped in from outside. The menus are not multi-ethnic, if I may say so. It's just like a fast food restaurant. (Staff)

6. Discussion

This discussion will focus on the specificity of the experience of nursing home of first-generation immigrants residents, but it will be examined within the broader context of institutional feeding from the perspective of all stakeholders, namely, residents, CA, family members, nurses, nutritionists, kitchen staff and managers.

6.1 *Food rejection, food socialization, flavor principle and immigrant background*

The results show the existence of a problem specific to residents from an immigrant background regarding the food offering. Though the residents who participated in the study and, more broadly, immigrants in nursing homes, settled in Canada often more than 50 years earlier, they remained very much attached to their cuisine and pre-migration style of eating, while diversifying their culinary repertoire and transforming many elements of their style of eating. The dynamics of this transformation have been documented elsewhere (Diner, 2001; Ray, 2004; Crenn *et al.*, 2010; Girard and Sercia, 2014). In fact, throughout their adult life, in a family context, they cooked with key elements of this cuisine, particularly seasonings, cooking techniques and sauces, using very distinctive ingredients, and preparing very distinctive specialties (recipes).

These key elements of a culinary culture constitute what Rozin (1976) referred to as flavor principles. These principles are tied to the objective and imaginary-symbolic gustatory and organoleptic properties of foods, which is to say that flavors are objectified in foods by how they are prepared – culinary techniques – and by how they are represented as something good “for us” or “for me,” all of which is developed through food socialization (Chiva, 1992; Dupuy and Watiez, 2012). Accordingly, a food or ingredient might be incorporated in an individual's, a family's or a particular group's repertoire by way of specific culinary (mainly cooking) techniques, the adjunct of spices, condiments or preparation that will wrap the ingredient or food in familiar characteristics and thus assign to it a legitimate place in the hierarchy of things that are good to eat (Rozin, 1978; Fischler, 1990; Girard, 2013).

This concept and its scope are important here because they allow us to understand in large part why residents in our study rejected most of the menus served, a fact attested to by their families and nursing home staff. In these cases, family and friends must then bring in home-cooked food that the resident appreciates and eats with gusto.

Another element worth underscoring here is the fact that, even when affected with dementia to varying degrees, residents seem to “recognize” the dishes brought by families and eat more heartily. Virginie Pouyet showed that the pleasure of eating remained intact regardless of a person's level of functional impairment, whether the person was a community-living senior receiving varying degrees of assistance or a senior living in a nursing home. However, she noted that the latter were significantly less satisfied with their meals than were the former. Pouyet concluded that undernutrition in France's EHPADs had more to do with meal dissatisfaction than with a decline in the pleasure of eating as such (Pouyet, 2018, p. 22).

There is more at play here than just food socialization and flavor principles. The wider meal context in nursing homes has a huge impact also on Canadian-born residents. Within this context of meals and food intake, two types of significant elements emerged from the transcripts and from our observations, namely, those related to organization and management, and those related to resident characteristics and institutional life, such as physical condition and mental health, appetite variability, adaptation to institutional life and the mealtime behaviors of other residents.

6.2 *Meal and food intake related to organization and management*

Regarding the elements related to organization and management, the fact that care staff did not meet resident needs and that the time allocated to meals and mealtimes was not flexible

obviously had more to do with managerial and resource optimization imperatives than to the actual needs of residents. Simmons *et al.* (2001) reached the same conclusion in their study. The CA reported during the interviews that more flexible hours and care and service processes were not feasible in the current context where the number of CA was barely enough to cover the basic needs of residents, whose care acuity continued to grow steadily (Bigaouette, 2007; Aubry, 2012, 2016). This situation surely affected the ability of CA to provide effective, compassionate and adapted services; instead, they were forced to rush through standardized processes that did not translate into a pleasant and enjoyable meal context for either the residents or the CA.

Food quality and preparation (variety, flavor, smell, cooking technique) were also mentioned as a barrier to eating. These elements include the visual esthetics of the plate and its contents, the availability of fresh produce (especially fruit), food texture and food portions. A study conducted in France's EHPADs by Divert *et al.* (2015) demonstrated that changing the amount served (smaller portions, giving residents the chance to decide on quantity) and increasing variety, especially where vegetables are concerned, had a positive effect on meal appreciation but not on amount eaten. Pouyet (2018) reported similar findings. Moreover, when residents decided on portions, amounts eaten fell below prescribed levels for seniors. The challenge here for institutions, then, is to address the dimensions of meal pleasure and appreciation and, contemporaneously, avoid elder undernutrition. Mealtime assistance from family and friends, volunteers or CA remains essential in this regard. This was an issue in the eyes of CA, who generally felt that the decline over the years of volunteer participation had contributed to make things worse.

Finally, Divert *et al.* (2015) showed that allowing residents to adjust the flavor of food with condiments available on tables was significantly associated with higher meal appreciation and greater consumption of rice, a food with little flavor. In this regard, given that criticism of the food offering from residents and family and friends often concerned the fact that meals served were bland, making condiments and spices available would probably stimulate appetite and improve satisfaction, plus afford residents greater control over their meals. Such an innovation would make a significant difference, especially for residents from an immigrant background. Preparing dishes from their culinary traditions would also be a path to explore. The other residents would benefit as well from greater attention paid to food flavor (Pouyet, 2018). The main challenge here for the organization is to measure up to the expectations created.

The issue of medication and its effects on appetite and the sense of taste was raised by participants in all three groups. The phenomenon has been verified scientifically (Schiffman and Graham, 2000; Chen *et al.*, 2001; Schiffman and Zervakis, 2002). Notwithstanding the medical concerns at play here, it is not unreasonable to question whether the medication administered is always necessary, particularly in the face of polypharmacy (i.e. the concurrent use of multiple medications by a patient, which is common among seniors), and whether it is part of a concerted strategy to maintain the overall wellness of people in light of their situation and condition. In short, it is a matter here of treatment priority centered not on illness but rather on the resident and their life expectancy (Couture and Côté, 2009). Gonthier *et al.* (2004) and Allison (2002) recommended diminishing prescriptions in order to prevent drug interactions and reduce side effects, including loss of appetite and altered sense of taste and smell. Needless to say that polypharmacy can elicit other physiological effects, but these are not relevant to this discussion.

6.3 Meal and food intake related to resident characteristics, cultural matrix and institutional life

The elements related to resident characteristics and institutional life, though of a more personal nature, were nonetheless common across the sample. These included, above all, appetite variability at different times of day, the effects of physical and mental condition on appetite regularity, and some dimensions of the meal context, such as commensality. Though this cannot be attributed to the organization, more flexible meal hours, access to cold plates and fresh fruit, and a wider variety of snacks would go a long way toward introducing mores choices. These measures would be well received not only by residents but also by their families who, as they indicated, must complement the current food offering with outside food.

Results showed that many of the residents we met were rather satisfied with the food offering. However, the terms they used in this regard require that we qualify their appreciation. Indeed, most

often, these residents indicated that they were not picky or that they took what they gave them. We can propose a few hypotheses to explain this “reserve” in expressing their satisfaction. First, a social desirability bias might be at play if participants wanted to show that they had adapted well to institutional life, if they wanted to please the care staff, or if they were ashamed to express their desires “selfishly.” Second, the upbringing and values imparted to these people back in the 1930s and 1940s emphasized that one must never refuse or complain about food offered and that it was practically a sin to let food go to waste. These phenomena have been well documented by Sidenvall *et al.* (1996). Third, at an advanced age, many people give up complaining or develop anxiety and fear losing certain rights if they do. Consequently, if they are dissatisfied or if they had complaints, care staff and managers would have no way of knowing.

As for the shock of going from an autonomous or semi-autonomous residential mode to a nursing home and adapting to institutional life, it no doubt entails a painful break. Often the break is double. The first is with one’s “healthy” body and the second, with one’s life environment (Hennion, 2006; Hugol-Gential, 2016). For example, where food is concerned, residents are subjected to new rules, new temporalities and new rituals, which, as pointed out by Corbeau (2012), have little or nothing to do with their cultural matrix and where the sensitive parameters of the eating experience are foreign and redefined. In this connection, a quote from a staff member speaks volumes: “People of a certain age are used to a certain etiquette, so to speak, and when it’s missing, they feel diminished.” Along these lines, one resident confided the following: “I really miss being able to cook what I want.”

Furthermore, the symbolic and cultural representations of eating, cooking, and mealtime by and large take a beating in this new environment where residents have little or no say over (and little or no knowledge of) the nursing home food pipeline. This pipeline encompasses all the players, products and processes, be they related to decision making (management), production or distribution, the meal context, and even the social and cultural imaginary of eater-residents. Thus, as pointed out by Jean-Pierre Corbeau regarding hospitals (but it applies just as well to nursing homes), “the opacity of the food pipeline in hospitals makes it hard to incorporate signs and symbols that allow renewing with one’s cultural matrix and habits, not to mention the affective dimension that food can have” (free translation) (Corbeau, 2012, p. 877). The meal context in nursing homes makes it hard to access foods and dishes that authentically connect with a social trajectory and a cultural, social and affective matrix (Corbeau, 2001) that defined residents as social actors with values, taste and needs. For example, we can lament the fact that residents’ birthdays are no longer marked the way they once were, with a special menu, a piece of cake and a glass of wine. These practices clearly illustrate the links between food, on the one hand, and sociality, affects and the eaters’ identity, on the other.

Further, the pre-institutional way of life incorporated food esthesia (ability to perceive sensations) and meal conditions. Regarding the latter, nursing home residents must learn to eat at set times, in impersonal settings (or alone in their room), with people with whom they might have little or no affinity and whose mealtime behavior, often due to degenerative conditions, can be off-putting (Sidenvall *et al.*, 1996; Le Breton, 2012). Moreover, health standards and production and service constraints imposed on institutional food units completely redefine the sensorial dimension of meals: residents no longer eat in plates but in trays with plasticware; they have no access to seasoning; food presentation is uninspired; and the food is very rarely cooked just right. This has repercussions on the smell and texture of the food and “this redefinition of food intake plays a role in the affective state of the patient” (free translation) (Hugol-Gential, 2016, p. 22) or, in our case, the eater-resident.

None of this is intended as a critique of the work performed in facilities that, it need be reminded, are subjected to administrative and managerial rules, constraints and realities that weigh heavily on production and service conditions and, generally, on the food offering. Instead, the aim was to examine the situation from the viewpoint of users, residents, family members and care staff in order to understand the context in which they are engaged. In this regard, it need be reminded, also, that these conditions and the context have deteriorated in recent years, as reported time and again by staff and family members, and that this renders the overall meal context quite difficult for all stakeholders.

7. Conclusion

A number of factors complicate how food is prepared in nursing homes, how it is served, and how (where and when) it is consumed by residents: presence of multiple stakeholders in a context marked by budget restrictions, staff shortages, process standardization, centralized managerial decision making and, last but not least, the exacerbation of the physical and mental conditions of residents.

Moreover, the current food offering is not adapted for immigrant residents. Indeed, it does not fall within their gustatory frame of reference and, more broadly, within their food culture, which, as we demonstrated, gives meaning to food and defines what food is “good for us” or “good for me.” Many of these residents do not get used to the food offering and often reject the dishes proposed on the menu.

The general living conditions in nursing homes and organizational constraints redefine the esthesia of meals compared to what residents enjoyed in the community. This has a major impact on the taste, smell, and texture of dishes and on their presentation and the context in which they are consumed. Adapting to these new realities is hard and can take a more or less long time for a fair share of residents and, more specifically, for those from an immigrant background. They experience a cognitive, and even gustatory, dissonance between how food was incorporated physically and symbolically at home and the overall meal context encountered in nursing homes.

Frontline care staff – CA – reported that their working conditions had deteriorated in the past three or four years. They had less time to devote to mealtime service, were monopolized by the most impaired cases, and could no longer look after partially autonomous residents who often required only a little assistance during meals. Furthermore, the standardization and routinization of tasks was such that the quality of moments spent with residents during meals was heavily affected. Yet, they were central players at mealtime (CSSS, 2016). Without them and all that they set in motion for meals to be moments of socialization, conviviality and comfort that also satisfy social expectations concerning the persistence and maintenance of social disposition, these meals would not be possible.

CA experience cognitive dissonances and a profound ambivalence: they hate increasingly demanding and dehumanizing tasks but love their work and the ties they forge with the people they look after on a daily basis. This ambivalence was documented also by Aubry (2012, 2016). What is at stake here is not only their wellbeing but also that of the people in their care.

For the family and friends of nursing home residents which are first-generation immigrants, the food offering is a source of many problems, given that they must often bring in home-cooked dishes. What is more, providing assistance at mealtime is an arduous task when they must encourage their loved one to eat what is on the institutional menu. This imposes on family and friends' duties that pile onto those they already have.

8. Avenues to explore

Revising the food offering with a view to improving the taste and texture of food and how well it is cooked (especially meat and vegetables) should be a top priority. This supposes having to increase the cost ratios per dish and adjusting portions in order to avoid the current enormous waste of food and thus cut costs. This also supposes a form of personalized customization of menus, better training and retention of kitchen staff, and stronger affirmation of the importance of this type of work in the organization.

Residents could have various seasonings and condiments from different culinary cultures (cultural kits based on flavor principles) at hand to spice up often bland dishes and render them more familiar.

The care team could reassess the relevance of certain medications, especially those that affect how foods taste and smell.

More volunteers should be recruited to supervise residents and help CA with their mealtime tasks, results shown that some CA share the opinion that having volunteers on mealtime is a great help. This would not erase the fact that more CA should be hired in order to slow down the work pace

and allow them time to develop more meaningful interpersonal relations with residents. More research should be conducted to understand more the actual transformation of the role of CA in the national public nursing home system and the impacts of this on the wellbeing of residents and CA as well as their capacity to provide effective and compassionate service.

There could be greater flexibility in the meal service. For example, service hours could be lengthened and a more personalized service could be developed. This supposes, however, that foods could be kept warm on each floor or that new dishes and menus could be developed. Also, varied, nutritional snacks and staples (e.g. bread, spreads, butter, compote, fresh fruit) could be offered round the clock; this could be managed (but not paid for) by a committee of residents and family and friends.

Initiatives should be undertaken to foster the development of a food offering tailored to the preferences of residents from an immigrant background. These “exotic” food choices would not be intended to appeal only to residents from an immigrant background but, as underscored at the start of this paper, also to a significant portion of the people who are set to be admitted to nursing homes soon and who, whether they are Canadian born or not, eat a variety of dishes from different food cultures on a regular basis.

In closing, we would like to quote a family member who shared his thoughts on developing a food offering more tailored to the preferences and needs of first-generation immigrant residents:

Yeah, that's important. If, for example, you could serve her quinoa soup, Vietnamese dishes, truly, typically Vietnamese, she'd love it. That, that would make her happy at least once a week. You understand? I mean, there are seven days in the week, at least she'd have that as a treat for her. Even a Chinese dish that's close to our own Vietnamese cuisine, Chinese, it would make people happy. (Family)

Notes

1. In Quebec, public nursing homes are referred to as *centres d'hébergement de soins de longue durée*, or CHSLD, which translates as long-term care residential centers.
2. Center de santé et de services sociaux (Health and Social Service Center).

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Corresponding author

Alain Girard can be contacted at: alaingirard5@sympatico.ca

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