Research Contribution

Journal of Foodservice Management & Education, Volume 18, Number 1, Pages 1– 7 . ©2024
Published jointly by the Foodservice Systems Management Educational Council and the National Association of College & University Food Services

EXPERIENCES OF HEALTHCARE FOODSERVICE WORKERS DURING THE COVID-19 PANDEMIC: A QUALITATIVE EXPLORATION

Oscar C. C. Lam[1]; Linda Mann, MBA, RD[1]; Phillip Joy, PhD, RD[1*]
[1]Applied Human Nutrition, Mount Saint Vincent University, Halifax, Nova Scotia

ABSTRACT
Healthcare foodservice workers provide important contributions to the care of patients despite low wages and physically demanding work. The objective of this study was to explore the experiences of healthcare foodservice workers during the COVID-19 pandemic. Semi-structured interviews were conducted with six healthcare foodservice workers who worked at a hospital or continuing care facility during the COVID-19 pandemic. Thematic analysis was conducted and four themes resulted: 1) navigating the changing workplace; 2) feelings of fear and disconnectedness; 3) feeling unsupported and unseen; and 4) feeling the rewards in their work. The participants experienced negative impacts to their wellbeing but recognized the importance of their work and a sense of reward from providing nutritional care to patients in their workplaces.

Keywords: foodservice, COVID-19, wellbeing, qualitative research

INTRODUCTION

When the World Health Organization (2020) declared COVID-19 as a global pandemic, countries around the world went into lockdown. While many people experienced job changes that impacted their mental health (Best et al., 2021; de Miquel et al., 2022; Liu et al., 2020), healthcare workers, including those in foodservice, did not have the opportunity to work from home to avoid infection. These workers reported increased workloads and decreased work-life balance that led to an increase in negative mental health symptoms, including fear, stress, anxiety, depression, and burnout since the start of the COVID-19 pandemic (Government of Canada, 2021; Shreffler et al., 2020).

Prior to the COVID-19 pandemic, the foodservice industry was characterized by low wages, low job autonomy, physically demanding work and a high rate of injury and illness among workers (Peters et al., 2020; Sorensen, Peters, et al., 2021). These job characteristics have been associated with reduced workers' motivation, work engagement, and job satisfaction that contributed to high absenteeism and turnover (Oldham & Hackman, 2010). Staff shortages and lack of equipment and food ingredients can also affect performance of foodservice workers (FSW), contributing to poor meal quality and service delays (Bertin et al., 2009).

Healthcare FSW significantly contribute to the care of patients (Collins et al., 2017; Laur et al., 2015; Murphy, 2017; Osman et al., 2021; Sorensen, Fletcher, et al., 2021) and food safety (Clayton et al., 2002; Isara et al., 2013; Lestantyo et al., 2017). They may be involved in providing meal choices (Barrington et al., 2018; Nor, 2010), offering meal assistance such as opening pre-packaged food and drink items, positioning trays (Sorensen, Fletcher, et al., 2021), and monitoring and reporting patient intakes, in addition to all other duties helpful to evaluating patient recovery progress (Budiningsari et al., 2016; Tulloch et al., 2018). Healthcare FSW have acknowledged their role in patient care and believe it is meaningful (Bertin et al., 2009), but they often felt undervalued among other healthcare workers (Bertin et al., 2009; Collins et al., 2017).

The aim of this qualitative study was to explore the experiences of healthcare FSW during the COVID-19 pandemic, a topic currently lacking in the literature (Adler & Bhattacharyya, 2021; Janson et al., 2021; Rosemberg et al., 2021).

METHODS

A qualitative design with a poststructuralism lens was used to explore how experiences are socially constructed through the interrelationships of knowledge, discourses, and relations of power (Foucault, 1980). Within qualitative research, it is recognized that the knowledge produced is shaped by the positionality of the researchers (Holmes, 2020). The authors brought a range of experience in dietetic and nutrition education, poststructuralism, and foodservice management to this study. The first author is a dietetic intern who completed this project as part of a honours course. The intern also worked within hospital foodservice during COVID-19. Two authors are faculty members in accredited dietetic programs (one with expertise in foodservice).

Ethical clearance was obtained from Mount Saint Vincent University. Recruitment for this study was conducted across Canada through email lists of the first author, and various social media apps, including Facebook and Twitter. Potential participants had to self-identify as 18 years or older, be able to speak English, and be a healthcare FSW in any capacity (i.e.: dishwasher, head cook, server) at a hospital or continuing care facility during the COVID-19 pandemic. Potential participants were asked to return by email the signed informed consent if they agreed to participate.

Semi-structured interviews were conducted on Teams (MS Office 365) by the first author during the winter of 2022. The open-ended questions focused on participants' experiences in their work before and during the COVID-19 pandemic (Table 1). Each interview was approximately an hour in length, recorded and transcribed with Teams (MS Office 365). Participants were given an honorarium ($25 CAN). They also reviewed and approved their transcripts; no changes were noted.

The thematic analysis process consisted of six phases: familiarization with the data by repeated reading the data; initial coding of the data by organizing data into each meaningful group; extraction and categorizing of different codes into themes and/or candidate themes; review of themes by reflecting on each individual theme and its relation to the data; defining and naming themes; and summarizing data (Braun & Clarke, 2014). Initial data coding was done in Word (MS Office 365) by the first author after repeated readings of the interview transcripts. After this initial coding, the research team met to discuss the coding. During these discussions, the team members merged and

*Corresponding Author: Phone: 1(902) 457-6722; E-mail: Phillip.joy@msvu.ca

Table 1. Semi-Structured Interview Guide.	
About the Participant	**Demographic type of work questions**
Relating to Work Before and During COVID-19	Can you tell me a bit about your usual role as a foodservice worker?
	What does your day to day work typically look like?
	Describe any differences in your job experience during COVID-19.
	What work have you been doing in the response to COVID-19?
	What has your facility done to support you and your foodservice worker team?
Relating to Wellbeing	How, if at all to you think your job has impacted your own overall wellbeing?
	How, if at all, did COVID-19 affect these impacts?
	How did you feel as a foodservice worker at your facility during COVID-19?
	Did COVID-19 affect any challenges you faced in your work? If so, how?
	How do you cope with these challenges?
	What types of supports have been available to you before and during COVID-19?
	How did you know about these supports?

grouped similar codes into candidate themes. These discussions also included resolving any conflicts about codes and grouping between the research team members. This was done by another review of the data and thorough discussion on the meanings of the data until a consensus was reached. After these discussions, each team member individually reviewed the candidate themes and reflected upon them. A final meeting took place in which the themes were finalized and named.

RESULTS

Table 2 summarizes the characteristics of the six healthcare FSW, all self-identifying as women, who participated in this study. Four main themes were created and quotes supporting these themes are provided.

Theme 1: Navigating the Changing Workplace

The COVID-19 pandemic created a sense of the unknown for participants in this study. This sense of the unknown created stress in their jobs. As one participant noted they felt many people did not think FSW had any concerns.

> *But I think it was just nobody thought it was as stressful for FSW, as they thought it was for nursing staff or doctors per se. I mean, we're all going through the same pandemic, you know, we all have the same concerns about it and yea you're going into healthcare facility. And I think as a FSW, some days it was even… like…. you're facing more unknown, because they are the care team upstairs. They might know if somebody was on the ward with COVID-19, whereas we wouldn't. You know, like we would not have that knowledge. So it's like we're actually dealing with more of that unknown stress. Whereas, it's like… you just don't know. They're (FSW) like, "oh great, we're not delivering trays again? like well…I don't know why…?" (P4).*

For this participant, the unknown, more specifically the lack of knowledge and communication from other healthcare providers was a source of stress.

Prior to the COVID-19 pandemic, most participants felt their role as a FSW was physically demanding and daily work routines often included working in the trayline, dishroom, cleaning, food preparation, and patient food delivery and pick-up. All participants reported that the COVID-19 pandemic required new procedures including almost constant sanitizing and new safety and personal protective equipment (PPE) protocols. One participant explained their situation.

> *As a FSW, work required to of course put on masks and PPE. When there was an outbreak we were required to put on gowns, while we were washing the dishes and goggles. And when we enter the facility we're required to have our temperatures checked, then we're required to fill a sheet with all of our like personal information as well as confirmation that we don't come into work with symptoms (P3).*

Another participant spoke about how these new changes negatively impacted them.

> *I think [my job experience during COVID-19 had impacted me] in a negative way. It's like I'm suffocating 'cause it's already so hot in the kitchen, in the dining room, especially in the summertime with the mask on, and I'm sweating... the hot plate is on, and I'm running around trying to do a million things. I just know if I didn't have that mask on, I would be so much cooler (P6).*

For this participant, new PPE procedures added to her physical discomfort. Overall, participants believed these new working conditions, routines, and PPE protocols made their work more difficult and negatively shaped their wellbeing experiences.

Staff shortages seemed to be the most common source of stress, negative mental health, and negative physical health reported by participants.

> *For the first time ever I was being called, to come in early or to stay late because we were short people. I would come in and I would find out that I was doing two jobs instead of one. Physically, I was starting to suffer. My doctor gave me prescription pain medication for the first time, where I was controlling it without that before […] Usually by the end of the work week I would get out of my car and I couldn't quite walk up to the house. My husband would come out to the car to grab anything that needed carrying because I would be hobbling up to the house. My lower back would hurt that bad… Yeah, so that's how my pre-existing condition worsened during COVID (P1).*

For this participant COVID-19 resulted in extra work that was physically demanding and worsened her pre-existing conditions and limiting her ability to work. Another participant described how they felt an obligation to cover other people's shifts and the result to their mental wellbeing.

> *Staff shortages were huge on mental health because you're required to pick up and also do additional work to catch up for the employees that aren't there…our main full-time staff weren't able to work, so foodservice is really relied on casual staffs. So having to kind of hold foodservice together*

Table 2. Characteristics of Participants.	
P1	Dietary aide, full time (long term relief assignment), hospital, approximately 2 years, south Asian, 25 years of age, undergraduate and dietitian in home country.
P2	Dietary aide, causal, hospital and long-term care facility, approximately 3years, east Asian, 24 years of age, current undergraduate student
P3	Head Cook, previous fulltime (current resigned), rural hospital, more than 14 years, Canadian, 51 years of age, college diploma
P4	Foodservice worker, full time, hospital, approximately 10 years, Canadian, 42 years of age, college/undergraduate
P5	Dietary aid, causal, hospital and long-term care facility, more than 2 years, southeast Asian, 25 years of age, undergraduate in home country
P6	Dietary aid, part time, long-term care facility, approximately 2 years, Canadian, 24 years of age, undergraduate

(gesture holding up), it was definitely a huge stressor. Like, I feel like if I wasn't there, it would be in shambles, but yeah I think just definitely huge for myself and my fellow co-workers (P2).

For this participant, she felt the weight of holding together foodservices was a major stress to her wellbeing. Another participant shared similar experience but felt that the extra work was needed in order to serve patients food and ensure patient care.

If I know we're short on my days off, I'm gonna be going into work. Because we need people to be there to do this (provide service), people (patients) need to get fed. So for me it was like you're overworking yourself during COVID-19 [….] That feeling of 'well I can't really stay home if I know that there's like not going to be anybody there to do it, and somebody else is going to have to work at 12 hour today' (P4).

Another area of work participants had to navigate was the information about COVID-19 and work protocols they received. Participants noted that during the initial period of the COVID-19 pandemic there was a lack of reliable information and a lot of false understandings of the virus. This contributed to many mixed messages in their work that threatened their safety and the safety of the patients. As one participant described,

We are trained that if there's the contact precaution card in front of the room, we do not deliver the tray. Because that card means you should be fully PPE-ed up, you have [to have] your gown on, mask and you're following certain procedures. So, it was kind of always interesting... because the direct care team would be like "Oh no, it's like there bed-B. So, you can drop the tray off to bed A." and it is like… no, we can't… like we, we cannot do this. So, it was a bit of a frustrating experience (P4).

For this patient, mixed messages caused frustration in their work. Another participant related an incident in which they were viewed as not working because they were following their precaution orders.

There's a sign (precaution sign) that's why we don't serve in the room. But they (nursing) want us to serve inside the room. So, we're confused, why would we serve here? Because there's a sign that our supervisor instructed us, 'don't go inside the room if there's a droplets sign.' But they (nurses) are like (to our supervisor;), 'Oh your FSWs are not working. Because they're not serving their room' (P5).

Participants felt that the instructions and practices about meal delivery were inconsistent or lacking, noting circumstances where FSW entered a patient's room with no precaution signage to deliver meals and found out later that the patient that they served was potentially COVID-19 positive.

The pink zone (signage) means that this person is COVID positive or 'do not go near that bed.' It (the room) didn't had anything (zone or signage) so I just went and delivered. When I came out of the room, a housekeeping lady was like, 'Oh, did you go into the room?' I said 'Yes.' 'but you should have not (said the housekeeping lady), because that patient is COVID positive' (*P1).*

The participant continued to explain how this incident triggered their anxiety and negatively impacted their wellbeing.

Theme 2: Feelings of Fear and Disconnectedness

Most participants expressed their fear of contracting a COVID-19 infection. As one participant said, this fear was an emotional drain.

It became an emotional drain, to have to worry about not only trying to keep yourself personally safe outside of work, but also now [at] work you're trying to (be safe) You're wondering, like, 'oh gosh, was my exposure to COVID-19 increased?' So you're stressing about that, I think it's just that mental toll. It became tiring for sure (P4).

Participants also expressed the fear of passing on a COVID-19 infection to their families and friends. At the start of the pandemic was particularly stressful, as described by a participant.

We didn't even have the kits in the initial days, right? So, we actually didn't know who is positive and who is not. And for me, it was my first year in Canada, first winters in Canada. And even if I caught like you know, a day off cold or common flu I was like maybe I have covid, you know. I was afraid for myself. I was afraid for my family, my siblings (P1).

For this participant, the fear felt at the start of the pandemic only intensified as it went on longer. She shared more of her story, noting her fear of passing COVID-19 onto the patients as well.

I was afraid of going to work, not because I don't want to work. [Yet,] because I was afraid that maybe I'm not having the symptoms, I am asymptomatic. But what if I had COVID? I'm delivering (meals) to the patient, and maybe God forbidden if I delivered the virus to them or what. You know that kind of dilemma was there every day (P1).

The fear also had direct consequences for the connections this participant had with others. She described first the implications to her family life.

And even though I got that love from them (sibling) like, uh, they call me Dida - that's what we use in India to respect their elders, and they were like "it's OK, you can hug us, right? That's OK. We will not catch anything, and you don't have any symptoms at all." But I used to push them aside like "no." I know I can have it. So yeah, you know that so was hard not just on the emotional kind of way, but physically (P1).

She then talked about the implications to her social connections at work.

> *We used to have potlucks in the kitchen, parties and get-togethers with supervisors. There's no difference, everybody drinks, everybody eats and that was all very nice. But now during COVID, we don't have any such thing. We are not doing any potlucks because we don't know where the food is coming from, who has cooked it and it can spread to everybody in the kitchen (P1).*

COVID-19 restrictions prevented an essential way to connect with others, thus contributing to a loss of social connections and feelings of isolation. Another participant shared a similar experience.

> *No one wants to use the staff room because there's all these rules in the staff room, you have to sign in with the date and time you're in the staff room, you have to wear a mask, unless you're eating, you're not allowed to sit next to your co -worker. So almost everybody, even during the winter, we would go out to our cars and just sit in our cars and eat in our car, and be alone so that you don't have to wear a mask… I found myself this time last year for a couple months, almost every break sitting in my car if not crying… silent screaming. As I was doing it, I was like…. "This is not normal." "I don't like this, I don't wanna do this anymore ... I don't want to do this anymore…" So… definitely… [impacted my mental health] I would sit there and I would realize my mental health is suffering (P3).*

For this participant, COVID-19 restrictions prevented her from interacting with co-workers and resulted in her expressing her suffering by crying in her car during her break. Participants also noted a sense of shared isolation with patients who were not allowed visitors and, for those in long term care facilities, not allowed to leave their rooms even for mealtimes.

> *As soon as there was COVID in the building, every single resident was [in isolation] and they weren't allowed to come out of their room. It was like that for few months when there was COVID in the building. […] the residents were just like sitting in their rooms all day long, not able to come out. It was really sad (P6).*

This participant shared the felt empathy for the patients who were in isolation. This furthered her own sense of isolation and disconnection.

Theme 3: Feeling Unsupported and Unseen

A lack of support and leadership from facilities was noted by participants.

> *It felt like it lacked little bit of leadership. Like the leadership was missing. So we kind of were left to struggle… almost? And navigate these changes (by themselves) it felt like really on our own as an employee level team. It is like "okay sure, oh great here is another memo." But like what does that (the memo) really mean for us, and how do we really do this? So, I would just say the biggest difference (of working during COVID-19) was just the added level of stress (P4).*

While these facilities provided information about resources and supports, participants felt that the delivery of this information in the form of memos or posters with lists of web sites lacked personalization and may not have been useful to employees who may not have been able to read English, as described by another participant.

> *They would post a poster on resources for mental health but I found that to be very unhelpful because it is just a sheet of paper with different URLs. Some of the FSW I work with, they don't even read English, so how is that going to help? (P2).*

These participants felt they needed to be responsible for their own mental and physical wellbeing while working during COVID-19 and believed that their organizations lacked an understanding of their workers' needs. However, training on safety, handwashing and use of PPE, when provided by a healthcare professional, was seen as supportive.

> *I mean they've definitely provided like masks and sanitizers, and appropriate cleaning and PPE for us during work. I guess there's that. And I think they've been forced like…. monthly audits related to COVID-19 that were required to fill out to ensure that the protocols are being put in place. Other than that, I don't. I don't know if I see anything else (P2).*

In addition to a perceived lack of support from their institution as a whole, participants also perceived a lack of support from other members of the healthcare team.

> *Sometimes when they [clinical staff] interact with us, FSW, you can feel the disrespect […], they'll come across as rude and very snappy, which I totally understand, because of the circumstances we're in, but it can feel very like dehumanizing when you're a FSW and you're kind of treated like dirt (P2).*

This participant described feeling disrespected by clinical staff under pressure from COVID-19. She recognized that the clinical team was also "extremely short on staff" but it still made her feel "a sense of inequity" and had a "dehumanizing" impact on her. Another participant discussed a similar incident.

> *Sometimes nurses are very… They always call our supervisor to complain like, "one of the foodservice workers didn't serve in the room." … Because there is a sign (precaution sign on the door) that is why we didn't serve in the room (to bedside) … it is like a balance (battle) between the other healthcare team members (P5).*

Again, this participant felt conflict in her work from clinical staff. Other participants, however, noted that COVID-19 has made their experiences with other members of the healthcare team better noting they have a "greater appreciation of what foodservice does" (P4).

> *I think maybe the healthcare members have a greater appreciation of what foodservice does. You know 'cause when protocols have to change. they have to come and deliver the trays now. Like every tray they have to do that. And so I think they kind of have a better understanding of what we do...? So there is that better relationship I guess I think it's become less demanding, I think before COVID-19 it was like "hey, we need this and we need it now. So let's call down to the kitchen." It doesn't matter if we know that they're in the middle of serving dinner, but we need our cream right now (P4).*

For this participant, the COVID-19 pandemic helped to give others a greater appreciation and understanding of the work of FSW.

Additionally, some participants noted that many of the social media postings and public acknowledgment recognized the hard work of healthcare workers but "there was no social media enhancement or encouragement for the dietary aides or FSW" (P1). This participant provided further discussion of this feeling of unappreciation.

I think initially, FSW were not a respectful job. You know the nurses and doctors were getting the respect when they are going into the field (continue working during COVID-19), but the initial three months (of COVID) we were just food delivery guys and we were not considered like (patient care, health care)… I feel that what I'm doing is good and I'm doing it for the community… I describe myself as a healthcare worker, but according to the media and according to the people… I'm not…. I know that I'm doing a job that is necessary, but they (the public) don't know that there is something known as FSW, or we are also the frontline... So, people don't know that there is occupation like this, or we are also working hard… but then it's like… they don't know, [so] it's [not] their fault. I know that I'm doing something good for the society so that's okay (P1).

This participant recognized the important work they do for patients in providing food to help patients recover. Another participant noted that many people do not realize the value of FSW, noting that "people seem to just forget that people (residents/patients) need to eat three times a day… and it is not the nurses who are doing it. For the most part, it is dietary workers" (P6).

Another participant also felt disappointed with public perception of FSW.

In the public eye, I think there'd be very few people that would be like, 'Okay, tell me about who works at a hospital?' 'Nurses and doctors.' It's just a complete, you're just… It's unseen… you're really unseen, and it (FSW) doesn't come to anybody's mind at the forefront when you think about 'hey, who works in healthcare?... If anything it's (foodservice) just feel more devalued, because there's so much focus on everything else. It's just a completely…. at least in this district, it's a completely overlooked part. So if anything… foodservice is just even more overlooked and there's no understanding… (of our role and challenges,) it's just …frustrating"(P4).

This participant believed that the public messages surrounding healthcare during COVID-19 were focused on nurses and doctors and felt discouraged that the rest of the support service workers were always overlooked.

Theme 4: Feeling the Rewards in their Work

Despite the many challenges faced by the participants, they all took pride in their work and attempted to make a positive contribution to the patients. P5 firmly believed that without foodservice, patients were "not going to get the nutrition that they needed to get better". Another participant took pride in providing food to patients.

It is just something for me (that) being able to provide food and meal that might be the highlight of somebody's day… I wanted it (the tray) to look nice and just take that extra level of caring…somebody would feel like "oh there was some thoughts put in this (tray; P3).

For this participant, providing an extra level of care by making food look nice was critical to making someone have a better day. This belief was share by another participant, saying

Being able to provide food and meals that might be the highlight of somebody's day […] I just found that to be such a privileged and a rewarding feeling […] I wanted it (the meal) to look nice and just take that extra level of caring. I guess… (hopefully) somebody would feel like, "Oh there was some thought put in this (meal)." Not somebody just 'so here's a scoop of ice cream…' or 'Here's like scoop pudding' and it's all kind of messy (P4).

These participants found positive feelings in providing an attractive meal to patients. Although many participants noted their feelings of isolation and witnessing patient isolation, as in Theme 2, they also recognized the personal rewards from their work during COVD-19. For example, P6 experienced improvements in her mood as she connected in the ways she could with the patients. She further emphasized how "at the end of the day, [patients] just want to be heard" and felt that "when [clients] are happy [she is] happy. It makes [her] day a lot easier and a lot better."

DISCUSSION

To our knowledge, this is the first qualitative study exploring the experiences of healthcare FSW during the COVID-19 pandemic. Although FSW often experience physically demanding workloads (Peters et al., 2020; Sorensen, Peters, et al., 2021), our findings indicate that healthcare FSW navigating the changing COVID-19 workplace faced many challenges that negatively impacted their wellbeing.

While it can be appreciated that there were evolving safety protocols during the early stages of the COVID-19 pandemic, it is the duty of healthcare facilities to ensure that those protocols are enforced consistently and to ensure effective communication when safety protocols are changed. Direct care providers were the most vulnerable and had the highest prevalence to COVID-19 virus exposure (Gómez-Ochoa et al., 2021; Nguyen et al., 2020). They also were the most likely to experience depression, anxiety, insomnia, and psychological distress (De Kock et al., 2021; Mohsin et al., 2021; Muller et al., 2020; van der Goot et al., 2021). Participants in this study also reported many fears, anxieties, and feelings of isolation in their work during COVID-19.

Staff shortages have become a major challenge since early 2021 and the foodservice sector is one that has been especially affected (Government of Canada, 2022). Staff shortages, turnover, and absenteeism have been found to be contributing factors to excessive workloads and stress for FSW and healthcare workers (Appelbaum et al., 2003; Nyashanu et al., 2022; Peters et al., 2020; Sorensen, Peters, et al., 2021). Again, COVID-19 has intensified these challenges (Government of Canada, 2022) and, as experienced by the healthcare FSW in this study, negatively affected their wellbeing.

Existing literature suggests that social disconnection and social isolation are key components that impacted healthcare workers' wellbeing (Huerta-González et al., 2021). The FSW in this study experienced a loss of social connections with their co-workers and a lack of support from their organizations, other health care workers and the general public. This, in turn, led to feelings of disconnection and frustration and could be expected to contribute to absenteeism, turnover and staff shortages. In earlier studies, organizational supports (Babin & Boles, 1996; Chatzittofis et al., 2021) and close connections between co-workers (Babin & Boles, 1996; LoGiudice & Bartos, 2021) were found to be associated with positive work outcomes and improved physical and mental health for healthcare workers. Organizational support has also been found to reduce the impact of the workplace stressors and contribute to employee self-efficacy resilience and growth (Niu, 2010).

Participants in this study recognized the importance of their work in providing nutritional care to patients in their workplaces. They had a sense of pride and accomplishment in knowing they were contributing positively to the healthcare team and such feelings

allowed them to move through the many challenges presented in their changing COVID-19 workplace.

While the sample size was small, in part reflective of challenges in recruitment from FSW who work long hours during a health crisis, we believe that meaning is found in the interpretation of data not in the repetitive nature of data (Braun & Clarke, 2021). Malterud et al. (2016) also suggested that sample size for qualitative studies be guided by 'information power' that is dependent on five considerations, including 1) the aim of the study, 2) sample specificity, 3) use of established theory, 4) quality of dialogue, and 5) analysis strategy. Studies that require a lower sample size are studies with narrow aims, high specificity of participants' experiences and knowledge, are grounded in a well-developed theoretical lens, contain strong dialogue from participants, and use an in-depth analysis process on the narratives or discourses within the data (Malterud et al. 2016). We suggest our study fulfils the criteria for a lower sample size. Our aim is narrow, the participants have specialized knowledge and experiences about working in food service during the COVID-19 pandemic, and our poststructural lens informs all aspects of the study. Additionally, concepts like data saturation are philosophically neo-positivist and not aligned with our poststructural theoretical lens. We presented strong dialogue from participants and analysed their narratives through thematic analysis, considering the discourses within the data.

The diversity within our sample is, however, limited in both geography, representation, and gender (all participants identified as women). Future studies could explore differences between rural and urban healthcare facilities, differences between hospital and continuing care facilities, and the influence of provincial and institutional regulations on FSWs' wellbeing. In relation to representation, future studies could explore the influence of gender, sexuality, and ethnicity. Finally, further studies are needed to more deeply investigate how to support FSWs, especially during healthcare crises.

CONCLUSION AND APPLICATIONS

While the COVID-19 pandemic has highlighted and exacerbated some pre-existing challenges in healthcare systems, such as shortages of staff, beds, medical supplies and PPE (Mehta et al., 2021; Ogoina et al., 2021), this study highlighted unique challenges faced by healthcare FSW.

Healthcare organisations should be reminded or the importance of clear and consistent leadership and messaging for all workers particularly during healthcare crises such as the COVID-19 pandemic. The importance of the work done by healthcare FSW should be acknowledged and the social connections among co-workers supported as this will contribute to job satisfaction, and reduced absenteeism, turnover (Oldham & Hackman, 2010). Ultimately this will support FSW in effective provision of nutritional care to patients (Tulloch et al., 2018).

The findings of this study also have important implications for foodservice and dietetic educators. We suggest educators make their teaching more critical. By using a more critical lens in teaching, educators can move their curriculum beyond merely acknowledging the mechanics of foodservice work to learnings about how the profession and those working it in, such as FSW, are socially constructed. Educators incorporating pedagogical strategies that critically explore relations of power that create working conditions and shape the health and wellbeing of workers (such as staffing) offer opportunities to their students to learn how to challenge such relations of power. Educators are also encouraged to emphasize practical applications of leadership and motivation theoretical frameworks through case study analyses and, whenever possible, though learning directly from the experiences of FSW. It has been reported that the use of experiential learning activities, including concrete experience, reflection, and practical applications, within foodservice management courses can help students make better connections between theoretical and applied learning, as well as help develop managerial skills such as critical thinking, teamwork, and independence (Holik et al., 2021).

Joy and Numer (2018) also provide several pedagogical strategies that may help dietetic and foodservice educators be more critical within their teaching, including the use of stimulations and case studies, the use of films for discussion and student engagement, and inviting guest presenters with "embodied experience" to challenge students' biases. As DePalma (2020, p. 9) suggested, "embodied experience" is a way to bring different ways of knowing in the classroom. For example, the findings of this research could be discussed as a case study in classes with students asked to think of ways to address issues that negatively influence the health and wellbeing of FSW. Alternatively, FSW could be invited into classrooms to discuss their work, especially during healthcare crises such as pandemics. Teaching such skills to students who will be the next leaders of foodservice in hospitals would potentially enable them to address issues noted in our research, such as conflicting communication, easing fears and anxieties, addressing feelings of disconnection and being unseen at work, and creating workplace environments that would positively support the health and wellbeing of FSWs.

REFERENCES

Adler, S., & Bhattacharyya, S. (2021). Beyond the nurses and doctors: Structural racism and the unseen frontline service workers during the COVID -19 pandemic. *Psychiatric Services*, *72*(5), 594–596.

Appelbaum, E., Bernhardt, A., & Murnane, R. J. (2003). *Low-wage America: How employers are reshaping opportunity in the workplace*. Russell Sage Foundation.

Babin, B. J., & Boles, J. S. (1996). The effects of perceived co-worker involvement and supervisor support on service provider role stress, performance and job satisfaction. *Journal of Retailing*, *72*(1), 57–75.

Barrington, V., Maunder, K., & Kelaart, A. (2018). Engaging the patient: Improving dietary intake and meal experience through bedside terminal meal ordering for oncology patients. *Journal of Human Nutrition and Dietetics*, *31*(6), 803–809.

Bertin, C. H. F. P., Rezende, M. A., Sigulem, D. M., & Morais, T. B. (2009). Hurdles at work: Perceptions of hospital food handlers. *Human Resources for Health*, *7*, 1–7.

Best, L. A., Law, M. A., Roach, S., & Wilbiks, J. M. (2021). The psychological impact of COVID-19 in Canada: Effects of social isolation during the initial response. *Canadian Psychology/Psychologie Canadienne*, *62*(1), 143.

Braun, V., & Clarke, V. (2014). What can "thematic analysis" offer health and wellbeing researchers? In *International journal of qualitative studies on health and well-being* (Vol. 9, Issue 1, p. 26152).

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201–216.

Budiningsari, D., Shahar, S., Manaf, Z. A., & Susetyowati, S. (2016). A simple dietary assessment tool to monitor food intake of hospitalized adult patients. *Journal of Multidisciplinary Healthcare*, *9,* 311–322.

Chatzittofis, A., Constantinidou, A., Artemiadis, A., Michailidou, K., & Karanikola, M. N. (2021). The role of perceived organizational support in mental health of healthcare workers during the COVID-19 pandemic: A cross -sectional study. *Frontiers in Psychiatry*, *12*, 707293.

Clayton, D. A., Griffith, C. J., Price, P., & Peters, A. C. (2002). Food handlers' beliefs and self-reported practices. *International Journal of Environmental Health Research*, *12*(1), 25–39.

Collins, J., Huggins, C. E., Porter, J., & Palermo, C. (2017). Factors influencing hospital foodservice staff's capacity to deliver a nutrition intervention. *Nutrition & Dietetics*, *74*(2), 129–137.

De Kock, J. H., Latham, H. A., Leslie, S. J., Grindle, M., Munoz, S.-A., Ellis, L., Polson, R., & O'Malley, C. M. (2021). A rapid review of the impact of COVID-19 on the mental health of healthcare workers: Implications for supporting psychological well-being. *BMC Public Health*, *21*(1), 1–18.

de Miquel, C., Domènech-Abella, J., Felez-Nobrega, M., Cristóbal-Narváez, P., Mortier, P., Vilagut, G., Alonso, J., Olaya, B., & Haro, J. M. (2022). The mental health of employees with job loss and income loss during the COVID-19 pandemic: The mediating role of perceived financial stress. *International Journal of Environmental Research and Public Health*, *19*(6), 3158.

DePalma, R. (2020). Queer Pedagogy as an impossible profession. In *Oxford Research Encyclopedia of Education*.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977*. Vintage.

Gómez-Ochoa, S. A., Franco, O. H., Rojas, L. Z., Raguindin, P. F., Roa-Díaz, Z. M., Wyssmann, B. M., Guevara, S. L. R., Echeverría, L. E., Glisic, M., & Muka, T. (2021). COVID-19 in health-care workers: A living systematic review and meta-analysis of prevalence, risk factors, clinical characteristics, and outcomes. *American Journal of Epidemiology*, *190*(1), 161–175.

Government of Canada, S. C. (2021, February 2). *The Daily—Mental health among health care workers in Canada during the COVID-19 pandemic*. https://www150.statcan.gc.ca/n1/daily-quotidien/210202/dq210202a-eng.htm

Government of Canada, S. C. (2022, June 23). *Analysis on labour challenges in Canada, second quarter of 2022*. https://www150.statcan.gc.ca/n1/pub/11-621-m/11-621-m2022011-eng.htm

Holik, M. T., Heinerichs, S., & Wood, J. (2021). Using Experiential Learning to Enhance Student Outcomes in a Didactic Program in Dietetics Foodservice Management Course. *Internet Journal of Allied Health Sciences and Practice*, *19*(1), 15.

Holmes, A. G. D. (2020). Researcher Positionality–A Consideration of Its Influence and Place in Qualitative Research–A New Researcher Guide. *Shanlax International Journal of Education*, *8*(4), 1–10.

Huerta-González, S., Selva-Medrano, D., López-Espuela, F., Caro-Alonso, P. Á., Novo, A., & Rodríguez-Martín, B. (2021). The psychological impact of Covid-19 on front line nurses: A synthesis of qualitative evidence. *International Journal of Environmental Research and Public Health*, *18*(24), 12975.

Isara, A. R., Aigbokhaode, A. Q., Onwusor, V. O., Onyeulo, E. C., & Orumwense, S. O. (2013). Food hygiene and safety practices of food service staff in University of Benin Teaching Hospital, Benin city, Nigeria. *Journal of Medicine and Biomedical Research*, *12*(2), 69–76.

Janson, M., Sharkey, J. D., & Del Cid, D. A. (2021). Predictors of mental health outcomes in grocery store workers amid the COVID-19 pandemic and implications for workplace safety and moral injury. *International Journal of Environmental Research and Public Health*, *18*(16), 8675.

Joy, P., & Numer, M. (2018). Queering educational practices in dietetics training: A critical review of LGBTQ inclusion strategies. *Canadian Journal of Dietetic Practice and Research*, *79*(2), 80-85.

Laur, C., McCullough, J., Davidson, B., & Keller, H. (2015). Becoming food aware in hospital: A narrative review to advance the culture of nutrition care in hospitals. *Healthcare*, *3*(2), 393–407.

Lestantyo, D., Husodo, A. H., Iravati, S., & Shaluhiyah, Z. (2017). Safe food handling knowledge, attitude and practice of food handlers in hospital kitchen. *International Journal of Public Health Science*, *6*(4), 324–330.

Liu, C. H., Zhang, E., Wong, G. T. F., & Hyun, S. (2020). Factors associated with depression, anxiety, and PTSD symptomatology during the COVID-19 pandemic: Clinical implications for US young adult mental health. *Psychiatry Research*, *290*, 113172.

LoGiudice, J. A., & Bartos, S. (2021). Experiences of nurses during the COVID-19 pandemic: A mixed-methods study. *AACN Advanced Critical Care*, *32*(1), 14–26.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research,* 26(13), 1753-1760.

Mehta, S., Machado, F., Kwizera, A., Papazian, L., Moss, M., Azoulay, É., & Herridge, M. (2021). COVID-19: A heavy toll on health-care workers. *The Lancet Respiratory Medicine*, *9*(3), 226–228.

Mohsin, S. F., Agwan, M. A., Shaikh, S., Alsuwaydani, Z. A., & AlSuwaydani, S. A. (2021). COVID-19: Fear and anxiety among healthcare workers in Saudi Arabia. A cross-sectional study. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, *58*, 00469580211025225.

Muller, A. E., Hafstad, E. V., Himmels, J. P. W., Smedslund, G., Flottorp, S., Stensland, S. Ø., Stroobants, S., Van de Velde, S., & Vist, G. E. (2020). The mental health impact of the covid-19 pandemic on healthcare workers, and interventions to help them: A rapid systematic review. *Psychiatry Research*, *293*, 113441.

Murphy, T. (2017). The role of food in hospitals. *HealthCareCAN, May*.

Nguyen, L. H., Drew, D. A., Graham, M. S., Joshi, A. D., Guo, C.-G., Ma, W., Mehta, R. S., Warner, E. T., Sikavi, D. R., & Lo, C.-H. (2020). Risk of COVID-19 among front-line health-care workers and the general community: A prospective cohort study. *The Lancet Public Health*, *5*(9), e475–e483.

Niu, H.-J. (2010). Investigating the effects of self-efficacy on foodservice industry employees' career commitment. *International Journal of Hospitality Management*, *29*(4), 743–750.

Nor, Z. M. (2010). *Hospital foodservice directors identify the important aspects when implementing room service in hospital foodservice*. Iowa State University.

Nyashanu, M., Pfende, F., & Ekpenyong, M. S. (2022). Triggers of mental health problems among frontline healthcare workers during the COVID-19 pandemic in private care homes and domiciliary care agencies: Lived experiences of care workers in the Midlands region, UK. *Health & Social Care in the Community*, *30*(2), e370–e376.

Ogoina, D., Mahmood, D., Oyeyemi, A. S., Okoye, O. C., Kwaghe, V., Habib, Z., Unigwe, U., Iroezindu, M. O., Garbati, M. A., & Rotifa, S. (2021). A national survey of hospital readiness during the COVID-19 pandemic in Nigeria. *PLoS One*, *16*(9), e0257567.

Oldham, G. R., & Hackman, J. R. (2010). Not what it was and not what it will be: The future of job design research. *Journal of Organizational Behavior*, *31* (2–3), 463–479. https://doi.org/10.1002/job.678

Osman, N. S., Md Nor, N., Md Sharif, M. S., Hamid, S. B. A., & Rahamat, S. (2021). Hospital food service strategies to improve food intakes among inpatients: A systematic review. *Nutrients*, *13*(10), 3649.

Peters, S. E., Nielsen, K. M., Nagler, E. M., Revette, A. C., Madden, J., & Sorensen, G. (2020). Ensuring organization-intervention fit for a participatory organizational intervention to improve food service workers' health and wellbeing: Workplace organizational health study. *Journal of Occupational and Environmental Medicine*, *62*(2), e33–e45.

Rosemberg, M.-A. S., Adams, M., Polick, C., Li, W. V., Dang, J., & Tsai, J. H.-C. (2021). COVID-19 and mental health of food retail, food service, and hospitality workers. *Journal of Occupational and Environmental Hygiene*, *18* (4–5), 169–179.

Shreffler, J., Petrey, J., & Huecker, M. (2020). The impact of COVID-19 on healthcare worker wellness: A scoping review. *Western Journal of Emergency Medicine*, *21*(5), 1059.

Sorensen, G., Peters, S. E., Nielsen, K., Stelson, E., Wallace, L. M., Burke, L., Nagler, E. M., Roodbari, H., Karapanos, M., & Wagner, G. R. (2021). Implementation of an organizational intervention to improve low-wage food service workers' safety, health and wellbeing: Findings from the Workplace Organizational Health Study. *BMC Public Health*, *21*, 1–16.

Sorensen, J., Fletcher, H., Macdonald, B., Whittington-Carter, L., Nasser, R., & Gramlich, L. (2021). Canadian hospital food service practices to prevent malnutrition. *Canadian Journal of Dietetic Practice and Research*, *82*(4), 167 –175.

Tulloch, H., Cook, S., Nasser, R., Guo, G., & Clay, A. (2018). Food service workers: Reliable assessors of food intake in hospitalized patients. *Canadian Journal of Dietetic Practice and Research*, *80*(1), 30–33.

van der Goot, W. E., Duvivier, R. J., Van Yperen, N. W., de Carvalho-Filho, M. A., Noot, K. E., Ikink, R., Gans, R. O., Kloeze, E., Tulleken, J. E., & Lammers, A. J. (2021). Psychological distress among frontline workers during the COVID-19 pandemic: A mixed-methods study. *PLoS One*, *16*(8), e0255510.