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ABSTRACT

A program was conducted to improve the quality of food service through the training of 44 food and nutrition service employees in a 200-bed hospital. A 12-week quality control program was implemented to address four key areas: food temperatures, food accuracy, food quality, and dietary personnel. Learning strategies, emphasizing critical thinking skills, included the following: inservice education with preestablished learning objectives, reports compiled to check tray-menu-temperature accuracy, and a 10-question evaluative essay in order to determine the target group's knowledge base before and after the 12-week implementation phase. The results indicated increased levels of awareness for the target group as compared with essay results prior to implementation. The study concluded that the established quality control program can improve employees' knowledge and awareness but does not guarantee target group compliance if departmental supervision does not enforce the program. (Appendixes, more than half the document, include the following: evaluative essay; patient tray accuracy and appearance report; retherm area process; tray assembly: menu monitor; quality patient service; dress code; modifying menus for calories, carbohydrates, fat, cholesterol, sodium, potassium, protein, and fluid restrictions; menu substitution; and nonselect menu rotation. There are nine references. (Author/KC)

FOOD AND NUTRITION SERVICES QUALITY CONTROL MANAGEMENT PROGRAM

by

Teresa S. Wimsatt-Fraim

A Practicum Report

submitted to the Faculty of the Center for the Advancement of Education, Nova University in partial fulfillment of the requirements for the degree of Master of Science

The abstract of this report may be placed in a National Database System for reference.

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Abstract - Final Report

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Descriptors: Measurement Objectives/Evaluation Methods/Accountability/Accreditation/Audits/Certification/ Editing/Error Correction/Inspection/Operations Research/Performance/Standards/Pretesting/Program Effectiveness/Quality Circles/Reliability/Food Standards/Foods Instruction/Evaluative Thinking/Decision Making/Cognitive Processes/Critical Thinking/On The Job Training/Staff Development/Improvement Programs/Program Development/Program Design/Program Implementation/Measurement Techniques/Evaluation Methods/Evaluation Needs/

The Food and Nutrition Services (FANS) department Patient Satisfaction Monitoring System (PSMS) results averaged below the corporations established penalty point maximums over a three year period. A 12 week quality control program was implemented to address four key areas: food temperatures, food accuracy, food quality and dietary personnel. Learning strategies varied from inservice education with pre-established learning objectives, reports compiled to check tray-menu-temperature accuracy and a 10 question evaluative essay in order to determine the target group's knowledge base before and after the 12 week implementation phase. The results indicated increased levels of awareness for the target group as compared with essay results prior to implementation. It was concluded that the established quality control program can improve one's knowledge and awareness but does not guarantee target group compliance if departmental supervision does not enforce the program. Appendices include evaluative essay, patient tray accuracy and appearance report, retherm area process, tray assembly, menu monitor, quality patient service, dress code, modifying menus for calories and carbohydrates, modifying menus for fat and cholesterol, modifying menus for sodium, modifying menus for potassium, modifying menus for protein, fluid restrictions, menu substitution and non-select menu rotation.

Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. When it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give this testimony freely, out of respect for the scholarship of other professionals in the field and in the hope that my own work, presented here, will earn similar respect.

Signed: Teresa S. Fraim

Table of Contents

CHAPTER I

Purpose

The practicum process was conducted in a 201 bed acute care hospital. This facility contains all private rooms and is operated by a for-profit corporation. The hospital is located in a predominately Hispanic metropolitan area which is known for its multitude of socioeconomic levels.

The department within this hospital which the practicum was conducted was the Food And Nutrition Services (FANS) Department. There are 44 FANS employees (full time and part time), four of which are of supervisory capacity. The hospital food service is designed to offer meals and provide sanitary meal service which is appetizing and nourishing to patients, employees, hospital visitors and medical staff. The FANS department is also responsible for catering special functions upon request. The FANS supervisors are assigned to provide control over the food production, service of meals, the accompanying dishwashing and cleaning procedures. Supervisors are also responsible for the management and enforcement of

policies within the department.

The writer serves as the registered dietitian (R.D.) and the assistant director of the FANS department. The writers duties include: supervision of nutritional/clinical staff and maintenance of hospital nutritional and therapeutic diet standards as outlined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and state regulatory agencies. The writer must meet nutritional education needs of the patients and employees. The writer must act as a liaison between nursing, medical staff and FANS, assist with the nutritional support of patients and contribute to the quality of food services for guest relations.

In most industries of today, quality is imperative if mere survival is to be anticipated. The healthcare industry is no exception. It is just now focusing on the realization of quality services in terms of patient satisfaction.

One of the biggest downfalls of our healthcare industry in the United States is that it assumes what is best for the customer, instead of asking them what they want. Here again, a change or shift is in order which is not only competitive but challenging. The

practicum site hospital/corporation is well on its way to try and make some positive changes in terms of quality. There is currently an intact monitoring systems called the Patient Satisfaction Monitoring System (PSMS), which presents results from a telephone survey of patients recently discharged from the hospital. The primary purpose of doing this is to provide the staff with a reliable, continuous system to monitor patients' satisfaction with key aspects of their hospital experience. Each department within the hospital is represented with their own individual results. The corporation sets cut off figures for each department called penalty points.

This is where the dilemma begins. The Food and Nutrition Services (FANS) department currently has a weak and fragmented quality control program which is loosely enforced. The corporations Research and Market Information Department established the PSMS and stipulated penalty point maximums for each department. FANS penalty points were established at 10 for 1988 and 1989 fiscal years, and was lowered to eight for the 1990 fiscal year. Departmental PSMS results over the

past three years averaged to equal 10 penalty points. (Appendix A:28). As can be seen, penalty point fluctuation is a major concern as well. These scores should improve and be consistent and not fluctutate. A more structured program needs to be implemented and documented.

Effective reasoning, otherwise known as critical thinking is crucial in order to solve these problems. Departmental staff involvement is of the utmost of importance especially since quality rests in their hands.

The following outcome objectives were addressed: Over a period of 12 weeks, through the use of critical thinking skills, 60 percent of the FANS personnel will increase their knowledge and understanding of nutritional standards by 80 percent as measured by an evaluative essay (Appendix B:29).

Forty percent of the FANS staff will increase tray accuracy as well as the quality and appearance of foods being served to patients over the past 12 week implementation phase as measured by the Patient Satisfaction Monitoring System.

Through the use of critical thinking skills, the

FANS staff will to reduce penalty points to eight points consistently over at least a three month period as measured by the Research and Market Information Department of the corporation.

CHAPTER II

Research and Solution Strategy

The concept of quality in the past was not as heavily emphasized as it is today. Quality consciousness is present not only in industry but also in healthcare. Laffel and Blumenthal (1989) imply when quality assurance programs are being established three major components should be taken into consideration: assessing or measuring performance, determining whether performance conforms to standards, and improving performance when standards are not met. The needs of patients or guests should always be paramount, but healthcare organizations are increasingly called on to meet the needs of other individuals and groups, such as patient's families, referring physicians, and third parties. In essence, all of the above would be considered customers according to industrial quality experts; quality is defined as a continuous effort by all members of an organization to meet the needs and expectations of the customer.

Similarily Miller and Miller (1989) study expanded on Edward Demings principles, that doing it right the first time saves money while assuring improved quality. Deming, an American, is a much admired quality guru that helped the Japanese business apply American technology developed in the 1920's to manufacturing products and delivering services. According to Deming, an organization should not focus on bad employees, but on bad systems. Deming estimates that 94 percent of all errors are system errors, not employee errors. In the past, managers were blaming product and service defects on workers, Deming exhorted Japanese managers to look at their systems (inputs, processes, outputs) to improve quality. The Japanese were taught to evaluate where, why, and how problems occur. One should not find fault with, nor point fingers at individuals. In healthcare, as in other disciplines, prevention is the key. Developing systems that prevent problems should be emphasized. Currently, the majority of efforts focus on finding errors rather than preventing them.

Insight shared by Gitlow and Hertz (1983) reveal that to change the system, management first needs to distinguish abnormal from normal variation. It also

needs to specify operationally what the system is supposed to produce. With these controls in hand, the organization can predict performance, cost and quality levels, and managers can communicate effectively with customers and people on the shop floor. The percentage of rework in many major corporations as well as the smallest business is astounding; an average of 15 percent has one or more product defects. This proportion of major defects in a product may well explain some of the problems with sales and profits. The amount of rework a worker has to do along the production line is also stifling profits. Management achieves a high quality by improving the process. A stable process that exhibits only variation due to inherent system limitations allows a manager to determine its capability, that is, what is normal. The specific highlight is the workers don't know what is acceptable or what is defective. Again this is where management must intercede. If management doesn't operationally define many critical variable and attributes so that workers as well as customers agree, serious problems will follow.

Caldwell, McEachen and Davis (1990) used statistical methods to analyze processes and implement

high customer impact change. Most usually one way to improve quality in a hospital is to wait for complaints; then devise a means, such as added procedures to address that concern. Unfortunately, by the time the mishap has gone this far problem solving becomes unnecessarily difficult. One hospital named West Paces Ferry, focused on redesigning the process rather than adding new processes. At this facility all employees are knowledgeable not only of the mission of the hospital, but of the definition of quality, how quality is measured, what tools are employed and how they personally fit into the quality improvement process. Modeled on the work of W. Edward Deming, the program rests on a three-pronged philosophy: customer mindedness (and this includes "internal" customers), process mindedness, and statistical mindedness (basic statistical tools are used by all employees at all levels). The Deming approach calls for an enduring commitment to continuous improvement by everyone in the organization. It requires a high level of participation in a climate where no one fears to speak out. Such a climate is nurtured by long-term employment, a deep belief that everyone has something to add to improvement, and a reduction of internal

competition among workers by eliminating individual rewards for productivity.

A study conducted by Arthur Andersen and Company (1988), grouped participants into five survey panels: healthcare executives, trustees, physicians and nurses, payors and government, and consumer representatives. The goal was for these experts to forecast trends for the U.S. healthcare system through 1995. The participants in this study feel strongly that everyone should have access to adequate care and that consumers will play an important role in demanding and defining quality. The demand for quality standards, most panelists agreed, will come from consumers and from providers through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), one of the most influential groups in the U.S. medical industry. Medicare and Medicaid agencies and legislators, will also create the demand for quality standards. The whole issue of quality of care - how it is defined and monitored and by whom - will be central to a hospital's future. The hospitals that most effectively communicate the quality of their care will be the ones that succeed in the 1990's.

Luft et al (1990) studied the question: Does

Quality Influence Choice of Hospital? In this article, it was examined whether choice of hospital is related to hospital quality, charges, ownership, and distance from the patient's home to the hospital for patients who underwent each of seven surgical procedures or had one to five medical conditions diagnosed. Physicians are usually the key decision makers in selecting the hospital. Proximity is also a major determinant of hospital choice. As far as quality is concerned, teaching hospitals may be perceived as superior to nonteaching hospitals. Referral and transfer patterns may also provide signals of quality. The transfer of patients to other acute-care facilities may indicate a lack of facilities or expertise to handle complex cases.

King (1990) delved deeper into the subject of Total Quality Management (TQM). TQM is a method for organizational transformation. Initially, healthcare organizations were conservative, using only long-established and clearly understood methods such as statistical tools and problem solving teams. Now healthcare organizations are increasingly becoming testing sites for the new aspects of the TQM process: daily and cross-functional management, new forms of

strategic planning, and customer-focused (patient and physician) performance measures. Compared to industry, healthcare may have a larger percentage of key employees who can easily grasp and practice TQM. Because healthcare is so regulated, a large segment of hospital staff understands the basic requirements of quality as historically defined by the JCAHO. This may make them more receptive to personal involvement in total quality than other industries have been. The bottom line is that the TQM process answers the following key questions: How do we get better results from quality assurance committees?, and How do we improve interdepartmental cooperation?

Similarily, Berwick (1989) revealed his findings of continuous improvement in an article entitled, "Sounding Board". Berwick clearly defined several very real theories presently in practice in industry and healthcare. One theory he refers to as the "Theory of Bad Apples". In this, it is determined that the cause of trouble is people - their venality, incompetence, or insufficient caution. According to this outlook, one can use deterrence to improve quality because intentions need to be changed, one can use reward or punishment to control people who do not care enough to

do what they can or what they know is right. The "Theory of Bad Apples" implies that people must be made to care; the inevitable response is the attempt to prove that one cares enough. On the contrary is the "Theory of Continuous Improvement". It was discovered that problems, and therefore opportunities to improve quality, had usually been built directly into the complex production process studied, and that defects in quality could only rarely be attributed to a lack of will, skill, or benign intention among the people involved with the process. Quality can be improved much more when people are assumed to be trying hard, and are not accused of sloth. Berwick suggests six steps to use as a guideline for continuous improvement and are as follows: leaders must take the lead in quality improvement, investments in quality improvement must be substantial, respect for the healthcare worker must be reestablished, dialogue between customers and suppliers of healthcare must be open and carefuly maintained, modern technical, theoretically grounded tools for improving processes must be put to use in healthcare settings and healthcare institutions must "organize for quality". In the discovery of imperfection lies the chance for processes to improve.

The implementation phase was based upon many of these numerous resources. The writer utilized several key factors brought about in the named references. The Laffel and Blumenthal (1989) article was taken into consideration during the planning phase of proposal because of their definition of quality. Quality is a continuous effort by all members of an organization to meet the needs and expectations of the customer. This was the ultimate key consideration during entire process. The Miller and Miller (1989) study proved relevant to proposal with concept of doing it right the first time saves money while assuring improved quality. This aspect was stressed during the numerous inservice education classes with target group. The systems were indeed looked at in hopes of discovering system errors rather than automatic laying blame on employees as done in the past. Gitlow and Hertz (1983) research was taken into consideration since it expanded on the idea of improving the process or system in order to achieve higher quality. The writer took this information and tried to reveal its relevance to employees by making them more aware and looking at end product (is it normal or abnormal or variation?) therefore assisting in problem solving through continuous communication

with supervisors. Management intercession was discovered to be of utmost importance since the manager is the one who should decide what is acceptable or what is defective and portray these decisions to employees and supervisors. The King (1990) article was utilized due to suggestions of forming cross functional problem solving teams. In the process, in depth system analysis was conducted from flow charts to actual updating of policy and procedures. Berwick's (1989) findings were drawn from as far as the six steps to continuous improvement are concerned. This projection of team efforts all striving for the same goal is exactly what it projects and that is the discovering of imperfection lies the chance for processes to improve. The ultimate goal was for the Food and Nutrition Services (FANS) staff to reduce their penalty points to eight points consistently over the 12 week implementation phase. The total quality management process has already been initiated by the corporation. The writer attempted to carry this mode of thinking out through the FANS department.

CHAPTER III

Method

The implementation phase of the practicum process consisted of 12 full weeks of problem solving techniques. The patient satisfaction monitoring system's (PSMS) purpose is to ascertain the patients opinion of four key areas: dietary personnel, food accuracy, food quality, and food temperature. They are asked to rate these areas on a scale of one to ten with ten being the maximum.

Within the first week an evaluative essay was administered to the target group. The results from this essay (Appendix B:29) assisted the writer in determining the depth of knowledge base. A report was conducted daily and throughout the entire 12 week period on tray accuracy and tray appearance (Appendix C:32). Different personnel of the target group was rotated to complete this report. The goal was to increase their understanding and appreciation of their jobs and how their daily tasks in the end effect our customers. Two inservices were conducted by the writer on the retherm area process (Appendix D:35) and on

the proper trayline assembly (Appendix E:37) for greater feasibility. Brainstorming ideas were strongly encouraged during these inservices on speculation for potential changes.

During the second week, continutation of the daily tray accuacy and appearance report (Appendix C:32) data was collected. Menu accuracy (Appendix F:39) was completed daily and on different meals each time. Beginning with the third week an inservice was conducted on quality patient service (Appendix G:40). The learning objective with this inservice included: the target group was able to explain the five components of the "Caring Team" concept for good guest relations and was able to set personal goals to provide quality patient service.

Week four emphasized proper uniform attire (Appendix H:45). Present policy and procedure was photocopied for each member of the target group to review. All members at this point were asked for their interpretation of the requirements and encouraged for input and/or changes.

Week five began with more focus on the clinical aspects of the FANS department. Inservice education was performed on diabetic diets (Appendix I:47).

The learning objectives of this inservice included: the target group was able to define what calories and carbohydrates are, identified three types of carbohydrates, provided examples of food sources, and outlined which types are emphasized in a carbohydrate controlled diet. The target group was asked to describe two situations when a calorie/carbohydrate controlled diet is used and given a meal pattern and asked to appropriately use the exhange lists to write a diabetic or other calorie/carbohydrate controlled diets.

Beginning with week six, menu accuracy (Appendix F:39) was inspected once again daily on different meals. Subsequent to week six all the data collected to this point was appraised in order to determine if the outcome objectives were being met. At this point a mid course evaluation was conducted in order to determine if implementation goals were indeed being met. Since different members of the target group were asked to complete tray accuracy and appearance report, it was noted that certain individuals were not filling the report out thoroughly. The writer followed up with these particular individuals to explain the proper procedure to collect the needed data. It was also

determined that lack of interest on certain key members of the target group was a big deterrent for proper success. The writer spoke with these individuals about general program goals and how it takes a team effort all striving for similar goals if success was expected.

The writer also during this time made visits to other area facilities which had similar tray delivery systems intact. This was done mainly to pick up on ideas that perhaps were overlooked initially by the writer and to verify how these facilities handled system errors and/or employee errors.

Continuing forward with week seven, the tray accuracy and an appearance report (Appendix C:32) continued. Performance of inservice on modifying menus for fat and cholesterol (Appendix J:51) was also conducted during this week. Learning objectives for the target group included: the target group defined fat and cholesterol, identified significant food sources of fat, saturated fat, and cholesterol, described the basics of a fat/cholesterol controlled diet and a situation when this diet is used. The group was also asked to modify menus to control fat and cholesterol according to the facility's diet manual.

Week eight focused on renal dietary guidelines

broken down into each individual restriction. The first of the series of inservices this week was modifying menus for sodium (Appendix K:54). Learning objectives included: the target group briefly defined sodium, identified foods high in sodium, described a situation when low sodium diets are used, and was asked to modify menus to decrease sodium according to the facility's diet manual. The next topic was modifying menus for potassium (Appendix L:57). Here the learning objectives were: the target group briefly defined potassium, identified good food sources of potassium, described a situation when a high potassium diet is used, and modified menus to increase or decrease potassium according to the facility's diet manual.

The next item of importance during week eight was modifying menus for protein (Appendix M:60). Learning objectives from this inservice included: the target group was asked to briefly define protein, identified good food sources of protein, described a situation when a high protein diet is used and one when a low protein diet is used, and modified menus to increase or decrease protein according to the facility's diet manual. The last topic to be discussed this week was fluid restrictive diets (Appendix N:63). After review

of present facility protocol on fluid restrictions, the target group was able to convert standard measures into metric, plus have a working knowledge of high moisture containing food items via a guided discussion.

Week nine was geared toward monitoring trayline production to assure that all needed food items were available (Appendix O:65). At that time an extra staff member, preferably a supervisor, was available on the trayline during all meals, to make certain all areas were stocked properly, as well as make notation of problem areas that focused upon trayline functioning.

Week 10 consisted of continuation of data collection on the tray accuracy and appearance report (Appendix C:32). Menu accuracy (Appendix F:39) was conducted this week on a daily basis on different meals. Beginning with week 11, an additional staff member, preferably a supervisor, was asked to be available on trayline during all meals in order to verify non selective menu food items with those on pre-planned nonselect menu rotation (Appendix P:66). Problem areas were noted and followed up on with personnel responsible.

With week 12, final data collection was concluded and the evaluative essay (Appendix B:29) was

re-administered in order to verify target group's ability to utilize their critical thinking skills to demonstrate everything they were taught during the preceding weeks.

The writers role and responsibility in above tasks and duties was to carry out named inservices to the target group with the assistance of departmental supervisors and to follow up for the possibility of projected changes and/or problems. Evaluation was done on a continual basis throughout the 12 week phase by gathered data. Decisions were made at that time if implementation changes were deemed necessary.

CHAPTER VI

Results

Once the 12 week implementation ended, an appraisal of all the data was initiated by the writer. The first outcome objective was to increase the FANS personnel's knowledge and understanding of nutritional standards by 80 percent. The evaluative essay (Appendix B:29), pre-implementation phase, was compared with the same evaluative essay, administered post implementation phase. This goal was met by the target group members who participated by a margin of 82 percent. Vast improvements were noted by more appropriate responses to essay questions and inservice testing.

The second outcome objective dealing with increasing by 40 percent tray accuracy and appearance as well as the quality and appearance of foods being served was judged by two instruments. The first instrument was the patient tray accuracy and appearance report (Appendix C:32) and the second measuring device was the PSMS monthly results. This objective was not met as can clearly be seen by the Patient Satisfaction

Monitoring System (PSMS) 1992 results thus far (Appendix Q:72). April results were not in from the corporation as of yet therefore only January, February and March data was utilized. Also an average of 10 of the total 44 FANS employees attended the offered inservices or took it upon themselves to show an interest in the policy changes which took place after implementation ended. This was only 22 percent of the FANS staff.

The final outcome objective, which consequently deals with a reduction of FANS penalty points to eight points consistently over at least a three month period, was determined on measured success via the Research and Market Information Department of the corporation and documented as PSMS points. By looking at the results per quarter (Appendix Q:72), virtually no improvement to departmental penalty points are seen. The average over the three months was 12 penalty points, the corporation stipulates a maximum of eight. The impact of this proposal on the target group was an eye opening experience. Some members took this seriously while others obviously did not.

All in all the implementation plan was not totally without merit. During the evaluative phase it was

determined that several policy and procedures within the department needed revisions. Also there are plans to refurbish the entire retherm cart system based upon the data collected from the tray accuracy and appearance reports (Appendix C:32). As far as looking at the problem of patients not receiving items which were selected on menus, it was concluded that certain staff members were not compliant with the food tallies made daily. Specific food items do however have to be made "ready to order" to increase the quality of that particular item (i.e.: shrimp and garlic). It was determined by using the data collected from week 11 that the puree food nonselect menu rotation was not used consistently via the trayline. Armed with this information, the writer sought for more eye appealing and a greater variety of food items that would not conflict with patients' diet order. There will be new changes initiated within the next few months.

CHAPTER V

Recommendations

This practicum process was a learning experience for all individuals of the target group. With the right frame of mind and a will to succeed on everyone's part, all objectives could have been met. There is too much assuming on the department manager's part that no intercessions are made until a mistake or problem is discovered. The writer suggests that monthly inservice education programs be initiated that are mandatory for all Food and Nutrition Services (FANS) employees to attend. If education and quality workmanship is not portrayed as extremely important by the department's manager, then how can this attitude be expected of the employees?

All facilities that were previously visited by the writer will be notified of the results of this practicum. The writers recommendations will be discussed at length with interested facilities. Suggestions from the other facilities will be encouraged and discussed.

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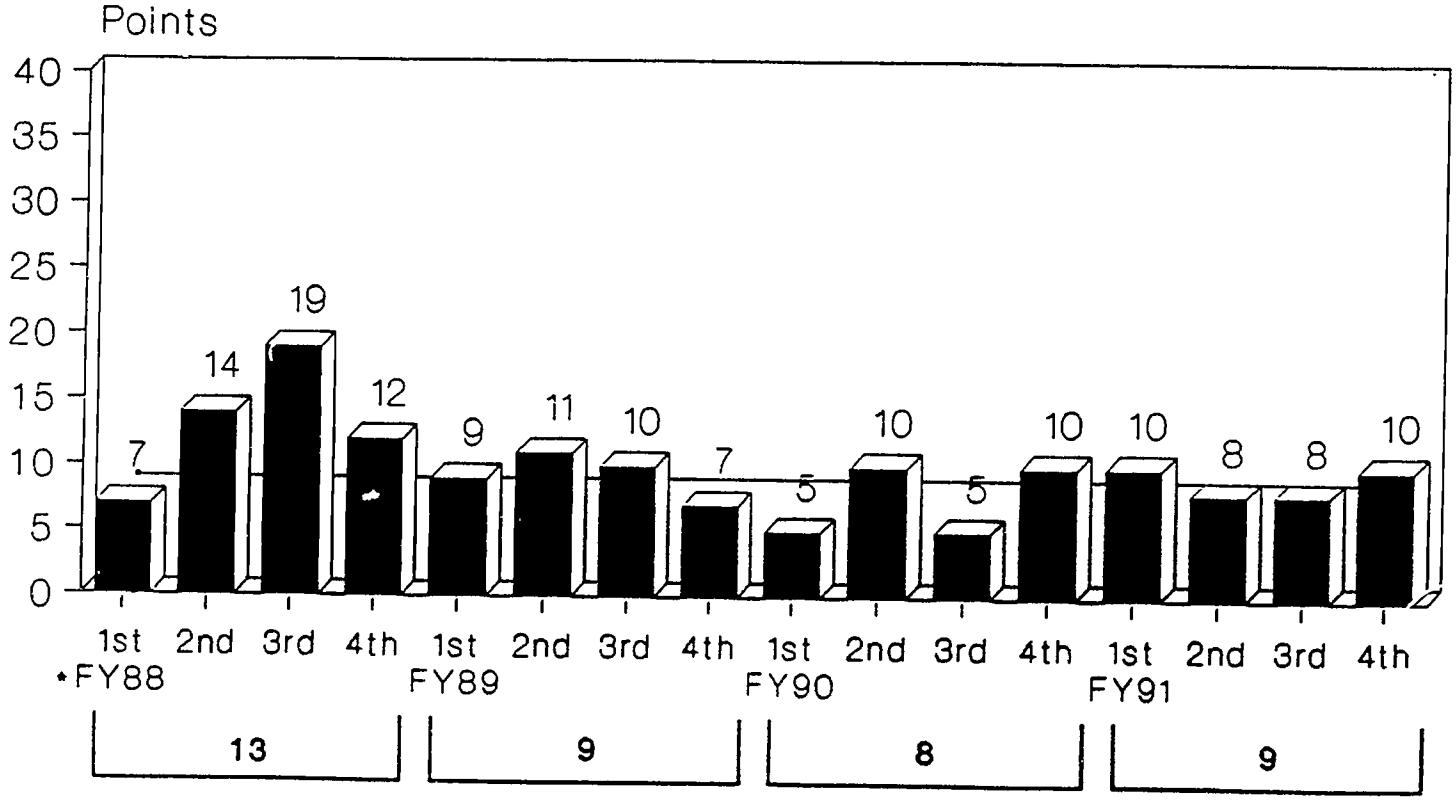
PSMS Results Per Quarter
F.A.N.S.
FY88 - FY91



* Fiscal Year

FANS EVALUATIVE ESSAY

We need your help. Please answer each question fully.

NAME _____

DATE _____

1. What is a Customer, and who are our Customers?

_____

_____

_____

2. What is Quality? _____

_____

_____

3. How would you handle the following situation? Mrs. A. calls FANS for the fifth time this week stating that she never receives what she marks on her selective menu. What do you do?

_____

_____

_____

4. Brainstorm at least 5 aspects which could effect the temperature of the food we serve our patients.

A. _____

_____

B. _____

_____

C. _____

_____

D. _____

_____

E. _____

_____

5. How can patient complaints help us?

6. What is the danger zone of food, and why should we be so concerned if our food falls within that range?

7. Given the following scene, discuss how you would apply your knowledge and understanding of nutritional standards to improve this situation. You are a patient service supervisor and are feeling troubled with your employees who assemble patient trays. While they work together well for the most part, at times they do not seem to care about the tray accuracy and the quality and appearance of the patients food trays.

8. What motivates you in your job and does this effect your morale?

9. What is portion control, and give two reasons why it is important?

10. Does it really matter that much how we present ourself to our patients/guests as far as personal hygiene, dress code and attitude are concerned? Briefly explain your answer.

Additional comments on any questions:

TRACKING FORM: PATIENT TRAY ACCURACY AND APPEARANCE REPORT

MEAL:_____ DATE:_____

STANDARD	TRAY 1	TRAY 2	TRAY 3	TRAY 4	TRAY 5	TRAY 6
ITEMS ON PATIENT TRAY ARE THE SAME AS THOSE CHECKED ON MENU.						
HOT FOODS ARE AT SPECIFIED TEMPERATURE (ERRORS ON BACK)						
COLD FOOD ARE AT SPECIFIED TEMPERATURE (ERRORS ON BACK)						
THE PORTIONS SERVED ARE STANDARD SIZES OR THE AMOUNT SPECIFIED ON MENU						
FOODS ARE GARNISHED ACCORDING TO SPECIFIED STANDARD						
APPEARANCE OF EACH FOOD ITEM MEETS RECIPE SPECIFICATIONS						
TRAYS ARE FREE FROM SPILLAGE						
PLACEMENT OF EACH FOOD ITEM IS IN ACCORDANCE TO MASTER TRAY PLAN (SEE ATTACHED SHEET)						
TRAYS ARE FREE FROM CHIPS, STAINS AND SOIL						
SILVERWARE PACK PROPERLY PLACED						
TOTAL						
GRAND TOTAL TRAY 1-6						

SIGNED: _____

****

COMMENTS:

TRACKING FORM: TRAY ACCURACY AND APPEARANCE

MEAL:_____
DATE:_____
UNIT:_____

****

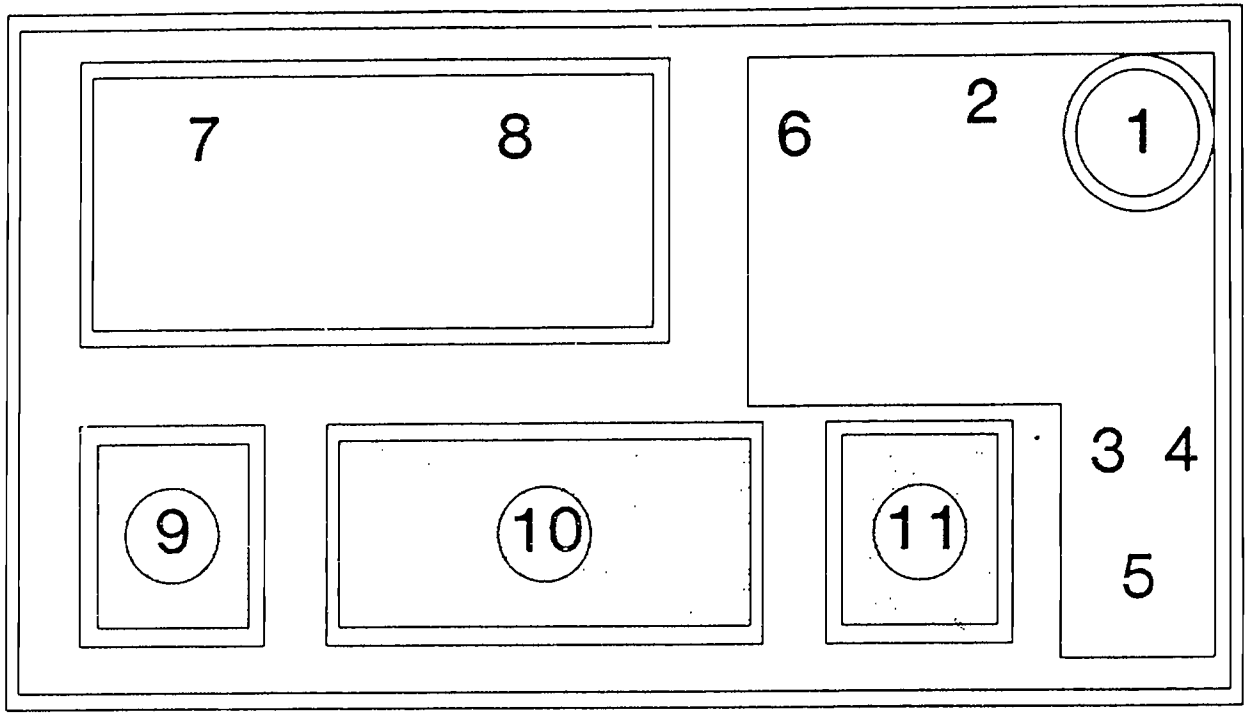
TEMPERATURES

RECOMMENDED:	FLOOR
Broth, soup	160F
Hot Beverage	180F
Casserole, Cream Soup, Cereal	140F
Eggs, Meat, Potatoes, Rice	125F
Vegetables	140F
Chilled Beverages	50F
Salads, Fruits	55F

ITEM:	TEMP ON FLOOR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SIGNED:_____

Master Tray Plan



The procedure used to position food items will vary with patient food selection.

1. Coffee, tea, or hot cocoa
2. Beverage - milk, juice
3. Dining Packet
4. Silverware
5. Selected menu or tray identification slip
6. Condiments
7. Salad or sandwich (cold food)
8. Bread or dessert (cold food)
9. Soup (hot food)
10. Entree facing patient with starch or additional vegetable (hot food)
11. Vegetable (hot food)

RETHERM AREA PROCESS

DISCHARGES:	1. Remove/save tray in refrigerated late tray cart. 2. Tear menu, leave on tray cart.
NPO	1. Remove/save tray in refrigerated late tray cart. 2. Tear menu, leave on tray cart.
DIET CHANGES	1. Remove meal tray from cart. 2. Make changes of the food/diet packet. 3. Retherm as usual in its same place on the cart shelf it was on.
TRANSFER	1. Change room # on the menu. 2. Remove/place tray in correct floor's retherm cart. 3. Leave the shelf empty where the tray was.
ADMISSION	1. Place menu on a universal tray from the refrigerated late tray cart. 2. Place tray in correct floor's retherm cart. 3. Retherm as usual.
HOLD/DELAY	1. Place HOLD Stamp on tray. 2. Retherm as usual on late tray cart. 3. Leave on late tray meal cart, reheat if needed when HOLD restriction is released.

HEATING OF RETHERM CARTS

A. All retherm carts will be heated in a staggered timing with a five (5) minute interval between each. Starting with 3-North, 3 South, 2 South and ICU. The first cart not to be started more than forty-five (45) minutes before delivery.

B. 3 North, 3 South, and 2 South floor hostesses are to go to the retherm area as soon as trayline is completed and help retherm person set-up carts with iced tea, coffee, ice cream and ices.

C. Line supervisor will put up and store all items pertaining to that particular meal.

Due to the relatively large number of late trays expedited through Nutritional Services (which are presently manufactured and microwaved individually), secondary rethermalization process will be put into effect. This process will supplant most of the microwaving of patient late trays resulting in a product of higher quality and the more effective utilization of labor by quality and the more effective utilization of labor by bulk re-heating. The following schedule depicts the temporality of the retherming process as it will be practiced by Nutritional Services.

Meal	1st* Retherm	To floor By	2nd* Retherm	2nd Retherm Stays Warm Until	Extended By
Breakfast	7/7:35	8	8/8:30	9:30 (after 9:30 discard trays)	Continental Breakfast 9:30-10:30 after 10:30 wait for lunch
Lunch	11/11:45	12	12/12:30	1:30 (after 1:30 discard trays)	Patient Pleasers from 1:30 until dinner.
Dinner	4/4:50	5:00	4/4:50	Send cart to floor with Pt. Pleasers	Patient Pleasers pass late trays

*** Begins/Ends**

(All times are approximate, give or take 10 minutes).

The number of late trays to be rethermed will be dictated by the patient census.

ASSEMBLING TRAYS

1. Cold tables on the assembly line are turned on at 6:00-6:15 a.m.

2. Menus for all patients are placed in numerical sequence for each nursing unit and fastened with a paper clip.

3. The packs of menus are then stacked in the order in which they are served.

4. Menus are placed at the starter's station.

5. Cold items are placed in the proper areas on the frost top unit and/or maintained in the air conditioned refrigerator.

6. At 7:00 a.m. and 11:00 a.m. and 2:00 p.m. the trays are assembled by the food service employees as outlined/specified (see attached sheet)

   A. The Supervisor checks the trays to make sure all items requested are on the tray.
   B. The trays are then placed on the food cart and sent to the food bank cooler.

The following steps are to be performed in the assembly of trays:

STEPS	ACTION
1. Check station; collect utensils.	1. Ten minutes prior to the starting time for tray assembly, check your station for all items you will be serving.
2. Collect any missing items.	2. Collect any foods or other items you may need which are not found at your station according to your position station list.
3. Wait quietly.	3. Stand quietly at your station and wait for tray assembly to begin.
4. Check menus, placing items on trays.	4. Check each menu carefully, placing all items needed from your station on the tray. If in doubt, check with trayline checker before you place an item on a tray or leave an item off your tray.
5. Clean station; clear all unused items.	5. Do not leave your station at any time. At the end of the tray assembly, go to retherm person, set carts with iced tea, coffee, ice cream and ices. The line supervisor will clean your station well and return all unused items to the proper storage place.

* Ensure at all times food items are maintained at appropriate temperature.

* No leaving position post during operation.

* Keep talking down to a minimum on trayline during operation.

Menu Monitor QA Tally

Date	# of Menus Checked	# Errors	% Error	%Accuracy

Total ____ Total ____

$\frac{\text{total errors}}{\text{total menus}} =$ ____%error

____%accuracy

Quality Patient Service
Handout #1

Warm-Up Questions

Directions: Circle either "True" or "False"

1. You should treat patients as guests.

   True False

2. Even when you may be having personal problems, it is important to take an interest in and work with, not against, your coworkers.

   True False

3. By coming to work properly groomed and dressed, you are taking pride in yourself and your job.

   True False

4. Working together as a team can make your job much more pleasant.

   True False

5. Learning to anticipate a patient's wants and needs is a worthwhile skill.

   True False

Name:_____
Date:_____

Quality Patient Service
Handout #2

Personal Patient Service Goals

Directions: In the blank before each patient service skill listed below, write down the number of the statement below that is more appropriate.

1. I perform this skill well.
2. I perform this skill fairly well, but I could work harder on it.
3. I could really work on this skill and improve the quality of patient services I provide.
4. This skill doesn't apply to my job.

Patient Service Skills

_____ Care about patients and coworkers.

_____ Cooperate with patients and coworkers.

_____ Anticipate patient's needs.

_____ Attend to patients' needs.

_____ Respect patients' rights.

_____ Respect yourself.

_____ Interact with patients and coworkers in a professional and friendly manner.

_____ Inform your supervisor of any on-the-job concerns.

_____ Be natural

_____ Use names when addressing patients and coworkers.

_____ Greet the patient.

_____ Be gracious when patients complain.

_____ Talk to and communicate with other team members.

_____ Take pride in your job and your department.

_____ Exhibit a thorough knowledge of your job.

_____ Be efficient on the job.

_____ Have an attitude that is positive.

_____ Actively listen to patients and coworkers.

_____ Make sure you look and feel good about yourself because your job is very important to many other people.

_____ Make eye contact when talking with patients and coworkers.

Quality Patient Service
Handout #3

Quiz

Explain how you can apply five parts of the Caring Team concept in your job.

1.

2.

3.

4.

5.

Quality Patient Service
Handout #4

Quality Patient Service

What is a patient?

- Our patients are the most important people in our health care facility. Without patients, we would have no purpose working here.
- Our patients likewise depend on us to meet many of their most important needs, such as meals and a courteous smile.
- Our patients are not an interruption of our work; they are the purpose of it, which makes our work very important.
- Our patients are not just names on a menu. They are human beings just like us who want to be treated with respect and kindness.
- Our patients are not to be argued with. Nobody ever wins an argument with a patient.

You are a member of a Caring Team of employees who provide patient service. Below are the components or parts of the Caring Team concept of providing quality patient service.

C: Care about patients and coworkers.
Cooperate with patients and coworkers.
A: Anticipate patients' needs.
Attend to patients' needs.
R: Respect patients' rights.
Respect yourself.
I: Interact with patients and coworkers in a professional and friendly manner.
Inform your supervisor of any on-the-job concerns.
N: Be natural.
Use names when addressing patients and coworkers.
G: Greet the patient.
Be gracious when patients complain.
T: Talk to and communicate with other team members.
Take pride in your job and your department.
E: Exhibit a thorough knowledge of your job.
Be efficient on job.
A: Have an attitude that is positive.
Actively listen to patients and coworkers.
M: Make sure you look and feel good about yourself because your job is very important to many other people.
Make eye contact when talking with patients and coworkers.

Appendix H

Dress Code

FEMALES

1. Black slacks or black skirt
2. White short sleeve blouse
3. Black Tie - on floor and cafeteria
4. Apron vest - on floor and cafeteria
5. White lab coat - Diet office & Supervisors
6. White sweater (plain)
7. White or black duty shoes (no canvas shoes, sandals) shoes are to be kept clean and polished at all times
8. If wearing a skirt, panty hose must be worn. No panty hose with designs or any decoration. No socks are permitted.
9. No dangling earrings.
10. No rings except plain wedding bands (worn at employees own risk, and/or department not liable if damaged, lost or stolen)
11. No chains are to show around the neck, if worn must be under the blouse
12. No bracelets
13. May wear a wrist watch
14. Hair - 90% - must be covered at ALL times in the kitchen, including when in the dishroom
15. Upon leaving diet office, personnel MUST COVER hair if going to the floor or the kitchen, (i.e., cold/hot food production, baking area, etc.)
16. No nail polish may be worn by kitchen or cafeteria personnel
17. LIGHT perfume may be worn by kitchen or cafeteria personnel
18. White aprons are distributed for your convenience, if worn must be clean on a daily basis

MALES

1. Black shoes and socks
2. White short sleeve shirt
3. Black bow tie - on floor and cafeteria
4. Apron vest - on floor and cafeteria
5. Black shoes with non-skid soles (No canvas, tennis shoes or sandals)
6. No rings except plain wedding band - see above #10
7. No chains unless worn inside of shirt
8. LIGHT aftershave may be worn
9. No caps/hats (baseball style)
10. Beards or mustaches MUST be kept neatly trimmed and closely shaved to the face
11. Hair should not exceed the collar of the shirt
12. White aprons are distributed for your convenience, if worn must be clean on a daily basis

FAILURE TO COMPLY WITH ANY PART OF THE ABOVE DRESS CODE WILL RESULT IN THE FOLLOWING:

1st offense - Verbal Counseling
2nd offense - Written Counseling
3rd offense - Written Counseling
4th offense - Immediate Termination

Appendix I

Modifying Menus for Calories and Carbohydrates
Handout #1

Warm-Up Questions

Directions: Check below the appropriate heading if you think the food is a significant source of refined sugar or starch.

Food	Refined Sugar	Starch
1. cola soft drink	_____	_____
2. baked beans	_____	_____
3. chocolate bar	_____	_____
4. white bread	_____	_____
5. potato	_____	_____
6. jelly	_____	_____
7. rice	_____	_____
8. corn	_____	_____
9. oatmeal	_____	_____
10. apple pie	_____	_____

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Name:_____

Date:_____

Modifying Menus for Calories and Carbohydrates
Handout #2

Quiz

1. Define calorie.

2. Define carbohydrate.

3. Fo. each type of carbohydrate listed below, give two significant food sources.

   Sugar:

   Starch:

   Fiber:

4. Which type of carbohydrates are emphasized in a carbohydrate-controlled diet?

5. Name one type of patient who is on a calorie/carbohydrate-controlled diet.

6. Correct and/or write menus as directed by your instructor.

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Name:_____

Date:_____

Modifying Menus for Calories and Carbohydrates
Handout #3

Modifying Menus for Calories and Carbohydrates

Calories are a measure of the energy in food. We use energy to make heat and to build and maintain our bodies, and we also store it away for future use, mostly in the form of fat. If you eat more calories than your body uses, you will gain weight. In order to lose weight, you need to control or lower your calorie intake.

Carbohydrate is one of several nutrients in food that we need to provide energy for the body. Examples of food containing carbohydrate include bread, fruit and table sugar.

There are three types of carbohydrate: sugar, starch, and fiber. Sugars are either refined or natural. Refined sugars such as table sugar appear in many foods and beverages such as soft drinks, sweetened cereals, candies, jams, jellies, and baked goods such as cakes. Natural sugars occur in fruits and also milk. The sugar in milk is really a sugar, although it does not taste sweet.

Starch appears in grains and products made from grains such as cereals, flour, breads, other baked products, and pasta. Grains include wheat, corn, rice, rye, barley, and oats. Starch also appears in vegetables and dried beans and peas.

Fiber is only found in foods from plants such as grains and grain products, fruits, vegetables, and dried beans and peas. Fiber is not found in any foods from animals such as meats, poultry, or dairy products.

In a carbohydrate-controlled diet, starch and fiber are emphasized, and refined sugars are limited. Natural sugar is the preferred sugar source.

A calorie/carbohydrate-controlled diet is used for diabetic patients who need a balanced intake of calories, carbohydrates, fat and protein. This type of diet helps them to keep sugar in their blood within a normal range, attain or maintain ideal body weight, and keep blood fat and cholesterol levels within a normal range; otherwise, serious long-term complications may arise. This diet is also used for patients who need to lose weight and eat a balanced diet.

Using the exchange lists for meal planning, you can write and correct calorie/carbohydrate-controlled diets. Follow these six steps to use the exchange lists for meal planning.

1. There are six lists of foods as follows: starch/bread, meat, vegetable, fruit, milk and fat.
2. The meat list is actually three lists: lean meat and substitutions, medium-fat meat and substitutions, and high-fat meat and substitutions.
3. The milk list is actually three lists: skim and very low-fat, low-fat, and whole.
4. There is also a list of free foods and beverages that contain less than 20 calories per serving. They can be eaten as desired, except that those with a portion size stated should be limited to two or three servings per day.
5. Each food on a list has approximately the same amount of calories, carbohydrate, fat, and protein as another in the portions listed. Therefore, any food on a list can be exchanged or traded for any other food on the same list in the portion size given.
6. When given a meal pattern that shows how many exchanges a patient may have at each meal and snack, simply choose foods from the appropriate lists in the portion sizes stated.

Appendix J

Modifying Menus for Fat and Cholesterol
Handout #1

Warm-Up Questions

Directions: Read the following list of foods, and check off any of them that are significant fat and/or cholesterol sources in the appropriate columns.

Food	Significant Fat Source	Significant Cholesterol Source
1. butter	_____	_____
2. margarine	_____	_____
3. eggs	_____	_____
4. whole milk	_____	_____
5. peanut butter	_____	_____
6. apple	_____	_____
7. corn oil	_____	_____
8. broccoli	_____	_____
9. steak	_____	_____
10. white bread	_____	_____

Name:_____

Date:_____

Modifying Menus for Fat and Cholesterol
Handout #2

Quiz

1. Define fat.

2. Define cholesterol.

3. List two significant food sources of each of the following:

   Fat:

   Saturated Fat:

   Cholesterol:

4. Describe the basics of a fat/cholesterol controlled diet.

5. Name one type of patient who is on a fat/cholesterol-controlled diet.

6. Correct and/or write menus as directed by your instructor.

Modifying Menus for Fat and Cholesterol
Handout #3

Modifying Menus for Fat and Cholesterol

Fat is an important nutrient that makes foods taste rich. Fat is also in the body where it is stored away as an energy source. Fat helps keep our bodies warm and protects our internal organs. Cholesterol is a fat-related substance found in food. Cholesterol is also made in the body and is an essential part of your body, especially in the brain and nerves.

There are many significant food sources of fat. Margarine, butter, lard, and oils are almost 100 percent fat. Mayonnaise and salad dressing are also high in fat, but lower-in-fat versions of these foods are often available.

Meats and poultry contain fat. Most luncheon meats, bacon, tuna in oil, sausage, and hot dogs are especially high in fat. It is possible to pick leaner cuts of meat that are not too high in fat. Poultry has less fat than red meats, and fish has less fat than meat or poultry. Much of poultry's fat is in the skin.

Whole milk and whole milk products are significant sources of fat. Lower-in-fat versions are often available, such as low-fat milk, low-fat cheeses, and ice milk.

Commercially baked goods are almost always high in fat, especially cakes, cookies, donuts, croissants, and biscuits. Baked goods not too high in fat include breads, some crackers, graham crackers, vanilla wafers, angel food cake, and muffins.

Other foods that are significant sources of fat include fried foods, snack chips, and chocolate. There is virtually no fat in fruits, vegetables, and egg whites.

Fats from animal sources, such as butter, dairy products, meat, poultry, fish and eggs, are high in what we call saturated fats. This type of fat is important because we know it increases the blood cholesterol level, which then increases the chances of having a heart attack.

Significant food sources of cholesterol include organ meats, such as liver and kidney, and egg yolks. These foods are the two highest sources of cholesterol. Other foods containing cholesterol include dairy products, meat, and poultry. There is no cholesterol in foods from plants, such as fruits, vegetables, dried beans and peas, and grains.

A fat/cholesterol-controlled diet will control and probably lower the level of fat, especially saturated fat, and cholesterol the patient is allowed to eat. This diet is used most often for patients with heart disease who are at risk for a heart attack.

Appendix K

Modifying Menus for Sodium
Handout #1

Warm-Up Questions

Directions: Check off the foods in the following list that are high in sodium.

Food	High in Sodium
1. ham	_____
2. salt	_____
3. canned soups	_____
4. carrots	_____
5. soy sauce	_____
6. bread	_____
7. pickles	_____
8. fresh ground beef	_____
9. bouillon	_____
10. butter	_____

Name:_____

Date:_____

Modifying Menus for Sodium
Handout #2

Quiz

1. Define sodium.

2. Circle any of the foods that are high in sodium:

cheeses	canned soups & vegetables
fresh fruits	regular convenience bases
fresh meats	prepared stuffing & gravy mix
fresh poultry	white bread
milk	salt
sauerkraut	frankfurters
luncheon meats	salted snack foods

3. Describe a situation when a low-sodium diet is used.

4. Correct and/or write menus as directed by your instructor.

Modifying Menus for Sodium
Handout #3

Modifying Menus for Sodium

Sodium is a mineral that is present in food and also in the body fluids such as blood. Sodium is important in maintaining water balance within the body and keeping blood and other body fluids from getting acidic. The nerves and muscles need sodium to function normally.

Foods high in sodium include the following:

- canned, cured, and/or smoked meats and fish, such as frankfurters, bacon, ham, corned beef, cold cuts, and canned tuna fish
- many cheeses, especially processed cheeses
- some seasonings and flavorings, such as salt (which is 40 percent sodium by weight), garlic salt, onion salt, soy sauce, Worchestershire sauce, catsup, and mustard
- canned soups and vegetables
- convenience bases
- foods prepared in brine, such as pickles, olives, and sauerkraut
- prepared mixes for stuffing,gravy, and rice dishes
- salted snack foods

Low-sodium diets are used to treat high blood pressure and to manage liver, kidney, and heart diseases in some patients.

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Appendix L

Modifying Menus for Potassium
Handout #1

Warm-Up Questions

Directions: Check off the foods in the following list that are high in potassium.

Food	High in Potassium
1. banana	_____
2. butter	_____
3. orange	_____
4. oatmeal	_____
5. broccoli	_____
6. spinach	_____
7. bread	_____
8. potato	_____
9. cake	_____
10. plain muffin	_____

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Name:_____

Date:_____

Modifying Menus for Potassium
Handout #2

Quiz

1. Define potassium.

2. Circle any of the following foods that are high in potassium:

orange	bread	margarine
cantaloupe	potato	cold cereal
tomato	cookie	broccoli
prune	salad dressing	banana
milk	danish	pasta

3. Describe a situation when a high-potassium diet is used and one when a low-potassium diet is used.

4. Correct and/or write menus as directed by your instructor.

Modifying Menus for Potassium
Handout #3

Modifying Menus for Potassium

Potassium is a mineral found in foods and also in the body fluids such as blood. It is important in maintaining water balance within the body and keeping blood and other body fluids from getting acidic. The nerves and muscles need potassium to function normally. If you do not have enough potassium, your muscles feel weak, and you could have serious problems with your heartbeat and breathing.

Following are six good sources of potassium (in decreasing order of prominence):

1. most fruits, and especially prune juice and canned prunes, nectarine, cantaloupe, honeydew, banana, orange, tangelo, and dried fruit
2. most vegetables, and especially broccoli, spinach, winter squash, potato, and tomato
3. milk
4. meat
5. dried beans and peas
6. some salt substitutes that contain significantly high levels of potassium

Grains and fats are low in potassium.

A high-potassium diet is used for patients who are on certain blood pressure medications that cause the loss of potassium from the body and for patients with any other condition involving potassium loss, such as diarrhea, vomiting, and malnutrition.

A low-potassium diet is used for some patients with kidney disease or renal failure.

Appendix M

Modifying Menus for Protein
Handout #1

Warm-Up Questions

Directions: Check off the foods in the following list that are high in protein.

Food	High in Protein
1. dried beans	_____
2. butter	_____
3. meat	_____
4. egg	_____
5. milk	_____
6. peanut butter	_____
7. bread	_____
8. fish	_____
9. cake	_____
10. cold cereal	_____

Name:_____

Date:_____

Modifying Menus for Protein
Handout #2

Quiz

1. Define protein.

2. Circle any of the following foods that are high in protein:

meat	fruits	dried beans & peas
breads	fish	margarine
pasta	vegetables	salad dressing
poultry	dairy products	
eggs	baked products	

3. Describe a situation when a high-protein diet is used.

4. Correct and/or write menus as directed by your instructor.

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Modifying Menus for Protein
Handout #3

Modifying Menus for Protein

Protein is a nutrient found in foods and also in the body. It builds and maintains your body. Protein is in your skin, hair, bones, nails, muscles, and tendons, to name just a few places. Protein is important in maintaining water balance within the body and keeping blood and other body fluids from getting acidic.

Good sources of protein include meat, poultry, fish, eggs, dairy products, and dried beans and peas. Grains and vegetables contain some protein but in much smaller amounts.

High protein diets are used for patients who have bedsores and patients whose disease, such as cancer, has wasted their body so that they need protein for rebuilding.

A low-protein diet is used for some patients with kidney disease or renal failure and some patients with liver disease who have trouble handling too much protein.

Appendix N

Fluid Restrictions
Distribution Between FANS and Nursing

In order for patients to receive an allotted amount of fluid on their meal trays this procedure will be followed.

1. When an order for a fluid restriction is ordered by the medical doctor, the Unit Secretary/R.N. will enter into computer for FANS as written on medical chart.

2. FANS and Nursing Services will adhere to the following guidelines for fluid distribution:

Fluid Restrictions		Allotments Nursing/Dietary	
800cc	=	800cc	0cc
1000cc	=	1000cc	0cc
1200cc	=	1000cc	200cc
1500cc	=	1000cc	500cc
1800cc	=	1000cc	800cc
2000cc	=	1000cc	1000cc

3. Nursing is thereby always allotted 1000cc on fluid restrictions of 1000cc or above.

4. Nursing will divide allotted fluid between shifts.

5. FANS will divide allotted fluid in meal trays.

6. It will be the responsibility of the R.N. to check meal trays for fluid consumption for Input/Output record.

7. If a nutritional supplement is ordered i.e., Ensure, Sustacal, it is recommended to offer the patient the supplement in pudding form, available from Pharmacy. Only Sustacal pudding is available. One 4 oz. portion provides 250 calories. M.D. will need to be notified by R.N. of this.

8. FANS will provide all patients on fluid restrictions a notice (see attached) stating they are on a fluid restriction, the conversion table of ounce to milliliter and indicating amount allowed on meal trays.

Dear Patient:

Your are on a _____cc fluid restriction as ordered by your medical doctor.

You will be allowed _____cc fluid on your meal trays each day. The remainder will be provided to you from your nurse.

Use the fluid table below to change fluids from household measure to metric:

Food	Fluid Oz.	Household Measurement	Metric Measurement
Milk	8	1 cup	240cc
Juices	4	1/2 cup	120cc
Coffee of Tea	6	2/3 cup	180cc
Gelatin	4	1/2 cup	120cc
Ice Cream or Sherbet	3	1/3 cup	90cc
Soup	6	2/3 cup	180cc
Coffee Creamer,Liquid	1	2 Tbsp.	30cc

Note: ml = cc

Appendix O

MENU SUBSTITUTION FORM

DATE:_____

ITEM SHORTAGE:

_____

_____

SUBSTITUTED WITH THE FOLLOWING ITEM:

_____

_____

REASON FOR SHORTAGE:

_____

_____

_____

APPROVED BY:_____

Appendix P

Non-Select Menu Rotation

Purpose: To provide patient's that do not select their menu with a weeks rotation of meals that meets dietary guidelines.

Procedure: When a patient is admitted or meal is resumed and a selected menu is not in for them, the diet clerk will provide a non select choice for the day, meeting specific dietary guidelines. When a tray is delivered, the patient will be offered a menu to select for the following meals.

(ATTACHED MEAL ROTATION)

REGULAR MENU

	MONDAY/THURSDAY	TUESDAY/FRIDAY	WEDNESDAY/SATURDAY	SUNDAY
BREAKFAST	Orange Juice	Grapefruit Juice	Cranberry Juice	Apricot Nectar
	Grits	Cream of Wheat	Oatmeal	Banana
	Scrambled Egg	French Toast	Poached Egg	Special K
	Hash Browns	-----	Hash Browns	-----
	Banana Bread	Blueberry Muffin	White Toast	Raisin Bagel
	-----	-----	-----	Skim Milk (1%)
	Coffee	Coffee	Coffee	Coffee
	Margarine/Jelly	Margarine/Jelly	Margarine/Jelly	Margarine/Jelly
	Sugar/Creamer	Sugar/Creamer	Sugar/Creamer	Sugar/Creamer
LUNCH	V-8 Juice	Apple Juice	Grape Juice	Tossed Salad
	Beef Stroganoff	Braised Pork	Cheddar Burger	Prime Rib SW
	Baby Carrots	Baked Potato	Cut Green Beans	Mashed Potato/Gravy
	-----	Mixed Vegetables	-----	Cauliflower
	Dinner Roll	Dinner Roll		Dinner Roll
	Cream Puff	Apple Pie	Carrot Cake	Double Chocolate Cake
	Margarine	Margarine	Margarine	Margarine
	-----	-----	Ketchup	Salad Dressing
	Iced Tea	Iced Tea	Iced Tea	Iced Tea
	Sugar/Lemon	Sugar/Lemon	Sugar/Lemon	Sugar/Lemon
DINNER	Cranberry Juice	Marinated Mushrooms	Beef Consomme	Soup of the Day
	Chicken Diablo	Fillet of Fish	Short Ribs Jard	Chicken Piccata
	Leaf Spinach	Yellow Rice	Buttered Noodles	Yellow Rice
	Mashed Potatoes	Asparagus	Squash Medley	Sugar Snap Peas
	Fruited Pound Cake	Flan	Cheese Cake	Cherry Pie
	Dinner Roll	Dinner Roll	Dinner Roll	Dinner Roll
	Margarine	Margarine	Margarine	Margarine
	Iced Tea	Iced Tea	Iced Tea	Iced Tea
	Sugar/Lemon	Sugar/Lemon	Sugar/Lemon	Sugar/Lemon

SOFT/BLAND/LR

	MONDAY/THURSDAY	TUESDAY/FRIDAY	WEDNESDAY/SATURDAY	SUNDAY
BREAKFAST	Orange Juice	Grapefruit Juice	Cranberry Juice	Apricot Nectar
	Grits	Cream Of Wheat	Oatmeal	Special K
	Scrambled Egg	French Toast	Poached Egg	Sliced Peaches
	Hash Browns	—	White Toast	Sliced Croissant
	Demi-Danish	Blueberry Muffin	—	—
	—	—	—	Skim Milk
	Decaf Coffee	Decaf Coffee	Decaf Coffee	Decaf Coffee
	Margarine/Jelly	Margarine/Jelly	Margarine/Jelly	Margarine/Jelly
LUNCH	V-8 Juice	Apple Juice	Grape Juice	Lettuce Wedge
	Beef Stroganoff	Braised Pork	Cheese Burger Delight	Prime Rib Sw
	—	Baked Potato	—	Winter Squash
	Baby Carrots	Steamed Vetegables	Cut Green Beans	Mashed Potatoes w/Gravy
	Dinner Roll	Dinner Roll	—	Dinner Roll
	Cream Puff	Apple Pie	Fruit Cocktail	Yellow Cake
	Margarine	Margarine	Margarine	Margarine
	—	—	Ketchup	—
	Iced Tea	Iced Tea	Iced Tea	Iced Tea
DINNER	Cranberry Juice	Marinated Mushrooms	Beef Consomme	Chicken Broth
	Chicken Diablo	Fillet of Fish	Short Ribs Jard	Lemon Chicken
	Leaf Spinach	Yellow Rice	Tender Noodles	Yellow Rice
	Mashed Potatoes	Asparagus	Squash Medley	Cut Green Beans
	Pound Cake	Flan	Cheese Cake	Ice Cream
	Dinner Roll	Dinner Roll	Dinner Roll	Dinner Roll
	Margarine	Margarine	Margarine	Margarine
	Iced Tea	Iced Tea	Iced Tea	Iced Tea

CALORIE CONTROLLED

	MONDAY/THURSDAY	TUESDAY/FRIDAY	WEDNESDAY/SATURDAY	SUNDAY
BREAKFAST	Orange Juice Grits Scrambled Eggs Toast — Skim Milk Decaf Coffee Margarine/Diet Jelly	Grapefruit Juice Cream of Wheat — French Toast — Skim Milk Decaf Coffee Margarine/Diet Syrup	Diet Cranberry Juice Oatmeal Poached Egg White Toast — Skim Milk Decaf Coffee Margarine/Diet Jelly	Banana Special K — — 1/2 Raisin Bagel Skim Milk Decaf Coffee Margarine/Diet Jelly
LUNCH	V-8 Juice Beef Stroganoff — Baby Carrots Dinner Roll Fresh Fruit — Margarine Iced Tea	— Braised Pork Baked Potato Mixed Vegetables Dinner Roll Fresh Fruit — Margarine Iced Tea	— Burger Deluxe — Cut Green Beans — Canned Fruit — Margarine/Ketchup Iced Tea	Apple Juice Tossed Salad Prime Rib SW Cauliflower Mashed Potatoes Dinner Roll Diet Salad Dressing — Iced Tea
DINNER	Diet Cranberry Juice Tossed Salad Chicken Diablo Mashed Potato Leaf Spinach Angel Food Cake — Dinner Roll Margarine Diet Salad Dressing Iced Tea	Assorted Relishes — Fillet of Fish Rice Asparagus Applesauce — Dinner Roll Margarine Iced Tea	Beef Consomme — Short Ribs Jard Tender Noodles Squash Medley Diet Gelatin Cubes Canned Fruit Dinner Roll Margarine Iced Tea	Garbanzo Bean Soup — Chicken Picatta Rice Sugar Snap Peas — Fresh Fruit Dinner Roll Margarine Iced Tea

LOW SODIUM/LOW FAT

BREAKFAST	MONDAY/THURSDAY	TUESDAY/FRIDAY	WEDNESDAY/SATURDAY	SUNDAY
	Orange Juice	Grapefruit Juice	Cranberry Juice	Apricot Nectar
	Grits	Cream of Wheat	Oatmeal	—
	Egg Beaters	—	Egg Beaters	Banana
	Hash Browns	French Toast	White Toast	Special K
	Demi - Danish	Citrus Sections	—	Raisin Bagel
	—	—	—	Skim Milk
	Decaf Coffee	Decaf Coffee	Decaf Coffee	Decaf Coffee
	Margarine/Jelly	Margarine/Jelly	Margarine/Jelly	Margarine/Jelly
LUNCH	V-8 Juice	Apple Juice	Grape Juice	Tossed Salad
	Beef Tips	Braised Pork	Burger Deluxe	Prime Rib SW
	Noodles	Baked Potato	—	—
	Baby Carrots	Mixed Vegetables	Cut Green Beans	Cauliflower
	Dinner Roll	Dinner Roll	—	Mashed Potatoes
	Fresh Fruit	Fresh Fruit	Canned Fruit	Dinner Roll
	—	—	—	Salad Dressing
	Margarine	Margarine	Margarine/Ketchup	Angel Food Cake
	Iced Tea	Iced Tea	Iced Tea	Iced Tea
DINNER	Cranberry Juice	Fruit Nectar	Beef Consomme	Soup of the Day
	Chicken Diablo	Fillet of Fish	Short Ribs Jard	Lemon Chicken
	Mashed Potato	Rice	Tender Noodles	Rice
	Leaf Spinach	Asparagus	Squash Medley	Sugar Snap Peas
	Angel Food Cake	Diet Custard	Gelatin Cubes	Frosted Fruit
	Dinner Roll	Dinner Roll	Dinner Roll	Dinner Roll
	Margarine	Margarine	Margarine	Margarine
	Iced Tea	Iced Tea	Iced Tea	Iced Tea

PUREED MENU

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Orange Juice	Apple Juice	Grape Juice	Grapefruit Juice	Prune Juice	Cranberry Juice	Apricot Necta
Yogurt	Yogurt	Yogurt	Yogurt	Yogurt	Yogurt	Yogurt
Grits Applesauce Scrambled Egg	Oatmeal (Reg) Pureed Pears	Farina (Reg) Pureed Peaches Poached Egg	Grits (Reg) Baby Banana	Oatmeal (Reg) Applesauce Scrambled Egg	Farina (Reg) Pureed Pears	Oat Bran ureed Peach
Milk Margarine Coffee	Milk Margarine Coffee	Milk Margarine Coffee	Milk Margarine Coffee	Milk Margarine Coffee	Milk Margarine Coffee	Milk Margarine Coffee
PUREE Cream of Potato Carrots Double Choc. Cake Apple Juice Milk Margarine Applesauce	PUREE Minestrone Beef Puree Beets Italian Ice Custard Grape Juice Milk Margarine	PUREE Chicken Noodle Chicken Pureed Carrots Ice Cream Cranberry Juice Ice Cream Cranberry Juice Milk Margarine	PUREE Clam Chowder Pork Choc. Cake Green Beans Jello Apple Juice Milk Margarine	PUREE Vegetable Beef Beef Pureed Squash Italian Ice Custard Grapefruit Juice Milk Margarine	PUREE Golden Gate Mushroom Pureed Chicken Pureed Beets Cranberry Juice Jello/Flan Milk Margarine	PUREE Tomato Florentine Pureed Pork Green Beans Cake Grape Juice Milk Margarine
PUREE Cream of Potato Chicken Mashed Potatoes w/Gravy Pudding Tomato Juice Milk Margarine	PUREE Minestrone Pureed Pork Sweet Potato Cheese Cake Tomato Juice Milk Margarine	PUREE Chicken Noodle Pureed Beef Meatloaf Pureed Beans Custard Tomato Juice Milk Margarine	PUREE Clam Chowder Pureed Chicken Sweet Potato Pureed Beets Pudding Tomato Juice Milk Margarine	PUREE Vegetable Beef Pureed Pork Pureed Carrots Cheese Cake Tomato Juice Milk Margarine	PUREE Golden Gate Mushroom Flaked Fish Pureed Beef Pureed Squash Ice Cream Tomato Juice Milk Margarine	PUREE Tomato Florentine Chicken Mashed Potato w/Gravy Pudding Tomato Juice Milk Margarine

PSMS Results Per Quarter
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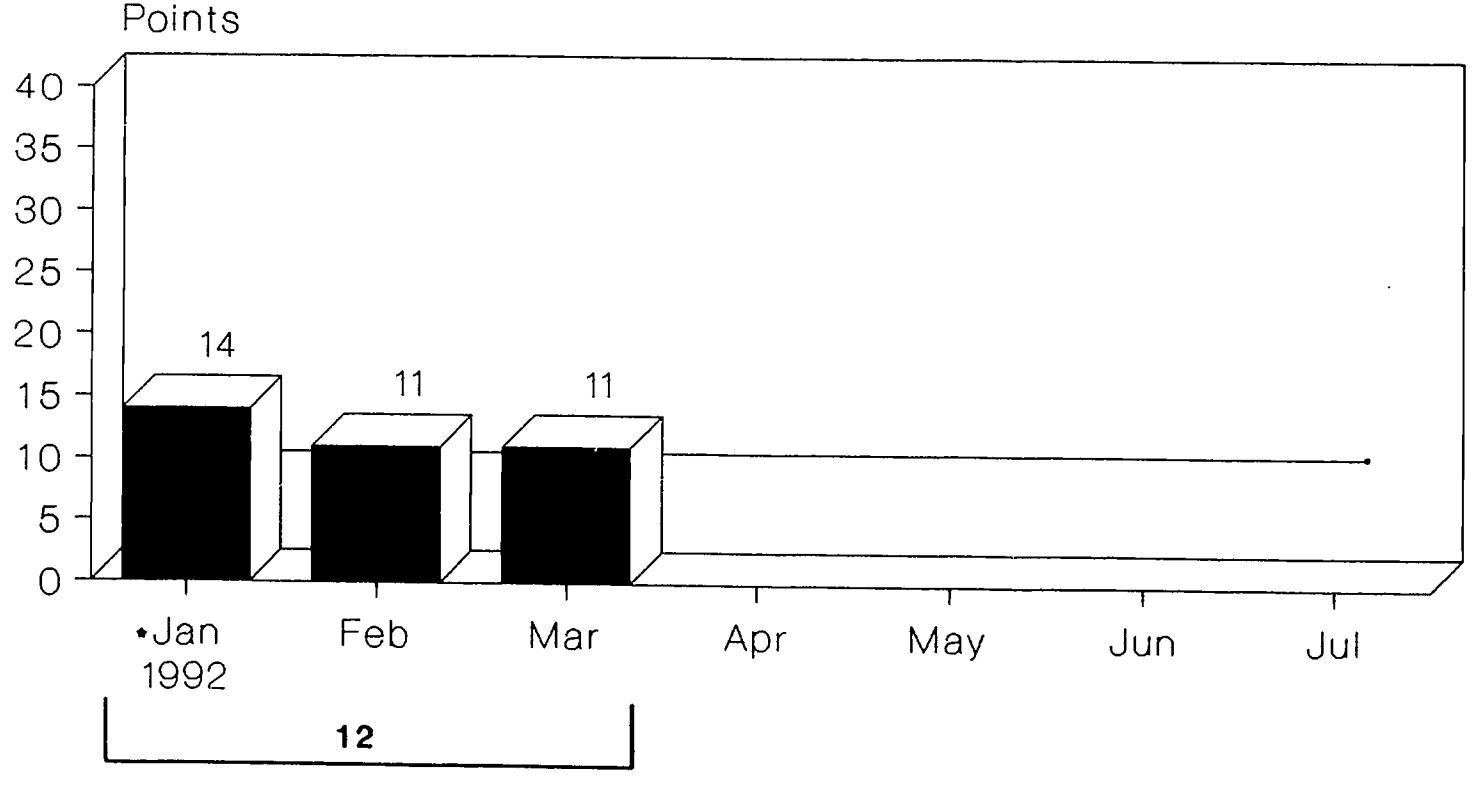

• Calendar Year