

# Cultural and Ethnic Dimensions of Mealtime Practices in Long-Term and Residential Care: a Comprehensive Scoping Review



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## ABSTRACT

### Background

As ethnically diverse populations increasingly access long-term care (LTC) and residential care facilities (RCF), mealtimes emerge as vital opportunities to preserve cultural identity, foster social connections, and support well-being. However, systemic barriers and institutional limitations often prevent culturally inclusive mealtimes, marginalizing minority populations and perpetuating inequities in mealtime delivery. This review explores the state of knowledge on cultural and ethnically diverse mealtime practices and menu options within LTC and RCF.

### Methods

Using the Joanna Briggs Institute framework and Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Review (PRISMA-ScR) guidelines, a comprehensive scoping review was conducted. Databases and grey literature sources were systematically screened, with data extracted and analyzed using a hybrid thematic analysis. Findings were organized by the socioecological model, exploring influences at intrapersonal, interpersonal, community, institutional, and societal levels.

### Results

A total of 126 full-text manuscripts were reviewed and 42 were included in the final analysis. Key themes emphasized food's role in cultural identity, and highlighted best practices in ethnic-specific facilities, which tailored menus and rituals to residents' needs. Barriers included budget constraints, limited access to culturally specific ingredients, insufficient staff training, and standardized menus. Families often bridged these gaps, straining their resources. Promising practices included flexible meal schedules, resident-centred menu planning, staff training, and partnerships with cultural organizations. Recommendations focused on increasing funding,

implementing flexible policies, and studying the long-term impacts of inclusive practices.

### Conclusions

Culturally inclusive mealtime practices have the potential to transform LTC and RCF by promoting dignity, enhancing quality of life, and addressing systemic inequities. Ethnic-specific facilities provide effective models, but broader adoption of best practices is necessary for mainstream care settings.

**Key words:** cultural diversity, long-term care, mealtime practices, person-centred care, residential care

## INTRODUCTION

With increasing immigration globally, an ethnically diverse community of older adults are living together in long-term care (LTC) and residential care facilities (RCF). For this review, LTC refers to government-licensed facilities that provide 24-hour supervised care, including comprehensive medical, personal, and support services.<sup>(1)</sup> In contrast, RCF encompass a broader range of licensed settings that offer accommodation, meals, and personal or custodial care, but typically provide less intensive medical support.<sup>(2)</sup> Historically, cultural and ethnic minority groups have relied on multi-generational family care at home rather than formal care settings.<sup>(3-5)</sup> However, economic pressures and rising rates of cognitive and physical impairments among aging populations have prompted many immigrant and ethnic minority families to seek care in LTC and RCF.<sup>(5)</sup> In Canada, this shift is reflected in emerging trends, with 2016 census data showing a significant proportion of residents who speak languages other than English or French,<sup>(6)</sup> suggesting similar cultural and ethnic diversity in care facilities. In the United States, African American and Hispanic older adults use LTC at higher rates than non-Hispanic

whites, often due to earlier onset of chronic conditions and limited access to home-based care.<sup>(7,8)</sup> Similarly, the proportion of Asian and Black residents in United Kingdom care facilities has been steadily increasing.<sup>(9)</sup> These trends highlight the urgent need for culturally inclusive practices, especially during essential daily activities like mealtimes, that respect and support the diverse needs of residents in these settings.

Over recent decades, person-centred care (PCC) has become a cornerstone of practice in LTC and RCF,<sup>(10,11)</sup> emphasizing the importance of honouring residents' individual preferences, values, and cultural backgrounds throughout their care journeys.<sup>(12)</sup> Research consistently shows that PCC enhances residents' well-being and overall quality of life. For example, individualized care plans that reflect residents' routines and life histories, such as offering choice in bathing times, meals, and other essential daily activities, have been linked to reduced agitation, stronger resident–staff relationships, and increased autonomy.<sup>(13)</sup> Similarly, opportunities for meaningful engagement, including resident-led activities and collaborative decision-making, are associated with improved mood, fewer behavioural incidents, and enhanced quality of life.<sup>(13-15)</sup>

Mealtimes, which occur three times daily and often last for extended periods of time, offer a valuable opportunity to embed PCC into LTC and RCF. Beyond meeting nutritional needs, they hold deep social and cultural significance, contributing to residents' emotional, psychological, and spiritual well-being.<sup>(16,17)</sup> Mealtime routines and rituals can affirm residents' identities, foster connection to personal histories, and support their evolving sense of self during the transition to institutional care. The structure of food services varies widely across facilities, ranging from large centralized kitchens to smaller household-style units that promote flexibility and resident involvement.<sup>(18)</sup> Some facilities rely on external catering or vendor services, providing either fully prepared meals or bulk ingredients for on-site finishing.<sup>(19-21)</sup> Hybrid models are also common, combining centralized preparation with unit-based customization, or incorporating restaurant-style dining, buffets, and partnerships with community food providers.<sup>(20,21)</sup> These operational differences influence the feasibility of offering culturally diverse meals and rituals, underscoring the importance of considering not only what is served, but how it is delivered.

When guided by evidence-based PCC practices, mealtimes offer meaningful benefits, not only for residents but also staff. Stakeholder-driven initiatives in formal care settings have been shown to empower staff, enhance engagement, and improve the overall quality of care.<sup>(22)</sup> Additionally, supportive PCC environments are associated with higher job satisfaction and lower staff turnover, contributing to better morale and workforce stability.<sup>(23)</sup> Despite these benefits, many mealtime practices in LTC and RCF remain shaped by task-oriented routines that reflect dominant cultural norms, often overlooking the needs of culturally and ethnically diverse residents.<sup>(22)</sup> This underscores the importance of viewing mealtimes as a key opportunity to implement both PCC and culturally inclusive practices, enhancing resident well-being while also supporting staff satisfaction and retention.

## Review Questions

The objective of this scoping review was to examine the current state of knowledge on planning, implementing, and delivering culturally and ethnically diverse mealtime routines and menu options in LTC and RCF, guided by the following research questions.

1. What research has been conducted regarding culturally and ethnically diverse person-centred mealtime practices and menu options in the context of LTC and RCF?
2. What is known about resident access to culturally and ethnically diverse menu options in LTC and RCF?
3. What is known about culturally and ethnically diverse service models relating to mealtime routines, rituals, and established manners being utilized in LTC and RCF?

To explore these questions and identify key themes and gaps in the literature, we conducted a scoping review using the Joanna Briggs Institute (JBI) methodological framework,<sup>(24)</sup> building on frameworks by Arksey and O'Malley<sup>(25)</sup> and Levac *et al.*<sup>(26)</sup> The review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines to ensure transparency and rigor.<sup>(24)</sup>

## METHODS

A review protocol was developed and registered with the Open Science Framework Registries on June 10, 2024. It can be accessed at <https://doi.org/10.17605/OSF.IO/D59KA>

### Eligibility Criteria

This review included both empirical studies such as observational, experimental, mixed-methods research, and literature reviews for their data-driven insights, as well as grey literature including policy documents, reports, opinion pieces, conference proceedings, and academic theses to provide broader contextual understanding. Sources were required to address mealtime policies, procedures, or practices in LTC and RCF, with a focus on the experiences of key stakeholders: residents, family members, staff, and administrators. Cultural, ethnic, and religious considerations were central to the review, but no exclusions were made based on demographic factors such as sex, age, or medical condition.

To support cross-cultural comparison, the review included global sources that provided insight into challenges and successful strategies in implementing culturally inclusive PCC. Only English-language sources published from 1992 onward were included, reflecting the introduction of PCC in LTC, following Tom Kitwood's foundational work, *Towards a Theory of Dementia Care: Personhood and Well-being*.<sup>(27)</sup> Recognizing that terminology for LTC and RCF varies across regions, we carefully reviewed descriptions of care settings to ensure they shared core characteristics, such as group-based mealtime delivery and communal dining spaces, allowing for consistent comparison across diverse cultural contexts.

## Search Strategy

A preliminary search of academic and grey literature sources relevant to the review's objectives was conducted across the Ovid MEDLINE, Embase, APA PsycInfo, Web of Science, Academic Search Complete, ProQuest Dissertations & Theses Global, Scopus, CINAHL, and Google Scholar databases to inform the development of our search strategy. The search was completed on May 7, 2024. An initial Term Chart was created (by ED) using title, abstract, and index terms from relevant articles, and guided by the Population, Concept, and Context framework for reviews.<sup>(28)</sup> This approach ensured comprehensive coverage of older adult populations, mealtime experiences, and LTC and RCF settings. The chart was reviewed by co-investigators (CZ and JHL) before being provided to a research librarian (CM), who refined the search strategy using controlled vocabulary (e.g., Emtree, MeSH), Boolean operators (AND, OR, NOT), and database-specific syntax. Spelling variations (e.g., centered vs. centred) were also considered.

The final search strategy included population terms (senior\*, elder\*, geriatric\*, aged, grandparent\*, pensioner\*, gerontology\*); concept terms (feed\*, meal\*, diet\*, food, nutritio\*), (cultur\*, ethnic\*, faith\*, religio\*, tradition\*, halal, kosher, family-center\*, family-centre\* patient-center\*, patient-centre\*, identit\*, heritage); and context terms (long-term care, LTC, nursing home\*, assisted living, residential care, RCF, convalescent care, convalescent home\*, custodial care, custodial home\*, retirement home\*, senior\* residence, senior\* house\*, senior\* facilit\*, senior\* living, senior\* centre\*, elder\* residence\*, elder\* hous\*, elder\* facility\*, elder\* living, care home\*, aged care facilit\*, aged centre\*, aged center\*). These terms were adapted for each database. A complete electronic search strategy for all databases is provided in Appendix A.

Grey literature searches were conducted using consistent search terms across multiple platforms, including Google, Google Advanced (NGO/IGO), Policy Commons, and Canadian Commons. The first 100 results from each platform were screened. Reference lists and cited articles from included sources were manually reviewed to identify additional sources. Details of source names, search dates, search terms, and URLs were systematically documented.

## Study Selection

We managed academic database records in Covidence systematic review software.<sup>(29)</sup> A total of 247 sources were identified and uploaded through the database search. After 54 duplicates were removed, 193 sources remained for title and abstract screening. During the title and abstract screening phase of the database search, 130 sources were excluded for not meeting the inclusion criteria, and three additional duplicates were identified (n=133). This left 60 sources for full-text screening, from which 15 were selected for inclusion in the final scoping review. To expand coverage, we conducted a citation search of the 15 included studies, yielding 211 additional records. A grey literature search was then performed (ED, PG, and CM) using Google and Google Advanced/NGO/IGO (n=349), Policy Commons, and Canadian Commons (n=50) yielding

399 records. Following citation and grey literature searches 610 records were identified, a total of 230 were retrieved for title and abstract screening based on availability and relevance. These records were managed in Microsoft Excel. Following the title and abstract screening, 66 records were retained for full-text assessment, of these 27 met inclusion criteria.

Two interrater reliability assessments were conducted during the review process. The first occurred after the initial database search: once 60 articles were identified for full-text review, two reviewers (ED and PG) independently screened a sample of 20 articles, achieving agreement on 13 of the 20 (65%). The second was conducted after the grey literature and citation searches were completed. A sample of five was screened independently (by ED and PG), with agreement on four of the five (80%). A third reviewer (JHL) was consulted, and discrepancies were resolved through discussion. Overall, across both reliability assessments, the reviewers achieved 68% on 17 out of 25 articles.

Across all phases (database, citation, and grey literature search), two reviewers (ED and PG) independently assessed titles, abstracts, and full-texts for eligibility, with disagreements resolved through discussion and consensus. While no third reviewer was required to mediate conflicts, a third reviewer (JHL) completed an audit of 10 titles and abstracts and 20 full-text sources (17 peer-reviewed, three grey literature) to confirm the appropriateness of inclusions. A summary of the study selection process, including reasons for full-text exclusions, is documented in the PRISMA-ScR flow diagram (Figure 1).

## Data Extraction

Data extraction was completed for all included full-text sources identified through the database search (n=15) using Covidence systematic review software,<sup>(29)</sup> and for grey literature sources (n=27) using a Microsoft Excel spreadsheet modelled after Covidence's extraction tool. Extraction instruments were designed (by PG) and piloted (by ED and PG) (three peer-reviewed, three grey literature), with modifications made as needed. For a table that lists extraction headings used in Covidence and Excel Extraction tools, see *Table S1 in the Supplementary Material*.

## Data Analysis

We employed a hybrid thematic analysis approach that combined inductive and deductive reasoning, guided by the Socioecological Model (SEM) to interpret patterns across multiple levels of influence.<sup>(30,31)</sup> The SEM conceptualizes human experiences as shaped by multiple layers: intrapersonal (individuals' characteristics, knowledge, and behaviours), interpersonal (relationships with family, peers, and caregivers), community (local ethnic food suppliers and diaspora organizations), institutional (organizational practices within LTC and RCF), and societal (policy and structural determinants).<sup>(30,31)</sup> The analysis began with an inductive process (led by ED and PG), identifying 63 meaningful patterns grounded in the data from the included sources, focusing on mealtime

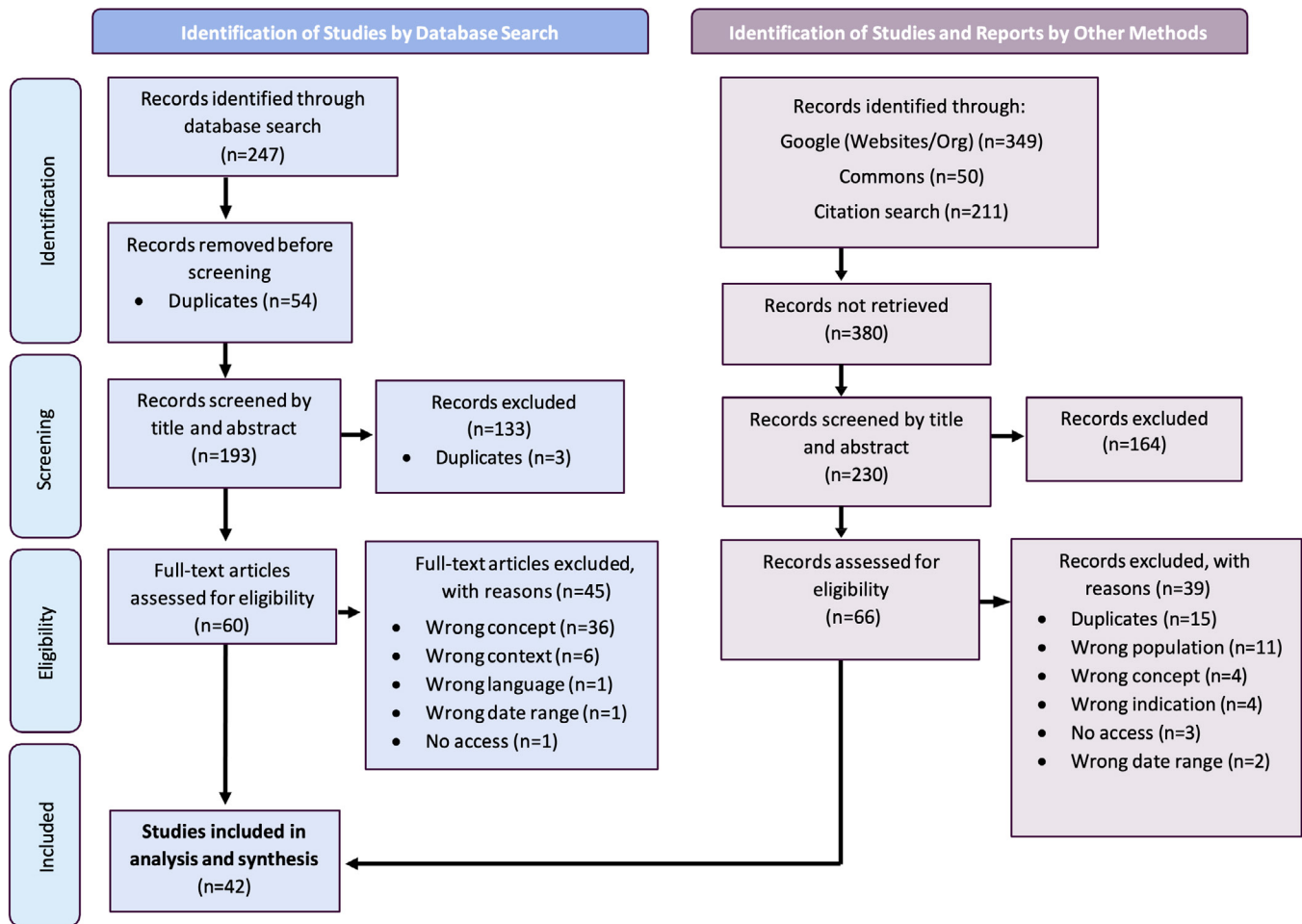


FIGURE 1. PRISMA flow chart diagram summarizing the study selection

experiences and service delivery aspects relevant to research Questions 2 and 3. These patterns were then deductively grouped according to the SEM layers. The interpretation of the findings was refined using feedback from two co-investigators (CZ and JHL).

## RESULTS

### Source of Evidence Inclusion

The final scoping review included 42 articles (Figure 1). An overview of the six themes derived from these articles, organized according to the SEM layers, is presented in Table 1. First, “Access and Identity Preservation” underscores how access to culturally appropriate food supports residents’ well-being and the maintenance of cultural and personal identity, highlighting how meals serve as a key expression of cultural belonging. Second, “Barriers to Menu Diversity” highlights challenges to offering culturally inclusive menus. Third, “Reported Success in Diversifying Menus” identifies strategies currently in place to increase cultural inclusivity in menu planning. Fourth, “Cultural Ritual” emphasizes the importance of mealtime traditions, prayer, and ritual in maintaining cultural identity. Fifth, “Barriers to Establishing

and Maintaining Cultural Meal Services” identifies the difficulties faced in integrating cultural rituals and traditions. Sixth, “Effective Current Practices” showcases existing approaches that successfully accommodate cultural ritual, tradition, and routine within LTC and RCF. Together, these themes illustrate how cultural needs intersect with identity, systems, and practices within LTC and RCF.

### Research Question 1: Characteristics of Included Sources

The included sources (n=42) consisted of primary research studies (n=20), evidence synthesis reviews (n=3), academic theses (n=6), clinical or government-funded reports/guidelines (n=11), organizational websites (n=1), and opinion/commentary pieces (n=1). Among primary studies and theses (n=26), qualitative methodologies were most prevalent (n=21), followed by mixed methods (n=4), and quantitative methods (n=1). Theses consisted of dissertations for Doctor of Philosophy degrees (n=4) and Master’s degrees (n=2). Three evidence synthesis studies were included in the review. Qualitative and mixed methods studies included ethnographies (n=5), exploratory (n=3), case studies (n=3), phenomenological (n=2), rapid inquiry (n=1), cross-section (n=1), and intervention (n=1); all others did

TABLE 1. Overview of research questions and themes, across the five layers of the socioecological model

<i>Layers of the Socioecological Model</i>					
<i>Questions and Themes</i>	<i>Intrapersonal</i>	<i>Interpersonal</i>	<i>Community</i>	<i>Institutional</i>	
<i>Societal</i>					
<i>Research Question 2: Access</i>					
Access and Identity Preservation: Food as reflection of cultural heritage and personal identity.	Preferences for culturally specific food Religious dietary rules as cornerstone for identity	Families' crucial role in maintaining cultural food preferences through home-cooked meals Peer influence in shared dining areas fostering cultural food practices	Communities and diaspora provide critical cultural support for LTC and RCF Local ethnic food suppliers ensure authenticity	Culturally inclusive menus reflect commitment to PCC Standardized menus fail to reflect cultural diversity	Food as belonging and dignity promotion Cultural meals as reflection of societal norms Culturally diverse menus as human rights
Barriers to Menu Diversity: Challenges to offering culturally inclusive menus arising across SEM layers.	Loss of autonomy Challenge adapting food preferences to health restrictions	Families struggle to communicate preferences Some residents do not have family support Limited family input in meal planning	Limited ethnic food supplies (especially in rural areas) Lack of community partnerships	Standardized menus neglect culture Budget constraints for sourcing culturally appropriate ingredients Lack of staff training in culturally specific meals	Financial prioritization over cultural accommodation Lack of efficient guidelines and policies for culturally inclusive menus
Reported Success in Diversifying Menus: Effective strategies currently in place to address cultural inclusivity in menu planning.	Balance cultural authenticity with health needs Provide culturally tailored substitutions (e.g., rice instead of potatoes)	Encourage families to bring supplementary meals Encourage families to provide recipes	Facilitating residents to attend community cultural events Working with community to provide cultural dinners and events Collaboration with ethnic food suppliers/markets	Partnering with suppliers to source ethnic ingredients Incorporating residents' favourite recipes into menus Staff cultural safety and menu diversity training	Highlighting successful inclusive practices in LTC and RCF Use of public campaigns to promote awareness
<i>Research Question 3: Service Models</i>					
Cultural Ritual: Significant mealtime traditions, prayer, and ritual in preserving cultural identity during mealtimes.	Residents value traditions Personal preferences in dining environment Culturally appropriate utensil and food preparation	Families are key in maintaining tradition Peer dynamics may conflict with residents' cultural needs	Community involvement supports cultural rituals and traditions	Adaptations to accommodate rituals and traditions Incorporate culturally significant traditions and rituals into policies	Societal norms influence how institutions prioritize cultural ritual Public perceptions underestimate the importance of mealtime rituals and tradition
Barriers to Establishing and Maintaining Cultural Meal Services: Integrating cultural rituals and traditions faces barriers at all SEM levels.	Loss of autonomy in rigid institutional settings Difficulties adjusting to loss of traditions and rituals	Encouragement of family involvement in rituals and meal traditions Facilitate communal dining experiences that respect diversity	Lack of formal partnerships with cultural groups Limited availability of resources for culturally appropriate rituals and traditions (especially in rural areas)	Staff lack training in cultural etiquette, utensil use, and scheduling Institutional rigidity prevents flexible meal schedule Institutional environments	Absence of policies supporting cultural inclusive mealtime practices Economic systems that favour efficiency over tradition
Effective Current Practices: Existing approaches to successfully accommodating cultural ritual, tradition, and routine.	Providing flexible meal schedules Offering customized utensils, appropriate mealtimes, and food presentation	Provide families with opportunities to co-host cultural mealtime activities Develop programs to celebrate diverse rituals in communal settings	Host community-supported cultural mealtime events Collaborating with local groups to source ritual-specific items, utensils, decorations	Staff training in cultural competence for mealtime traditions Incorporating ritual-sensitive dining practices into protocols	Highlighting facilities that successfully integrate ritual-sensitive practices Advocating for public awareness campaigns promoting the importance of ritual and tradition

not specify methodological approaches. Data were collected through semi-structured and in-depth interviews (n=20), observation (n=10), focus groups (n=3), document reviews (n=3), and surveys (n=2). Data were analyzed utilizing thematic analysis (n=16), content analysis (n=3), grounded theory (n=2), hermeneutics (n=2), descriptive statistics (n=2), event analysis (n=1), and reduction analysis (n=1). The lone quantitative study utilized descriptive statistical analysis.

The studies included reflect the perspectives of participants from 21 cultural, ethnic, and religious groups, including Aboriginal (Australia), African, Armenian, Chinese, English (in non-English speaking homes), Finnish, Greek, Haitian, Hungarian, Indigenous (Canadian), Japanese, Jewish, Korean, Malaysian, Muslim, Navajo, Sami, South African, South Asian, Torres Strait Islander, and Vietnamese. Additionally, these studies were conducted across various countries: Australia, Canada, United States, United Kingdom, India, Malaysia, Norway, South Africa, and Sweden, with some studies spanning multiple countries. A detailed summary of study characteristics, including study type and methodology, is provided in Appendix B.

## Research Question 2: Access

### *Access and Identity Preservation*

Consistent with prior findings, access to culturally appropriate food is essential for resident well-being,<sup>(32-51)</sup> and studies in this review demonstrate that residents' cultural, ethnic, and religious dietary needs, including preference for traditional meals and adherence to rules such as halal and kosher, persist today.<sup>(32-38,40-43,45-64)</sup> At the intrapersonal level, residents may face challenges meeting their personal, cultural, or religious dietary needs when facilities offer limited menu options. While some facilities provide inclusive menus such as vegetarian, halal, and kosher options, many rely on standardized menus that restrict residents' ability to maintain culturally meaningful diets.<sup>(32,34-40,42,44,46,48,53-55,61,65-69)</sup> Residents themselves often noted how these practices diminished cultural meaning; Chinese residents in an American nursing home described how familiar dishes like hot tea and rice porridge (juk) lost their cultural meaning when served in paper or plastic dishes and cups.<sup>(50)</sup> Similarly, one Hungarian resident in Canada expressed dissatisfaction with bland meals lacking traditional spices and flavours, leaving him reluctant to eat.<sup>(37)</sup> These examples highlight how institutional food services often strip meals of their cultural significance, reducing them to utilitarian functions rather than identity-affirming rituals.

Interpersonally, families play a key role in helping residents to maintain cultural food practices, often by bridging gaps in institutional provisions by bringing in home-cooked meals and snacks or strongly advocating for cultural preferences.<sup>(33,35,37,40,42-45,50,53,54,57-59,63,67-72)</sup> At the community level, access to culturally appropriate foods is often supported by local ethnic food suppliers who provide essential ingredients, recipes, and culinary knowledge.<sup>(37,40,42,53,54,59,62,66,68)</sup> However, these practices are found to be typically limited

to ethnic-specific facilities, as most LTC and RCF do not routinely engage with community suppliers or cultural organizations to support access to culturally appropriate foods.<sup>(32,34,35,38,40,42,46,48,53,54,65-68)</sup>

Institutionally, ethnic-specific facilities ensured food aligned with residents' backgrounds,<sup>(33,42,43,48-52,54,55,58,59,62,63,66,67,69,71,72)</sup> and prioritized cultural authenticity in both menu options and dining environments.<sup>(33,47,49,51)</sup> Examples include care homes entirely designed for Japanese American Elders,<sup>(72)</sup> culturally specific units or floors for Korean American elders within larger care homes,<sup>(59)</sup> and Anglo-Indian care homes that integrate cultural practices while remaining inclusive to other residents.<sup>(33)</sup> Societally, access to culturally specific food reflects broader values around human rights, dignity, and belonging.<sup>(32,34,41,43,46,50,55,60-64)</sup>

### *Barriers to Menu Diversity*

Systemic and logistical barriers often limited access to culturally inclusive menu options.<sup>(42,44,54,59,68,69)</sup> At the intrapersonal level, residents face multiple challenges in accessing culturally appropriate meals. Non-native speakers or residents with limited proficiency in the dominant language generally struggle to communicate dietary preferences, restricting access to culturally familiar foods.<sup>(37,38,42,44,45,53,54,58,59,63,66,68,70-73)</sup> Health-related dietary restrictions, cognitive decline, and age-related sensory changes (e.g., alterations in taste or smell or reliance on a limited pureed menu) can further limit the ability to enjoy traditional meals.<sup>(44,63,71)</sup> Some residents lack the knowledge, confidence, or resources to advocate for culturally relevant menu options, and cultural norms may discourage voicing complaints or requests, further limiting autonomy and access to traditional foods.<sup>(58,64,66,72)</sup>

At the interpersonal level, there is significant reliance on families to fill the gaps in providing culturally appropriate meals or ingredients that LTC and RCF failed to supply, placing considerable strain on family members, especially if they live far from facilities.<sup>(35,37,40-45,50,51,53-55,58,62,63,66-72)</sup> Some families lack the means to provide supplementary meals, either physically or financially.<sup>(37,39,42,45,54,57,62,66-68,70,72)</sup> Additionally, some residents have no family support to assist with culturally appropriate food or anyone to advocate for their dietary needs.<sup>(37,38,40,42-45,50,53,54,57-59,63,68-71)</sup> Cultural norms and language barriers also create challenges. Families often refrain from raising concerns or advocating, perceiving such complaints as disrespectful or inappropriate within their cultural contexts.<sup>(37,43-45,50,53,54,58,59,63,66-68,71,72)</sup>

Access at the community level is limited by the availability of ethnic food suppliers, particularly in rural areas, and by the absence of formal partnerships between facilities and cultural organizations.<sup>(34,36-39,42-45,49-53,55,59,62-64,67,68,71)</sup> While ethnic-specific facilities demonstrate that partnerships with cultural groups and suppliers can effectively enhance access, most LTC and RCF do not routinely engage with these community resources.<sup>(32,34,36,37,47-52,54,55,59,62,63,66,67,71)</sup> Institutionally, budget constraints<sup>(40,43,48,49)</sup> and insufficient staff training in culturally specific menus and meal

preparation<sup>(32,34-37,40-45,48,50-55,58-64,66,68,69,71,72)</sup> significantly limit access to culturally appropriate meals. Standardized menus and expectations of assimilation prioritize operational efficiency over residents' cultural needs,<sup>(35,37-41,43-45,48,53,54,56-59,63,66,68-72)</sup> and staff often struggle to adapt traditional foods to meet dietary restrictions, such as low-sodium or puree diets.<sup>(37,40-43,45,46,48,53,59,61,66-69,71)</sup> The dominance of medical priorities, such as strict adherence to dietary modifications, further overshadows the social and cultural significance of food, reinforcing a utilitarian rather than person-centred approach to mealtimes.<sup>(35,37,40,42,43,45,50,53,54,57,62,66-69,71,72)</sup>

At the societal level, the drive for efficiency, profitability, and cost containment in health-care and institutional food services often deprioritizes culturally inclusive practices.<sup>(35,37-45,48-51,53,54,56,58,59,62-64,66,68-72)</sup> Task-oriented care environments and resource allocation decisions are shaped by broader capitalistic logic and policy gaps often limit regulatory incentives, leading to the commodification of care.<sup>(37,41-45,48,50,51,53,54,58,59,62,63,66,68-72)</sup>

### ***Reported Success in Diversifying Menus***

Ethnic-specific facilities stood out as a successful model, providing culturally tailored menus and embedding cultural traditions into all aspects of care.<sup>(33,36,37,42,43,47-49,53,54,58,59,62,66,69,71,72)</sup> Across multicultural settings, other promising strategies have been implemented to address barriers. At the intrapersonal level, residents' ability to maintain cultural food practices was supported when facilities offered accommodations such as culturally tailored substitutions (e.g., rice instead of potatoes),<sup>(43)</sup> the inclusion of favourite recipes into menus,<sup>(37,43,53,59,66,70-72)</sup> and access to culturally appropriate spices and condiments.<sup>(33,34,36,40,43,53,59,61,66)</sup> Multilingual menus further empowered residents to communicate their preferences and sustain culturally meaningful eating habits.<sup>(34,43,53,54,61,66,71)</sup>

At the interpersonal level, families are encouraged to contribute recipes and bring supplementary meals, fostering a collaborative approach to menu planning.<sup>(43-45,50,59,69)</sup> Peer engagement with individuals from the same culture in communal dining spaces, in many facilities, is encouraged and facilitates cultural exchange, enhancing residents' satisfaction and belonging.<sup>(33,35,37,39,43,49,50,54,58,59,62,69,71,72)</sup> At the community level, there was demonstrated success of partnerships with ethnic food suppliers and markets to source authentic ingredients.<sup>(40,43,53,64,66)</sup> Facilities hosted cultural dinners and events in collaboration with diaspora groups, providing residents with opportunities to engage in cultural practices.<sup>(32,34-36,43,45,47,49-52,55,58,59,62,66,68,69,71)</sup>

At the institutional level, staff cultural safety training and resident-centred menu diversity practices were highlighted as effective approaches.<sup>(32,34,36,37,40,42,43,45-50,52-55,59,62,66,68,69,73)</sup> Facilities that incorporated residents' preferences into menu planning<sup>(32,34,35,39,41-43,45-55,59,61,62,64,66-69,71)</sup> and those with multicultural staff<sup>(33,39,41,43,47,54,58,59,62,67-69)</sup> were more successful in accommodating the cultural needs of their residents. At the societal level, public awareness campaigns promoted the importance of cultural inclusivity and increased funding needed to LTC and RCF.<sup>(34,36,40,43,48-52,62,68)</sup>

### **Research Question 3: Service Models**

#### ***Cultural Ritual***

Cultural rituals were central to identity preservation, encompassing mealtime traditions, religious observances, and culturally significant food preparation and presentation practices.<sup>(32-39,43-45,47-55,58,59,61-63,66,68-70,72)</sup> Intrapersonally, residents valued rituals such as meal blessings, fasting, specific utensil and food presentation, or dining sequences, which reinforced a sense of belonging and cultural continuity.<sup>(32,34,36,39,43,47-49,51-53,55,58,59,61-63,65,66,72,73)</sup>

Interpersonally, families supported traditions by facilitating rituals or providing culturally appropriate dining tools and décor.<sup>(37,43-45,49,51,53,54,58,59,62,63,66-72)</sup> However, peer dynamics occasionally created challenges, such as conflicts arising from differing cultural needs.<sup>(35,37,43,54,58,59,63,68,69)</sup> For example, while Korean cultural practice is to share dishes (banchan), many residents were found to be choosing to eat alone in their rooms and avoiding communal dining areas to avoid feeling obligated to share their special dishes.<sup>(59)</sup> Syed & Mann found that residents from diverse backgrounds expressed preferences for culturally familiar foods, and that they would choose to dine alone to avoid communal settings where their traditional dishes might not be respected or understood by others.<sup>(64)</sup>

Community organizations and diaspora groups played a vital role in supporting rituals through the donation of items, organization of cultural events, and collaboration with ethnic-specific facilities.<sup>(33,35,39,43,45,58,59,68,69)</sup> Yet, limited partnerships and access to ritual-specific supplies posed ongoing challenges, especially in rural areas.

Institutionally, successful facilities adapted policies and meal services to incorporate culturally significant practices, including flexible mealtimes, customized dining environments, and appropriate utensils.<sup>(33,37,43,53,57-59,66,69,72)</sup> Still, implementation was inconsistent, hindered by rigid schedules, limited staff training, and environments designed more for efficiency than cultural accommodation.<sup>(37,43,58,69)</sup> At the societal level, economic pressures and policy gaps de-prioritized mealtime ritual, often treating them as non-essential compared to clinical or operational goals,<sup>(34,35,42,43,50,53,57,62,67-69,72)</sup> and public undervaluation of cultural importance has shaped institutional norms.<sup>(37,38,42-45,53,54,57-59,66,68-72)</sup>

#### ***Barriers to Establishing and Maintaining Cultural Meal Services***

Systemic and logistical barriers impede the integration of culturally inclusive meal practices in LTC and RCF. Many of these barriers mirrored those identified in relation to menu access such as language barriers, reliance on families, and limited community partnerships, as well as institutional constraints around budgets, staff training, and standardized practices. However, additional challenges emerged that were unique to the mealtime environment.

At the interpersonal level, similar barriers to culturally inclusive meal practices were found as those previously discussed regarding menu diversity that led to residents struggling with a loss of autonomy when expressing cultural dining preferences.<sup>(35,37,38,40-45,48,50,51,53-55,57-61,64,66-72)</sup> Unique to mealtime

practices, however, were difficulties maintaining rituals and religious observances, such as fasting and prayer, as well as the absence of familiar utensils, food presentation styles, and culturally resonate dining cues in the environment.<sup>(32,34,36-47,49,51-55,57-61,63,64,66-72)</sup> These absences deepened the disconnection from tradition and personal identity, with negative emotional impacts.<sup>(45,48,49,51,68)</sup> Interpersonally, families were again expected to bridge cultural gaps, unsupported by institutional policies.<sup>(42-44,54,59,63,66,68,69,72)</sup> For example, Korean families in U.S. care homes often supplied ritual items to help residents maintain cultural practices that were unsupported by the facility.<sup>(63)</sup> In addition to this, peer interactions in communal dining spaces sometimes led to misunderstanding or exclusion, especially when rituals clashed or were not respected.<sup>(42,43,53,54,59,63,66,68,69,72)</sup> At the community level, as with menu diversity, limited access to authentic ethnic resources and formal partnerships restricted cultural inclusion.<sup>(32,34,36,42-46,48,49,51,52,55,58,62-64,66,68,69,71)</sup> Facilities that intentionally built community connections were better able to preserve the authenticity of dining experiences and environments, but such practices were the exception rather than the norm.<sup>(32,34,36,37,47-50,52,54,55,58,59,62,63,66,71)</sup>

Institutionally, operational efficiency was consistently prioritized over cultural responsiveness. While overlaps with menu-related barriers were clear (such as standardized processes and lack of staff training), unique barriers to the dining environment included rigid mealtime schedules, task-oriented routines that marginalized ritual-sensitive practices, and assimilationist dining models that undermined the social and cultural meaning of shared meals.<sup>(35,37-41,43-45,48,53,54,56-59,63,66,68-72)</sup> Consistent with societal level barriers to menu diversity, funding and policy frameworks continued to deprioritize cultural inclusion, treating it as an optional enhancement rather than a fundamental aspect of PCC.<sup>(35,37-39,41-45,48-51,53,54,56-59,62-64,66,68-72)</sup> The undervaluing of rituals and social meaning was widespread, reinforcing a view that food is purely utilitarian rather than relational or identity-affirming.<sup>(35,37-40,42,43,45,53,54,57-59,63,66,68-70,72)</sup>

### ***Effective Current Practices***

Culturally inclusive mealtime practices have been successfully implemented across various LTC and RCF settings. While many strategies mirrored those reported for diversifying menus, such as the use of multilingual supports, family contributions, supplier partnerships, and staff cultural safety training, additional practices unique to mealtime environments were identified.

Intrapersonally, facilities promoted autonomy by offering flexible mealtime schedules,<sup>(32-34,36,40,42,43,46-50,52-55,58,59,61,62,65-67)</sup> and accommodating culturally specific preferences around utensils, food presentation, and décor.<sup>(32,33,36,38,41-43,45-55,58,59,61,62,69,71,72)</sup> Additionally, multilingual menus supported residents in communicating preferences.<sup>(34,43,53,54,61,66,71)</sup> These environmental and ritual-sensitive adaptations supported residents' sense of identity and belonging beyond the content of food itself. Interpersonally, while families frequently contributed recipes and supplementary meals, unique to mealtime practices

were their role in co-hosting cultural celebrations and reinforcing intergenerational connections.<sup>(43,66)</sup> Communal dining spaces also served as sites of intercultural exchange, where shared celebrations promoted inclusion and strengthened social bonds among residents.<sup>(33,35,42,43,45,46,50,53,58,66,68,69,71)</sup> At the community level, similar partnerships with cultural organizations and diaspora groups supported the provision of ritual-specific utensils, decorations, and culturally resonant events.<sup>(33,35,43,46,50,53,58,66)</sup> These collaborations enriched the overall dining environment and strengthened cultural continuity.

Institutionally, cultural awareness must be embedded into not just menu planning but also meal protocols, rituals, and service routines.<sup>(32,34,36,37,40,42,43,45-50,52-55,59,62,66,68,69,73)</sup> Facilities with multicultural staff, flexible care models, and dedicated feedback mechanisms were better able to adapt mealtime environments to align with residents' cultural and religious needs.<sup>(32,34,36,37,40,42,43,45-50,52-55,59,62,66,68,69,73)</sup> Integrating resident feedback helped ensure rituals and cultural practices were meaningfully incorporated into daily care.<sup>(35,41-43,53,54,58,59,61,66,72)</sup> At the societal level, overlaps with menu diversification were evident in public awareness campaigns and advocacy for cultural inclusivity.<sup>(32,43,49,50,53,61,62,67)</sup> Unique to mealtime-focused initiatives, however, were the use of research informed guidelines and participatory feedback from residents, families, staff, and communities to develop inclusive service models that recognized the social and cultural meaning of dining experiences.<sup>(40,66,67)</sup>

### **Recommendations**

The following recommendations are synthesized from the review literature and do not represent original recommendations from these studies. A complete list of evidence-informed recommendations is available in *Appendix S1 in the Supplemental Material*.

To effectively integrate culturally inclusive meal practices in LTC and RCF, a comprehensive approach across policy, operational, community, and research domains is necessary. Standardized policies should mandate cultural meal accommodations as an essential aspect of PCC rather than an optional feature.<sup>(48,49,68)</sup> Increased funding is crucial to ensuring access to diverse ingredients and supporting culturally appropriate food services.<sup>(44,47,64)</sup> Additionally, regulatory bodies should establish enforceable compliance criteria, alongside policies that encourage flexible meal schedules to accommodate fasting, prayer, and other cultural dining practices.<sup>(46-49)</sup>

Facilities must take proactive steps to provide culturally tailored menu options that reflect resident demographics, incorporating traditional condiments, meal substitutions, and serving styles. Encouraging flexible dining arrangements and designated cultural dining spaces will foster a sense of familiarity and belonging for residents.<sup>(50,57,73)</sup> Staff training in cultural food preparation and meal etiquette is essential to ensuring authentic and respectful meal service.<sup>(47,48,63,68)</sup> Further, multilingual menus and communication aids should be implemented to support meal selection for non-English-speaking residents.<sup>(47,54)</sup>

Engaging families and communities is key to sustaining culturally inclusive meal practices. Facilities should formalize partnerships with cultural organizations and ethnic food suppliers to ensure consistent access to traditional foods.<sup>(44,48,49,64)</sup> Structured family-led meal programs can strengthen intergenerational connections while reducing the burden on families to provide culturally appropriate meals.<sup>(50,58,71)</sup> Additionally, involving diaspora communities in menu planning and cultural celebrations can enhance residents' experiences and create a more inclusive environment.<sup>(40,45,72)</sup>

Further research is needed to evaluate the long-term impacts of culturally tailored meals on residents' health, psychological well-being, and overall quality of life.<sup>(42,63)</sup> Studies should explore cost-effective strategies for integrating cultural meal services into mainstream LTC settings, while identifying best practices from ethnic-specific homes.<sup>(49,63,69)</sup> Research should also investigate the role of communal dining and mealtime rituals in fostering social connections and preserving cultural identity.<sup>(50,57,58)</sup> These insights can inform the development of a national framework for culturally inclusive food services that ensure consistency and sustainability across facilities.

By implementing these recommendations (see *Appendix S1 in the Supplemental Material* for a full list of recommendations), LTC and RCF can create inclusive dining environments that respect and celebrate cultural diversity, ultimately enhancing residents' well-being and quality of life. An accompanying infographic summarizing key implementation strategies is provided in *Appendix S2 in the Supplemental Material*.

## DISCUSSION

The objective of this scoping review was to examine the state of knowledge on culturally and ethnically diverse person-centred mealtime practices and menu options in LTC and RCF. We asked three guiding questions: 1) What research has been conducted regarding culturally and ethnically diverse person-centred mealtime practices and menu options in LTC/RCF? 2) What is known about resident access to culturally and ethnically diverse menu options? and 3) What is known about culturally and ethnically diverse service models relating to mealtime routines, rituals, and established manners? Because the first question is addressed in detail in the Results section, this Discussion focuses on Questions 2 and 3. It is important to note that the current evidence base remains limited in scope and future research directions are discussed later in this section.

### Access to Diverse Menus

Across mainstream LTC and RCF, findings reveal a persistent structural pattern: menus are largely standardized, with only occasional cultural or religious adaptations.<sup>(32,36,41,46,48,49,52,56)</sup> When familiar dishes are offered, they often present in Westernized form, prepared with substitute ingredients or simplified methods that diminish their authenticity.<sup>(35,37,41,42,48)</sup> In response, families frequently compensate by supplying home-cooked meals and snacks, which helps sustain residents but also outsources the costs and labour onto families, and

amplifies inequities between those with and without strong familial support.<sup>(37,44,50,54,58,67)</sup> By contrast, ethnic-specific homes and specialized units demonstrate greater success in embedding cultural authenticity through partnerships with ethnic suppliers, multilingual menus, and the incorporation of resident or family recipes.<sup>(47,49,51,59,63,67)</sup> In these settings, staff and leadership with cultural expertise, alongside community partnerships, make diverse menus routine rather than exceptional.<sup>(34,40,47,49,51,59)</sup>

### Service Models and Dining Practices

Mealtimes are shaped not only by what is served but how it is delivered. Residents and families emphasize the importance of rituals and manners: prayers or blessings, serving order, utensil norms, presentation, décor, and timing aligned with religious observance.<sup>(34,35,37,39,50,58,67,70)</sup> Facilities that integrate flexible mealtime windows,<sup>(36,43)</sup> culturally congruent utensils and décor,<sup>(39,50,58)</sup> multilingual ordering supports,<sup>(34,37)</sup> and structured family feedback<sup>(41,67)</sup> report higher satisfaction, identity continuity, and greater participation in communal dining. Tensions do arise in some contexts; for example, residents sometimes declined communal dining to avoid the expectation of sharing specialty dishes while, in multi-ethnic settings, unfamiliar rituals occasionally led to misunderstandings.<sup>(37,58,59,63)</sup> For instance, Girard and El Mabchour<sup>(37)</sup> describe immigrant residents in Quebec nursing homes who sometimes avoided communal dining because foods brought in by family members created pressure to share, leaving those without such support feeling excluded. Nevertheless, most studies suggest that shared dining with ritual accommodation is feasible and beneficial when supported by staff mediation and culturally sensitive design.<sup>(34,35,37,39,43,51,58)</sup>

### Positioning Within Person-Centred Care Frameworks and Mealtime Literature

Culturally inclusive meals are core to PCC, not optional enhancements. PCC frameworks emphasize dignity, choice, relational care, and identity continuity.<sup>(10,13,74,75)</sup> Previous mealtime research has highlighted autonomy, social interaction, dining environment, and food quality as central to residents' well-being.<sup>(76-80)</sup> Our review extends this literature by showing that cultural authenticity and ritual accommodation are equally fundamental to dignity, belonging, and meaningful choice. Without explicit cultural adaptation, mealtime practices reproduce assimilationist norms, narrowing "choice" to dominant Western traditions, and undermining the autonomy that PCC aims to protect.<sup>(32,41,42,46,48,49)</sup> In such contexts, choice is formally preserved but substantively undermined, as menus rarely reflect cultural authenticity or ritual meaning.<sup>(32,37,50,81,82)</sup>

Building on evidence that shared meals reduce isolation,<sup>(76,83,84)</sup> our synthesis illustrates how communal dining can either reinforce or erode cultural identity depending on whether rituals are acknowledged. When facilities accommodate prayers, serving order, utensils, and scheduling, communal dining supports identity continuity; when absent,

residents may withdraw to avoid misunderstanding or loss of dignity.<sup>(34,35,39,63)</sup> Finally, while family involvement is often framed as supportive,<sup>(50,58,67)</sup> reliance on families to provide culturally meaningful food can deepen inequities.<sup>(37,44,54,75,77,82,83)</sup> In contrast, ethnic-specific homes and culturally targeted units normalize cultural inclusion through supplier partnerships, multilingual menus, and culturally knowledgeable leadership.<sup>(47,49,51,59)</sup> This highlights that person-centred mealtimes require systemic and organizational commitments, not only individual or family efforts.

### Insights from the Socioecological Model

Applying the SEM helped to clarify actionable levers for change. At the intrapersonal level, language barriers, sensory loss, and therapeutic diets can limit residents' ability to request or enjoy cultural foods; supports such as multilingual or pictorial menus and culturally sensitive therapeutic recipes can mitigate these barriers.<sup>(31,43,85)</sup> At the interpersonal level, families often mediate cultural inclusion, which is effective but inequitable in that it privileges those with available and engaged family.<sup>(37,44,54,77,82)</sup> At the community level, diaspora networks and ethnic suppliers are crucial yet often under-formalized partners.<sup>(34,40,47,49,51,55,59,86,87)</sup> At the organizational level, procurement systems prioritize cost/volume, mealtime schedules can clash with fasting or prayer, staff are often under-trained, and menu planning tools discourage variation.<sup>(37,44,46,54,56,88,89)</sup> Our findings support the practices of embedding cultural practices into procurement, negotiating diverse supplier relationships, adapting service protocols, and reframing mealtime schedules.

### Barriers and Facilitators at Institutional and Societal Levels

Moving beyond individual facilities, the wider institutional and policy environment plays a decisive role in enabling or constraining culturally inclusive mealtime practices. Barriers at institutional and societal levels include standardized menus and assimilationist assumptions, insufficient staff training, inflexible schedules, procurement practices that lack cultural sensitivity, and regulatory logics that prioritize efficiency over inclusion.<sup>(61,80,82-84,90,91)</sup> In contracts, facilitators include multilingual menus, substitution protocols, condiments/spice kits, resident/family co-design, flexible mealtime schedules, culturally congruent dining environments, and diaspora partnerships.<sup>(34,35,37,39-41,49,59)</sup> However, many exemplar practices identified within our review were at single sites and thus scalability requires further study.

### Gaps and Future Research

Despite promising practices, significant research gaps remain. The most notable gap in the literature is studies with quantitative outcomes. Specifically, few studies have tested whether culturally tailored menus or ritual-aware service models improve food intake, health outcomes, or cost-effectiveness.<sup>(41,61)</sup> Future research should therefore include intervention trials that incorporate culturally adapted menus

and service models, with clear outcome measures such as nutritional status, well-being, satisfaction, and cost analysis. Underexamined contexts include rural or low-resourced care facilities, as well as multicultural facilities serving diverse groups.<sup>(32,37,54,55,69,92,93)</sup> Addressing these contexts requires comparative and multi-site studies that examine how cultural inclusion can be sustained in settings with limited resources or highly diverse populations.

Intervention fidelity and sustainability, along with monitoring metrics, are also rarely reported in the literature.<sup>(35,37,50,51)</sup> Future research should embed implementation science approaches to assess not only whether interventions work, but also how they are maintained and adapted across diverse care contexts. The dynamics of multicultural dining rooms, including cross-cultural tensions and strategies for mutual accommodation, remain limited in their exploration.<sup>(35,37)</sup> Further studies should investigate how staff facilitation, environmental design, and resident-led initiatives can support positive intercultural dining experiences. Finally, policy, funding, and regulatory requirements are seldom tied to empirical outcomes.<sup>(74,77,80,83,91,94)</sup> Future research should evaluate how regulatory frameworks and funding models influence cultural inclusion in mealtimes, and test policy levers that may facilitate wider adoption of culturally responsive practices.

### Policy and Practice Implications

To address these gaps, policy and practice must reframe cultural inclusion as essential to PCC.<sup>(10,13)</sup> Accreditation and regulatory standards should require facilities to demonstrate culturally inclusive menus and ritual accommodation.<sup>(36,42,52,68,77,82)</sup> Procurement should prioritize supplier diversity, enable culturally appropriate substitutions, and support authentic ingredients.<sup>(32,41,46,52,61,77,95)</sup> Mealtime schedules should flex for religious observance.<sup>(34,36,75,81)</sup> Dining environments should include culturally meaningful décor, utensils, and multilingual supports, with structured feedback loops for residents and families.<sup>(35,43,50,56,81,83,90,93,95)</sup> Staff training in cultural competence should be routine.<sup>(44,54,69,74,75)</sup> Partnerships with diaspora organizations and ethnic suppliers should be formalized to institutionalize authenticity and reduce reliance on families.<sup>(47,49,59,75,82)</sup> Finally, measurement systems should capture cultural satisfaction, ritual-accommodation rates, intake/health outcomes, and costs to guide scaling.<sup>(41,42,75,80,91,95)</sup>

### Strengths and Limitations

Strengths of this review include a focus on cultural authenticity across menu and ritual dimensions, application of the SEM to identify change levers at multiple levels, inclusion of peer-reviewed and grey literature reflecting practice realities, and the collaborative expertise of our interdisciplinary research team.<sup>(24,28,30)</sup> Limitations include reliance on English-language evidence sources, heterogeneity of study designs precluding meta-synthesis, and the fact many findings are drawn from small or single-site studies. Several promising practices should therefore be used for hypothesis generation rather than as universal prescriptions.<sup>(25,26)</sup>

## CONCLUSION

Current LTC and RCF meal service models fail to adequately meet the needs of diverse resident populations, reinforcing assimilationist norms that overlook cultural and emotional needs of residents. Culturally inclusive meals are central to equitable PCC. Addressing systemic barriers—spanning organizational, institutional, and societal levels—is an essential first step towards creating dining environments that affirm cultural identity and provide PCC.

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## CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal's* policy on conflicts of interest disclosure and the authors declare that they have no competing interests.

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## SUPPLEMENTAL MATERIALS

Supplemental material linked to the online version of the paper (<https://doi.org/10.5770/cgj.29.878>):

- **Table S1:** Data Extraction Headings
- **Appendix S1:** Recommendations for Enhancing Cultural Mealtimes in Long-Term and Residential Care.
- **Appendix S2:** Enhancing Cultural Mealtimes in Long-Term and Residential Care Infographic.

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**APPENDIX TABLE A (part 1 of 3). Final search strategy adapted for each database conducted May 7, 2024****Ovid MEDLINE®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	exp Long-Term Care/	28966
2	Long-Term Care.tw,kf.	28097
3	LTC.tw,kf.	4857
4	Long term care.tw,kf.	28097
5	exp Residential Facilities/	59304
6	exp Homes for the Aged/	14894
7	exp Nursing Homes/	45251
8	exp Assisted Living Facilities/	1627
9	exp Housing for the Elderly/	1652
10	((retirement or senior* resident* or custodial or elder* or nursing or assisted or convalescent or custodial) adj2 (home or hous* or facilit* or living or centre or centre or care)).tw,kf.	88561
11	exp Senior Centers/	258
12	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11	158081
13	senior*.tw,kf.	54641
14	elder*.tw,kf.	321948
15	elder*.tw,kf.exp Geriatrics/	31811
16	geriatric*.tw,kf.	81523
17	exp Grandparents/	787
18	grandparent*.tw,kf.	4078
19	Aged/	3448715
20	aged.tw,kf.	773088
21	pensioner*.tw,kf.	1121
22	gerontolog*.tw,kf.	9293
23	13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22	4127244
24	((feed* or meal* or diet* or food or nutritio*) adj3 (cultur* or ethnic* or faith* or religio* or tradition* or halal or kosher or relevan* or family-center* or family-centre* or patient-centre* or patient-center* or person-center* or person-centre* or identit* or heritage)).tw,kf.	15865
25	12 and 23 and 24	53

**Embase®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	exp Long-Term Care/	2435250
2	Long term care.tw,kf.	35214
3	Long-Term Care.tw,kf.	35214
4	LTC.tw,kf.	6253
5	exp residential home/	8055
6	exp assisted living facilities/	3363
7	exp home for the aged/	11664
8	((retirement or senior* resident* or custodial or elder* or nursing or assisted or convalescent or custodial) adj2 (home or hous* or facilit* or living or centre or centre or care)).tw,kf.	108141
9	exp senior centers/	479
10	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9	2557997
11	senior*.tw,kf.	77219
12	elder*.tw,kf.	459563
13	exp geriatrics/	42389
14	geriatric*.tw,kf.	106516
15	exp grandparents/	5271
16	grandparent*.tw,kf.	5093
17	exp pensioner/	2308
18	pensioner*.tw,kf.	1441
19	gerontolog*.tw,kf.	12823
20	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19	626711
21	((feed* or meal* or diet* or food or nutritio*) adj3 (cultur* or ethnic* or faith* or religio* or tradition* or halal or kosher or relevan* or family-center* or family-centre* or patient-centre* or patient-center* or person-center* or person-centre* or identit* or heritage)).tw,kf.	19635
22	10 and 20 and 21	57

**APPENDIX TABLE A (part 2 of 3). Final search strategy adapted for each database conducted May 7, 2024**

**APA PsycInfo®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	exp Long Term Care/	6836
2	Long-term care.tw,id.	9269
3	LTC.tw,di.	152
4	Long term care.tw,id.	9269
5	exp Residential Care Institutions/	51750
6	exp Nursing Homes/	10579
7	exp Assisted Living/	908
8	((retirement or senior* resident* or custodial or elder* or nursing or assisted or convalescent or custodial) adj2 (home or hous* or facilit* or living or centre or centre or care)).tw,id.	27581
9	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8	76689
10	senior*.tw,id.	33041
11	elder*.tw,id.	80606
12	exp Geriatrics/	15729
13	geriatric*.tw,id.	20843
14	exp Grandparents/	3142
15	grandparent*.tw,id.	5117
16	exp Older Adulthood.	19048
17	aged.tw,id.	303820
18	pensioner*.tw,id.	275
19	gerontolog*.tw,id.	7253
20	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19	425506
21	((feed* or meal* or diet* or food or nutritio*) adj3 (cultur* or ethnic* or faith* or religio* or tradition* or halal or kosher or releven* or family-center* or family-centre* or patient-centre* or patient-center* or person-center* or person-centre* or identit* or heritage)).tw,id.	2977
22	9 and 20 and 21	17

**Web of Science®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	https://www.webofscience.com/wos/woscc/summary/f6495963-fcf4-47a1-a708-d12aa0fd6c0c-e6854ce3/relevance/1 [All Fields] “nursing home” OR “assisted living” OR “longterm care” OR “long-term care” AND [All Fields] senior* OR elder* AND [All Fields] Mealtime AND [All Fields] cultur* OR ethnic* OR faith* OR religio* OR tradition* OR halal OR kosher OR family-center* OR family-centre* OR patient-centre* OR patient-center* OR person-center* OR person-centre* OR identit* OR heritage	18

**Academic Search Complete®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	[All Fields] “nursing home” OR “assisted living” OR “longterm care” OR “long-term care” AND [All Fields] senior* OR elder* AND [All Fields] Mealtime AND [All Fields] cultur* OR ethnic* OR faith* OR religio* OR tradition* OR halal OR kosher OR family-center* OR family-centre* OR patient-centre* OR patient-center* OR person-center* OR person-centre* OR identit* OR heritage	9

**APPENDIX TABLE A (part 3 of 3). Final search strategy adapted for each database conducted May 7, 2024**

**ProQuest Dissertations & Theses Global®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	abstract(feed* or meal* or diet* or food or nutritio*) AND abstract(cultur* or ethnic* or faith* or religion* or tradition* or halal or kosher or relevan* or family-center* or family-centre* or patient-centre* or patient-center* or person-center* or person-centre* or identit* or heritage) AND abstract(senior OR elder* OR geriatric OR gerontol* OR resident*) AND abstract(“long term care” OR “long-term care” OR “nursing home” OR “assisted living”)	57

**ProQuest Dissertations & Theses @ University of Calgary®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	abstract(cultur* OR ethnic* OR faith* OR religio* OR tradition* OR halal OR kosher OR relevan* OR family-center* OR family-centre* OR patient-centre* OR patient-center* OR person-center* OR person-centre* OR identit* OR heritage) AND abstract(“long term care” OR “long-term care” OR “nursing home” OR “assisted living”)	2

**Scopus®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	[article title, abstract, keywords] “nursing home” OR “assisted living” OR “longterm care” OR “long-term care” AND [article title, abstract, keywords] senior* OR elder* AND [article title, abstract, keywords] mealtime AND [article title, abstract, keywords] cultur* or ethnic* or faith* or religio* or tradition* or halal or kosher or relevan* or family-center* or family-centre* or patient-centre* or patient-center* or person-center* or person-centre* or identit* or heritage	30

**CINAHL®**

<i>Search #</i>	<i>Search Words and Phrases</i>	<i>Results Retrieved</i>
1	[All Fields] “nursing home” OR “assisted living” OR “longterm care” OR “long-term care” AND [All Fields] senior* OR elder* AND [All Fields] Mealtime AND [All Fields] cultur* OR ethnic* OR faith* OR religio* OR tradition* OR halal OR kosher OR family-center* OR family-centre* OR patient-centre* OR patient-center* OR person-center* OR person-centre* OR identit* OR heritage	4

**APPENDIX TABLE B (part 1 of 2). Study characteristics**

<i>Author(s)</i>	<i>Year</i>	<i>Country</i>	<i>Source Type</i>	<i>Population Characteristics</i>	<i>Setting</i>
Aged Care Quality & Safety Commission	2022	Australia	Fact sheet	Aged care staff	Aged care
Anderson L.	2017	Canada	Report	Residents, patients	Hospitals, long-term care, prisons
Andrews R.	2012	Australia & India	Qualitative: Observations, interviews, archival material	Residents, staff, family	Residential care facilities
Bartl & Bunney	2015	Australia	Report	Content experts	Aged care
Brauer <i>et al.</i>	2022	Canada	Report	Dietitians	Long-term care
Brooks <i>et al.</i>	2024	Multiple	Systematic review	Indigenous & First Nations residents	Long-term care
Care Quality Commission	2024	United Kingdom	Fact sheet	Regulators of health & social care	Care homes
Chamberlain <i>et al.</i>	2024	Canada	Qualitative: Rapid inquiry	Residents, staff, family	Supportive living homes
Chan <i>et al.</i>	2005	United States	Qualitative: Observations, in-depth interviews	Residents of Chinese descent	Nursing homes
Chee S.	2024	Malaysia	Qualitative: In-depth semi-structured interviews	Residents of at least 6 months aged 60+	Seniors living facilities
Cragg S.	2017	Canada	Report/literature review	Residents, family, staff, key informants	Long-term care
Cragg,S.	2018	Canada	Report: Literature review, consultations, focus groups, brainstorming sessions	Key informants	Long-term care
Dietitians of Canada	2019	Canada	Report	Content experts	Long-term care
Ducak <i>et al.</i>	2011	Canada	Qualitative: Interviews	Nutrition managers & registered dietitians	Long-term care
Ferdous <i>et al.</i>	2023	Canada	Qualitative: Observations	Residents, almost all ethnically Chinese (99%)	Long-term care
Gaviola <i>et al.</i>	2023	Multiple Countries	Scoping review	Culturally diverse residents living with dementia	Nursing homes, residential care facilities
Girard <i>et al.</i>	2019	Canada	Qualitative: Semi-structured questionnaire, observations	Residents born outside of Canada	Nursing homes
Hanssen I.	2013	Norway	Qualitative: Narrative interviews	Family members & nursing staff of Sami residents living with dementia	Nursing homes
Hanssen <i>et al.</i>	2016	South Africa & Norway	Qualitative: In-depth interviews	Proxy informants of residents living with advanced dementia of Sami, Bergen, and European decent	Nursing homes
Hikoyeda N.	2000	United States	Qualitative: Interviews, observations	Female Japanese American residents & their family members	Residential care
Jamal S.	2021	Canada	Qualitative: In-depth interviews, observations, document review	South Asian residents, family, key informants, those contemplating placement	Long-term care, assisted living, community
Koehn <i>et al.</i>	2018	Canada	Qualitative: Interviews, observations	Cantonese speaking residents 65+ and their family	Long-term care
Koehn <i>et al.</i>	2016	Canada	Qualitative: Interviews, observations	Resident families	Long-term care

**APPENDIX TABLE B (part2 of 2). Study characteristics**

<i>Author(s)</i>	<i>Year</i>	<i>Country</i>	<i>Source Type</i>	<i>Population Characteristics</i>	<i>Setting</i>
Lee E.	2010	United States	Qualitative: In-depth interviews, observations, document review	Korean American residents aged 55+	Nursing homes
Maggie Beer Foundation, Palliative Care Victoria	2021	Australia	Qualitative report	Residents of Indian origin	Aged care facilities
Maggie Beer Foundation	2021	Australia	Report	Aged care content experts	Aged care
Martindale K.	2024	Australia	Web article	N/A	Aged care
Raj <i>et al.</i>	2023	United States	Qualitative: Online survey	Registered dietitians, food service directors	Long-term care, hospitals
Raj <i>et al.</i>	2024	United States	Commentary	N/A	Long-term care, hospital
Reimer <i>et al.</i>	2009	Canada	Literature review	N/A	Nursing homes
Rosendahl <i>et al.</i>	2016	Sweden	Qualitative: Semi-structured interviews	Family members & professional caregivers of people with dementia	Group homes for individuals living with dementia
Selle M.	2006	United States	Qualitative: Telephone survey	Residents, administrators, owners, caregivers, cooks, dietician, certified dietary managers	Long-term care
Shippee <i>et al.</i>	2022	United States	Mixed Methods: Interviews, observations, survey	Residents reflecting the racial/ethnic diversity of facilities, staff	Nursing homes
Soderman <i>et al.</i>	2016	Sweden	Qualitative: Semi-structured interviews	Non-Swedish speaking persons with dementia in Finish & Swedish speaking facilities	Swedish & Finish speaking group homes
Suh <i>et al.</i>	2007	United States	Qualitative: Observations, interviews	Korean residents, nurses	Nursing homes
Syed & Mann	2020	Canada	Qualitative: Semi-structured interviews	First-generation immigrant residents	Long-term care, assisted living, retirement living
Thaitrong P.	2023	United States	Qualitative: Focus groups, field notes	Registered dietitian	Long-term care
The Staff of Long Island Care Centre	2002	United States	Intervention: Questionnaire, focus groups, descriptive statistics	Asian residents	Nursing homes
Wang <i>et al.</i>	2020	Australia	Qualitative: In-depth semi-structured interviews	Residents, staff	Residential aged care
Westbrook <i>et al.</i>	1992	Australia	Qualitative: Interviews, surveys	Caregivers of frail Greek & Chinese residents	Ethnic-specific & mainstream nursing homes
Wu <i>et al.</i>	2008	United States	Qualitative: Observations, interviews	Chinese residents & their family, staff	Nursing homes with large Asian populations
Xiao <i>et al.</i>	2003	Australia	Qualitative: Interviews, focus groups	Greek & Italian residents	Not-for-profit mainstream & ethnic-specific nursing homes