Policy & Procedure Manual
For Nutrition and Food Service in Healthcare Facilities

Becky Dorner & Associates, Inc.

Becky Dorner, RD, LD, President

www.beckydorner.com

info@beckydorner.com

License Agreement and Restrictions

READ THE FOLLOWING TERMS AND CONDITIONS BEFORE USING THIS MANUAL/CD-ROM OR ELECTRONIC VERSIONS. USING THIS MATERIAL INDICATES YOUR ACCEPTANCE OF THESE TERMS AND CONDITIONS.

LICENSE. The materials that are the subject of this Agreement (hereinafter referred to as the "Licensed Materials") shall consist of printed materials, electronic information, audio or video/DVD information or published information in any form by Becky Dorner & Associates, Inc. (hereinafter referred to as BD&A). Licensee and its Authorized Users acknowledge that the copyright and title to the Licensed Materials and any trademarks and service marks relating thereto remain with BD&A. Neither Licensee nor its Authorized Users shall have right, title or interest in the Licensed Materials except as expressly set forth in this agreement. In consideration of payment, BD&A hereby grants Licensee a non-exclusive, non-transferable, and revocable License to make permitted use of the Licensed Materials and to provide the Licensed Materials to Authorized Users in accordance with this Agreement.

USAGE. The Licensee shall ensure that only Authorized Users are permitted access to the Licensed Materials. Licensee may install and/or use Licensed Materials based on the agreed upon number of Authorized Users per terms of the Purchase Agreement, Letter of Agreement or Invoice. Licensee is not permitted to make unauthorized copies, alterations or modifications to the Licensed Materials unless specified in the Users' Manual or by prior written authorization of BD&A. Other than as specifically permitted in this Agreement, Licensee may not use the Licensed Materials for commercial purposes, including but not limited to the sale of the Licensed Materials or bulk reproduction or distribution of the licensed materials in any form.

MATERIAL CONTENT. The Licensed Materials are provided for your own personal, educational non-commercial use as a resource aid only. If you intend to use this material for the nutritional needs of an aged, sick or injured person or a person who suffers from a chronic disorder or disease, you should first consult that person's physician or physicians and if none, a physician who practices in the applicable field of medicine.

The Licensed Materials are in the nature of general concepts and, therefore, where its use may be appropriate for one person, its use may not be appropriate for another. The Licensed Materials are not intended to be a substitute for professional medical advice. Consequently, BD&A shall not be liable for any loss or damage directly or indirectly to the Licensee or Authorized Users of any material or information contained in the licensed materials.

LIMITATIONS ON WARRANTIES. BD&A shall not be liable to the Licensee for any indirect, special, incidental, punitive or consequential damages, including but not limited to loss of data, business interruption, or loss of profits arising directly or indirectly from or in connection with the license granted under this Agreement. The forgoing applies regardless of whether the claim or damages result or arise under breach of contract, tort, or any other legal theory.

BD&A makes no representation or warranty, and expressly disclaims any liability with respect to the content of any Licensed Materials, including but not limited to errors or omissions contained therein, libel, infringement of rights of publicity, privacy, trademark rights, moral rights, or the disclosure of confidential information. Except for the express warranties stated herein, the Licensed Materials are provided on an "as is" basis, and BD&A disclaims any and all other warranties, conditions, or representations (express, implied, oral or written), relating to the Licensed Materials or any part thereof, including, without limitation, any and all implied warranties of quality, performance, merchantability or fitness for a particular purpose. BD&A makes no warranties respecting any harm that may be caused by the transmission of computer virus, worm, time bomb, logic bomb or other such computer program. BD&A further expressly disclaims any warranty or representation to Authorized Users, or to any third party.

ACKNOWLEDGEMENT. THE LICENSEE AND AUTHORIZED USERS ACKNOWLEDGES THAT THEY HAVE READ THIS LICENSE, UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS AND CONDITIONS.

COPYRIGHT 2013, 2010, 2008, 2005, 2000, 1999, 1995, 1990 by Becky Dorner & Associates, Inc., all rights reserved. With the exceptions indicated in this agreement, no part of the Licensed Materials may be distributed, copied, modified, or revised without the prior written consent of the Becky Dorner & Associates, Inc. for commercial use or financial gain. **If the Licensee wishes to purchase a License for additional material reproduction or distribution, contact Becky Dorner & Associates, Inc. at 1-800-342-0285.**

Acknowledgements

Thank you to the following professionals for their tireless effort in revising this and past editions:

Author:
Becky Dorner, RD, LD
President, Becky Dorner & Associates, Inc., Akron, OH

Contributors:
Anna de Jesus, MBA, RD
President, Nutrition Alliance, LLC
Tempe, AZ

Gretchen Robinson, MS, RD, LD, FADA
Consultant Dietitian
Ada, OH

Reviewers:
Pam Brummit, MA, RD/LD
President/Owner, Brummit & Associates, Inc., Enid, OK

Elizabeth Friedrich, MPH, RD, CSG, LDN
Owner, Friedrich Nutrition Consulting
Salisbury, NC

Sandy Gary, MS, RD, LD
Consulting Dietitian, Nutrition Consulting Services, Inc.
Akron, OH

Kim Hofmann, RD, LD
Owner, Get to the Point
Akron, OH

Mary Ellen Posthauer, RD, CD, LD
President, MEP Healthcare Dietary Services
Evansville, IN

Terri Raymond, MA, RD, LD
President, Dietitian Consulting Services, LLC, Mercer Island, WA

Brenda Richardson, MA, RD, LD, CD
Chief Operations Officer, Dietary Consultants, Inc.
Salem, IN

Elise Smith, MA, RD, LD
VP Clinical Services
Nutrition Systems, Jackson, MS

Past Contributors and Reviewers:
Mary Abshire, RD, LD
President/Owner, Abshire Dietary Consultants, LLC, El Campo, TX

Lesli Doshier, RD
Dietary Directions
Fresno, CA

Vicki Redovian, MA, RD, LD
Director of Operations, Nutrition Consulting Services, Inc.
Akron, OH

Marolyn Steffen, RD, CD
Past Owner Steffen & Associates, Inc.
Valparaiso, IN

Mary Vester-Toews, RD
President, Dietary Directions
Fresno, CA

Data Processing:
Joni Kelly
Becky Dorner & Associates, Inc.
Akron, OH

©2013 Becky Dorner & Associates, Inc.

Policy & Procedure Manual for Nutrition and Food Service in Healthcare Facilities

This Manual is Approved for Use In:

____
Facility

____

____
Address

Administrator	Date
Registered Dietitian	Date
Director of Nursing	Date
Food Service Manager	Date

Administrator	Date
Registered Dietitian	Date
Director of Nursing	Date
Food Service Manager	Date

Administrator	Date
Registered Dietitian	Date
Director of Nursing	Date
Food Service Manager	Date

Administrator	Date
Registered Dietitian	Date
Director of Nursing	Date
Food Service Manager	Date

Administrator	Date
Registered Dietitian	Date
Director of Nursing	Date
Food Service Manager	Date

Administrator	Date
Registered Dietitian	Date
Director of Nursing	Date
Food Service Manager	Date

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Definitions ix
Introduction xii
Purpose and Objectives of the Nutrition and Food Services Department........ xiii

Menus and Special Diets
Menu Planning 1-1
Menu Shell Sample Form........ 1-2
Production Sheet Sample Form 1-4
Selective Menus........ 1-5
Standardized Recipes 1-6
Menu Substitutions........ 1-7
Menu Substitution Sheet Sample Form........ 1-17
Diet/Nutrition Care Manual 1-18
Transmission of Diet Orders........ 1-19
Diet Orders........ 1-20
Diets Available on Menu........ 1-21
Diet Order Sample Form 1-22
Diet Order Form 1-23
Diet Order Audit 1-24
Diet Order Audit Sample Form 1-25
Nutrition Supplement Order Audit Sample Form 1-26
Weekly Diet Census Sheet Sample Form 1-27
Foods Not Allowed on the Physician Ordered Diet 1-28
Use of Salt Substitute........ 1-29
Food Replacement for Individuals with Diabetes 1-30
Renal Diets........ 1-31
Dysphagia Diets 1-32
Altered Portions........ 1-33
Festivity Foods or Diet Holiday........ 1-34
Food and Beverages for Activities........ 1-35
Clear Liquid and Full Liquid Diet 1-36
NPO Diet Orders 1-37

Dining/Meal Service
The Dining Experience: Staff Responsibilities........ 2-1
Dining and Meal Service 2-2
The Person Centered Dining Approach........ 2-4
Resource: Traits of Great Service 2-5
Customer Service........ 2-6
Dining Room Service........ 2-7
Dining Atmosphere........ 2-8
Serving the Meal 2-9
Service Staff........ 2-10
Handling Customer Concerns 2-11
Dining Satisfaction Sample Form 2-12
Dining Satisfaction Meal Evaluation Sample Form........ 2-13
Table Setting 2-14
Condiments, Food Baskets and Food Items at the Table........ 2-15

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Restaurant Style Dining....2-16
Family Style Dining....2-17
Buffet Style Dining....2-19
Open Style Dining....2-21
In-Room Dining (Room Service)....2-23
24 Hour Dining....2-24
Special Occasions – Holiday and Theme Meals....2-25
Paid Feeding Assistants (Nursing Facilities)....2-26
Timely Meal Service....2-28
Meal Times and Frequency....2-29
Early and Late Meals....2-30
Select Menus....2-31
Meal Identification and Preference Cards/Tickets....2-33
Offering Food Replacements at Meal Times....2-34
Resource: Available Food Replacements Sample....2-35
Food Replacements Sample Form....2-36
Displaying the Menu....2-37
Accuracy and Quality of Tray Line Service....2-38
Portion Control....2-39
Adaptive Eating Devices....2-40
Meal Time Observation....2-41
Following the Meal Service....2-42
Packed Meals....2-43
Pets....2-44
Leave of Absence....2-45
Guest Meals....2-46
Food Availability....2-47
Nourishments and Supplements....2-48
Nourishments and Supplements Sample Form....2-49

Food Production and Food Safety
Hours of Operation....3-1
Food Service Manager's Responsibilities....3-2
HACCP and Food Safety....3-3
Resource: Pathogenic Microorganisms and Strategies for Their Control....3-6
Resource: CCP Decision Tree Table....3-7
HACCP Principles....3-8
Resource: HACCP Recipe Sample....3-10
Resource: Flow Chart....3-11
General HACCP Guidelines for Food Safety....3-12
Food Procurement and Facility Gardens....3-15
Accepting Food Deliveries....3-16
Food Storage....3-17
Freezer and Refrigerator Temperatures Sample Form 1....3-19
Freezer and Refrigerator Temperatures Sample Form 2....3-20
General Food Preparation and Handling....3-21
Meat and Vegetable Preparation....3-23
Food Temperatures....3-24

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Resource: Critical Temperatures for Safe Food Handling 3-25
Resource: Taking Accurate Temperatures 3-26
Resource: Final Cooking, Holding and Reheating Temperatures 3-28
Food Temperatures Sample Form 3-30
CCP Documentation Sample Form 3-31
Handling Cold Foods for Trayline 3-32
Taste Tasting 3-33
Use of Leftovers 3-34
Food Allergies 3-35
Ice 3-37
Personal Food Storage 3-38
Resource: Food Safety for Your Loved One 3-39
Providing Food and Supplies for Other Departments 3-40
Special Events Food/Meal Sample Form 3-41
Floor Stock 3-42
Floor Stock Supply Sample Form 3-43
Food Service Problems/Referral to Food Service Manager 3-44
Reporting a Foodborne Illness (FBI) 3-45

Sanitation And Infection Control
Food Safety and Sanitation 4-1
Food Safety – Food Service Manager's Responsibility 4-3
Employee Sanitary Practices 4-4
Authorized Personnel in Food Service Department 4-5
General Sanitation of Kitchen 4-6
Hand Washing 4-7
Use of Hand Antiseptic 4-8
Bare Hand Contact with Food and Use of Plastic Gloves 4-9
Cleaning Dishes/Dish Machine 4-10
Resource: Sanitation of Dishes/Dish Machine 4-11
Dish Machine Temperature Log 4-12
Dish Machine Temperature and Sanitizer Log Sample Form 4-13
Resource: Dish Machine Problems and Solutions 4-14
Maintenance of Dish Machine 4-15
Cleaning Dishes - Manual Dishwashing 4-16
Resource: Sanitation of Dishes/Manual Dishwashing 4-17
Handling Clean Equipment and Utensils 4-18
Bedside Water Containers 4-19
Dry Storage Areas 4-20
Production, Storage and Dispensing of Ice 4-21
Isolation Meals 4-22
Kitchen Cloths 4-24
Waste Disposal 4-25
Pest Control 4-26

Cleaning Instructions
Cleaning and Sanitation of Dining and Food Service Areas 5-1
Sample Cleaning Schedule 5-2

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Daily Cleaning Schedule Sample Form....................5-3
Weekly Cleaning Schedule Sample Form....................5-4
Monthly Cleaning Schedule Sample Form....................5-5
Resource: Infection Control Cleaning Agents....................5-6
Material Safety Data Sheets....................5-7
Cleaning Instructions
- Broilers....................5-9
- Cabinets and Drawers....................5-10
- Can Opener....................5-11
- Cleaning Cloths, Pads, Mops and Buckets....................5-12
- Coffee, Beverage, Juice, Frozen Yogurt or Ice Cream Machines....................5-13
- Counter Space....................5-14
- Cutting Boards....................5-15
- Floors, Tables and Chairs....................5-16
- Food Carts....................5-17
- Food Preparation Appliances....................5-18
- Freezers....................5-19
- Fryers....................5-20
- Garbage Disposals....................5-21
- Hoods and Filters....................5-22
- Ice Machine and Equipment....................5-23
- Microwave Oven....................5-24
- Ovens....................5-25
- Ranges....................5-26
- Refrigerators....................5-27
- Slicers....................5-28
- Steam Tables....................5-29
- Toasters....................5-30

Safety
Safety Guidelines....................6-1
Safety in Food Preparation....................6-3
Equipment Safety....................6-4
Knife Safety....................6-5
Dishware and Glassware Safety....................6-6
Dish Clearing and Cleaning Safety....................6-7
Receiving and Storage Safety....................6-8
Lifting Techniques....................6-9
Floor Safety....................6-10
Fire Prevention....................6-11
Fire Plan for Food Service Department....................6-12
Fire Safety Rules....................6-13
Resource: How to Contain Food Service Department Fires....................6-14
Facility Specific Policy and Procedure for Fires....................6-15
Resource: Emergency First Aid....................6-16
Emergency Eye Wash....................6-17
Incident Report....................6-19
Malfunctions and Repairs....................6-21

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Personnel/Training

Personnel - General 7-1
Food Service Supervision 7-2
Line of Authority 7-3
Staffing the Food Service Department 7-4
Interview Sample Questions 7-5
Employee Physical Sample Form 7-6
Mantoux Test Sample Form 7-8
Reference Check Sample Form 7-10
Employee Information Sample Form 7-12
Training/Orientation 7-13
Nursing Homes: Resident's Rights Training 7-15
Hospitals: Patient's Rights Training 7-16
Training/Orientation Sample Form 7-17
Health Insurance Portability and Accountability Act of 1996 (HIPAA) 7-18
Personal Hygiene Training 7-19
Inservice Training 7-20
Resource: Inservice Training 7-21
Inservice Training Report Sample Form 7-22
Inservice Sign In Sheet Sample Form 7-23
Evaluating Food Service and Clinical Nutrition Personnel 7-24
Employee Evaluation Forms 7-25
Vacation/Leave Request Sample Form 7-26
Employee Request for Leave Sample Form 7-27

Clinical Documentation

Right to Deviate from Clinical Policy and Procedure 8-1
Philosophy and Standards of Clinical Care 8-2
Documenting in the Medical Record 8-3
Diet History 8-4
Food Preferences Sample Form 8-5
Alternates for Food Dislikes 8-6
System for Recording Food Preferences 8-7
Recording Food Preferences 8-8
Recording Percent of Meal Consumed 8-9
Alternate Meal Recording System 8-10
Food Intake Record Total Meal Percentage Sample Form 8-11
Food Intake Record – Point System Sample Form 8-12
Food Intake Record 8-13
Nutrient Intake Study 8-14
Food Intake Study Sample Form 8-15
Individuals Who Do Not Drink Milk 8-16
Nutrition Screening for Referrals to the Registered Dietitian 8-17
Referrals for Registered Dietitian Sample Form 1 8-19
Referrals for Registered Dietitian Sample Form 2 8-20
Nutrition Screening Sample Form 8-21
Letter to Physician Sample Form 8-22
MNA Physician Communication Mini Nutritional Assessment Report for Malnutrition 8-23

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Medical Nutrition Therapy Documentation 8-24
Comprehensive Medical Nutrition Therapy Assessment 8-28
Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment 8-31
Comprehensive Care Plan 8-34
Resource: Weight-Related Nutrition Interventions 8-36
Medical Nutrition Therapy Documentation Forms (Hospital) 8-39
Nutrition Care Process Medical Nutrition Therapy Assessment Forms
- Medical Nutriton Therapy Abbreviations 8-40
- Medical Nutrition Therapy Assessment Sample Form 8-41
- Medical Nutrition Therapy Notes Sample Form 8-42
- Worksheet for MDS 3.0 Section K Swallowing/Nutrition Status Sample Form 8-43
- Medical Nutrition Therapy Re-Assessment Sample Form 8-44
- Medical Nutriton Therapy Care Plan Sample Form 8-45

Medical Nutrition Therapy Documentation Forms 8-46
Medical Nutrition Therapy Recommendations 8-47
Nutrition Recommendations Sample Form 8-48
Communication of Nutritional Concerns 8-49

Anthropometrics
Obtaining Accurate Heights 9-1
Resource: How to Obtain Accurate Heights 9-2
Obtaining Accurate Weights 9-3
Resource: How to Obtain Accurate Weights 9-4
Adjusting Weights for Amputees 9-6
Obtaining Measurements for Unweighable Individuals 9-7
Measurement Tracking for Unweighable Individuals Sample Form 9-8
Resource: Height/Weight Tables for Determining Body Weight Ranges 9-9
Body Mass Index 9-10
Resource: Body Mass Index Tables 9-11
Resource: Significant Weight Change 9-13
Significant Weight Change Chart 9-14
Tracking Weight Changes 9-18
Monthly Weight Record Sample Form 9-19
Individual Weight Chart Sample Form 9-20
Weekly Weight Record Sample Form 9-21
Significant Weight Changes Sample Form 9-22
Weight Change Notification and Recommendations Sample Form 9-23
Significant Weight Loss Sample Form 9-24
Immediate Temporary Interventions for Unplanned Significant Weight Loss 9-25
Significant Weight Loss 9-26
Significant Weight Gain 9-29

Nutrition Interventions
Resident Wound, Weight Intervention and Nutrition Support (WINS) Committee 10-1
Interventions for Unintended Weight Loss 10-2
Resource: Interventions for Unintended Weight Loss 10-3
Resource: Calorie Boosters/Fortified Foods 10-6

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Resource: Protein Boosters 10-7
High Calorie/High Protein Supplements 10-8
Supplement Formulary 10-9
Dehydration 10-10
Resource: Additional Recommendations for Promoting Adequate Hydration 10-12
Fluids at the Bedside 10-13
Encourage Fluids Order 10-14
Fluids Restriction Order 10-15
Distribution of Fluids for Fluid Restriction/Encourage Fluids Orders Sample 10-16
Pressure Ulcers 10-17
  Resource: Risk Factors for Pressure Ulcers 10-19
  Resource: Recommended Nutritional Needs for Pressure Ulcers 10-20
Individuals on Unsupplemented Clear Liquids or NPO 10-21
Dysphagia 10-22
Resource: Dysphagia Warning Signs 10-23
EAT-10 Swallowing Screening Tool 10-24
Resource: Positioning Tips to Increase Independence and Reduce Risk of Aspiration or Choking 10-25
Thickened Liquids 10-26
End of Life Decisions 10-28
Guidelines for Enteral Feeding Eligibility 10-29
Enteral Nutrition Care 10-30
Basic Guidelines for Enteral Feeding 10-31
Documentation for Enteral Feeding 10-32
Enteral Feeding Assessment 10-33
Transitioning to Oral Feedings from Enteral Feedings 10-34
Enteral Formulas 10-35
Total or Peripheral Parenteral Nutrition 10-36
Food-Medication Interactions 10-38
Education for Food-Medication Interactions 10-39

Quality Assurance/Performance Improvement
Quality Assurance/Performance Improvement 11-1
Facility Goals 11-3
Monthly QA/PI Reports Sample Form 11-5
Sanitation Audit 11-7
Sanitation Audit Sample Form 1 11-8
Sanitation Audit Sample Form 2 11-10
Meal Preparation and Service Audit 11-15
Meal Preparation and Service Audit Sample Form 11-16
Steam Table and Tray Line Audit 11-18
Steam Table and Tray Line Audit Sample Form 11-19
Meal Round Audit 11-20
Meal Round Audit Sample Form 11-21
Food Satisfaction Audit 11-23
Food Satisfaction Questionnaire Sample Form 11-24
Test Meal/Tray Audit 11-25
Test Meal/Tray Audit Sample Form 11-26

©2013 Becky Dorner & Associates, Inc.

Table of Contents

Medical Record and Documentation Audit 11-27
Chart Audit Sample Form 11-29
Diet Order Audit Sample Form 11-30
Supplements/Nourishments Audit Sample Form 11-31
In-Depth Documentation Audit Sample Form 11-32
Nourishment/Supplement Audit 11-33
Nourishment/Supplement Audit Sample Form 11-34
Meal Survey Sample Form 1 11-36
Meal Survey Sample Form 2 11-37
Resource: Audit to Assess Quality of Care Provided and to Prepare for Surveys 11-38

Disaster Planning
Emergency/Disaster Planning 12-1
Emergency Plan Employee Training 12-2
Resource: Food Service Disaster Plan 12-4
Coordination of Emergency and Disaster Plan 12-6
Responsibilities and Assignments Sample Form 12-7
Letter of Intent for Provision of Emergency Supplies Sample 12-8
Emergency Contact Information 12-9
Employee Contact Information Sample Form 12-10
Water Requirements 12-11
Sources of Water During an Emergency 12-12
Water Purification 12-13
Non-Perishable Foods List 12-14
Emergency Menu and Supplies 12-15
Resource: Emergency Plan Special Diets Conversion Table 12-17
Sample Menu Shell 12-18
Suggested Emergency Menu Pattern 12-19
Suggested Serving Sizes for Starches 12-20
Day 1 Emergency Meal Plan – Assumes No Utilities 12-21
Day 2 Emergency Meal Plan – Assumes No Utilities 12-22
Day 3 Emergency Meal Plan – Assumes No Utilities 12-23
Sample 3 Day Emergency Meal Plan for Pureed Diets 12-24
Hand Washing During a Disaster 12-25
Sanitizing Dishes During a Disaster 12-26
General Disaster Supplies 12-27
Disaster Resources 12-29

Appendix
Index to Federal Policies and Procedures and Nursing Home Federal Regulations 13-1
References and Resources 13-14

©2013 Becky Dorner & Associates, Inc.

Definitions

Food Service Manager: Directs the food service department. May also be called food service director, dietary manager or dining services director. May also be involved with documentation and care plan meetings. May be a certified dietary manager (CDM) and/or certified in food protection (CFPP). Works under the supervision of the registered dietitian for clinical documentation. The CMS State Operations Manual states:

> A director of food services has no required minimum qualifications, but must be able to function collaboratively with a qualified dietitian in meeting the nutritional needs of the residents.
>
> 42 CFR 483.35(b), F362, Standard Sufficient Staff: Determine if the facility employs sufficient support personnel competent to carry out the functions of the dietary service.

Facilities should employ a qualified food service manager, since this is the person in charge of the kitchen who is ultimately responsible for assuring safe, wholesome, high quality food and resident/patient satisfaction.

Qualified Dietitian: The CMS State Operations Manual requires that

> The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.
> §483.35(a)(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.
>
> §483.35(a)(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.
>
> A dietitian qualified on the basis of education, training, or experience in identification of dietary needs, planning and implementation of dietary programs has experience or training which includes: Assessing special nutritional needs of geriatric and physically impaired persons; Developing therapeutic diets; Developing ―regular diets‖ to meet the specialized needs of geriatric and physically impaired persons; Developing and implementing continuing education programs for dietary services and nursing personnel; Participating in interdisciplinary care planning; Budgeting and purchasing food and supplies; and Supervising institutional food preparation, service and storage.

Registered Dietitian (RD): Registered by the Commission on Dietetic Registration (CDR) of the Academy of Nutrition and Dietetics (minimum of bachelor degree in dietetics and/or nutrition with approved internship, and has passed registration exam). CDR defines the Registered Dietitian (RD) as:

> …an individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years). (2012)

©2013 Becky Dorner & Associates, Inc.

Definitions

Licensed Dietitian (LD): Licensed by the state if the state has dietetic licensure. Each state has different requirements for licensure however, most include minimum qualifications of the RD as noted above. Some states use licensed dietitian/nutritionist or LDN.

Certified Dietitian (CD): Four-year degree in nutrition/dietetics or food and nutrition. Certified by the state. Each state has different requirements for certification however, most include minimum qualifications of the RD as noted above.

Nutrition or Support Staff: May include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers.

Nutrition Associate: Four-year degree in nutrition/dietetics or food and nutrition. Works under the supervision of the RD/LD

Dietetic Technician: Minimum completion of an associate degree in nutrition/dietetics. May be registered by the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics (dietetic technician, registered or DTR – has completed a qualified internship and passed the CDR registration exam). Works under the supervision of the RD/LD.

CDR defines the Dietetic Technician, Registered (DTR) as:

> "an individual who has met current minimum requirements through one of three routes:
>
> 1. Successful completion of a minimum of an Associate degree and Dietetic Technician Program through a program accredited by Accreditation Council for Education in Nutrition and Dietetics (ACEND) of The Academy of Nutrition and Dietetics (Academy).
> 2. Successful completion of a Baccalaureate degree; met current academic requirements (Didactic Program in Dietetics) as accredited by ACEND of the Academy; successfully completed a supervised practice program under the auspices of a Dietetic Technician Program as accredited by ACEND.
> 3. Completed a minimum of a Baccalaureate degree; successfully completed a Didactic Program in Dietetics as accredited by ACEND of the Academy.
>
> In all three routes, the individual must successfully complete the Registration Examination for Dietetic Technicians. To maintain the DTR credential, the DTR must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 50 hours of approved continuing professional education every five years)." (2012)

Medical Nutrition Therapy (MNT): According to the Academy of Nutrition and Dietetics:

> "is an evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/ reassessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions". (2012)

Nutrition Care Process: According to the Academy of Nutrition and Dietetics:

> A process for identifying, planning for, and meeting nutritional needs. Includes four steps: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, Nutrition Monitoring and Evaluation. (Reference: The Academy's International Dietetics and Nutrition Terminology Reference Manual 3rd Edition.)

©2013 Becky Dorner & Associates, Inc.

Definitions

Therapeutic Diet: According to the Academy of Nutrition and Dietetics:

A diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium, potassium). (Reference: McCauley S, MS MBA RD LDN FADA and Hager M, PhD RD FADA. Practice Applications. Why Are Therapeutic Diet Orders an Issue Now and What Does It Have To Do with Legal Scope of Practice? J Am Diet Assoc. 2009; 109: 1515-1519.)

The definition for Therapeutic Diet is used by CMS in its Resident Assessment Instrument Minimum Data Set (MDS) 3.0 for Long Term Care/Nursing Homes. CMS additionally included the Academy of Nutrition and Dietetics' interpretive recommendations for clarifying a "supplement" and mechanically altered diets for coding purposes on the MDS:

- Therapeutic diets are not defined by the content of what is provided or when it is served, but ***why*** the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition, which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0500D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).
- A mechanically altered diet should not automatically be considered a therapeutic diet. (Reference: MDS 3.0 RAI Manual, Chapter 3, Section K: Swallowing/Nutritional Status.)

Scope of Practice: According to the Center for Health Professions:

Legal scopes of practice for the health care professions establish which professionals may provide which health care services, in which settings, and under which guidelines or parameters. With few exceptions, determining scopes of practice is a state based activity. State legislatures consider and pass the practice acts, which become state statute or code. State regulatory agencies, such as medical and other health professions' boards, implement the laws by writing and enforcing rules and regulations detailing the acts." (Reference: Promising Scopes of Practice Models for the Health Professions. Catherine Dower, JD; Sharon Christian, JD; and Edward O'Neil, PhD, MPA, FAAN. The Center for the Health Professions, University of California, San Francisco, 2007.) For more information, please visit the Center for Health Professions http://futurehealth.ucsf.edu. (The Academy of Nutrition and Dietetics has adopted this definition.)

©2013 Becky Dorner & Associates, Inc.

Introduction

It is the policy of this company to ensure that nutritional and dietary needs are met to promote optimal health of all individuals.

This manual will address policies and procedures for the following:

1. Menus and Special Diets
2. Dining/Meal Service
3. Food Production and Food Safety
4. Sanitation and Infection Control
5. Cleaning Instructions
6. Safety
7. Personnel/Training
8. Clinical Documentation
9. Anthropometrics
10. Nutrition Interventions
11. Quality Assurance/Improvement
12. Disaster Planning

A qualified dietitian is available to assist with the food service and the nutritional needs of the customer (individuals/patients/residents). If a full-time dietitian is not employed, a manager of food service is designated (referred to as food service manager for the purpose of this manual), and a part-time dietitian or consultant dietitian is available. Nutrition support staff such as a four year nutrition/dietetics graduate, dietetic technician registered, certified dietary manager, etc. work under the supervision of the registered dietitian (RD). This manual is utilized in conjunction with these professionals.

Note: A qualified dietitian is one who meets the criteria for licensure or certification by the state dietetic board, or is registered, or eligible for registration by the Academy of Nutrition and Dietetics (Academy).

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Purpose and Objectives of the Nutrition and Food Service Department

The purpose of the nutrition and food service department is to provide high quality, nutritious, palatable and attractive meals in a safe sanitary manner. Therapeutic diets, written and maintained by the registered dietitian (RD) or designee, are served as prescribed by the attending physicians. An effort is made to cater to personal preferences and food is prepared to meet individual needs.

The department functions following policies developed in accordance with local, state and federal regulations. The department is responsible for planning, organizing, evaluating and directing all food and nutrition services.

Objectives of the Nutrition and Food Service Department:

1. To provide nutritious, palatable and attractive meals to meet and satisfy individual needs.

2. To provide the highest quality food possible at a cost consistent with the policy of the facility.

3. To promote optimal nutritional status of each individual through medical nutrition therapy (MNT), in accordance with the physicians' orders and consistent with each individual's physical, cultural, religious and social needs.

4. To establish standards for planning menus, preparing and serving food, and controlling meal costs.

5. To communicate as needed to achieve department goals. To review the work of the nutrition and food service department for the purpose of improving the services rendered.

6. To provide the services of a RD or designee to assure that the nutritional needs of individuals living in the facility are met.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Menus and Special Diets

- ♦ Menu Planning 1-1
- ♦ Menu Shell Sample Form 1-2
- ♦ Production Sheet Sample Form 1-4
- ♦ Selective Menus 1-5
- ♦ Standardized Recipes 1-6
- ♦ Menu Substitutions 1-7
- ♦ Menu Substitution Sheet Sample Form 1-17
- ♦ Diet/Nutrition Care Manual 1-18
- ♦ Transmission of Diet Orders 1-19
- ♦ Diet Orders 1-20
- ♦ Diets Available on Menu 1-21
- ♦ Diet Order Sample Form 1-22
- ♦ Diet Order Form 1-23
- ♦ Diet Order Audit 1-24
- ♦ Diet Order Audit Sample Form 1-25
- ♦ Nutrition Supplement Audit Sample Form 1-26
- ♦ Weekly Diet Census Sheet Sample Form 1-27
- ♦ Foods Not Allowed on the Physician Ordered Diet 1-28
- ♦ Use of Salt Substitute 1-29
- ♦ Food Replacement for Individuals with Diabetes 1-30
- ♦ Renal Diets 1-31
- ♦ Dysphagia Diets 1-32
- ♦ Altered Portions 1-33
- ♦ Festivity Foods or Diet Holiday 1-34

©2013 Becky Dorner & Associates, Inc.

Menus and Special Diets

♦ **Food and Beverages for Activities....................1-35**

♦ **Clear Liquid and Full Liquid Diet....................1-36**

♦ **NPO Diet Orders....................1-37**

©2013 Becky Dorner & Associates, Inc.

Menu Planning

Policy:

Nutritional needs of individuals will be provided in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences (adjusted for age, gender, activity level and disability), through nourishing, well-balanced diets, unless contraindicated by medical needs.

Procedure:

1. Menu planning is completed by the facility for at least two weeks in advance of need and menus are kept on file for a minimum of 90 days (check individual state regulations for exceptions to this procedure). All current menus will be posted in the kitchen area during the appropriate time period. Regular and therapeutic menus are written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances. If menus are written in cycles, they are rotated. Menu cycles should cover a 4 to 5 week period of time for long term care settings. If select menus are in place, rotations can be as little as 1 to 7 days depending on the number of selections, and the average length of stay. (See Menu Shell Sample Forms on the following pages.)

2. Menus are written using an accepted, standard meal planning guide, such as the USDA Choose MyPlate.

3. Regular and therapeutic menus are written by the facility's food and nutrition professional in accordance with the facility's approved diet manual. All menus should be approved by the registered dietitian (RD) or designee.

4. Menus are written to include at least three meals daily at regular times, in amounts consistent with nutritional needs. A substantial evening meal consisting of three or more menu items is offered, one of which includes high quality protein. The meal contains no less than 20% of the day's total nutritional requirements. A nourishing snack is offered at bedtime. A nourishing snack is defined as a verbal offering of items, single or in combination, from the basic food groups. In order for the nourishing snack to be considered adequate, individual patients/residents should participate in the selection, and verbalize satisfaction.

5. Menus are posted in areas, and at heights where all individuals can easily view them.

6. Temporary changes in the menu are noted on the menu substitution sheets and posted for the staff's benefit. (See Menu Substitution Sheet Sample Form in this section of the manual.) Permanent menu changes are approved by the (RD) or designee.

7. Significant information pertaining to individual's diets and response to the diets are recorded in the medical record.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Menu Shell Sample Form

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BREAKFAST							
	Substitutions:						
LUNCH							
	Substitutions:						
DINNER							
	Substitutions:						
HS							

©2013 Becky Dorner & Associates, Inc.

Menu Shell Sample Form 2

	REGULAR/NAS	MECHANICAL SOFT	PUREE	CONSISTENT CARBOHYDRATE	CONSISTENT CARBOHYDRATE PUREE
B R E A K F A S T					
	Substitutions:				
L U N C H					
	Substitutions:				
D I N N E R					
	Substitutions:				
H S					

©2013 Becky Dorner & Associates, Inc.

Production Sheet Sample Form

Cycle __________ Week __________ Day ____________________

Item	Portion Size	Amount to Prepare	Special Instructions (Recipe #)

Freezer Pull	Pre-Preparation

©2013 Becky Dorner & Associates, Inc.

Selective Menus

Policy:

If selective menus are offered, selections will be provided within allowed dietary modifications. A non-select menu will be available for anyone who does not make meal choices on their own. If an individual is unable to make their own choices, a family member may make the selection, or staff will choose based on known food preferences and diet order. Nutritional supplements may be added to the selective menu after discussion with the individual.

Procedure:

1. Selective menus are provided to all individuals who choose to make their own menu selections. Assistance from family or staff is encouraged for those who cannot make their own menu choices.

2. Nutrition and food service staff will label menus with the individual's name, room number and diet, and deliver the menus.

3. Nursing staff may assist in the delivery of menus and in menu selection as deemed necessary. Family members are also encouraged to assist when needed. Menus are returned to the food service department when complete.

4. The Food Service Manager, or designee will review food choices for individuals on therapeutic diets, and refer to the registered dietitian (RD) or designee if there are concerns.
   a. The RD or designee will counsel individuals, if needed, on appropriate choices for their therapeutic diets to encourage a nutritionally adequate diet and will document accordingly in the medical record. Interview the individual regarding nutritional interventions that are acceptable (i.e. milkshake, fortified cereal, etc.) for those needing high calorie/protein supplements or other nutrition interventions.
   b. The RD or designee will add the intervention to the individual's selective menu.
   c. The RD or designee will observe the individual's acceptance and tolerance to the nutritional intervention and adjust as needed.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Standardized Recipes

Policy:

Standardized recipes are used when preparing menu items.

Procedure:

1. Standardized recipes (in appropriate portion sizes) for each set of cycle menus are maintained in the facility.

2. The food service manager or designee is responsible for adjusting and recording the recipes for the needed yield.

3. Cooks/chefs are expected to use and follow the recipes provided.

4. In addition to the recipes provided with the menus, a collection of additional recipes should be available in the kitchen (these should also be adjusted to the needed yield).

5. Cooks/chefs should discuss problems or concerns about recipes with the food service manager so that issues can be resolved.

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Policy:

To provide a substitute when an uncontrollable situation (i.e. inventory emergency) has temporarily made the item unavailable, decisions on menu substitutions will be made after discussion with the food service manager whenever possible.

Procedure:

1. Kitchen staff will consult with the food service manager or designee on any needed menu substitutions.

2. If the food service manager is unavailable, the designated staff (i.e. assistant supervisor, cook/chef) will refer to the Substitution Lists. (See Substitution Lists in this section of the manual).

3. All changes to the menu will be recorded on the Menu Extension Sheets and the Menu Substitution Sheet (see sample forms in this section of the manual). The date, menu item, substitution and reason for the substitution will be recorded on the Menu Substitution Sheet.

4. Menu changes should be evaluated periodically by the registered dietitian (RD) or designee and an appropriate plan of action should be made according to the facility's needs.

5. Records of menu substitutions are retained for 12 months. These records should be reviewed periodically by the food service manager and/or RD or designee to assess for any concerns that may need to be addressed.

Note: To use the Substitution Lists, staff may choose any food within the same list to substitute for the unavailable food. For example, if 1/2 cup corn is the scheduled item, then a starchy vegetable from on the "Breads and Starches" list (where corn is listed) may be substituted, such as 1/2 cup peas, 1/3 cup yams, etc.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Vegetables

Provide carbohydrates, vitamin A, vitamin B6, potassium, copper, dietary fiber, calcium, iron, magnesium, vitamin C and folate
Preferably prepared without added fats

Food and Amount Equivalent to ½ Cup	
Fresh • 1 cup raw vegetables	**Canned, Cooked, Frozen or Juice** • ½ cup

Vegetables are organized into 5 subgroups, based on their nutrient content. Include a vitamin C source every day and a vitamin A source 3 to 4 times a week. Some commonly eaten vegetables in each subgroup are:

Dark Green Vegetables
- +*Broccoli
- *Collard greens
- +*Dark green leafy lettuce
- Edamame (fresh soy beans)
- *Endive
- *Escarole
- *Kale
- *Mesclun
- *Mustard greens
- *Romaine lettuce
- Snow peas
- +*Spinach
- *Turnip greens
- *Watercress

***Red & Orange Vegetables**
- *Carrots
- *Carrot juice
- *Pumpkin
- +*Red peppers
- *Sweet potatoes (starchy)
- +Tomatoes
- +Tomato juice
- +*Vegetable juice
- +*Winter squash (acorn, butternut, hubbard)

Dry Beans And Peas (Starchy)
- Black beans
- Black-eyed peas
- Butter beans
- Garbanzo beans (chickpeas)
- Kidney beans
- Lentils
- Lima beans (mature)
- Navy beans
- Pinto beans
- Purple hull peas
- Soy beans
- Split peas
- Tofu (bean curd made from soybeans)
- White beans

Other Starchy Vegetables
- +*Acorn squash
- Corn (white or yellow)
- *Green peas
- Jicama (yam bean root)
- Lima beans (green)
- Potatoes

Other Vegetables & Juices
- Artichokes
- Asparagus
- Bean sprouts
- Beets
- *Bok choy
- +Brussels sprouts
- *Cabbage
- Cauliflower
- Celery
- Cucumbers
- Eggplant
- Green beans
- +Green peppers
- Iceberg (head) lettuce
- Mushrooms
- Okra
- Onions
- Parsnips
- Summer squash
- Turnips
- Wax beans
- Zucchini

+ Good source of vitamin C
* Good source of vitamin A

Note: Dry beans and peas may be counted as either a vegetable or a protein food

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Fruits

Provide carbohydrates, dietary fiber, minerals, potassium, vitamins A and C
Choose majority of servings from whole fruits (fresh, frozen, canned or dried) rather than juice

Food and Amount Equivalent to ½ Cup	
Fresh Fruit (1 piece) • Apple • *Apricots (4 whole or 5½ ounces) • Banana • Figs • +Guava • +Grapefruits • Grapes (1 small bunch) • +Kiwi • *Mango • Nectarine • +Orange • +*Papaya • Peach • Pear • Pineapple • Plum (2 small) • Raspberries • +Tangerine **Fresh Fruit** (1 cup) • Cubed Melon (+*cantaloupe, honeydew, watermelon) • Strawberries • Fresh fruit cubed/small pieces • Berries: blueberries, red or black raspberries	**Fruit Juice:** ½ cup fruit juice (100% juice) • Apple juice • Apricot nectar • Cranberry juice • Grape juice • +Grapefruit juice • +Orange juice • Peach nectar • Pear nectar • Pineapple juice • Pomegranate juice • Prune juice • +Vitamin C Fortified juices **Canned or Frozen Fruit** ½ cup canned or frozen fruit **Dried Fruit** ¼ cup dried fruit • Apples • Apricots • Bananas • Dates • Figs • Mango • Papaya • Prunes • Raisins

+ Good source of vitamin C
* Good source of vitamin A

Please Note: According to ChooseMyPlate, the serving size for juice is ½ cup. However, in order to provide 90 mg vitamin C a day, many health care facilities serve 6 ounces of a high vitamin C juice or vitamin C fortified juice. Some states also require a 6 ounce serving. Please check your state regulations to assure that all requirements are met.

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Grains (Whole Grain/enriched)

Provides B vitamins, carbohydrates, dietary fiber and iron
Choose at least half of the grains as whole
Preferably prepared without added fats or sugars

Food and Amount Equivalent to 1 Ounce	
Breads • 1 slice bread • ½ bun, bagel or English muffin • 1 small pancake or waffle • 1 taco or tortilla shell, 6" across (corn or flour) **Cereals** • 1 cup dry cereal or 1 ¼ cups puffed cereal • ½ cup cooked cereal	**Crackers** • 7 round or square crackers • 2 rye crisps • 5 whole wheat crackers **Grains** • ½ cup pasta • 3 cups popcorn • ½ cup rice, couscous, barley, bulgar, risotto, polenta

Notes :

- For whole grain choices, the first ingredient listed on the label should be a whole grain
- When grains have been refined, they should be enriched (B vitamins and iron are added to replace nutrients lost during refinement)
- Grains fortified with folic acid (i.e. some ready to eat whole grain cereals) should be included especially for women who are capable of becoming pregnant

Dairy (Milk and Milk Products)

Provides carbohydrates, protein, calcium, vitamin D, potassium, magnesium, phosphorus, riboflavin, vitamin A and saturated fat if fat containing options are chosen
Choose fat free or low fat options

Food and Amount Equivalent to 1 Cup	
Milk • 1 cup milk • ½ cup evaporated milk • 1 cup Yogurt **Miscellaneous** • 1 cup pudding made with milk • 1 cup frozen yogurt **Milk Substitutes** • 1 cup fortified soy beverage (calcium, vitamin A and D) • 1 cup fortified soy yogurt (calcium, vitamin A and D) • 3 oz Tofu made with calcium-sulfate	**Cheese** • 1½ oz hard cheese (cheddar, mozzarella, parmesan, Swiss) • 1/3 cup shredded cheese • ½ cup ricotta cheese • 1 ½ oz soy cheese • 2 oz processed cheese • 2 cups cottage cheese (for calcium equivalent of 300 mg)

Notes:

- Choose fat free, reduced fat or nonfat dairy products milk depending on diet goals
- Choose fresh, dried or evaporated
- Milk and dairy products may be used in cooking and food preparation (i.e. cream soups, puddings, etc.)

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Protein Foods (Seafood, Poultry, Meat and Alternatives)
Provides protein, fat, B vitamins (niacin, thiamin, riboflavin, B6), iron,
magnesium and omega-3 fatty acids
Choose low fat, lean or fat free protein foods preferably prepared with little, if any added fat

Food and Amount Equivalent to 1 Ounce	
Fish and Seafood • 1 oz fish, shellfish • **Note:** Include 8 oz or more of seafood each week* **Dried Beans, Peas** • Legumes: ¼ cup cooked peas or beans (baked, black, butter, garbanzo, kidney, lentils, navy, pinto, white, etc.) **Nuts and Seeds** (unsalted) • ½ oz nuts (almonds, pistachios, walnuts, seeds, etc.) • 1 Tbs peanut butter or almond butter	**Lean Meat, Poultry** • 1 oz beef, pork, veal, chicken, turkey **Meat Alternates** • 1 egg, or 2 egg whites or ¼ cup egg substitute • 3 oz vegetarian soy or "meat" product • ¼ cup or 2 oz tofu • 1 oz tempeh, cooked • 1 oz cheese, preferably low fat • ¼ cup cottage cheese, preferably low fat **High Fat Meats** (Use very sparingly) • 1 oz chorizo (Mexican sausage) • 1 oz lunch meat • 1 oz sausage

*Preferably seafood that is high in omega-3 fatty acids, eicosepentaenoic acide (EPA) and docoosahexaenoic acid (DHA). Choose a mixture of seafood that are high in EPA+DHA and relatively low in methyl mercury, including salmon, anchovies, herring, sardines, Pacific oysters, trout, Atlantic and Pacific mackerel (not king mackerel which is high in mercury). A total of 1750 mg per week of EPA+DPA provides an average of 250 mg per day of omega-3 fatty acids.

See *Appendix* for a list of seafood choices and their EPA+DHA fatty acid content. If pregnant, refer to chapter on *Pregnancy and Lactation* for seafood to avoid or limit.

Healthy Fats

Provides calories, essential fatty acids and vitamin E. Use in small amounts.
Choose mostly healthy oils

Food and Amount Equal to 1 Serving (1 teaspoon each)	
Monounsaturated oils	**Polyunsaturated oils**
• Canola	• Corn
• Olive	• Cottonseed
• Peanut	• Soybean
• Safflower	• Sunflower

Notes:

- Nuts and seeds (unsalted) are also healthy sources of monounsaturated fats (see Protein foods above)
- Olives and avocados are also naturally high in oils
- Avoid: Coconut oil, palm kernel oil and palm oil (high in saturated fat and trans fat)

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Saturated Fats, Added Sugars (SoFAS) and Alcohol

Provides calories, carbohydrates, fats, alcohol
Poor sources of healthy nutrients

Food and Amount	Alcohol and Amount
• 1 tsp of butter, stick margarine or soft margarine • 1 tsp cream cheese • 1 tsp whipping cream or dessert topping • 1 tsp regular mayonnaise or salad dressing • 2 Tbs cream or sour cream • 2 Tbs low fat salad dressing • 2 Tbs low fat mayonnaise • 1 cup ice cream or frozen yogurt • 1 cup fruit flavored low fat yogurt • 1 cup chocolate milk • 8 to 12 oz soft drink • 2 mini plain doughnuts, 1 glazed doughnut • 1 cinnamon sweet roll • 2 large chocolate chip cookies • 1 piece cake ½ cup French fries or 6 onion rings • 1 oz candies	• 12 oz regular beer (5% alcohol) • 5 oz wine (12% alcohol) • 1 ½ oz 80 proof distilled spirits (40% alcohol) **Note:** Recommend no more than one drink a day for women and 2 drinks a day for men

These foods are meant to be used sparingly to round out the menu for a pleasing appearance and satisfying meals.

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Discretionary Calorie Foods/Beverages

Discretionary calorie foods are generally good sources of calories, carbohydrates and fats, but poor sources of healthy nutrients. There are healthy and unhealthy discretionary calories. Discretionary calories are meant to round out the menu for a pleasing appearance and satisfying meals. They may be used in the form of high fat milk, milk products, solid fats, added sugars or additional servings of any other food.

These contain 15 grams carbohydrate and can count as 1 starch or 1 fruit or 1 milk (approximately 60 to 80 calories each). Doubling a portion will double the calories and carbohydrates. Some of these choices include extra fat.

Desserts/Sweets/Miscellaneous	Portion
Angel Food Cake, Unfrosted	1 oz
Brownie, Unfrosted	1 oz
Ginger Snaps, Small	3
Vanilla Wafers	5
Frozen Fruit Juice Bar, 100% Juice	3 oz
Sherbet	1/4 cup
Ice Cream, Light	1/2 cup
Granola Bar or Breakfast Bar	1 oz
Lorna Doones®	3
Cake, Unfrosted	1 oz
Cake, Frosted	1 oz
Cookie or Sandwich Cookie	2 small
Cookie, Sugar Free	1 oz
Gelatin, Regular	1/2 cup
Pudding, Sugar Free Made With Low Fat Milk	1/2 cup
Syrup, Regular	1 Tbsp
French Fries, 2” to 3 ½” long (1 to 1/2 oz.)	10
Cranberry Sauce, Jellied	3 Tbsp
Cupcake, Frosted	1 oz
Doughnut, Plain, Cake	1 oz
Fruit Snack, Chewy (Puree Fruit Concentrate)	¾ oz
Ice Cream	½ cup
Ice Cream, Light	½ cup
Ice Cream, No Sugar Added	½ cup
Frozen Yogurt	1/3 cup
Frozen Yogurt, Fat Free	1/3 cup
Jam or Jelly, Regular	1 Tbsp
Honey	1 Tbsp
Milk, Chocolate, Whole	½ cup
Pudding, Regular, Low Fat	¼ cup
Pudding, Sugar Free and Fat Free	½ cup
Reduced Calorie Meal Replacement Shake	7 to 8 oz
Rice Milk, Low Fat or Fat Free, Plain	1 cup
Salad Dressing, Fat Free (High Sodium)	¼ cup
Sorbet	¼ cup
Spaghetti Sauce, Canned (High Sodium)	½ cup
Sugar	1 Tbsp

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Discretionary Calories

Alcohol	Portion	Calories, Approximate
Beer	12 oz	146
Wine	5 oz	72
Spirits (Gin, Vodka, Rum, etc.)	1 ½ oz	97

Fats

Each portion contains approximately 45 calories and 5 grams of fat

Fat	Amount	Nuts & Seeds	Amount
*Butter	1 teaspoon	Dry Roasted:	
Margarine: Regular	1 teaspoon	Almonds, Whole	6 nuts
Diet	1 Tablespoon	Cashews	6 nuts
Mayonnaise: Regular	1 teaspoon	Peanuts	10 nuts
Calorie-Reduced	1 Tablespoon	Walnuts, Whole	2
Salad Dressing:		Pecans, Whole	2
Regular	1 Tablespoon		
Reduced Calorie	2 Tablespoon		
Oil (Peanut)	1 teaspoon	Other Nuts	1 Tablespoon
*Coconut, Shredded	2 Tablespoon	Seeds: Pine Nuts or	
*Coffee Whitener,		Sunflower	1 Tablespoon
Liquid	2 Tablespoon	Pumpkin Seeds	2 Tablespoon
Powder	4 teaspoon	Peanut Butter	2 teaspoon
*Cream: Half & half	2 Tablespoon		
*Sour Cream	2 Tablespoon		
*Cream Cheese	1 Tablespoon		
Olives, Black	8 large		
Olives, Green, Stuffed	10 large		
Avocado, Medium	1/8		
*Gravy	2 Tablespoon		

***Saturated Fats**

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Combination Foods

Main-Dish	Amount	Food Equivalents
Casseroles, Homemade	1 cup (8 oz)	2 Starch, 2 Meats, 2 Fats
Cheese Pizza, Thin Slice	1/4 of 10 inch (5 oz)	2 Starch, 2 Meats, 3 Fats
Chili with Beans	1 cup (8 oz)	2 Starch, 2 Meats, 2 Fat
Chow Mein (No Noodles or Rice)	2 cups (16 oz)	1 Starch, 2 Very Lean Meats
Macaroni and Cheese	1 cup (8 oz)	2 Starch, 2 Meats, 2 Fats
Spaghetti and Meatballs	1 cup (8 oz.	2 Starch, 2 Meats, 2 Fats
or Lasagna	1 cup (8 oz)	2 Starch, 2 Meats, 2 Fats

Soups:	Amount	Food Equivalents
Bean	1 cup (8 oz)	1 Starch, 1 Very Lean Meat
Cream (Made with Water)	1 cup (8 oz)	1 Starch, 1 Fat
Vegetable, Chicken Noodle, or Broth Based Soup	1 cup (8 oz)	1 Starch
Split Peas (Made with Water)	1/2 cup (4 oz)	1 Starch
Tomato	1 cup (8 oz)	1 Starch

Miscellaneous:	Amount	Food Equivalents
Ice Cream	1/2 cup	1 Starch, 2 Fat
Snack Chips	1 oz	1 Starch, 2 Fat

Free Foods

Free Foods in Unlimited Amounts of 1 Serving per Meal

Sugar Substitute
Coffee/Tea
Fat Free Broth, Bouillon, Consommé Without Added Fat
Sugar-Free Carbonated Beverages, Club Soda, Sugar-Free Tonic Water
Carbonated Water
Sugar-Free Gelatin
Sugar-Free Pickles
Vinegar
Spices and Herbs
Mustard
Horseradish
Drink Mixes, Sugar-Free
Nonstick Pan Spray
Gum, Sugar-Free

©2013 Becky Dorner & Associates, Inc.

Menu Substitutions

Free Foods

Free Foods in Limited Amounts	Amount
Catsup	1 Tablespoon
Cocoa Powder, Unsweetened	1 Tablespoon
Jam/Jelly, Sugar-Free	2 teaspoon
Pancake Syrup, Sugar-Free	1 to 2 Tablespoons
Whipped Topping	2 Tablespoons
Salad Dressing, Low Calorie	2 Tablespoons
Taco Sauce	1 Tablespoons
Wine, Used in Cooking	1/4 cup
Fruits	**Amount**
Unsweetened or Sweetened with Sugar Substitute	
Cranberries	1/2 cup
Lemon	1/2 cup
Lime	1/2 cup
Rhubarb	1/2 cup
Vegetables, Raw	**1 cup**
Cabbage	Hot Peppers
Celery	Lettuce
Chinese Cabbage	Mushrooms
Cucumber	Radishes
Endive	Romaine
Escarole	Spinach
Green Onion	Zucchini

©2013 Becky Dorner & Associates, Inc.

Menu Substitution Sheet Sample Form

Date	Scheduled Food Item	Substitute	Reason for Substitution	Employee Signature	Supervisor Initials

Maintain this record on file for quality assurance.

©2013 Becky Dorner & Associates, Inc.

Diet/Nutrition Care Manual

Policy:

The diet/nutrition care manual used in the facility will reflect current nutritional knowledge and recommendations, and will be approved for use by the medical staff.

Procedure:

1. The registered dietitian (RD) reviews available diet/nutrition care manuals, selects and makes recommendations for approval by the medical staff. The medical director or designee approves the manual, along with the RD, Administrator, and Director of Nursing (DON).

2. The selected diet/nutrition care manual will:
   - Reflect current nutritional knowledge based on evidence based research and/or best practice standards
   - Meet the National Research Council nutritional standards
   - Have a revision/review date that is less than three (3) years old
   - Be representative of the diets needed by the patients/residents in the facility
   - Specify diets that are nutritionally deficient
   - Provide clear guidelines

3. Diet/nutrition care manuals will be provided and placed in appropriate areas for staff reference:
   - At each nursing station
   - In the food service manager's office
   - In the kitchen

4. The diet/nutrition care manual will be reviewed on a regular basis (minimum of every one to three years):
   - Revisions will be identified and dated
   - The revised manual will be approved in the same manner as described above for the original manual
   - Diet/nutrition care manuals will be replaced every three (3) years to assure they are up to date with the most current standards of practice

For information on Becky Dorner & Associates, Inc. Diet/Nutrition Care Manuals, visit www.beckydorner.com/dietmanuals.

©2013 Becky Dorner & Associates, Inc.

Transmission of Diet Orders

Policy:

The food service department must receive a completed diet order as soon as possible after admission or following a diet order change.

Procedure:

1. The nursing staff sends the diet order (per physician's orders) to the food service department as soon as possible after admission or change (preferably within 1 to 2 hours), using the Diet Order Form.

2. When an individual is admitted at mealtime, the diet order may be telephoned to the food service department by the nursing staff to assure that the individual receives his/her diet at that meal. This should be followed immediately by a written diet order.

3. When the food service department has been made aware of a new admission but has not been notified regarding the diet order, a regular diet will be served. Staff should make every attempt to get the proper diet order first.

4. A temporary meal identification (ID) card/ticket is used until a permanent meal identification card/ticket is prepared.

5. When a diet order is changed, an individual changes rooms, or is discharged, the food service department will be notified in writing using the Diet Order Form or a computerized notification if applicable.

6. Diet orders are filed in the food service department for a minimum of 30 to 60 days.

7. Meal identification cards/tickets are adjusted accordingly.

©2013 Becky Dorner & Associates, Inc.

Diet Orders

Policy:

When there is a nutritional indication, the facility will provide a therapeutic diet that is individualized to meet the clinical needs and desires of the patient/resident to achieve outcomes/goals of care. These diets coincide with the therapeutic diets on the facility menus.

Procedure:

1. The registered dietitian (RD) will approve all therapeutic diets on the menus. The RD or designee will be notified of any therapeutic (special) diets not listed on the menu, so that they can be developed as appropriate.
2. A list of diets will be available to the nursing staff who will notify physicians of the diets available in the facility. These diets coincide with the therapeutic diets on the facility menus.
3. Diets will be offered as ordered by the physician. If the RD or designee finds through nutritional assessment that the diet order is not appropriate for the individual, she/he will notify the physician with a recommendation for a more appropriate diet.
4. Individual response to therapeutic and modified diets will be evaluated. Ineffective or inappropriate diets (including texture modifications) will be referred to the physician with a request to change to a more appropriate diet (this includes liberalization of the diet).
5. When appropriate, an individual will be educated by the RD or designee about his/her diet.
6. The individual's medical record or computerized order sheet must be reviewed on a regular basis to assure that diet orders are current. (See Diet Order Audit Sample Form.)
7. A diet/nutrition manual is available in the food service department and the nurses' stations for staff use. This manual is updated as needed and is considered current if the copyright date is within three years of the current date.

Definition of Therapeutic Diets and Nutritional Supplements

- A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (Academy of Nutrition and Dietetics, 2011).
- Therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration. A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition). (Reference: MDS 3.0 RAI Manual, Chapter 3, Section K: Swallowing/Nutritional Status.)

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Diets Available on the Menu

Policy:

The nursing staff and/or registered dietitian (RD) or designee will notify physicians of the diets that are offered on the menu.

Note: Although therapeutic diets are designed to improve health, they can negatively affect the variety and flavor of the food offered. Individuals on restrictive diets often find the food unpalatable, which can result in reducing the pleasure of eating, decreasing food intake, unintended weight loss and undernutrition - the problems practitioners are trying to prevent. In an effort to provide individualized (and liberalized) diets, the following procedure will help to assure that the most appropriate diet is provided.

Procedure:

1. Diets will be offered as ordered by the physician. If the RD or designee finds through nutritional assessment that the diet order is not appropriate for the individual, she/he will notify the physician with a recommendation for a more appropriate diet.

2. The main diet orders that will be offered are:
   - Regular/No Added Salt
   - Mechanical Soft
   - Puree
   - Consistent Carbohydrate
   - Consistent Carbohydrate Puree
   - Other:

3. In an effort to liberalize therapeutic diet orders, secondary diet orders are offered and can be combined with the main diet order to achieve desired results. The following secondary diets are offered:
   - No Salt Pack/No Salt at Table
   - No Salt Pack, No Salty Meats, Vegetables, Soups (i.e. ham, bacon, sausage, lunchmeat)
   - No Sugar Pack, Low Sugar Desserts
   - Chopped Meat
   - Puree Meat
   - Other:

©2013 Becky Dorner & Associates, Inc.

Diet Order Sample Form

Diet Order

Name ____________________________________ Room ______________

	Please check main diet order:		Please check secondary diet order:
____	Regular	____	No Salt Pack/No Salt at Table
____	Mechanical Soft	____	No Salt Pack, No Salty Meats, Vegetables, Soups
____	Pureed		
____	Consistent Carbohydrate	____	No Sugar Pack, Low Sugar Desserts
____	Consistent Carbohydrate Puree	____	Chopped Meat
____	Other:	____	Ground Meat
		____	Puree Meat
____	Discharged/Expired	____	LOA ______Date __________Meal

Signature: Date:

Diet Order

Name ____________________________________ Room ______________

	Please check main diet order:		Please check secondary diet order:
____	Regular	____	No Salt Pack/No Salt at the Table
____	Mechanical Soft	____	No Salt Pack, No Salty Meats, Vegetables, Soups
____	Pureed		
____	Consistent Carbohydrate	____	No Sugar Pack, Low Sugar Desserts
	Consistent Carbohydrate Puree	____	Chopped Meat
____	Other:	____	Ground Meat
			Pureed Meat
____	Discharged/Expired	____	LOA ______Date __________Meal

Signature: Date:

©2013 Becky Dorner & Associates, Inc.

Diet Order Form

Insert your facility diet order form here.

©2013 Becky Dorner & Associates, Inc.

Diet Order Audit

Policy:

The individual's medical record or the computerized physician's order sheet must be reviewed on a regular basis to assure accuracy.

Procedure:

1. A diet roster is provided for the food service department at least once a month.

2. The diet roster includes the individual's name, room number, and diet as stated in the physician's orders (including oral nutrition supplements, enteral feedings, or supplemental feedings).

3. The Food Service Manager or designee compares the physician's diet orders to the diet orders recorded on the meal identification (ID) card no less than monthly. Oral nutrition supplement orders should also be audited in a similar fashion. (See Sample Audit Forms on the follow pages.)

4. The registered dietitian (RD) or designee will be notified of any therapeutic diets not listed on the menu so that they can be developed as appropriate.

5. Facility staff is trained to carefully prepare an individual's meals/snacks and serve each meal/snack to the correct individual.

Note: A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (i.e. sodium or potassium), or to provide mechanically altered food when indicated. (Academy of Nutrition and Dietetics, 2011)

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Diet Order Audit Sample Form

Room	Name	Physician Diet Order	Diet Roster	Diet for Food Service Records

©2013 Becky Dorner & Associates, Inc.

Nutrition Supplement Audit Sample Form

Room	Name	Physician Order	Nutrition Supplement List

Note: This information may be computerized.

©2013 Becky Dorner & Associates, Inc.

Weekly Diet Census Sheet Sample Form

Week of: ______________________

Diets	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Regular							
Mechanical (Dental) Soft							
Puree							
Chopped Meat							
Ground Meat							
Pureed Meat							
Consistent Carbohydrate							
Consistent Carbohydrate Puree							
Other:							
Guest Meals							
Staff Meals							
Daily Totals							

Daily counts should be used for the production sheets so the proper foods/amounts can be prepared.

Note: This information may be computerized.

©2013 Becky Dorner & Associates, Inc.

Foods Not Allowed on the Physician Ordered Diet

Policy:

If an individual exhibits a pattern of requesting foods that are not allowed on the physician's ordered diet, the facility staff should refer the person to the registered dietitian (RD) or designee for re-evaluation and counseling.

Procedure:

1. Food service staff should serve only the foods permitted on each diet order as planned on the menus. If an individual is very insistent with facility staff that they want a food that is not allowed on the physician ordered diet, staff should remind the individual that the food is not allowed. If the individual continues to insist they want the food item, it is their right, and facility staff may serve it. Staff should document consistent requests for foods not allowed on the diet.

2. If food service staff or nursing staff are not sure about foods permitted on a diet, they should refer to the diet manual, or contact the RD or designee as needed.

3. If a pattern of requesting inappropriate foods continues repeatedly, the individual should be referred to the RD or designee for re-evaluation and counseling.

4. A new diet order slip is required before an individual can be served consistencies of food or fluids that are a higher level than the physician ordered diet/fluid. For example:
   - If an individual is NPO and has an order for enteral feeding only, staff is NOT permitted to serve any food or beverage without a diet order slip.
   - When on a full liquid diet, all foods served must follow the full liquid diet guidelines. A diet requisition is required before staff is permitted to serve any other foods.
   - If an individual has an order for a puree diet, the speech–language pathologist (SLP) may request a trial diet when working with the individual.

5. It is the responsibility of the RD or designee and the SLP to discuss the possibility of upward progression of a consistency altered diet (i.e. pureed to mechanical soft diet), and to obtain physician's orders in advance of serving foods not listed on the current diet.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Use of Salt Substitute

Policy:

The use of salt substitute requires a physician's order.

Procedure:

1. Salt substitute can only be given with a physician's order.

2. Once the physician's order is obtained, "Salt Sub" is noted on the meal identification (ID) card/ticket, care plan and progress notes as appropriate.

3. When salt substitute that is high in potassium is given, electrolytes should be monitored. If potassium blood level increases above normal, refer to the physician. Use of salt substitute high in potassium may need to be discontinued.

4. Instruct individuals to use salt substitutes sparingly. Staff should monitor individuals at meal time for complaints of "food tasting bitter" as salt substitutes may impart a bitter taste.

Note: Alternates for salt substitutes such as herb and spice mixes may provide a healthier option.

©2013 Becky Dorner & Associates, Inc.

Food Replacement for Individuals with Diabetes

Policy:

If an individual with diabetes refuses to eat meals, nursing will be notified. If a pattern of refusal exists, nursing will refer to the registered dietitian (RD) or designee as appropriate.

Procedure:

1. Facility staff will offer alternative choices to individuals who do not eat the meal served.

2. Nursing will contact food service for meal/food replacements as needed.

3. Nursing will determine if medication or insulin adjustment is required.

4. Nursing will refer to the physician as needed.

5. If nursing notices a consistent pattern of refusal of food at mealtime, a referral will be made to the RD or designee.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

.

©2013 Becky Dorner & Associates, Inc.

Renal Diets

Policy:

Individuals requiring renal meal plans will be supervised by the registered dietitian (RD) or designee. The facility RD or designee will contact the dialysis unit's RD for specific diet patterns if needed. The facility RD or designee will plan menus in accordance with the physician ordered diet restrictions.

Note: Restrictive therapeutic diets may be unpalatable to individual residents/patients, causing reduced food intake, unintended weight loss and undernutrition. It is the resident's right to refuse any therapeutic diet. It is the RD's role to educate and counsel, and determine the best approach in these cases. Refer to your Diet/Nutrition Care Manual for more information.

Procedure:

1. The RD or designee will review the physician ordered diet and assess for appropriateness in relation to the individual's complete Medical Nutrition Therapy (MNT) assessment.

2. The RD or designee will contact the dialysis center to discuss the individual's needs.
   a. The RD or designee will discuss the individual's needs with the dialysis RD, and request a copy of the dialysis daily meal plan/pattern, or refer to the facility's Diet/Nutrition Care Manual as appropriate.
   b. Information should be sent as soon as possible so that the meals can be followed as planned.
   c. Renal diets should be as liberal as appropriate to meet the individual's needs.

2. The RD or designee will add each day's meal pattern to the daily menu extension sheets.

3. The RD or designee should provide specific instructions to the food service department regarding preparation (with the cooks, chefs and dietary aides) on an ongoing basis as appropriate.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Dysphagia Diets

Policy:

Dysphagia diets will be individualized with modifications made by the speech-language pathologist (SLP) and physician working in conjunction with the registered dietitian (RD) or designee and food service manager. A physician's order is needed.

Note: There is little evidence based research to support texture modified diets for treatment of dysphagia and prevention of aspiration. The person centered approach to diet, and providing individualized intervention is most important. Some individuals may be averse to consistency-altered (texture modified) diets, and therefore may refuse to eat much of their food, leading to unintended weight loss and undernutrition. In these cases, resident's rights take precedence, and an individual has the right to refuse any therapeutic diet (including consistency modifications). Refer to your Diet/Nutrition Care Manual for more information.

Procedure:

1. Individuals who wear dentures will be reminded to have dentures in for meals and snacks as needed. If dentures do not fit properly, facility staff will refer for a dental consult.

2. Individuals with observed indicators of dysphagia (coughing, choking, delayed swallow, pocketing of food, inability to manipulate food in the mouth, wet, gurgly voice, etc.) will be referred to the SLP for evaluation of dysphagia.

3. The SLP may request a video fluoroscopy to assess the individual's condition. Once a diagnosis has been made, the SLP will work with the RD or designee to make appropriate recommendations to the physician for proper food and fluid consistency.

4. Nursing staff will notify the food service manager of needed consistency changes using the Dietary Order Form.

5. The food service department will be responsible for preparing and serving the diet and fluid consistency as ordered.

6. Individuals needing a change in diet consistency may be placed on a dysphagia diet level 1, 2 or 3 (or on a mechanical soft diet, chopped, ground, or pureed foods). Diets should be adjusted to meet individual needs. For example, if the individual has difficulty chewing meats only, the meats may be chopped, ground or pureed and other foods may be of regular consistency.

7. Care will be taken to serve the foods and fluids as ordered on the consistency-altered diet or fluids.

Note: It is advisable to state the reason for a pureed diet in the documentation. Do not allow food consistency changes without a physician's order. Upgrading or downgrading consistency may need to be evaluated by a SLP and requires a physician's order for a permanent change.

©2013 Becky Dorner & Associates, Inc.

Altered Portions

Policy:

The food serviced manager or designee shall interview all individuals upon admission and periodically as needed for food preference and meal satisfaction. Altered portion sizes will be served upon request however; small portions require a physician's order.

Procedure:

1. Refer to the facility diet/nutrition care manual and preplanned menus for guidelines for serving various portion sizes.

2. Small portions are planned on the menu to meet nutritional needs. The individual is interviewed for snack options between meals. This information is documented in the individual's chart and care plan. The RD or designee monitors the individual's weight and food intake for adequacy. A second portion is given if requested.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Festivity Foods or Diet Holiday

Policy:

Individuals on oral diets (with the exception of clear or full liquid diets and dysphagia or modified consistency diets) will be granted a diet holiday from their therapeutic diet for special holidays and events. The words “Festivity Foods PRN” or “Diet Holiday PRN” will appear on the physician’s orders.

Procedure:

Individuals on special diets will receive the same food as those on regular diets for special holidays and events. These special holidays and events may include:

New Year’s Eve
New Year’s Day
Martin Luther King Day
Valentine’s Day
St Patrick’s Day
Good Friday
Easter
Passover
Cinco de Mayo
Mother’s Day
Memorial Day
Father’s Day
Independence Day
Labor Day
Rosh Hashanah
Yom Kipper
Columbus Day
Halloween
Veterans Day
Thanksgiving Day
Christmas Eve
Christmas Day
Hanukkah (Chanukah)
Kwanza
Other Pertinent Religious Holidays
Special Activities and Parties

Note: Diabetics will continue to receive lower carbohydrate alternatives to sweet desserts, snacks and beverages. Consistencies will be provided to meet individual needs.

For more ideas, refer to Holiday Menus: Making Mealtime Special, Becky Dorner & Associates, Inc. found at http://www.beckydorner.com/products/159.

©2013 Becky Dorner & Associates, Inc.

Food and Beverages for Activities

Policy:

Safety and diet compliance will be maintained as appropriate for individuals who consume food and beverages during activities.

Procedure:

1. The activities director or designee will provide the food service department with the monthly scheduled activities that require food or beverage from the department.

2. Foods and beverages are requisitioned from the food service department per facility policy.

3. The food service manager or designee maintains a diet listing for all individuals. The list must include all therapeutic and food texture modifications, and be the most current available.

4. The activities director will notify the food service manager of individuals planning to attend each event so that therapeutic and texture modifications can be planned.

5. The food service department will prepare the requisitioned food and beverage for service during the activity. Proper storage for food safety and transport will be maintained.

6. The activities director will follow prescribed texture modified diet orders when serving food and beverages during the activity.

7. The activities department will monitor food and beverage consumption during the activity for signs and symptoms of choking, aspiration, or other adverse reaction to the food or beverage. Any concern will be reported to nursing immediately. Activities personnel should also be trained in the Heimlich maneuver.

8. The food service department will dispose of any single service use food or beverage brought back to the department after the activity. Leftovers will only be used if food safety can be confirmed, and only after following proper procedures for storage and reheating.

©2013 Becky Dorner & Associates, Inc.

Clear Liquid and Full Liquid Diet

Policy:

Food items for liquid diets will be available as needed. Individuals will be provided with a liquid diet when needed due to flu, cold, dental problems, etc. A physician's order is required, if the order exceeds 24 hours.

Procedure:

1. Nursing will advise the food service department in writing of the individual, the diet, and when it should be started and stopped. See below for examples of clear liquid and full liquid diet supplies that should be available at all times.

2. A physician's order is obtained for any change in diet that exceeds 24 hours. Nursing will send a diet order to the food service department for any changes in diet.

Supplies	Clear Liquid	Full Liquid
Soft Drinks		
Ginger Ale or Lemon Lime Soda	√	√
Juices		
Apple, Cranberry, Grape and/or Orange (no pulp)	√	√
Peach, Pear, Apricot Nectars	√	√
Broth/Bouillon		
Chicken, Beef and/or Vegetable	√	√
Gelatin		
Cherry, Lime, Orange, Raspberry, Strawberry	√	√
Hot Cereal		
Cream of Rice or Cream of Wheat	**No**	√
Nutritional Supplements/Shakes		
Instant Breakfast Mix	**No**	√
High calorie/protein Clear Liquid Supplements (variety of types and flavors)	√	√
Desserts		
Fudgesicles™	**No**	√
Ices	√	√
Ice Cream	**No**	√
Plain Popsicles	√	√
Plain, Smooth Pudding (vanilla, chocolate, butterscotch)	**No**	√
Sherbet, Plain, Smooth (no chunks of fruit)	**No**	√

Source: Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH 2011.

©2013 Becky Dorner & Associates, Inc.

NPO Diet Orders

Policy:

The food service department will not send food to any individual with an NPO diet order.

Procedure:

1. Nursing will notify the food service department of all NPO (nothing by mouth) diet orders.

2. The food service department will not send a meal until notified by nursing that the individual is able to eat. This shall also include NPO orders needed for lab tests.

3. An NPO order should not last more than 1 to 2 days. Any individual on NPO more than 2 days should be referred to the RD or designee (unless the individual is on enteral/parenteral feeding).

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Dining/Meal Service

- ♦ The Dining Experience: Staff Responsibilities 2-1
- ♦ Dining and Meal Service 2-2
- ♦ The Person Centered Dining Approach 2-4
- ♦ Resource: Traits of Great Service 2-5
- ♦ Customer Service 2-6
- ♦ Dining Room Service 2-7
- ♦ Dining Atmosphere 2-8
- ♦ Serving the Meal 2-9
- ♦ Service Staff 2-10
- ♦ Handling Customer Concerns 2-11
- ♦ Dining Satisfaction Sample Form 2-12
- ♦ Dining Satisfaction Meal Evaluation Sample Form 2-13
- ♦ Table Setting 2-14
- ♦ Condiments, Food Baskets and Food Items at the Table 2-15
- ♦ Restaurant Style Dining 2-16
- ♦ Family Style Dining 2-17
- ♦ Buffet Style Dining 2-19
- ♦ Open Style Dining 2-21
- ♦ In-Room Dining (Room Service) 2-23
- ♦ 24 Hour Dining 2-24
- ♦ Special Occasions – Holiday and Theme Meals 2-25
- ♦ Paid Feeding Assistants (Nursing Facilities) 2-26
- ♦ Timely Meal Service 2-28
- ♦ Meal Times and Frequency 2-29

©2013 Becky Dorner & Associates, Inc.

Dining/Meal Service

- ♦ **Early and Late Meals 2-30**
- ♦ **Select Menus 2-31**
- ♦ **Meal Identification and Preference Cards/Tickets 2-33**
- ♦ **Offering Food Replacements at Meal Time 2-34**
- ♦ **Resource: Available Food Replacements Sample 2-35**
- ♦ **Food Replacements Sample Form 2-36**
- ♦ **Displaying the Menu 2-37**
- ♦ **Accuracy and Quality of Tray Line Service 2-38**
- ♦ **Portion Control 2-39**
- ♦ **Adaptive Eating Devices 2-40**
- ♦ **Meal Time Observation 2-41**
- ♦ **Following the Meal Service 2-42**
- ♦ **Packed Meals 2-43**
- ♦ **Pets 2-44**
- ♦ **Leave of Absence 2-45**
- ♦ **Guest Meals 2-46**
- ♦ **Food Availability 2-47**
- ♦ **Nourishments and Supplements 2-48**
- ♦ **Nourishments and Supplements Sample Form 2-49**

©2013 Becky Dorner & Associates, Inc.

The Dining Experience: Staff Responsibilities

Policy

The goals of the dining experience are to enhance the individual's quality of life through person centered dining: providing person centered care and attention; nourishing, palatable, and attractive meals that meet the individual's daily nutritional and special dietary needs.

Procedure:

1. Staff will work with each person as an individual to meet their personal needs. Each individual will be treated with dignity and respect. Staff will socialize with each individual, focus on the individual - listen, pay attention, and converse with each individual (rather than only with other staff).

   a. Remain confidential with patient/resident instructions.

   b. Be positive. Staff attitudes and actions directly affect the individual's acceptance of the meal.

   c. Keep noise levels to a minimum. (If playing music in the dining area, make sure the type of music is appropriate for the population being served.)

2. Staff should provide service that will help to make dining a special "event" that individual patients/residents will look forward to and that will create lasting memories.

   a. Offer as many choices as possible when it comes to mealtime: Choices on what to eat, when to eat and who to eat with. Selective menus are ideal, and waiter/waitress style service (allowing the individual to choose from a menu right before a meal) is best.

   b. The dining area will be attractive, functional, home-like or restaurant-like (depending on the facility), roomy, comfortable with nice décor, contrasting colors, and appropriate furniture.

   c. All dining areas will have comfortable sound levels, adequate lighting, furnishing, ventilation, space and absence of odors to accommodate dining.

3. The food service manager will perform meal rounds routinely to determine if the meals are timely, attractive, nutritious, and meet the needs of the individual. The food service manager will observe meals for preferences, portion sizes, temperature, flavor, variety and accuracy. The food service manager will report any concerns to the administrator, nursing director, registered dietitian (RD) or designee, or other staff as appropriate.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

.

©2013 Becky Dorner & Associates, Inc.

Dining and Meal Service

Policy:

The dining experience will be person centered with the purpose of enhancing each individual patient's/resident's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional and special dietary needs. Individuals will be provided with services to maintain or improve eating skills.

Procedure:

1. Dining areas will have comfortable sound levels, adequate lighting, furnishing, ventilation, space and absence of negative odors to accommodate dining.

2. The table should be properly set (forks on the right, spoon on the left). If knives are not provided in certain dining areas and an individual needs their food cut, food should be cut neatly, so the individual can still see what the original food was.

3. Individuals will be provided with proper hygiene prior to each meal or snack, prepared for the meal by the nursing staff (i.e. hearing aids in place, dentures in, hair combed, dressed properly, and eyeglasses on); and assisted to the dining area as needed.

4. Individuals will be positioned comfortably for the meal, and in a way that will assist with independent eating (i.e. positioned to encourage proper range of motion for eating, promote safe swallowing).

    a. Tables will be adjusted to accommodate wheelchairs, etc.

    b. Positioning and assistance at mealtime must be appropriate for individual needs. Individuals should eat in an upright position unless otherwise specified by the interdisciplinary team or a physician.

    c. Individuals seated in wheel chairs will be encouraged/assisted to transfer to a dining room chair as appropriate.

    d. Individuals will be positioned properly in chair, wheelchair, etc. at an appropriate distance from the table.

    e. If eating in bed, tray tables and beds will be at the appropriate height and position for those eating in bed (as close to a 90 degree angle as possible, or as recommended by the speech language pathologist, occupational therapist or physical therapist for special needs).

5. Use of dining napkins will be encouraged, and dignified clothing protectors will be available as needed.

6. Individuals will be provided with the proper assistive devices and utensils identified by the care plan.

7. Food placement, colors and textures are in keeping with the individuals' needs or deficits (ex: vision, swallowing, etc.).

©2013 Becky Dorner & Associates, Inc.

8. Individuals at the same table will be served and assisted at the same time.

9. Food will be at the proper texture/consistency to meet each individual's needs and desires. Mechanically altered diets, such as pureed diets, are prepared and served as separate entrée items (except when meant to be combined food such as stews, casseroles, etc.).

10. Appropriate staff will assist as needed to assure adequate intake of food and fluids at the meal.

    a. Individuals will be assisted promptly and in a timely manner after the meal arrives.

    b. Individuals who need extensive assistance will be seated in appropriate dining areas.

11. Individuals will be monitored by the nursing staff to determine the amounts of food/fluids consumed. (Refer to food and fluid intake policies in this section).

12. Individuals will be assisted to leave the dining room promptly after each meal.

13. The dining room will be cleaned promptly after each meal.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

The Person Centered Dining Approach

Policy:

Person centered care allows individuals to live as normal a life as possible. To that end, person centered care and hospitality services are adapted as much as possible into the everyday living arrangement, included dining. The person centered dining approach focuses on each individual's needs related to food, nutrition, and dining.

Procedure:

1. Each person is treated like a special individual, with a focus on individualizing all interactions, interventions, and care including food, nutrition and dining.

2. The atmosphere and surroundings should be cheerful, clean, tidy, inviting, warm and friendly. This includes the environment of the building, and also the attitude and actions of the staff.

3. Staff should come to work with a professional appearance (neat, clean uniforms or clothing, hair, etc.), and more importantly, with a positive attitude towards serving residents/patients.

4. All individuals are treated with the utmost courtesy, respect and dignity. Each person is treated as if they were the most special guest.

   a. This includes greeting people by name (using Mr., Mrs., or Ms.), recognizing their unique wants and needs, and providing for their comfort at all times.

   b. Individuals should be greeted with a smile and a friendly "Hello! How can I serve you?"

   c. Staff should make all efforts to satisfy individual requests, and always be sure to follow through on any promises made.

   5. Guests should be welcomed into the dining environment and thanked for coming.

6. Seating preferences, beverage preferences, and special dietary needs should be met per individual choice.

©2013 Becky Dorner & Associates, Inc.

Resource: Traits of Great Person Centered Service

1. Treat each guest as if they were the most important person ever served.
2. Be enthusiastic.
3. Have an attitude of service. Make the commitment to provide great service.
4. Act with empowerment. Be confident in your ability to provide what is needed, and make timely and appropriate decisions.
5. Deliver what is promised. Take notes if needed to remember what has been promised.
6. Have a sense of urgency. Serve people in a timely manner. Respond quickly. Be organized.
7. Have a genuine caring attitude. Treat others with respect and dignity. Have a sense of empathy.
8. Be flexible and adaptable. Have a steady, patient mood.
9. Communicate well. Ask good questions, and then truly listen to the answers, and follow through on requests.
10. Be willing to improve.
11. Be willing to learn. Be proactive and try to avoid mistakes by knowing how things should be done. But when mistakes are made, learn from them.
12. Set and strive for high standards.
13. Have a sense of family. Be trustworthy and empathetic. Put yourself in the customer's place, and serve them as you would want to be served.
14. Use body language can show caring: Lean forward, look into the person's eyes, nod your head, and acknowledge what others say. Smile if appropriate - the smile is a universal language that all people understand.

©2013 Becky Dorner & Associates, Inc.

Customer Service

Policy:

All individuals will be treated with respect and prompt service. It is the employee's responsibility to find the best solution for any concerns of the individual being served. Employees should be empowered to "do whatever it takes" to provide great service.

Procedure:

1. Staff members support everyone on the team to get the job done right.

2. Staff members must have an attitude of truly wanting to help and serve people. Managers should watch for what staff are doing correctly and reinforce it. (Expect a high level of service, and then praise it and reward it when staff achieve it).

3. Management staff should encourage front line staff to make suggestions for improving individual service. Management staff should act as coaches to teach frontline staff how to deal with any issues that arise at meal time.

4. Management staff should be visible, involved, and accessible. Management staff should give support and training wherever needed and support frontline staff in providing excellent service.

5. Staff should be trained to treat each individual with the utmost dignity, respect and care.

©2013 Becky Dorner & Associates, Inc.

Dining Room Service

Policy:

Individuals will be encouraged to receive dining room service. A comfortable, attractive atmosphere will be maintained in the dining room area.

Effective equipment shall be provided and guidelines established to maintain food at proper temperatures during meal service. Food will be delivered promptly to assure quality.

Procedure:

1. Meals are distributed promptly to maintain adequate temperature and appearance.

2. Dining room tables should be adequate in height so that wheel chairs can fit underneath them for more comfortable eating. If possible, individuals should be encouraged to sit in a dining room chair.

3. Staff will notify the food service department of those who wish to receive room service.

4. Staff should check individual name and diet on the meal identification (ID) card/ticket to verify that the meal is served to the correct person, and check items on the plate/tray to assure accuracy for therapeutic diets.

5. There should be enough available staff in the dining areas to assist those who need help and to handle any situation that may arise.

©2013 Becky Dorner & Associates, Inc.

Dining Atmosphere

Policy:

Person centered dining is the focus of the dining atmosphere. Meals will be served in a way to enhance the individual's dining experience. Because the presentation of the meal directly affects how much an individual eats, presentation will include the dining environment, the attitude of the server, and the appearance of the meal.

Procedure:

1. The Dining Environment
   - The dining area should be appealing to the individuals being served. It should reflect the preferences of the residents/patients being served.
   - The dining areas must be clean, with adequate lighting, and free of unpleasant odors.
   - Suggestions for a pleasant environment include use of clean, wrinkle-free tablecloths, appropriate color dishes and napkins, centerpieces, soft background music, place mats, colorful dishes, and nice décor.

2. The Attitude of the Server
   - Servers should use friendly, courteous, and considerate behavior when serving meals.
   - Servers should be enthusiastic about the food being served.
   - Servers should focus on each individual's needs and desires, and do their best to satisfy those needs and desires .

3. Appearance of the Table and Meal
   - Use attractive dishware: Clean, eye appealing, matched, without chips, appropriate colors.
   - Flatware will be clean, neatly placed, and in good condition. All meals served must include a minimum of fork and spoon (and knife as appropriate).
   - Glasses will be clean and free of stains or spots.
   - Placemats, tablecloths and napkins will be clean and wrinkle-free.
   - Items will be placed so they are convenient for the individual and neatly and correctly arranged.
   - Serve food carefully to avoid drips and spills.
   - Use suitable dishes for the proper size for various food items. For example:
     - Salads served on individual salad plates or bowls
     - Bread and butter served on individual plates
     - Saucers for coffee or teacups (Mugs do not require a saucer)
   - Hot food must be hot and cold food must be cold (as acceptable to the individual being served).
   - Assure that the correct condiments and beverages are available for the meal.
   - Servers will offer assistance as needed.

4. Appearance of the Server
   - The food service manager will provide training on personal hygiene.
   - Aprons or other special uniforms will be made available to staff as appropriate (such as waiter/waitress uniforms, chef's uniforms, etc.).
   - Each facility will address issues such as appropriateness of tattoos, body piercings, hair restraints, etc.
   - All staff will abide by the facility dress code. (Staff dress/appearance should be acceptable to the individuals being served).

©2013 Becky Dorner & Associates, Inc.

Serving the Meal

Policy:

Food will be served with enthusiasm in a pleasant and tasteful manner to please all individuals.

Procedure:

1. Staff should make every effort to make dining special.

    a. Wait staff should greet and seat individuals as they enter the dining area, then offer a beverage and a menu or listing of food options for the meal.

    b. Wait staff should wear colorful aprons or other uniforms that are different from what is worn for providing other services.

    c. Staff should be trained to handle situations such as choking, quarrels, evacuation of the dining area, etc.

2. The appropriate type of meal service will be chosen for the individuals being served. Depending on the setting, one or a combination of the following service styles may be used: restaurant, family style, buffet dining, open dining, 24 hours service and/or room service. See each policy and procedure (in this section) for details.

3. If appropriate, staff should offer choice of beverage, salad or fruit, bread, entrée, starch, vegetable, dessert and/or soup du jour. A sample plate of the featured entrees is a nice way to show the day's specials.

4. After all individuals have left the table, tables should be sanitized and prepared for the next meal.

©2013 Becky Dorner & Associates, Inc.

Service Staff

Policy:

Staff treats each individual as the focus during mealtime to create a person centered dining approach to the dining experience.

Procedure:

Facility staff will:

1. Greet each individual by name as they enter the dining area.
2. Carry on normal conversations with individuals. Encourage conversation among the guests.
3. Keep distraction in the dining areas to a minimum and focus on the individual.
4. Notice who is absent for the meal and follow-up to be sure no one is missing or forgetting a meal.
5. Notice if someone is having difficulty with a meal and inform the appropriate staff. (Ex: difficulty using utensils, cutting food, self feeding, etc.)
6. Serve individuals beyond expectations: Do whatever is needed to assure a positive dining experience.
7. Take care of all issues before the end of the shift. If for some reason this is not possible, staff must be sure to pass on the information to the next shift so that they can take care of the issues.
8. Refuse to accept tips and other forms of gratuity.
9. Present a professional appearance at all times.
10. Abide by the facility dress code. (Staff dress/appearance should be acceptable to the individuals being served.)

The food service manager will:

- Provide training on personal hygiene.
- Make aprons or other special uniforms available to staff (such as waiter/waitress uniforms, chef's uniforms, etc.) as appropriate.
- Address issues such as appropriateness of tattoos, body piercings, hair restraints, etc.

©2013 Becky Dorner & Associates, Inc.

Handling Customer Concerns

Policy:

All concerns will be handled promptly, confidentially, and to the individual's satisfaction.

Procedure:

1. Staff should be trained to handle complaints in a positive manner. The following are good basic training points:
   a. Complaints are extremely valuable. They identify problems and allow us to develop solutions. Listen to the complaint and have a clear understanding of the problem. Repeat back to be sure you understand.
   b. Identify the cause of the problem and ask the individual what they want. Discuss possible solutions and resolve the problem. Ask if the individual is satisfied with the solution.
   c. Think about how you can keep the problem from recurring with that individual or any other individual.
   d. Know when to listen. The most common complaints are due to the following: Rudeness, lack of follow through, not listening to customer concerns, negative attitude.
   e. Keep a steady, pleasant mood, especially when stress is high. When stress levels are extreme, take a break if able, or talk to someone.
   f. Be flexible and adapt to change as much as possible.
   g. Share your improvement ideas with fellow staff and management staff.
   h. Be willing to constantly learn and improve.
   i. Embrace change for the betterment of service.

2. Management conducts customer satisfaction surveys on a regular basis as part of ongoing quality assessment and performance improvement. (See Dining Satisfaction Sample Form and Dining Satisfaction Meal Evaluations Form on the following pages.)

3. Management must continually monitor how staff handles complaints, and intervene with training and/or support as needed.

©2013 Becky Dorner & Associates, Inc.

Dining Satisfaction Sample Form

Optional: Name ________________________________ **Date**______________

	Yes	No
Was your meal service timely?		
Was the service courteous?		
Was the hot food hot?		
Was the cold food cold?		
Were your food preferences honored?		
Were your food substitutions available in a timely manner? (if applicable)		
Was the dining atmosphere pleasant?		
Did you enjoy your dining experience?		
Did the food taste good?		
What foods would you like added to the menu?		
What foods would you like taken off the menu?		
Suggestions/Comments:		

©2013 Becky Dorner & Associates, Inc.

Dining Satisfaction Meal Evaluation Sample Form

Name ____________________ **Date** _______________ **Time** _________

	Yes	No
The meal selection of food and beverage choices meets my needs? If no, please explain:		
The quality and presentation of the food is colorful and appealing.		
The food and beverage choices are served at proper temperature. If no, please explain:		
The staff were friendly and attentive to my needs.		
The service was timely.		
The dining room is clean and well organized.		
The hours of service met my needs.		
Suggestions/Comments:		

©2013 Becky Dorner & Associates, Inc.

Table Setting

Policy:

Individuals will be provided with an attractive table setting that enhances the dining experience.

Procedure:

1. Assure enough room at the table for proper place setting and comfort of each individual (elbow room, space for wheelchairs, accommodations for those who need them, and adequate room for place settings).

2. Provide chairs with sturdy side arms and cushions.

3. Centerpieces should be low in height, so they do not interfere with the ability to socialize. Vary colors, shapes, and items used depending on the occasion.

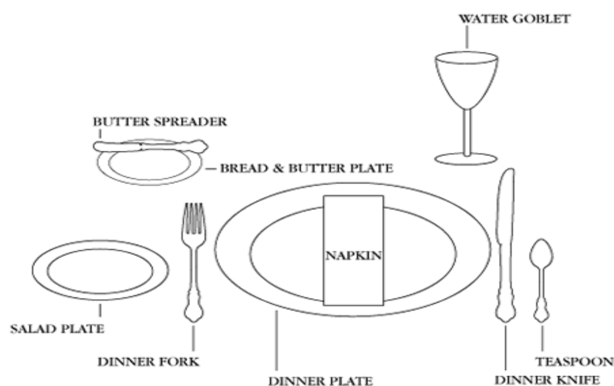
4. If linens are used, they should be easily cleaned. As an alternate, consider the use of a linen service.

5. Napkins should be folded to present an upscale dining style.

6. Glasses should not be too heavy to handle.

7. Dishware should be durable and replaceable, with appropriate designs and colors for those being served.

   Example of an appropriate dinner place setting:



8. Make sure that dishes, glasses, and silverware are placed appropriately (see graphic above).

©2013 Becky Dorner & Associates, Inc.

Condiments, Food Baskets and Food Items at the Table

Policy:

Individuals who are able should be allowed to self-select items such as condiments, bread and crackers. Condiments placed on tables for meal service will be monitored for diet compliance to physician prescribed diets (both therapeutic and texture modifications) by designated facility staff during meal service.

Procedure:

1. Condiments (such as salt, pepper, sugar, sugar substitutes, creamer, catsup, mustard, bread, butter, spreads, and crackers) placed on tables for meal service will be on the table in clean containers with appropriate lids or covers to maintain food safety.

    a. If using individual packages, make sure individuals are able to open packages easily.

2. Designated facility staff will monitor use of condiments by individuals during the meal service.

    a. Diet compliance to physician prescribed diets will be encouraged. A roster of prescribed therapeutic and texture modified diets will be provided to appropriate designated facility staff for monitoring during the meal service.

    b. If the individual chooses not to follow their specific therapeutic diet, there is an obligation to educate on the risk of not following the diet.

    c. If the individual is not able to make appropriate decisions, then the family physician, durable power of attorney for medical care, etc. will be educated on the risks versus benefits and will determine what is best.

3. Diet education for compliance will be provided to individuals by designated facility staff.

4. Designated facility staff will monitor and discourage collecting (hoarding), or inappropriate use of condiments, bread and crackers, and report such behaviors to their immediate supervisor.

©2013 Becky Dorner & Associates, Inc.

Restaurant Style Dining

Policy:

Restaurant style dining will enhance the individual's quality of life through provision of nourishing palatable attractive meals that meet the individual's daily nutritional and special dietary needs. The purpose of this policy is to provide personal choice dining during meal service.

Procedure:

1. Restaurant style dining is available during breakfast, lunch and dinner.

2. Nursing staff will remind all residents/patients of the meal. Nursing is responsible for assisting those needing help to the dining room. Individuals are assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc.)

3. Nursing and/or food service staff will offer food and beverage choices to the individual at the point of service.

4. Nursing and/or food service staff will report the individual food and beverage choices to the food service staff member serving the meal.

5. Food service staff members will serve the food choices made with consideration given to dietary restrictions/texture modifications. Plates will be verified for accuracy of service.

6. If the individual decides not to follow specific diet recommendations, there is an obligation to educate on the risk of not following the diet. If the individual cannot make this decision, then family, physician, POA, etc., will be educated on the risks and will determine what is best.

7. Food service and nursing staff members serve food to the individual with nursing providing any eating/dining assistance as necessary.

8. Nursing staff are responsible for recording food and beverage intakes. The information is recorded per facility policy.

9. Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room.

10. The food service manager will perform meal rounds routinely to determine if the meals are attractive and nutritious and meet the needs of the individual; and will observe meals for preferences, portion sizes, temperature, flavor, variety and service accuracy.

©2013 Becky Dorner & Associates, Inc.

Family Style Dining

Policy:

Family style dining supports the rituals of dining at home. Individuals participating in family style dining will be monitored for safe food handling and needs during the meal. Individuals will be offered personal choice in dining service.

Procedure:

1. Family style dining is available to individuals during breakfast, lunch and dinner.

2. Nursing staff will remind all residents/patients of the meal. Nursing is responsible for assisting those needing help to the dining room. Individuals are assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc.)

3. Nursing and food service staff will offer food and beverage choices to the individual at the point of service.

4. Food is placed in bowls or on platters and delivered to the dining tables just prior to service. The food will:
   - Be covered if necessary.
   - Be at the appropriate and required temperature for service.
   - Have the appropriate size serving utensil according to the planned menu.

5. Food bowls and platters used are appropriate for passing at the table. Soup and dessert items may not lend themselves to family style dining and may be serviced similar to restaurant service.

6. A staff member will:
   - Oversee the passing and serving of the food as needed.
   - Encourage appropriate portion size. Assist those with manual dexterity limitations.
   - Monitor for any unsafe food handling practices during the meal (such as direct hand contact with the food by an individual, or other forms of contamination such as sneezing, coughing or spitting on or near the food to be passed).
   - If a food item is considered contaminated, the fold will be removed from the table and a replacement obtained.

7. If the individual decides not to follow specific diet recommendations, there is an obligation to educate on the risk of not following their diet. If the individual cannot make this decision, then family, physician, durable power of attorney for medical care, etc. will be educated on the risks and will determine what is best.

8. For those individuals unable to pass dishes, Russian-style of family-style service may be used. Waiters offer choice of entrée, vegetable and starch from divided dishes. Leftovers served in this manner can be properly returned to the kitchen.

9. Nursing staff are responsible for recording food and beverage intakes. This information is recorded per facility policy.

10. Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room.

©2013 Becky Dorner & Associates, Inc.

11. The food service manager will perform meal rounds routinely to determine if the meals are attractive and nutritious and meet the needs of the individual; and will observe meals for preferences, portion sizes, temperature, flavor, variety and service accuracy.

©2013 Becky Dorner & Associates, Inc.

Buffet Style Dining

Policy:

Buffet Style Dining offers the individual infinite possibilities for meal time food combinations and selections. Individuals will be provided personal choice dining and the ability to choose food portions that match their appetite. Appropriate assistance will be provided during meal service and dining. Infection control systems will also be followed.

Note: Much of this also applies to food/salad bars and self-service stations.

Procedure:

1. Buffet style dining is available during breakfast, lunch and dinner. Foods and beverages should allow for variety and rotation of various food items.

2. Nursing staff will remind all residents/patients of the meal. Nursing is responsible for assisting those needing help to the dining room. Individuals are assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc.)

3. Nursing and food service staff will offer food and beverage choices to the individual at the point of service.

4. Independent residents are encouraged to plate their own hot and cold food items. Nursing staff is available to facilitate others with their self-selection of hot and cold food items from the buffet line. Dietary staff members will plate the food items chosen. Most residents will require tray service of food items selected to table side.

5. If the individual decides not to follow specific diet recommendations, there is an obligation to educate on the risk of not following their diet. If the individual cannot make this decision, then family, physician, durable power of attorney for medical care, etc. will be educated on the risks and will determine what is best.

6. Nursing staff members place the food items from the tray to each resident's/patient's table place setting and provide eating/dining assistance as needed.

7. Any resident/patient or staff member returning to the buffet line should obtain a clean plate.

8. Staff should monitor individuals to assure that unsafe practices do not occur (such as reaching into the food and then putting it back on the food bar)

9. Dietary staff must be attentive to food holding times and the possible need for batch cooking to assure a quality product. Remove food pans prior to replacing food items. Never add new food to older food that has been sitting on a buffet table.

10. Staff must assure that food is safe. Food must be held at ≥ 135 degrees F for hot foods ≤ 41 degrees F for cold foods. Food should not be held longer than 2 hours.

11. Sneeze guards should be provided.

12. Nursing staff members are responsible for recording food and beverage intake. This is recorded per facility policy.

©2013 Becky Dorner & Associates, Inc.

Buffet Style Dining

13. Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room.

14. The food service manager will perform meal rounds routinely to determine if the meals are attractive and nutritious and meet the needs of the individual; and will observe meals for preferences, portion sizes, temperature, flavor, variety and service accuracy.

15. Food service staff will break down, clean and sanitize the buffet equipment after each meal.

©2013 Becky Dorner & Associates, Inc.

Open Style Dining

Policy:

Open style dining will allow the individual choice of dining time to foster independence, enhance nourishment, and quality of life. Individuals will be provided choices of what to eat, when to eat and who to eat with.

Procedure:

1. Open dining is available during breakfast, lunch and dinner to provide the opportunity to dine at the individual's choice of time.

2. The dining room will be open for a minimum of two hours at each meal. Individuals are encouraged to choose the time they prefer to eat their meals.

3. Independent diners have the opportunity to start breakfast early or finish late.

4. Individuals that cannot make the choice of time to eat will be served meals at 7:30 AM, 11:30 AM, and 5:30 PM.

5. Nursing staff will remind all residents/patients of the meal. Nursing is responsible for assisting those needing help to the dining room. Individuals are assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc.)

6. Nursing and food service staff will offer food and beverage choices to the individual at the point of service.

7. Dietary and nursing staff will offer food and beverage choices to the individual at the point of service.

8. Nursing and food service staff will report the food and beverage choices to the food service staff members responsible for serving the food.

9. The food service staff members will serve food and beverage choices made with consideration given to any dietary restrictions/texture modifications.

10. If the individual decides not to follow specific diet recommendations there is an obligation to educate on the risk of not following their diet. If they can't make decisions, then family, physician, durable power of attorney for medical care, etc., will be educated on the risks and will determine what is best.

11. Dietary and nursing staff members will deliver hot and cold food choices to the individual with nursing providing eating/dining assistance as necessary.

12. Nursing staff members are responsible for recording food and beverage intake. The information is recorded per facility policy.

13. Individuals will be allowed to linger and visit throughout breakfast setting a relaxed tone throughout the day. Individuals are offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room.

14. Staff will clear and reset tables as needed between services.

©2013 Becky Dorner & Associates, Inc.

15. The food service manager will observe the meals served for preferences, portion sizes, temperature, flavor, variety and service accuracy.

Note: The Federal nursing home tag F368 requires no more than 14 hours to elapse between the evening and morning meals. As long as the morning meal is available within 14 hours, the intent of the regulation is met.

©2013 Becky Dorner & Associates, Inc.

In-Room Dining (Room Service)

Policy:

In-Room Dining (room service) will be served in a way to compliment the primary dining program. Individuals admitted for short term rehab therapy may have little interest in socializing and may request meals in their room. This style dining may also be used for critically ill/bed-bound residents/patients who have increased nutrition and hydration needs. Because the presentation of the meal directly affects how much the individual eats, presentation will include dining environment, the attitude of the server, and the appearance of the meal.

Procedure:

1. The In-Room Dining Environment
   - The room must be clean, well lit, and free of unpleasant odors.
   - Suggestions for a pleasant environment include the use of colorful placemats, dishware.
   - Use of tray favors is also suggested.
   - To assure foods are served at proper temperatures use insulated plate covers coffee pots or mugs and bowls. Cover all foods. Deliver the food within 20 minutes of plating.
   - Deliver trays to the room. Set tray up and uncover all food items.
   - Individuals order from a rotating or fixed menu, which is the same menu as what is being served in the dining room. Selections can be customized. May require individuals to select meal 12 to 24 hours prior to service.

2. The Attitude of the Server
   - Servers, generally nursing staff will use friendly, courteous, and considerate behavior when serving meals.
   - Servers will be enthusiastic about the food being served.

3. Appearance of the Meal
   - Use attractive dishware: Clean, eye appealing, matched, without chips or stains.
   - Flatware will be clean, without spots, neatly placed, and in good condition. All meals served must include a minimum, fork, and spoon (and knife as appropriate).
   - Glasses will be clean and free of stains or spots.
   - Tray covers and napkins will be clean and wrinkle free.
   - Items will be placed so they are convenient for the individual and neatly and correctly arranged.
   - Serve food carefully to avoid drips and spills.
   - Use suitable dishes for the proper size for various food items. For example:
     - Salads served in individual bowls with dressing on the side.
     - Bread and margarine served on individual plates.
     - Saucers for coffee or teacups (mugs do not require a saucer).
   - Hot food must be hot and cold food must be cold (as acceptable to the individual being served).
   - Assure that the correct condiments and beverages are available for the meal.

4. Appearance of the server
   - The food service manager will provide service training to the servers.
   - All staff will abide by the facility dress code. (Staff dress/appearance should be acceptable to the individuals residing at the facility).
   - Each facility will address issues such as appropriateness of tattoos, body piercings, and hair restraints.

©2013 Becky Dorner & Associates, Inc.

24 Hour Dining

Policy:

Twenty four hour dining will focus on the residents'/patients' needs, wants, and desire for greater choice and flexibility by providing meals and snacks continuously around the clock to meet daily nutritional and special dietary needs, and enhance patient's quality of life. The at home kitchen is never closed. 24 hour dining provides a variety of food choices throughout the day and night.

Procedure:

1. Individuals are provided 24 hours dining opportunities throughout the day and night with a choice between daily specials, a meal cooked-to-order and a variety of snacks.

2. Individuals are assisted by staff as needed to request meal and snack items.

3. The individual determines when, where and what time they would like to eat breakfast and have it cooked to order per preference.

4. Around 10:30 AM, the individual may participate in a breakfast/brunch with items found on the daily menu.

5. In the afternoon, the individual may desire a snack to eat and go to the dining room at 2:00 PM for a cup of tea, fresh baked product, fresh fruit or a sandwich.

6. Between the hours of 4:30 PM and 6:00 PM, a hearty meal is available from the main kitchen with many choices. If the individual doesn't like the meal option, they may select from a list of always available choices.

7. As the sun sets, the individual may want to select from a simple cup of soup or a grilled sandwich menu.

8. After hours, the individual may select from list of snacks such as fresh fruit, vegetables, yogurt, ice cream, pudding, gelatin, cereals, cookies, soups, deli meats and assorted breads. Other food items can be kept in a small refrigerator that staff, family and residents/patients have access to throughout the day and night.

9. Staff is available to help individuals make good choices but continue to honor their right to choose.

10. If the individual decides not to follow specific diet recommendations there is an obligation to educate on the risk of not following their diet. If they can't make decisions, then family, physician, durable power of attorney for medical care, etc. will be educated on the risks and will determine what is best.

11. If the individual cannot make choices, meal and snack items will be served at scheduled meal and snack times and foods provided will be based on recorded preferences and dietary needs.

12. The nursing staff will record food and fluid intake daily. This is recorded per facility policy.

13. Food safety, sanitation, infection control, and resident/patient safety policies and procedures will be reviewed with staff routinely.

©2013 Becky Dorner & Associates, Inc.

Special Occasions – Holiday and Theme Meals

Policy:

Facility staff will plan special occasions, holiday and theme meals that highlight traditions that are most important to the individuals being served.

Procedure:

1. Meet with customers (patients/residents) to discuss and plan special events and celebrations. Get input from staff and families as well.

2. Plan ahead. A yearly calendar may be helpful.

3. Define desired outcomes (function, time, place, cost, number of people to be served, type of service, decoration/theme).

4. Define each person's responsibilities. Plan the menu and activities together. Plan for extra supplies (tables, chairs, china, linen, glassware, utensils).

5. Prepare work schedules/timetables. Include set-up, break down, service.

6. Do a final report with suggestions for the next time this type of event is to be planned.

Ideas for theme meals:

- Movies (Gone with the Wind, Wizard of Oz, Casablanca, Singing in the Rain, True Grit)
- Las Vegas Night
- Western Day
- Holidays (Valentine's Day, Halloween, Memorial Day, Veteran's Day, etc.)
- Mock weddings/real weddings
- Ethnic meals (French, German, Irish, Italian, Mexican, Oriental, Polish, Russian)
- Tailgating/football parties
- Barbeques or picnics
- Special events for small groups
- Special small dining room for family meals
- Community involvement – boy scouts/girl scouts, churches

©2013 Becky Dorner & Associates, Inc.

Paid Feeding Assistants (Nursing Facilities)

Policy:
Paid feeding assistants will only be used if they have met the criteria as outlined in the Center for Medicare/Medicaid Services (CMS) State Operations Manual under §488.301 tag F 373 Paid Feeding Assistants. Paid feeding assistants will be: Properly trained and adequately supervised; will assist only those residents without complicated feeding problems and who have been selected as eligible to receive these services from a paid feeding assistant; and will provide assistance in accordance with the resident's needs, based on individualized assessment and care planning.

Procedure:

1. The facility will assure that any paid feeding assistants have been trained using a:

   (1) State-approved training course.
   a. The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and
   b. The use of feeding assistants is consistent with State law.

   (2) Supervision.
   a. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). Supervision must avoid negative outcomes for residents.
   b. The supervisory nurse should monitor the provision of the assistance provided by paid feeding assistants to evaluate on an ongoing basis:
      i. Their use of appropriate feeding techniques;
      ii. Whether they are assisting assigned residents according to their identified eating and drinking needs;
      iii. Whether they are providing assistance in recognition of the rights and dignity of the resident; and
      iv. Whether they are adhering to safety and infection control practices.
   c. In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.
      i. Regardless of where a resident is being assisted to eat or drink, in the case of an emergency, the facility needs to have a means for a paid feeding assistant to obtain timely help of a supervisory nurse.

   (3) Resident selection criteria.
   a. A facility must ensure that paid feeding assistants are permitted to assist only those residents who have no complicated eating or drinking problems. This includes residents who are dependent in eating and/or those who have some degree of dependence, such as needing cueing or partial assistance, as long as they do not have complicated eating or drinking problems.
   b. Facilities may use paid feeding assistants to assist eligible residents to eat and drink at meal times, snack times, or during activities or social events as needed, whenever the facility can provide the necessary supervision.
   c. Paid feeding assistants are *not* permitted to assist residents who have complicated eating problems, such as (but not limited to) difficulty swallowing,

©2013 Becky Dorner & Associates, Inc.

recurrent lung aspirations, or who receive nutrition through parenteral or enteral means. Nurses or nurse aides must continue to assist residents to eat or drink who require the assistance of staff with more specialized training.

   i. The facility must base resident selection on the charge nurse’s (RN, or LPN if allowed by State law) current assessment of the resident's condition and the resident’s latest comprehensive assessment and plan of care.
   ii. Charge nurses may wish to consult with interdisciplinary team members, such as speech-language pathologists or other professionals, when making their decisions.

2. Paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:
   a. Minimum training course contents. A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
      (1) Feeding techniques;
      (2) Assistance with feeding and hydration;
      (3) Communication and interpersonal skills;
      (4) Appropriate responses to resident behavior;
      (5) Safety and emergency procedures, including the Heimlich maneuver;
      (6) Infection control;
      (7) Resident rights; and
      (8) Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

3. The facility must maintain a record of all individuals used by the facility as feeding assistants, including verification of successful completion a State-approved training course for paid feeding assistants.

4. Use of Existing Staff as Paid Feeding Assistants
   a. Facilities may use their existing staff to assist eligible residents to eat and drink.
      i. These employees must have successfully completed a State-approved training course for paid feeding assistants, which has a minimum of 8 hours of training as required in §483.160.
      ii. Staff may include administrative, clerical, housekeeping, dietary staff, or activity specialists.
   b. Employees used as paid feeding assistants, regardless of their position, are subject to the same training and supervisory requirements as any other paid feeding assistant.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Timely Meal Service

Policy:

Food will be delivered promptly to assure proper temperatures and high quality food.

Procedure:

1. Nursing staff will notify the food service department in writing of individuals who wish to eat in their rooms.

2. Meals will be placed in the cart in sequence to achieve the most effective service. Each meal will be identified by the meal identification (ID) card/ticket with the individual's name, room number and diet order.

3. Food service staff will notify the appropriate staff as each cart is ready for delivery. Food service personnel deliver carts to the wings. Nursing or food service staff will return the carts to the kitchen after meal service per facility policy.

4. Meals are distributed promptly with supervision as needed by nursing staff. (Close supervision may be needed for those on special diets, or with feeding difficulties). Staff should check each individual name and room number to verify correct information, and check items on the plate or tray against the meal ID card/ticket to assure accuracy.

5. At least one person will be stationed in the dining room during meal service to assist individuals with eating and to handle any emergency situation that might arise.

©2013 Becky Dorner & Associates, Inc.

Meal Times and Frequency

Policy:

The facility provides at least three meals daily at regular times comparable to normal mealtimes in the community. Meals will be served in a timely manner.

Procedure:

1. There will be no more than fourteen (14) hours between a substantial evening meal (dinner) and breakfast the following day, unless a nourishing snack is provided at bedtime. If a nourishing snack is provided at bedtime, then up to 16 hours may elapse between a substantial evening meal (dinner) and breakfast the next day. However, the individuals in the group must agree to this meal span.
   Note: Check state regulations to assure compliance.

2. There will be at least a four hour interval between breakfast and lunch, and between lunch and dinner.

3. Meals and HS snack will be served at the following times:

   Breakfast: ____________

   Lunch: ____________

   Dinner: ____________

   HS Snack: ____________

Note: A “substantial evening meal” is defined as an offering of three or more menu items at one time, one of which includes a high quality protein such as meat, fish, eggs or cheese. The meal should represent no less than 20% of the day’s total nutritional requirement.

“Nourishing snack” is defined as verbal offering of items, single or in combination, from the basic food groups. Adequacy of the snack will be determined both by individuals in the group and evaluating the overall nutritional status of those in the facility.

©2013 Becky Dorner & Associates, Inc.

Early and Late Meals

Policy:

Early and late meals will be provided to any individual who needs them.

Procedure:

Early Meals:

1. Nursing and/or the food service department determine which individuals may benefit from an early meal, on either a temporary or permanent basis.

2. The early meals will leave the food service department at approximately:

   Lunch ___________

   Dinner ___________

3. Upon arrival on the floor, it is the responsibility of nursing to see that the meals are passed and individuals receive assistance as quickly as possible.

Late Trays:

1. Food service staff will pull the meal identification (ID) cards/tickets for those who need to have their meal held. Meal cards will be placed in a designated area in the kitchen. The food service manager notifies the cook at the start of the tray line how many late trays there are.

2. After the meal is served, the cook will reserve enough food for the meals that will be going out later. These foods should be held safely at the proper temperatures.

3. When the nursing department phones that a certain individual may eat, the cook prepares the meal and one of the food service staff delivers it to the proper nursing station, assuring that the meal is properly labeled with the name and room number of the individual.

©2013 Becky Dorner & Associates, Inc.

Select Menus

Policy:

If select menus are offered, they will be provided within each individual's dietary modifications. Menus will be reviewed to assure therapeutic correctness and nutritional adequacy while respecting the individual's food preferences. Select menu sheets may be used for meal/tray identification. Those who are not able to make meal choices independently will be provided with assistance, or a non-select menu will be provided (and altered for individual food preferences and diet order).

Procedure:

Diet Clerk/Aide/Secretary:

1. Print the individual's name and room number on the select menu according to the diet order. Select menus are provided to all individuals who choose to make their own menu selections. Assistance from family or staff is encouraged for those who cannot communicate their own choices.

2. Distribute menus in advance of the meal so that each individual may make their menu choices for each meal. Depending on style of service, this may be done as the individual is seated in the dining room; or if disposable paper menus are used, it may be done in advance of the meal. In this case, facility staff may assist in the delivery of menus and in menu selection as deemed necessary. Family members are also encouraged to assist when needed. Menu choices are returned to the food service department once they are completed.

3. Collect marked menus.

4. Assemble select menus in order according to the service procedure.
   - Check the marked menus to be sure that there is a menu for each individual (except NPO) and menus are correct according to the physician ordered diet.
   - Check for any missing select menus or incomplete menus.
   - Retrieve the missing select menus and visit or call individuals who did not complete menus, assisting them with menu marking, if necessary.
   - Assemble select menus in order according to service. These select menus will act as the individual's meal identification (ID) card/ticket.
   - Assure that there is a select menu available for every individual who uses the select menu system.

5. Correct select menus following these guidelines:
   - Complete the heading on the menu with name, diet order, dining area and day.
   - Verify name, diet order and menu with the individual's current records.
   - Check the non-modified menus for completeness and nutritional adequacy (example: if an individual selected cereal, check that milk is also selected; if an individual selects only fruit, visit the individual and assist in completing the menu. Refer to the RD or designee for diet education if needed.
   - Check the modified menus for therapeutic accuracy, nutritional adequacy, and completeness using the individual's records and the diet/nutrition care manual.
   - Correct all menus within the parameters of the individual's recorded likes/dislikes, food intolerances and allergies.
   - Verify substitutions with the individual if the food item selected for substitution is not listed as a preference.

©2013 Becky Dorner & Associates, Inc.

- Verify that each food item on the menu is legible and neatly circled.
- Refer complicated therapeutic diets to the RD or designee as needed to review and approve.

6. If an individual has been unable to mark a menu, make menu selections using the above guidelines.

For Trayline Service:
1. Diet changes received during tray line will be processed immediately and inserted in the appropriate place in the tray line.

2. Prior to each meal, check to be sure there is a correct menu for every individual (except those who are NPO).

3. Place the select menus (meal ID card/ticket) for the next meal at the starter station on tray line.

Starter Position:
1. Place select menu (which is now the meal ID card/ticket) on the tray to be used by other tray line associates to complete meal assembly.

Diet Clerk/Supervisor:
1. Check accuracy of meal according to the menu.

Nursing:
1. When passing meals, use the meal (ID) card/ticket to verify the individual's name and diet order to assure it is provided to the correct individual.

For Dining Room Service:
1. Follow the same basic guidelines as with trayline service and adapt as needed for dining room service.

Note: The menu selection procedure may be automated using spoken menus and wireless data transfer to the kitchen/service area.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Meal Identification and Preference Cards/Tickets

Policy:

A meal identification (ID) and food preferences card (meal ID card/ticket) is used to properly identify each individual's needs and desires for food.

Procedure:

1. The food service manager visits a newly admitted individual to obtain food and beverage preferences, dislikes and food allergies/intolerances before a permanent meal ID card/ticket is written.

2. A temporary meal ID card/ticket containing the individual's name, room number and diet order may be used until a permanent one is prepared (usually for the first meal or two).

3. The permanent meal ID card/ticket includes the name of the individual, diet order, beverage preferences, food dislikes and any other specific diet information. Food allergies should be written in red, or printed boldly to call attention to them. Room number or dining area may also be included.

4. Meal ID cards/tickets are used during meal service to assure the correct diet is being served and food preferences are honored.

5. Meal ID cards/tickets are placed with corresponding meals to assure delivery to the correct individual.

Meals delivered to the dining rooms, wings/neighborhoods:

6. Meal ID cards/tickets are removed by the server after the meal is served and placed in a container to be sent to the kitchen.

7. Food service staff are responsible for keeping meal ID cards/tickets clean and in the correct serving order.

8. The food service manager or designee is responsible for keeping meal ID cards/tickets up-to-date and for replacing worn cards when appropriate and/or printing all meal ID cards as needed for meal service.

9. Hard copy plastic meal ID cards are sanitized following each meal.

Note: Staff may use paper tray cards to note changes in preferences, food intake percentages and other pertinent information to send back to the food service department.

©2013 Becky Dorner & Associates, Inc.

Offering Food Replacements at Meal Time

Policy:

Each individual receives appropriate nutrition when a food replacement is offered.

Procedure:

1. If an individual is not eating a food (or foods) served, the nursing staff is responsible for asking why and for verbally offering a suitable food replacement. (Please see Menu Substitution Lists in the Menus/Therapeutic Diets Section.) The individual is encouraged to give input for his/her choice of substitution. A minimum of three substitutes should be offered verbally.

2. For those on special diets, be sure the food replacements offered are appropriate for the therapeutic diet order.

3. If an individual agrees to eat the food replacement, the nursing staff tells the food service staff what is needed, for whom and why. This may be done verbally, or in writing to avoid mistakes (see Food Replacements Sample Form in this section).

4. The food server is responsible for preparing the food replacement as soon as the current series of meals has been served; making sure it is delivered to the individual in a timely manner.

5. The food service manager should be notified by staff so that an accurate list of dislikes can be created and used for future reference as appropriate.

6. If the individual refuses the served or offered food replacement, the staff is not required to offer any further food replacements. The staff does document that the individual did not eat the particular food(s) served and that the substitute was also refused. Additional nourishment is offered at the next nourishment time. For diabetics that refuse meals and substitutes, notify nursing and if refusal of meals continues, refer to registered dietitian (RD) or designee.

7. When food replacements are consistently refused, the staff will notify the food service manager or designee who is then responsible for discussing food preferences with the individual, making revisions as necessary, and documenting specific problems in the progress notes and care plans. The food service manager or designee will refer individuals to the RD or designee as appropriate.

8. The following page lists the items that will be available for food replacement at all meals. It is the responsibility of the food service manager to provide this list to the nursing staff. It is the responsibility of the nursing staff to know the alternates available for the meal.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Resource: Available Food Replacements Sample

When an individual refuses to eat, a food replacement (or substitute) should be offered to assure that all individuals receive adequate nourishment.

- If an individual is not eating a food (or foods) served, the staff should ask why and offer a suitable replacement. The individual is encouraged to give input for his/her choice of replacement. Staff should verbally offer a choice of at least 3 different food replacements.
- Food replacements should be provided within 15 minutes of determining an individual's wishes. The food service department should keep an accurate list of dislikes for future reference.
- The following chart lists the items that will be available for replacement at all meals. When an individual consumes less than 75% of their meal, a replacement should be offered.

Note: Individuals have the right to refuse food replacements. Some individuals receiving supplements or enhanced food items may not need or want additional foods or fluids.

When an Individual Consumes < 75% of:	Offer:
Entrée/Meat 2 to 3 ounces*	• Alternate meat or entrée item • Sandwich with 2-3 ounces meat or cheese (such as a hamburger with bun, or turkey and cheese sandwich) • ½ cup cottage cheese • 2 ounces cheese (with crackers or bread) • 2 cooked eggs (with 1 ounce cheese, optional)
Milk 8 ounces*	• 1 cup yogurt • 1 ½ ounces cheese • 1 cup chocolate milk • 1 cup buttermilk • 1 cup pudding or custard • 1 cup cream soup made with milk and/or cream
***If an individual refuses the offered choices, the facility staff may choose to offer:** • 6 to 8 ounce milkshake or high calorie/protein supplement • ½ cup pudding made with milk or substitute which provides a minimum of 4 to 5 grams protein • Other supplement of choice	

©2013 Becky Dorner & Associates, Inc.

Food Replacements Sample Form

Nursing:
The following choices are available for individuals who do **not** eat at least **75%** of their meals. Write in the names of those who do not eat 75% of their meals. Verbally ask if they would like one of the replacements listed below. Mark the number of their replacement choice under the meal column. Send this sheet to the kitchen. The kitchen will fill the order and send the food and this sheet back to you to serve. If the individual refuses a meal replacement, place a check in the appropriate column. After meal replacements are passed, mark whether food was accepted or refused, and note percentage eaten (25% / 50% / 75% / 100%).

1. Alternate meat or entrée item
2. ½ cup cottage cheese
3. 2 ounces cheese
4. 2 cooked eggs
5. Sandwich with 2 ounces meat or cheese
6. 1 cup yogurt
7. 1 ½ ounces cheese
8. 1 cup chocolate milk
9. 1 cup buttermilk
10. 1 cup pudding or custard
11. 1 cup cream soup made with milk and/or cream
12. 6 to 8 ounce milkshake or high calorie/protein supplement
13. 4 to 5 ounce pudding made with milk or substitute which provides a minimum of 4 to 5 grams protein
14. Other supplement of choice

Location_____________________ **Meal:**__________________ **Date:**______________ **Deliver to:**_______________________

Food Service Department:

1. Prepare indicated nourishments. Label each with individual's name and dining area, date and time to be given.
2. Prepare and deliver nourishments to the appropriate dining area.
3. Send this sheet back to nursing with the food.

Name	Number of Replacement Chosen	Percent Accepted					Check if Refused	Comments
		0	25	50	75	100		

©2013 Becky Dorner & Associates, Inc.

Displaying the Menu

Policy:

The planned menus will be posted each week, and the daily menus will be posted daily.

Procedure:

1. Planned written menus will be posted by the dietary staff in a clear, obvious area that is easily viewed by all individuals.

2. Daily menus will be clearly posted outside the dining area on the menu board.

3. Food service staff is responsible for posting revisions to the planned menu in a timely manner.

©2013 Becky Dorner & Associates, Inc.

Accuracy and Quality of Tray Line Service

Policy:

Tray line positions and set up procedures are planned for efficient and orderly delivery. All meals are checked by food service personnel for accuracy, and by the employees serving the meals prior to serving to the individual.

Procedure:

1. The menu extension sheet displays food items and amounts for each regular or therapeutic diet.

2. The food service manager or designee is responsible to assure that all foods needed for meal assembly are present at the appropriate time.

3. Tray line and/or meal service positions for breakfast, lunch and dinner are determined and planned:
   - According to the menu
   - To operate at maximum efficiency
   - To obtain maximum accuracy

4. The meal is checked against the therapeutic diet spread sheet to assure that foods are served as listed on the menu.

5. Staff will refer to the meal identification (ID) card/ticket for food dislikes, allergies and other details and substitute appropriately for those items. (See Menu Substitution Lists in the Menus/Therapeutic Diets section of this manual.)

6. All foods will be covered. Hot foods will be kept hot (>135 degrees F) and cold foods will be kept cold (<41 degrees F). Cooking of hot foods will be completed no more than 30 minutes prior to meal service.

7. Each meal will be checked for:
   - Correct name, room number and diet order
   - Accuracy of following the therapeutic diet extension
   - Proper portion sizes
   - Special requests (food preferences)
   - Neatness of tray and attractiveness of the food served

8. Problems with meal accuracy are resolved immediately.

9. Ongoing problems are brought to the attention of the food service manager.

©2013 Becky Dorner & Associates, Inc.

Portion Control

Policy:

Individuals will receive the appropriate portions of food as planned on the menu. Control at the point of service is necessary to assure that accurate portion sizes are served.

Procedure:

1. Use standardized recipes to avoid waste caused by overproduction. Recipes should be adjusted as needed and the yield and serving size specified on each recipe.

2. The menu should list the specific portion size for each food item. Menus should be posted at the tray line for staff to refer to for proper portions for each diet.

3. Serve the food with ladles, scoops, spoodles and spoons of standard sizes. Scales should be used as needed to weigh meat portions. Scoops should be leveled off (not overflowing) for the most accurate portion size.
   - Portions that are too small result in the individual not receiving the nutrients needed.
   - Portions that are too large increase the costs as well as providing the individual more food than needed or allowed (i.e. therapeutic diets).

4. Food service staff will be inserviced by the food service manager on proper portion sizes at regular intervals. Meal observations for quality control of portion sizes should be conducted by the food service manager, or registered dietitian (RD) or designee on a routine basis.

Serving Utensils		
Utensils	**Cup Amount**	**Ounce Amount**
# 5 scoop	3/4 cup	6 ounces
# 6 scoop	2/3 cup	5.34 ounces
# 8 scoop	1/2 cup	4 ounces
# 10 scoop	2/5 to 3/8 cup	3 1/4 ounces
# 12 scoop	1/3 cup	2.67 ounces
# 16 scoop	1/4 cup	2 ounces
# 20 scoop	3 1/8 Tbs	1 3/4 to 2 ounces
# 24 scoop	2 2/3 Tbs (1/6 cup)	1 1/2 to 1 3/4 ounces
# 30 scoop	2 Tbs	1 ounce
# 40 scoop	1 1/2 Tbs	3/4 ounce
6 ounce ladle	3/4 cup	6 ounces

©2013 Becky Dorner & Associates, Inc.

Adaptive Eating Devices

Policy:

Adaptive eating devices are available for those who need them.

Procedure:

1. Individuals are reviewed on admission, and periodically to assess the need for adaptive devices. Referrals for needed equipment may come from occupational therapy, nursing, physician or registered dietitian (RD) and/or designee

2. Refer to the occupational therapist for evaluation for adaptive devices, if needed.

3. A physician order is obtained for adaptive devices.

4. Adaptive devices are noted on each individual's meal identification (ID) card/ticket and medical record.

5. The food service department is responsible for ensuring that each individual receives the appropriate feeding devices for each meal.

6. Adaptive devices are cleansed and sanitized in the kitchen and provided for each meal and/or snack as appropriate.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Meal Time Observation

Policy:

All individuals will be observed during mealtime to monitor meal acceptance. All individuals will receive complete dining service for the meal. Staff will assure that all individuals have been served appropriately before leaving the dining area.

Procedure:

1. The food service manager or designee will do meal rounds in the dining rooms and resident/patient rooms during meal times.

2. Nursing will provide supervision and observation during mealtime, in both the dining areas and resident/patient rooms.

3. Staff will visit every table to be sure that all individuals have received the appropriate meal and service.

4. Observations will be noted and referrals will be made as needed to the appropriate staff (for difficulty chewing, swallowing, using utensils, self-feeding, etc.).

5. Meal/food substitutions will be provided in a timely manner as needed.

6. Acceptance and appropriateness of therapeutic or mechanically altered diets will also be monitored.

7. Follow up on problems or concerns for food preference is the responsibility of the observer and should be completed within 48 hours.

©2013 Becky Dorner & Associates, Inc.

Following the Meal Service

Policy:

Staff will assist individuals to exit the dining areas, and then clean and prepare the dining areas for the next meal.

Procedure:

1. Staff will provide assistance to individuals as needed to exit the dining area.

2. Staff will initiate cleaning of the dining area after all individuals have been served and have left the dining area. Individuals will not be rushed through the meal.

3. The dining area will be thoroughly cleaned and re-set for the next meal.

4. The dining area will be inspected by the food service manager or designee after every meal for cleanliness and preparation for the next meal.

©2013 Becky Dorner & Associates, Inc.

Packed Meals

Policy:

Individuals requiring a meal away from the facility shall be provided with a packed/boxed meal. This includes those attending medical appointments, dialysis, extended trips for treatments, or for other purposes.

Procedure:

1. The nursing department will notify the food service department at least 24 hours in advance of an individual's need for a packed/boxed meal.

2. Nursing will include the individual's diet order for the meal, and the time of departure from the facility.

3. The food service staff will prepare the packed/boxed meal according to the individual's food preferences. The meal will contain no less than two carbohydrate choices, two ounces of edible protein, vegetable and/or fruit, beverage, and other menu choices to round out the meal. If clear or full liquids are required, the meal may include a liquid nutritional supplement.

4. The food service staff will store the meal under safe and sanitary conditions and temperatures in the department, and pack the meal in a cooler or similar transportable container to help maintain safe food temperatures in transport.

5. The nursing department will contact the food service department for the meal when needed.

6. The nursing department will notify the food service department upon the individual's return to the facility for normal resumption of meals. The nursing department will notify the food service department of any change in diet orders for the individual returning to the facility.

©2013 Becky Dorner & Associates, Inc.

Pets

Policy:

Pets are not permitted in the food preparation areas, storage and receiving areas, or pantry areas at any time. Pets are not be permitted in the dining area during meal service.

Procedure:

1. All facility staff will be trained/in-serviced no less than yearly on the facility's policies and procedures for facility pets.

2. Employees that handle pets during working hours must follow all facility policies and procedures for hand washing.

3. All facility staff will be responsible for keeping pets out of the food preparation areas, storage areas, and receiving areas.

4. Pets will be kept out of the dining areas during meal service. This does not include contained/enclosed aviaries or aquariums.

5. Food service staff will not be responsible for the feeding or maintenance of pets at the facility during their working hours in the food service department.

©2013 Becky Dorner & Associates, Inc.

Leave of Absence

Policy:

The food service department will be notified in writing or via telephone call when an individual will be away from the facility during mealtimes.

Procedure:

1. Nursing will send a diet change sheet or call the food service department when an individual will be away during meal service. Indicate the date, and meal(s) the individual will be away.

2. The dietary staff will remove the individual's meal identification (ID) card/ticket for the designated meal(s).

©2013 Becky Dorner & Associates, Inc.

Guest Meals

Policy:

Guests may purchase meals and eat with a patient/resident.

Procedure:

1. Whenever family or friends wish, they may purchase a meal at the business office so they can eat with an individual patient/resident.

2. The cost of a guest tray is $__________.

3. The business office informs the kitchen of extra guests as soon as possible, preferably one day before the meal is served.

4. The food service staff sets up and serves the guest meal along with the individual patient's/resident's tray. Guests receive the same meal that those on regular diets receive, unless special requests are prearranged and approved by the food service manager or designee.

5. Guest meals are delivered along with the individual's meals so that they may eat together unless otherwise directed.

6. The food service manager should keep an accurate record of all guest meals served, and reconcile this with the bookkeeper so that money from guest trays is credited to the food service department.

7. Follow the facility policy on tracking and collecting money for guest meals.

©2013 Becky Dorner & Associates, Inc.

Food Availability

Policy:

Supplies of food and beverage items will be available around the clock in the kitchenette or pantry areas.

Procedure:

1. The food service manager will determine food and beverage items and par levels to be delivered to the patient/resident areas.

2. The food service staff will deliver items daily to the appropriate kitchenette or pantry, replenishing items according to predetermined par levels. They are also responsible for:
   - Rotating stock and removing outdated items.
   - Checking the temperatures of the refrigerators/freezers in kitchenettes or pantries weekly and maintain documentation (see Refrigerator and Freezer Temperatures Sample Forms in Food Production and Food Safety section).
   - Checking the internal food temperatures randomly to assure proper temperatures (< 41° F).
   - Cleaning and sanitizing refrigerators on a regular cleaning schedule, and as needed for spills.

©2013 Becky Dorner & Associates, Inc.

Nourishments and Supplements

Policy:

The food service manager will assure that individuals receive the nourishments/supplements that have been ordered by the physician and/or recommended by the registered dietitian (RD) or designee. Nursing staff will deliver the nourishments/supplements and assist individuals to consume them.

Procedure:

1. Nourishment/Supplement Lists
   a. The food service manager or designee writes nourishment/supplement lists using the care plan, physician's orders, and individual(s)' requests as a guide.
   b. Copies are given to appropriate staff for preparation.
   c. As changes occur they are revised on all lists and copies by the food service manager or designee.
   d. New lists are made as needed for legibility.

2. Preparation of Nourishments and Supplements
   a. Assigned staff prepares all nourishments and supplements according to the nourishment/supplement lists.
   b. All "high protein/high calorie supplements", special nourishments, and other nourishments/supplements are individually wrapped, labeled and dated and include the resident/patient's last name and room number for delivery.

3. Designated staff delivers nourishments/supplements.

4. Staff provides assistance to those who need it.

5. "Dirty" dishes and silverware are returned to the "dirty" dish area by staff after nourishments are completed.

6. Nursing staff reports intake problems to the nursing supervisor and documents percent intake of nourishment/supplement on the appropriate form.

7. Nursing notifies the food service manager, RD or designee of needed changes in nourishments/supplements based on the individual's acceptance (or lack of acceptance).

©2013 Becky Dorner & Associates, Inc.

Nourishments and Supplements Sample Form

Date: ___________________________

Nourishments

Room	Name	Diet Order	10 AM	2 PM	HS

This form may be computerized.

©2013 Becky Dorner & Associates, Inc.

Food Production and Food Safety

- ♦ Hours of Operation 3-1
- ♦ Food Service Manager's Responsibilities 3-2
- ♦ HACCP and Food Safety 3-3
- ♦ Resource: Pathogenic Microorganisms and Strategies for Their Control 3-6
- ♦ Resource: CCP Decision Tree Table 3-7
- ♦ HACCP Principles 3-8
- ♦ Resource: HACCP Recipe Sample 3-10
- ♦ Resource: Flow Chart 3-11
- ♦ General HACCP Guidelines for Food Safety 3-12
- ♦ Food Procurement and Facility Gardens 3-15
- ♦ Accepting Food Deliveries 3-16
- ♦ Food Storage 3-17
- ♦ Freezer and Refrigerator Temperatures Sample Form 1 3-19
- ♦ Freezer and Refrigerator Temperatures Sample Form 2 3-20
- ♦ General Food Preparation and Handling 3-21
- ♦ Meat and Vegetable Preparation 3-23
- ♦ Food Temperatures 3-24
- ♦ Resource: Critical Temperatures for Safe Food Handling 3-25
- ♦ Resource: Taking Accurate Temperatures 3-26
- ♦ Resource: Final Cooking, Holding and Reheating Temperatures 3-28
- ♦ Food Temperatures Sample Form 3-30
- ♦ CCP Documentation Sample Form 3-31
- ♦ Handling Cold Foods for Trayline 3-32
- ♦ Taste Tasting 3-33
- ♦ Use of Leftovers 3-34

©2013 Becky Dorner & Associates, Inc.

Food Production and Food Safety

♦ **Food Allergies 3-35**

♦ **Ice 3-37**

♦ **Personal Food Storage 3-38**

♦ **Resource: Food Safety for Your Loved One 3-39**

♦ **Providing Food and Supplies for Other Departments 3-40**

♦ **Special Events Food/Meal Sample Form 3-41**

♦ **Floor Stock 3-42**

♦ **Floor Stock Supply Sample Form 3-43**

♦ **Food Service Problems/Referral to Food Service Manager 3-44**

♦ **Reporting a Foodborne Illness (FBI) 3-45**

Note: Also see sample job descriptions available from Becky Dorner & Associates, Inc. at www.beckydorner.com.

©2013 Becky Dorner & Associates, Inc.

Hours of Operation

Policy:

The kitchen will open promptly at__________AM and will be closed at__________PM.

Procedure:

1. The morning/day cook will be responsible for opening the kitchen and the afternoon cook will be responsible for closing and securing the kitchen at night.

2. The kitchen will be thoroughly cleaned prior to closing each day.

©2013 Becky Dorner & Associates, Inc.

Food Service Manager's Responsibilities

Policy:

A well-trained food service manager assures that instructions for the food service department are properly carried out, and that all local, state and federal food, food safety and sanitation regulatory requirements are met.

Procedure:

1. Instructions are prepared and carried out to assure positive results in food preparation and service.

2. The food service manager is familiar with all local, state and federal regulatory requirements related to food, food safety and sanitation; and assures that all requirements are met.

3. Workers are trained, assisted and encouraged as needed. Workers are free from symptoms of contagious diseases.

4. Written work schedules are posted well in advance.

5. Food is procured from sources approved or considered satisfactory by federal, state or local authorities.

6. Food is prepared in a manner that prevents food borne illness. Staff follows proper sanitation and food handling practices. Food is served as soon as possible after it has been prepared, and at the proper safe temperature.

7. Standardized recipes are followed. These recipes should include:
   - Amount of ingredients, either by weight or volume
   - Method of combining ingredients
   - Cooking or baking temperatures and approximate time required
   - Size, shape and type of pan to be used, and amount for each pan
   - Adjustments for yield to the number of meals served in the facility: total yield, the size of one serving portion, and the number of portions per pan or the yield in cups, quarts or gallons

8. Food waste is prevented.

9. Food is prepared according to procedures that minimize fatigue and save time for workers (i.e. work simplification methods).

10. Good equipment and correct tools are available. Equipment is properly used, cleaned and sanitized, and kept in good repair.

11. The menus provide a variety of foods acceptable to the individual being served.

12. Food served is attractive, palatable and meets the dietary needs of the individual being served. All food is tasted before it is served to assure quality.

©2013 Becky Dorner & Associates, Inc.

HACCP and Food Safety

Policy:

Facility staff will be well trained on food safety policies and procedures. Supervisors will monitor staff and correct any problems or concerns at the time they occur. The food service manager will implement a food safety system to prevent food borne illness.

Note: Food borne illness (FBI) is an illness that is transmitted to humans through food. A food borne outbreak is when 2 or more people have the same illness after ingesting a common food. Contamination is caused by harmful substances present in foods or added to foods (usually accidentally by food handlers). A hazard is a food product that may cause health risk to customers.

These hazards may be biological, chemical or physical. Biological hazards account for 93% of all FBI (survival and growth of bacteria and viruses). Chemical hazards account for approximately 4% of all FBI: toxins, heavy metals, pesticides, cleaning compounds, and food additives/preservatives. Physical hazards may include: foreign objects such as metal, glass, plastic or wood. Cross contamination occurs when harmful substances are transferred from one source (i.e. hands, food contact surfaces, unsanitary cleaning cloths, raw foods) to the food. It is vital to control the growth of bacteria during food storage and preparation because raw or uncooked food may naturally contain pathogenic organisms (i.e. bacteria such as salmonella in poultry).

The U.S. Department of Health and Human Services Food Code uses 41° F for cold foods and 135° F for hot foods. However, temperatures may vary from state to state. Please check your state regulations for appropriate temperature ranges. In addition, some people find that a temperature danger zone of 40° F to 140° F is easier for staff to learn and remember. The food service manager and the registered dietitian (RD) should determine the appropriate temperature ranges for the food service operation.

Procedure:

1. Be aware of sources of food-borne organisms in food service:
   - Humans (nose and throat, hands, infections, feces and clothing): Poor personal hygiene; poor hand washing practices.
   - Foods of animal origin (poultry, meat, eggs, fish/shellfish): Inadequate cooking and improper holding temperatures; unsafe food sources; cross contamination.
   - Foods of plant origin (due to contaminated soils and water): Unsafe food sources; cross contamination.
   - Contaminated equipment: Improper sanitation; cross contamination.

2. Pay special attention to individuals at a higher risk of FBI: older adults, children, pregnant women, immune-compromised individuals, those who have had recent surgery or have chronic illness.

3. Certain foods are considered potentially hazardous foods (PHF) because of their protein content, moisture content and food source. They are also described as time/temperature controlled for safety (TCS) foods. Be careful when handling:

   - Milk and milk products (yogurt, cottage cheese, cheese, sour cream, etc.)
   - Poultry
   - Fish and shellfish
   - Soy protein foods/Tofu
   - Shell eggs/unpasteurized eggs
   - Meat (beef, pork)
   - Sliced or cut melon
   - Baked or boiled potatoes
   - Raw seeds and sprouts

©2013 Becky Dorner & Associates, Inc.

4. Bacteria need certain things to reproduce: warmth, moisture, food, time. It is helpful to remember the acronym, FAT TOM
   - **F**ood - High protein food or foods that are already contaminated
   - **A**cidity of the food - pH (Acidity is measured from 0 which is very acid to 14 which is very alkaline). An acidity of <5.0 inhibits bacterial growth (ex: vinegar, lemon juice)
   - **T**ime - Avoid the Temperature Danger Zone (TDZ) for more than 4 hours during entire preparation and service time. Be sure foods are not past expiration dates
   - **T**emperature - Avoid TDZ of 41° F to 135° F
   - **O**xygen - Most bacteria need oxygen, some do not (botulism)
   - **M**oisture - Free moisture available in food (water activity or Aw) of > 0.85 such as meat and poultry which have an Aw of 0.98. Also described as the water percentage of food. Foods with a high water level encourage bacterial growth.

   Time and temperature are the most critical factors and are easily controllable. Food should not be exposed to any of the above elements for long periods of time. Bacteria can grow rapidly especially in the right conditions.

5. **Viruses** cannot reproduce without a living host (animal or human). While they cannot reproduce in or on food, viruses may survive long enough in or on a food to be transmitted to a new host. Two viruses that are well known for being spread by poor food handling practices are hepatitis A and Norovirus (formerly known as Norwalk virus).

   Toxins are poisonous substances that come from a variety of sources. Some pathogens (staphylococcus aureus and clostridium botulinum) produce toxins as a byproduct of their growth. Most toxins are not destroyed by high temperatures. A PHF/TCS food that is allowed to remain in the temperature danger zone long enough for the bacteria to produce toxins will become unsafe to eat.

   A **spore** is an inactive form of an organism that is highly resistant to extreme temperatures, acidity, and dehydration. The organism is reactivated once conditions become favorable for its growth. Two common spore-forming pathogens are bacillus cereus and clostridium botulinum. Temperature control is the way to minimize the danger associated with spore-forming organisms. (From CMS State Operations Manual, F371 Surveyor Guidance, 2011. See reference at the end of this policy.)

6. There is a flow of food as it goes through kitchens:
   Receive ⇒ Store ⇒ Prep ⇒ Cook ⇒ Hold ⇒ Serve ⇒ Cool ⇒ Re-heat.
   Most operations handle food at every step.

7. There are certain **critical control points** at which food is handled when contamination or bacteria growth can be **prevented**. The goals are to eliminate or reduce significantly the possibility of a hazard or food borne illness (FBI), and/or prevent a hazard from happening. The most critical control points are:
   - Cooking
   - Cooling
   - Holding
   - Re-heating

8. The leading cause of FBI is **improperly cooled foods**, followed by:
   - Food not thoroughly heated or cooked
   - Infected employees/poor personal hygiene
   - Food prepared a day or more in advance of serving

©2013 Becky Dorner & Associates, Inc.

- Raw, contaminated ingredients added to food
- Food left too long at temperatures that favor bacterial growth
- Failure to reheat food to temperatures that kill bacteria
- Cross contamination - cooked food by raw food, equipment not properly cleaned/sanitized, mishandling of food by employees

9. At each of these critical control points, staff should ask the following questions and take action as appropriate:
   - Can the food become contaminated?
   - Can the contaminants increase?
   - Will the contaminants survive?
   - Can hazards be prevented with corrective actions?
   - Can hazards be prevented, eliminated or reduced in steps later in the handling process?
   - Can CCP's be monitored?
   - How will CCP's be measured?
   - Can CCP's be documented?

Sources: Food Code 2009 US Department of Health and Human Services, Food Drug Administration, Washington, DC, 20204.
http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/.
Accessed September 5, 2012.

Center for Medicare & Medicaid Services State Operations Manual for Nursing Homes, Tag F371 Surveyor Guidance available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Pathogenic Microorganisms and Strategies for Their Control

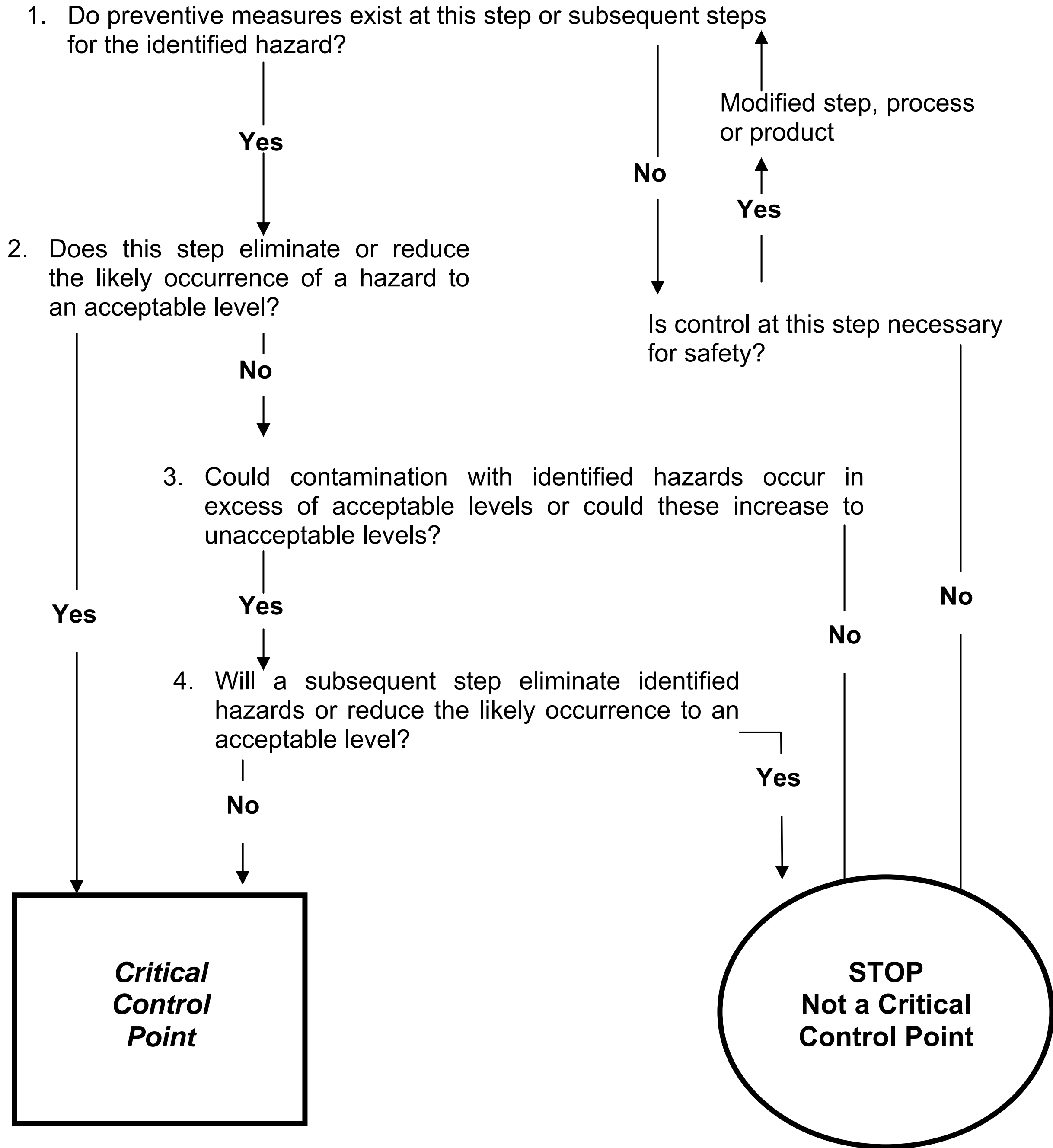
The table below illustrates the more commonly identified ingestible items which have been associated with the listed illness-producing organisms. The primary agents are the organisms that have been associated with the ingestible food source. Further, the primary control strategies list the preventive actions to inhibit the growth of these organisms.

Source of Contamination	Primary Agents of Concern	Primary Control Strategies
A. Hazards that are likely to occur - strategies that must be in place to prevent food borne illness		
Eggs, raw or unpasteurized	• Salmonella	• PHF/TCS • Cook to proper temperature • Prevention of cross-contamination to ready-to-eat foods
Poultry, raw	• Campylobacter • Salmonella	• PHF/TCS • Cook to proper temperature • Prevention of cross-contamination to ready-to-eat foods
	• Clostridium perfringens	• PHF/TCS • Cook to proper temperature
Meat, raw	• E. Coli 01507:H7 • Salmonella • Campylobacter	• PHF/TCS • Cook to proper temperature • Prevention of cross-contamination to ready-to-eat foods
	• Clostridium perfringens	• PHF/TCS • Cook to proper temperature
Infectious food workers	• Norovirus • Hepatitis A virus • Shigella • Salmonella	• Exclusion of infectious food workers • Proper hand-washing procedures • Avoid bare-hand contact with ready-to-eat foods
	• Staphylococcus aureus	• PHF/TCS • Proper hand-washing procedures • Avoid bare-hand contact with ready-to-eat foods
B. Hazards that may occur as a result of adulteration of food products and for which good food handling practices are needed to minimize the potential for food borne illness transmission.		
Fruits and vegetables, fresh	• E. Coli 01507:H7 • Salmonella • Norovirus • Hepatitis A virus • Shigella	• Wash prior to use (unless pre-washed) • Keep cut and raw fruits and vegetables refrigerated
Ready-to-eat meat and poultry products	• Listeria monocytogenes	• Proper refrigeration during storage
Pasteurized dairy products	• Listeria monocytogenes	• Proper refrigeration during storage
Ice	• Norovirus	• Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines

Center for Medicare & Medicaid Services State Operations Manual for Nursing Homes, Tag F371 Surveyor Guidance available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: CCP Decision Tree Table



Decision Tree adopted from NACMCF.
Source: Food Code 2009 found at www.fda.gov/Food/GuidanceComplianceRegulatoryInformation/GuidanceDocuments, updated November 9, 2011. Accessed September 5, 2012.

©2013 Becky Dorner & Associates, Inc.

HACCP Principles

Policy:

The facility utilizes a Hazardous Analysis Critical Control Points (HACCP) centered system to prevent food borne illness (FBI). HACCP is a food safety system with a focus on preventative controls. The goal is to prevent food borne illness before it can occur by implementing an effective system of controls.

Note: HACCP helps to: 1) Identify potentially hazardous foods; 2) Identify points at which foods may become unsafe; 3) Identify the points at which danger can be eliminated or controlled, so one can:

- Monitor the process and document key data.
- Intervene to reduce or eliminate hazards wherever possible.

HACCP is not mandatory from a federal standpoint, but the federal government encourages the states to update their individual state laws to incorporate HACCP procedures in their laws and inspection process. HACCP guidelines are described in the 2009 Food Code, Annex 4.

Procedure:

The facility staff follow the seven HACCP principles:

1. Identify hazards and risks, and develop preventive measures to improve food safety.
    a. Review menus and recipes and identify potentially hazardous foods (PHF), time/temperature controlled for safety (TCS) foods, or complicated multiple step recipes that can be influenced by time or temperature.
    b. Review how staff handles non-potentially hazardous foods.
        i. Is there a risk of cross contamination?
    c. Review suppliers, personnel and equipment.
        i. Are staff trained in proper food handling?
        ii. Are staff clean and free of disease, cuts, and infections?
        iii. Do staff handle equipment properly?
        iv. Do staff handle food properly?
        v. Is equipment up to date, clean and sanitary?
        vi. What can reasonably and safely be monitored to assure food safety?
    d. Some PHC or TCS with multiple food handling steps may be more safely purchased as a prepared item which only requires heating and serving.
        i. Determine which foods have the potential to cause severe hazards and determine the probability of occurrence.
        ii. Avoid food items that pose the greatest risk of FBI.

2. Identify critical control points (CCPs) and develop a prevention plan.
    a. Identify the points during food preparation where hazards can be prevented or controlled through:
        i. Good personal hygiene.
        ii. Preventing cross contamination.
        iii. Proper cooking temperatures and times, and proper internal temperatures.
        iv. Rapid cooling.
        v. Proper re-heating and holding temperatures.
        vi. Specific sanitation procedures.
        vii. Preparation ahead of time.
    b. Identify all steps of food preparation that need to be monitored.
        i. Hand washing/contamination of hands.

©2013 Becky Dorner & Associates, Inc.

   ii. Recipes need to include all CCPs as appropriate (receiving, holding, serving, cooling, reheating).
   iii. Sanitary equipment and surfaces.
   iv. Time and temperature (avoiding the temperature danger zone).
   v. Cross contamination.

c. Develop guidelines to prevent hazards at each step (this can be done on a flow chart).
   i. Wash hands before beginning preparation.
   ii. Utilize clean, sanitized equipment.
   iii. Utilize gloves if coming in direct contact with food, and change gloves as often as needed.
   iv. Maintain temperature at less than 41° F or greater than 135° F during preparation.

3. Set up guidelines for critical control points (CCPs).
   a. Define standards which must be met at each of the CCPs. Be sure they are measurable and can be monitored at any time. Standards could include:
      i. Specific cooking times and internal temperatures.
      ii. Specific holding and cooling instructions.
      iii. Directions for hand washing and sanitizing equipment where appropriate.
      iv. Systems to assure foods are properly covered, labeled and dated.
   b. Enforce standards (time, temperature, holding/cooling, hand washing, sanitizing, covering, dating, etc.).
   c. Include this information in standardized recipes (see sample recipe in this section).

4. Monitor CCPs.
   a. Monitor PHFs/TCSs through the preparation process and identify hazards.
   b. Assign one person to be responsible for each area of CCP monitoring.
   c. Make corrections as needed immediately upon identifying a hazard.
   d. Keep accurate records of CCP issues.

5. Take corrective action.
   a. Implement corrective guidelines.
      i. Explain to staff why there is a problem or potential problem.
      ii. Determine corrections based on facts.
      iii. Develop measurable goals.
      iv. Teach staff how to decide if food should be discarded.
      v. Maintain records of corrective actions taken.

6. Document findings.
   a. Set up a record keeping system to document monitoring and corrective efforts. Review records daily to assure systems are working.
   b. Investigate immediately if you think records indicate potential problems.
   c. Have a thorough HACCP manual available for reference.
   d. Keep all records on file.
   e. Keep all food service related laws available as a reference.

7. Verify that the HACCP system is working.
   a. Analyze records to determine whether changes in systems are needed.
   b. Review any problems to see whether they were corrected.
   c. Inspect the kitchen and observe food preparation to verify systems are working.
   d. Take random food samples to be evaluated.
   e. Take corrective actions as needed.

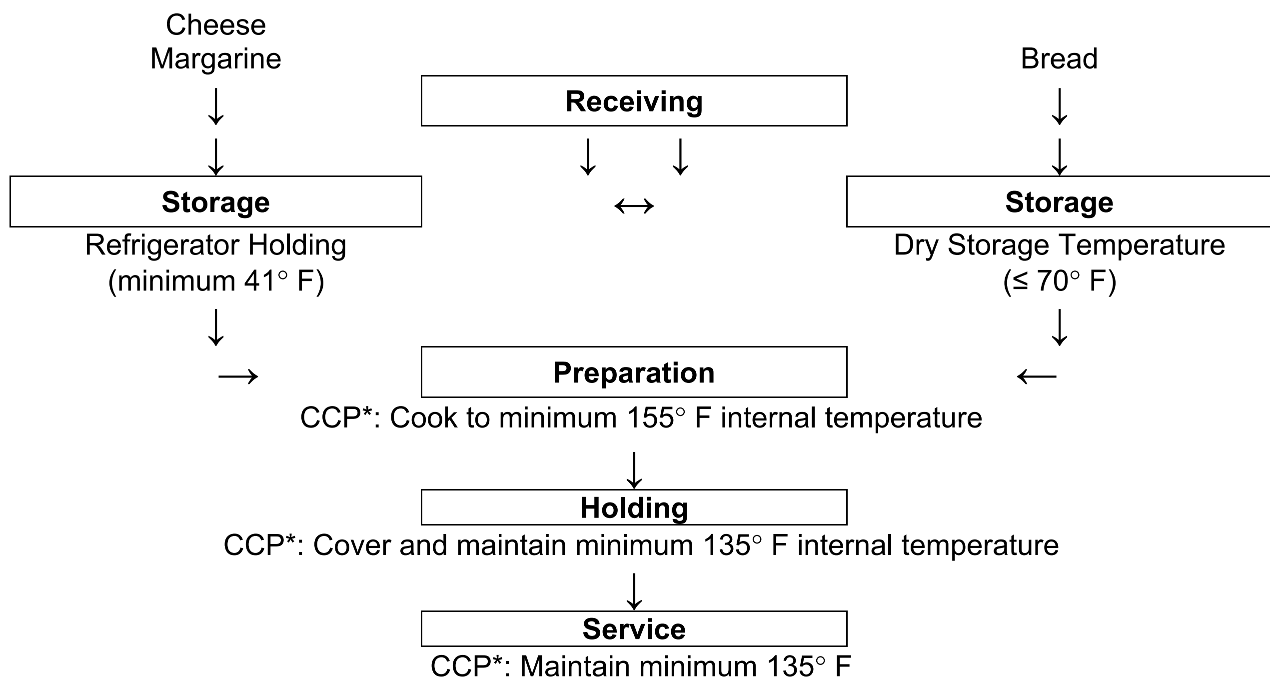
©2013 Becky Dorner & Associates, Inc.

Resource: HACCP Recipe Sample

Recipe that has been converted to the HACCP system:

Grilled Ham and Cheese Sandwich

Ingredients	Measurement	Servings					
		4	8	12	16	20	Custom Serving
Bread	Slices	8	16	24	32	40	
Ham	Ounces	16	32	48	64	80	
Cheese	1 ounce slices	8	16	24	32	40	
Margarine, melted	Tablespoons	2 1/2	5 1/3	7 2/3	10 1/3	12 2/3	



Preparation:

Wash, rinse and sanitize all equipment and utensils before and after use.

1. Place 2 ounces ham and 2 slices of cheese between two slices of bread. Cover and refrigerate until final preparation (41° F, maximum 4 hours).
2. Brush sandwich with melted margarine. Place on pre-heated grill top (350° F) until delicately browned (5 minutes). Turn and grill second side.
3. CCP: Internal temperature of sandwich must register 155° F or above for 15 seconds at the end of the cooking period.
4. CCP: Cover and hold until service, no longer than 30 minutes (135° F, maximum 30 minutes).

Service:

1. CCP: Maintain temperature of finished product above 135° F during entire service period. Keep covered whenever possible. Discard and replenish with fresh sandwiches every 30 minutes (for quality). Maximum holding time, 30 minutes.

*CCP = Critical Control Point

©2013 Becky Dorner & Associates, Inc.

Resource: Flow Chart

Most food items produced in a retail or food service establishment can be categorized into one of three preparation processes based on the number of times the food passes through the temperature danger zone (TZD) between 41° F to 135° F.

- **Process 1: Food Preparation with No Cook Step**
  Example flow: Receive – Store – Prepare – Hold – Serve
  Other food flows are included in this process, but there is no cook step to destroy pathogens while in the retail or food service facility.

- **Process 2: Preparation for Same Day Service**
  Example flow: Receive – Store – Prepare – Cook – Hold – Serve
  Other food flows are included in this process, but there is only one trip through the TDZ.

- **Process 3: Complex Food Preparation**
  Example flow: Receive – Store – Prepare – Cook – Cool – Reheat – Hot Hold Serve
  Other food flows are included in this process, there are always two or more complete trips through the TDZ.

Source: Food Code 2009,
www.fda.gov/food/guidancecomplianceregulatoryinformation/guidancedocuments
Accessed September 5, 2012.

©2013 Becky Dorner & Associates, Inc.

General HACCP Guidelines for Food Safety

Policy:

Staff must be educated and supervised on all HACCP information and procedures. A good training program and the proper systems and tools will help to assure a successful HACCP/Food Safety program.

Procedure:

Educate and monitor staff on the following:

1. **Hand Washing**
   Train staff to wash hands prior to working with food, after using the restroom or soiling hands in any way. (See Hand Washing in the Sanitation and Infection Control section of this manual.)

2. **The Time-Temperature Connection**
   - Limiting the time that food is in the temperature danger zone (TDZ).
   - The TDZ: Food must be held >135° F or <41° F.
     a. Limit the time that food is in the TDZ to no more than 4 hours combined total for all preparation (thawing, preparation, cooling and re-heating).

3. **Minimal Safe Internal Cooking Temperatures** (See Food Temperatures and Final Cooking, Holding and Reheating Temperatures in this section)

4. **Prevent Cross Contamination and Employee Contamination**
   - Preparation: Avoid the TDZ, prevent cross contamination and employee contamination.
   - Cooking: Final internal temperatures as noted earlier.
   - Hot holding: >135° F, cover and stir often.
   - Cooling: Safe cooling to <41° F within 4 hours, or to 70° F in 2 hours and from 70° F to 41° F in 4 hours (not to exceed 6 hours).
   - If food drops <135° F, reheat to 165° F for minimum of 15 seconds.

5. **Essentials of Cooling**
   - Cool from 135° F to 70°F in 2 hours and from 70° F to 41° F in 4 hours (not to exceed 6 hours). If food is not cooled to 41° F within 6 hours, reheat to 165° F for at least 15 seconds (within 2 hours) and discard if not served immediately. This includes mechanically altered foods. Take temperatures frequently to determine if altered methods are needed.
   - Cut food into smaller pieces. Cut meat into pieces no more than 3" thick. Divide food into several smaller batches, and in containers that permit the food to cool rapidly. Place smaller amounts in pre-chilled stainless steel pans.
   - Place pans in an ice bath and stir foods as they cool, then refrigerate (ice bath should contain more ice than water). Avoid cooling foods in storage refrigerators or freezers. (This can bring the total temperature of the unit up to an unsafe level.)
   - Place cooling items on top shelf of refrigerator or freezer-uncovered or loosely covered in 2" shallow pans and stir every 15 to 60 minutes.
   - Allow air to circulate around the food.

6. **Safe Thawing Practices**
   - Thaw meat, fish and/or poultry in a refrigerator in a drip proof container and in a way that prevents cross contamination (on a lower shelf with nothing underneath or near it).

©2013 Becky Dorner & Associates, Inc.

- Completely submerge the item in clean running water (< 70º F) that is running fast enough to agitate and float off loose ice particles.
- Thaw the item in a microwave oven using the defrost mode only if it is to be cooked immediately after thawing.
- Thaw as part of the cooking process.

7. **Food temperatures for Meal Service**
   - Check to be sure the staff actually takes food temperatures and takes them correctly.
   - Teach staff what to do if temperatures are in the TDZ. Be sure temperatures are taken again halfway through tray line to assure safety.

8. **Test Trays**
   - When temperatures are poor, take immediate action.
   - Consider taking the problem to the quality assurance committee if necessary. Other departments may be involved with the problem and therefore, need to be involved with the solution.

9. **Refrigerator/Freezer Temperatures**
   - Take the internal temperatures of each unit.
   - Periodically, take internal temperatures of foods in the unit.
   - Consistently schedule a plan to take the internal temperature of cooling foods to assure proper cooling.
   - If temperatures are poor (< 41° F for refrigerators or > 0° F for freezers), call immediately for repair. Assess safety of foods in the unit, and discard any questionable foods. Transfer safe foods to a temperature controlled refrigerator/freezer.

10. **Dishwashing**
    - Be sure the wash and rinse temperatures are appropriate for your dish machine.
    - Document temperatures regularly on a temperature log.
    - Use one staff person to load dirty dishes and another to pull clean dishes.
    - Air Dry - use drying racks if needed; do not stack dishes immediately before or after washing.
    - Silverware - special guidelines: run silverware through twice (once with silverware spread out on a dish rack and once with bowls of the silverware upright in a holder). Train staff to pull silverware without touching mouthpieces with their hands.

11. **Receiving**
    - Take food temperatures upon receiving. Be sure the vendors you buy from have refrigerated trucks that are clean and in good repair.
    - Label and date foods and put foods away promptly.
    - Check temperatures upon delivery and reject any damaged goods: Cans dented on the seams, refrigerator or freezer foods at improper temperatures, damaged boxes of dry goods that expose the foods, etc.

12. **Crisis Management** (if a FBI does occur):
    - Obtain complete and reliable information.
    - Evaluate the complaint and take immediate action to correct the problem.
    - Deal with regulatory agencies in a positive manner.
    - Reapply HACCP guidelines, and make corrections as needed to prevent it from recurring.

Note: Pooled eggs (raw eggs that have been cracked and combined together): Crack only enough eggs for the immediate service or as an ingredient immediately before baking. The use of pasteurized shell eggs or egg products is preferable. Waivers to allow undercooked

©2013 Becky Dorner & Associates, Inc.

unpasteurized eggs are not acceptable. Use pasteurized eggs for safe consumption of under-cooked eggs (sunny side up fried eggs, soft cooked eggs, etc.)

Resources on Food Safety:

- Food Code 2009, www.fda.gov/food/guidancecomplianceregulatoryinformation/guidancedocuments Accessed September 5, 2012.
- Centers for Disease Control and Prevention. Food safety at CDC. Available at: http://www.cdc.gov/foodsafety/. Accessed September 5, 2012.
- FoodSafety.gov. Your gateway to government food safety information. Available at: http://www.foodsafety.gov/. Accessed September 5, 2012.
- National Restaurant Association Educational Foundation. ServeSafe®. Available at: http://www.servsafe.com/. Accessed September 5, 2012.
- U.S. Department of Agriculture, Food Safety and Inspection Service. Protecting public health through food safety and defense. Available at: http://www.fsis.usda.gov/. Accessed September 5, 2012.
- U.S. Department of Agriculture, National Agricultural Library. HAACP. Available at: http://search.nal.usda.gov/nalsearch/result-list/fullRecord:Haccp/. Accessed September 5, 2012.
- U.S. Department of Health and Human Services. FDA Center for Food Safety and Applied Nutrition—CFSAN/FDA. Available at: http://www.healthfinder.gov/orgs/HR2504.htm. Accessed September 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Food Procurement and Facility Gardens

Policy:

Food produced and/or harvested from facility gardens will be safe for consumption.

Procedure:

1. Facility staff in charge of facility gardens will be knowledgeable in use of safe fertilizers, soil, etc. for use in gardening foods. Gardens will be maintained to keep food safe (including free from pests as much as possible, fertilizers, pesticides, soil, etc.).

2. Garden foods will be harvested using safe food handling practices to mitigate the dangers of food borne illness.

3. Once foods are harvested, safe food handling practices will be followed for delivery to the kitchen.

4. The kitchen staff is responsible to handle harvested foods properly once they reach the kitchen. This includes safe storage, thorough washing, and appropriate handling for preparation, service and storage of leftovers.

Note: Check your state regulations for any additional requirement for compliance.

Resource: Center for Medicaid, CHIP and Survey & Certification Group. Survey & Certification (S & C): 11-38 – NH. September 7, 2011

©2013 Becky Dorner & Associates, Inc.

Accepting Food Deliveries

Policy:

Food deliveries will be accepted into the facility only by the following procedure.

Procedure:

1. Refrigerated delivery trucks must be used for refrigerated and frozen items. Staff will spot check temperatures of refrigerated and frozen foods upon delivery to assure safe and appropriate food temperatures.

2. Direct the delivery person to the food storage area where the items are to be unloaded:
   - Ask for a copy of the delivery slip and check off all items as they are unloaded. Count carefully the number of cases, boxes, cartons, etc. of each item.
   - If items are missing, bring it to the attention of the delivery person and have him sign both copies of the delivery slip stating that those items were not delivered.
   - Sign both copies of the delivery slip, and return one copy to the delivery person. Make arrangements to order any needed items that were not delivered.
   - Do not allow delivery people to inventory and restock items without supervision.

3. Staff will refuse or remove any foods not safe for consumption.

4. Perishable foods will be properly covered, labeled and dated and promptly stored in the refrigerator or freezer as appropriate.

©2013 Becky Dorner & Associates, Inc.

Food Storage

Policy:

Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination.

Procedure:

1. Dry storage rooms must be well ventilated. All storage areas should have adequate illumination with temperature and humidity controls to prevent condensation of moisture and growth of molds.

2. Storage rooms must have only one access door. If the storage room has more than one door, only one door will be used. All other doors must be locked and their use prohibited. Secure locks must be installed on all other doors and windows. The keys to storage rooms shall be controlled by the food service manager or designee.

3. Food items will be stored on shelves, with heavier and bulkier items stored on lower shelves.

4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated.

5. Chemicals must be clearly labeled, kept in original containers when possible, kept in a locked area and stored away from food.

6. Scoops must be provided for bulk foods (such as sugar, flour, and spices). Scoops are not to be stored in food or ice containers, but are kept covered in a protected area near the containers. Scoops are to be washed and sanitized on a regular basis.

7. Hands must be washed after unloading supplies and prior to handling food items.

8. All stock must be rotated with each new order received. Rotating stock is essential to assure the freshness and highest quality of all foods.
   a. Old stock is always used first (first in - first out method).
   b. Supervise the person designated to put stock away to make sure it is rotated properly.
   c. Food should be dated as it is placed on the shelves.
   d. Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded will be visible on all high risk food (see chart on next page).
   e. Foods will be stored and handled to maintain the integrity of the packaging until ready for use. (Food stored in bins may be removed from its original packaging.)

9. Food is purchased in quantities that can be stored properly.

10. Food is arranged in food groups in the storage areas to make it easier to store, locate, and inventory.

11. Food is stored a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall on clean racks or other clean surfaces, and is protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.).

©2013 Becky Dorner & Associates, Inc.

Food Storage

12. Perishable food such as meat, poultry, fish, dairy products, fruits, vegetables and frozen products must be frozen or stored in the refrigerator or freezer immediately after receipt to assure nutritive value and quality. Refrigeration temperatures should be thermostatically controlled to maintain food temperatures at or below 41° F and freezer temperatures to keep food frozen solid.

13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. (Also see policy on Use of Leftovers in this section.) Check state regulations for more detail.

14. Refrigerated Food Storage:
    a. All refrigerator units are kept clean and in good working condition at all times.
    b. PHF/TCS foods must be maintained at or below 41° F unless otherwise specified by law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41° F. Temperatures for refrigerators should be between 35 to 39° F. Thermometers should be checked at least two times each day. (See Freezer and Refrigerator Temperature Sample Form in this section.) Check for proper functioning of the unit at the same time.
    c. Every refrigerator must be equipped with an internal thermometer.
    d. Each nursing unit with a refrigerator/freezer unit will be supplied with thermometers and monitored for appropriate temperatures.
    e. Cooked foods must be stored above raw foods to prevent contamination. Raw animal foods will be separated from each other and stored on lower shelves (below cooked foods or raw fruits and vegetables) and in drip proof containers.
    f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded.
    g. All foods should be stored to allow air circulation.
    h. Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed.
    i. All foods will be stored off the floor.

15. Frozen Foods:
    a. All freezer units are kept clean and in good working condition at all times.
    b. Frozen foods must be maintained at a temperature to keep the food frozen solid. Freezer temperatures should be checked at least two times each day. (See Freezer and Refrigerator Temperature Sample Form in this section.) Check for proper functioning of the unit at the same time. Periodically, check the firmness of foods in the freezer to assure temperatures are maintained to keep food frozen solid.
    c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded.
    d. All foods should be stored to allow adequate air circulation.
    e. All food items should be stored upon delivery and careful rotation procedures should be followed.
    f. Meat, fish, and poultry should be stored on lower shelves, while fruits, vegetables, juices and breads should be stored on upper shelves.
    g. All foods will be stored off the floor.
    h. Safe thawing: Frozen meat, poultry, and fish should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing.

16. Storage areas are free from rodent and insect infestation.

©2013 Becky Dorner & Associates, Inc.

Freezer and Refrigerator Temperatures Sample Form 1

Month/Year ___________________________

Record both internal and external temperatures of freezers and refrigerators at least twice a day (approximately 6:00 AM and 7:00 PM).

Unit/Day		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	NOTES
	AM																																
#1 Freezer	PM																																
	AM																																
#2 Freezer	PM																																
	AM																																
#3 Freezer	PM																																
	AM																																
#1 Refrigerator	PM																																
	AM																																
#2 Refrigerator	PM																																
	AM																																
#3 Refrigerator	PM																																
	AM																																
#4 Refrigerator	PM																																
	AM																																
#5 Refrigerator	PM																																
	AM																																
#6 Refrigerator	PM																																
	AM																																
Milk Cooler	PM																																
Initials																																	

Any unit not at the proper temperature must be reported to the supervisor at once for corrective action.
Refrigeration/freezer units may include milk or ice cream coolers or any unit used to keep foods cold or frozen. All units must be monitored daily.

©2013 Becky Dorner & Associates, Inc.

Freezer and Refrigerator Temperatures Sample Form 2

Unit: ___________ **Month/Year:_______________________**

Take AM Temperatures at ____AM **Take PM temperatures at ____PM**

Day	AM Temp.	Corrective Action	Initials	PM Temp.	Corrective Action	Initials
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26						
27						
28						
29						
30						
31						

Adapted from Nutrition Alliance, LLC. Used with permission.

©2013 Becky Dorner & Associates, Inc.

General Food Preparation and Handling

Policy:

Food items will be prepared to conserve maximum nutritive value, develop and enhance flavor and keep free of injurious organisms and substances.

Procedure:

1. The kitchen is kept neat and orderly.
   a. The kitchen and equipment are clean and sanitized as appropriate.

2. Food Storage
   a. Foods are received, checked and stored properly as soon as they are delivered.
   b. Potentially hazardous food is refrigerated or frozen except when being handled.
      - Food is covered for storage.
      - Food is cooked as soon as possible after defrosting.
   c. Food in broken packages or swollen cans, cans with a comprised seal, or food with an abnormal appearance or odor will not be served.

3. Food Preparation
   a. Meats, fish and poultry are defrosted using safe thawing practices:
      - In the refrigerator in a drip proof container, and in a manner that prevents cross contamination.
      - In the microwave if foods are cooked and served immediately after defrosting.
      - In the sink, submerging the item under cold water (<70° F) that is running fast enough to agitate and float off loose ice particles.
      - Thawing as part of a continuous cooking process.
   b. All meats are to be cooked or heated to a safe minimum internal temperature. (Refer to the charts on Minimum Cooking Food Temperatures and Holding Times and Suggested Food Cooking Temperatures and Holding Times in this section.) Use a meat thermometer to check internal temperatures. Stuffing should be baked in separate pans.
   c. All cold meat/fish/poultry salads, potato/vegetable salads, egg salads, cream filled pastries and other potentially hazardous foods shall be prepared from chilled products and refrigerated below 41° F IMMEDIATELY after preparation.
   d. No raw eggs are to be served. They must be cooked. Pasteurized eggs are the exception (these may be served soft cooked).
   e. Separate cutting boards for raw and uncooked food and for raw fruits and vegetables are used.
      - Prepared foods should not be cut on the same boards as raw food.
      - Cutting boards should be of hard rubber construction (not wood) and must be dishwasher safe.
      - Cutting boards are washed and sanitized after each use, following the dish machine or 3 compartment sink methods, and are air dried before storing.
   f. Raw, unprocessed fruits and vegetables are thoroughly washed under clean, potable, running water before use.
   g. Bare hands should never touch raw food directly; tasting must be done with a tasting spoon. Follow proper tasting procedures: Remove food with a serving spoon and transfer to a tasting spoon. Always use clean spoons.
   h. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of prepared foods. Any utensil or serving dish must be thoroughly cleaned and sanitized prior to use.
   i. Any food that is dropped on the floor must be discarded.
   j. Wash all tops of canned foods before opening; wash and sanitize the can opener daily.

©2013 Becky Dorner & Associates, Inc.

4. Food Service
   a. Foods that stand four or more hours at room temperature cannot be considered safe and free from contamination and cannot be made so by refrigeration, especially in warm temperatures. They must be discarded.
   b. Prepared food will be transported to other areas in covered containers.
   c. Individual portions of food once served will not be served again.
      - Single-service articles will be discarded after one use.
   d. Leftovers must be dated, labeled, covered, cooled and stored (within 1/2 hour after cooking or service) in a refrigerator. Leftovers must be cooled to < 41° F within 4 hours (or cooled to 70° F within 2 hours and then down to 41° F within another 4 hours). Prior to re-serving, leftover foods must be reheated to a minimum internal temperature of 165° F for a minimum of 15 seconds. (Refer to the Resource: Final Cooking, Holding and Reheating Temperatures in this section.) Leftovers are not to be used as pureed food. Use leftovers within 3 days or discard. Check state regulations for more detail.

5. Equipment
   a. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use.
   b. Plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of.
   c. Disposable containers and utensils should be discarded after one use. Only food approved, dishwasher safe containers may be reused.
   d. Silverware is stored in such a manner to encourage contact with handles only.
   e. Staff handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces that food or drink will come in contact with.
   f. Use tongs or other serving utensils to serve breads or other items. Never touch food directly with bare hands.

Note: If individual residents/patients assist in food preparation and handling, the staff will assist and supervise to see that the above procedures are followed.

©2013 Becky Dorner & Associates, Inc.

Meat and Vegetable Preparation

Policy:

Meats and vegetables will be prepared to conserve maximum nutritive value, to develop and enhance flavor and appearance and to prevent injurious organisms and substances.

Procedure:

1. Suitable utensils such as forks, knives, tongs, spoons or scoops are used to minimize handling of food at all points where food is prepared.

2. Vegetables
   a. All raw vegetables are thoroughly washed before being cooked or served.
   b. Vegetables should be cooked in the least amount of water and for the shortest time possible. If a steamer is available, it should be utilized. Avoid overcooking and long holding times.

3. Meats
   a. Meat is defrosted using safe thawing methods (never at room temperature):
      - In the refrigerator in a drip proof container, and in a manner that prevents cross contamination.
      - In the microwave if foods are cooked and served immediately after defrosting.
      - In the sink, submerging the item under cold water (<70° F) that is running fast enough to agitate and float off loose ice particles.
      - Thawing as part of a continuous cooking process.

   b. A meat thermometer must be used to check the internal temperature. Conventional oven temperature should be no higher than 325 to 350° to assure quality. Cooking at too high a temperature results in an internal temperature that is too high, and decreases the yield and the quality of the food.
   c. Refer to the Resource: Final Cooking, Holding and Reheating Temperatures in this section for specific cooking information.
   d. Unpasteurized eggs cooked to order (for immediate service) must be cooked to an internal temperature of 145° F. Unpasteurized eggs to be held for service must be cooked to an internal temperature of 155° F. Only pasteurized eggs may be used for soft cooked eggs.
   e. Meat/poultry/fish salads, potato/vegetable salads, egg salad, and other potentially hazardous foods will be prepared using chilled products, with no bare hand contact, using sanitized surfaces and utensils. These items must be refrigerated as soon as they have been prepared.

Note: When taking temperatures, the meat thermometer should be inserted into the thickest part of the meat; being sure the bulb of the thermometer does not touch bone or fat. (Refer to Taking Accurate Temperatures in this section.)

©2013 Becky Dorner & Associates, Inc.

Food Temperatures

Policy:

The temperatures of the food items will be taken and properly recorded for each meal.

Procedure:

1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135° F. Take temperatures often to monitor for safe food holding temperature ranges of at or below 41° F for cold foods; and at or above 135° F for hot foods.
   a. Cooking temperatures must be reached and maintained according to regulations, laws, and standardized recipes while cooking.
   b. Hot food items may not fall below 135° F after cooking, unless it is an item which is to be rapidly cooled to below 41° F and reheated to at least 165° F prior to serving. Caution should be taken to avoid serving food and liquids at temperatures that are too hot. (Avoid the risk of burning the resident or patient.)

2. All cold food items must be maintained and served at a temperature of 41° F or below.

3. Temperatures should be taken periodically to assure hot foods stay above 135° F and cold foods stay below 41° F during the portioning, transporting and delivery process until received by the individual recipient. (See Resources: Taking Accurate Temperatures and Final Cooking, Holding and Reheating Temperatures in this section.)

4. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e. hot/cold carts, pellet systems, insulated plate bases and domes, etc.).

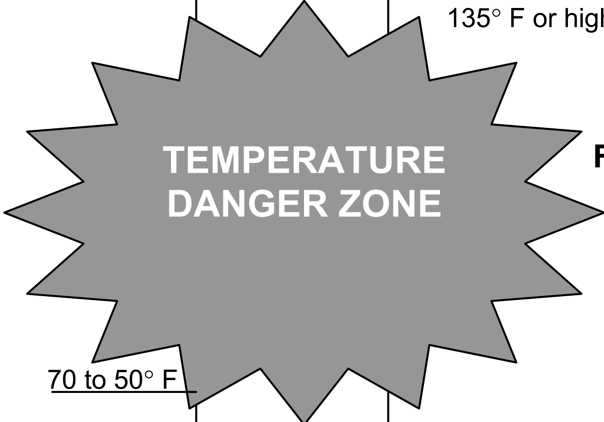
5. Tray line and alternative meal preparations and service areas will **avoid** the following methods:
   - Holding foods in the temperature danger zone (41° to 135° F).
   - Using the steam table to heat foods.
   - Holding foods on a steam table for more than 4 hours.

6. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to maintain temperatures at or below 41° F for cold foods and at or above 135° F for hot foods. Unit refrigerators will be monitored for temperatures that maintain foods at or below 41° F.

7. Foods prepared during special events (such as cookouts, picnics and barbeques) or for takeout (such as packed lunches) will be handled using the same safe temperature guidelines as all other foods. Appropriate food transport equipment or other methods of maintaining safe temperatures will be utilized.

©2013 Becky Dorner & Associates, Inc.

Resource: Critical Temperatures for Safe Food Handling



(1) Microwave cooking and reheating:

- When cooking animal foods in the microwave, rotate and stir foods during the cooking process so that all parts of the food are heated to a temperature of at least 165° F.
- Allow food to stand covered for at least 2 minutes after cooking so the food is heated throughout.

(2) Unpasteurized shell eggs that have been cooked to order should be served and eaten immediately.

©2013 Becky Dorner & Associates, Inc.

Resource: Taking Accurate Temperatures

Choosing the Right Thermometer

Start with an accurately calibrated thermometer that is in good working condition. There are many types of thermometers available. Check state regulations for more specific guidelines.

For general use, the bimetallic thermometer is a cost efficient tool and if used correctly can provide accurate temperatures. When using the bimetallic stem thermometer, remember that the sensor on the probe is 1 to 2” above the tip. This area must be submerged into the food for several seconds to achieve an accurate temperature. Other types of thermometers available include: the digital thermistor thermometer, thermocouple technology and the digital thermocouple thermometer. Infrared thermometers are also available but they are generally not used in health care kitchens.

- The digital thermistor is usually battery powered, takes only a few seconds to register the temperature, and the sensor is near the tip of the probe.
- The thermocouple has two wires of dissimilar metals joined together at both ends. When one end is heated, the difference that is generated is proportional to the junction of temperature. Their small size makes them very sensitive to temperature fluctuations.
- The digital thermocouple thermometer gives the quickest temperature response, has the widest temperature range, and is field calibratable.
- Data collection thermometers are handheld instruments that can store up to 2000 entries. They download data to a PC, sort and graph temperature reports.

Calibrating the Thermometer

For all thermometers, follow the manufacturers’ directions for calibration.

Bimetallic Thermometers

There are two ways to calibrate a bimetallic thermometer: the ice point method and the boiling point method. Thermometers should be calibrated at least monthly.

Ice Point

1. Start with a container large enough to easily accommodate your thermometer. Fill it with ice (crushed is best). Add tap water to fill and stir. Allow ice water mixture to cool for a few minutes.

2. Put the thermometer probe into the ice water mixture. It is important to wait about 30 seconds without having the probe touch the sides or bottom of the container. Be sure the temperature indicator is no longer moving.

3. Look for the nut on the underside of the thermometer, use a wrench* and turn the head of the thermometer until the reading on the face of the dial reads 32° F (0° C).

Boiling Point

1. In a fairly deep pan, bring tap water to a boil.

2. Place the probe of the thermometer carefully into the boiling water so the sensor on the stem is completely submerged without touching the sides or bottom of the pan.

3. Wait about 30 seconds or until the temperature on the face of the dial stops moving.

©2013 Becky Dorner & Associates, Inc.

4. Again, look for the nut on the underside of the thermometer and use a wrench* and turn the head of the thermometer until the temperature reads 212° F (100° C) or at the boiling point for your elevation.

**Some bimetallic thermometers have a "wrench" tool attached to the case or sheath.*

Taking Accurate Temperatures using Metal Stem Thermometers

1. To take temperatures, a clean, rinsed, sanitized and air-dried thermometer that is the metal stem type, numerically scaled and accurate to plus or minus 2° F is needed. Should this thermometer have a tube type cover, it must also be sanitized as indicated for the thermometer. A temperature record for recording the temperatures is also needed. Choose the proper thermometer for the food to be monitored. (Thin foods will require a different thermometer than thick foods.)

2. To take hot food temperatures, insert the thermometer at a 45 degree angle to the middle of the food item, taking care not to touch the container or bone if applicable. Wait for the thermometer to rise to the maximum temperature, read and record the temperature and then remove the thermometer from the food item and immediately clean and sanitize. Repeat these guidelines until all hot food temperatures have been taken.
   - Normally, hot foods will be 165° to 180° F or higher when removed from the cooking heat source. Assure a high enough holding temperature to maintain a temperature at or above 135° F during holding, distribution and service

3. To take cold food temperatures, insert the thermometer at a 45 degree angle to the middle of the food item using care not to touch the container. Wait for the thermometer to drop to the minimum temperature, read and record the temperature and then remove the thermometer from the food item and immediately clean and sanitize. Repeat this guideline until all cold food temperatures have been taken. The thermometer must be sanitized between uses in different foods.**

4. Temperatures should be taken periodically to assure hot foods stay above 135° F and cold foods stay below 41° F during the portioning, transporting and serving process until received by the customer.
   - Maintain a cold enough holding temperature to assure sure foods are maintained at or below 41° F until served
   - Frozen items such as ice cream and sherbet should be held at a low enough temperature to maintain their frozen state until service, at which time they should remain in a solid state with little melting

***Thermometers should be sanitized according to manufacturer's instructions. Bimetallic thermometers may be sanitized using a dish machine or three sink method. In between uses at one meal, an alcohol swab may be used to sanitize. (Use a new swab for each sanitizing.)*

For more information on thermometers, visit the USDA Food Safety and Inspection Service website: Types of Food Thermometers: Choose the One that is Right for You! http://www.fsis.usda.gov/food_safety_education/Types_of_Food_Thermometers/index.asp. September 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Final Cooking, Holding and Reheating Temperatures

Cooking is a critical control point in preventing food borne illness. Cooking to heat all parts of food to the temperature and for the specified time below will either kill dangerous organisms or inactivate them sufficiently so that there is little risk to the individual if the food is eaten promptly after cooking. Monitoring the food's internal temperature for 15 seconds determines when micro-organisms can no longer survive and food is safe for consumption. Foods should reach the following internal temperatures:

Food	Minimum Temperature	Minimum Holding Time at the Specified Temperature
Ground meat (e.g. ground beef or pork), ground fish, eggs held for service	**155° F**	**15 seconds**
Fish and other meats not otherwise specified in this chart	**145° F**	**15 seconds**
Unpasteurized eggs when cooked to order in response to individual request and to be eaten promptly after cooking	**145° F (until the white is completely set and the yolk is congealed)**	**15 seconds**
Poultry and Stuffed Foods (Stuffed Fish; Stuffed Meat; Stuffed Pasta; Stuffed Poultry Stuffing Containing Fish; Meat, or Poultry; Wild Game Animals)	**165° F**	**15 seconds**
When cooking **raw animal foods** in the microwave oven, foods should be rotated and stirred during the cooking process so that all parts of the food are heated to an internal temperature of at least	**165° F**	**and allowed to stand covered for at least 2 minutes after cooking to obtain temperature equilibrium**

Source: CMS State Operations Manual, Appendix PP, F371, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Final Cooking, Holding and Reheating Temperatures

Food	Minimum Temperature	Minimum Holding Time at the Specified Temperature	Maximum Time to Reach Minimum Temperature
Reheated Foods: Food that is cooked, cooled, and reheated	**All parts of the food must reach an internal temperature of 165° F**	**15 seconds**	**2 hours**
Fresh, frozen or canned fruits or vegetables that are cooked	**135° F**	**For holding and hot service**	
Ready to eat food that is taken from a commercially processed, sealed container or intact package from an approved processing source	**135° F**	**For holding and hot service**	**2 hours**

Note: Do NOT use the steam table to reheat food (food cannot reach the proper temperature within acceptable time frames).

©2013 Becky Dorner & Associates, Inc.

Food Temperatures Sample Form

.

Week of: __________Record food temperature PRIOR to service, and AGAIN after half of the meals have been served.

Breakfast	**Sunday**		**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**	
Eggs														
Hot cereal														
Entrée														
Pureed Hot Item														
Pureed Cold Item														
Juice														
Milk														
Initial														

Lunch	**Sunday**		**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**	
Entrée														
Alternate														
Potato/Starch														
Vegetable														
Soup														
Mech Soft Meat														
Pureed Meat														
Pureed Vegetable														
Cold Fruit														
Dessert														
Pureed Cold Item														
Milk														
Initial														

Dinner	**Sunday**		**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**	
Entrée														
Alternate														
Potato/Starch														
Vegetable														
Soup														
Mech Soft Meat														
Pureed Meat														
Pureed Vegetable														
Cold Fruit														
Dessert														
Pureed Cold Item														
Milk														
Initial														

Hot foods should be ≥ 165° F prior to trayline and ≥ 135° F through end of trayline. Cold foods must be maintained at ≤ 41° F.

Report any foods that are in the temperature danger zone of > 41° F to < 135° F to the supervisor immediately for corrective action.

©2013 Becky Dorner & Associates, Inc.

CCP Documentation Sample Form

1. Temperature and time during various points of preparation (including cooling) and service. (A. beginning temperature, B. during preparation, C. finished product).
2. Temperature during service.

Critical Control Point (CCP) Date	Meal	Food Item	1 Temperature/Time			2 Temp. ° F	Actions to Resolve Problem Temperatures
			A	*B*	*C*		

CCP Items Any foods containing the following:

Dairy products (milk, cheese, sour cream, cream cheese, etc.)	Sliced melon
Meat, fish or poultry	Baked or boiled potatoes
Eggs	Raw seeds and sprouts
Protein (including tofu)	Beans that have been heat treated

Report to the supervisor any foods that do not cool to 135° F to 70° F within 2 hours and from 70° F to 41° F within another 4 hours.

©2013 Becky Dorner & Associates, Inc.

Handling Cold Foods for Trayline

Policy:

Proper cold food temperatures will be maintained during meal service.

Procedure:

Prior to service:

1. Canned fruits, desserts, salads, puddings, cottage cheese, juices, milks and other cold food items for meal service are placed in the refrigerator at least 3 to 4 hours before serving. Food should be chilled to $\leq$ 41° F.

2. Cold temperatures will be taken prior to meal service and recorded on the appropriate form.

At the time of service:

1. Cold food items will be taken from the refrigerator one tray at a time to be used at the meal service (unless a reach-in refrigerator is available).

2. Milk will be iced to chill it for use at meal service.

3. Cold temperatures will be taken and recorded prior to and halfway through service to assure foods are $\leq$ 41° F.

©2013 Becky Dorner & Associates, Inc.

Taste Testing

Policy:

All food is taste tested prior to serving.

Procedure:

1. The cook is responsible for tasting all food before it is served. The supervisor should also participate in this procedure.

2. Proper tasting procedure should be used: Use one spoon to serve food onto a dish or bowl, and use a new spoon to taste the food.

3. All food not passing the taste test due to seasoning, toughness, color, or other negative factors is not to be served until the problem has been corrected.

©2013 Becky Dorner & Associates, Inc.

Use of Leftovers

Policy:

Excess leftovers should be avoided. Leftovers will be properly handled and used or discarded as appropriate. Leftover foods are NOT used for pureed diets.

Procedure:

1. Recipe quantities should be controlled as closely as possible to avoid leftovers.

2. Leftovers will be covered, labeled, and dated; then stored appropriately (refrigerated or frozen if necessary) immediately after the end of the meal service.

3. Leftovers must be cooled to 70° F within 2 hours and then down to 41° F within another 4 hours.

4. Leftovers that have not been properly stored will be discarded. (When in doubt, throw it out.)

5. Any food that is leftover will be handled as noted above and may be used as follows:
   - Leftovers may be given as nourishments as allowed by diet order.
   - Leftovers can be used if used within 72 hours (3 days) and if reheated to 165° F for a minimum of 15 seconds for hot foods.
   - Leftovers are not to be used as pureed food.
   - Use leftovers within 3 days or discard. See state regulations for more guidelines.

Note: A leftover is any food that was prepared for service but was not served.

©2013 Becky Dorner & Associates, Inc.

Food Allergies

Policy:

Patients/residents with food allergies will be provided with safe foods/fluids, and appropriate substitutions to maintain health.

Procedure:

1. Patients/residents who have food allergies will be identified during the admission process. The admitting nurse is responsible for identifying any health-threatening or life-threatening food allergies during the initial assessment with the patient/resident and/or family.

2. If an individual indicates that they have a food allergy/allergies, all known food allergies should be identified and documented in the medical record. Any food can cause an allergic reaction, so details are important. Questions should also include whether the individual is allergic to any of the following eight foods which are known to cause 90% of all food allergies:
   - Eggs
   - Fish (bass, flounder, cod, etc.) – fish and shellfish cause the most allergic reactions
   - Shellfish (shrimp, crab, lobster, etc.) - shellfish and fish cause the most allergic reactions
   - Milk
   - Soy
   - Peanuts – cause the most *severe* allergic reactions. The individual allergic to peanuts is also advised to avoid tree nuts.
   - Tree nuts (walnuts, pecans, almonds, cashews, hazelnuts/filberts, macadamia nuts, pistachio nuts, etc.) - The individual allergic to tree nuts is also advised to avoid peanuts.
   - Wheat

3. The admitting nurse should also determine the type of allergic reaction caused and note this in the medical record. If the reaction is anaphylaxis, all departments must be aware of this, how to avoid it, and how to treat it.

4. The facility must determine a practice for patient/resident identification for food allergy. For example, the facility may choose to use the food allergy identification color of orange and to provide the individual with an orange alert band which lists the food allergy/allergies. The facility may also mark the front of the medical record with an orange colored food allergy label which lists the identified food allergies. In addition, food trays may be lined with orange placemats to cue staff that the meal tray is for an individual with a life-threatening food allergy.

5. The diet order must include the primary diet order as well as a listing of all known food allergies.

6. When the food service department receives the diet order, the allergies listed trigger the food service manager or designee, or registered dietitian (RD) or designee to interview the individual and clearly identify and confirm all food allergies.

©2013 Becky Dorner & Associates, Inc.

Food Allergies

7. Once food allergies are confirmed they must be clearly communicated to the food service department personnel using documentation systems including the meal identification (ID) card/ticket.

8. The food service manager is responsible for training food service staff on how to handle foods to avoid any inappropriate foods being served to individuals with food allergies. This may include special designated food preparation space in the case of life-threatening food allergies.

9. The food service manager or designee is responsible for maintaining a list (either hard copy or electronic) which contains a listing of menu items, ingredients, and food manufacturers to determine which foods may contain allergens. This list must be updated regularly to assure tracking of changes in food products.

10. The food service manager or designee is responsible for preparation and service of foods to prevent contamination or cross-contamination of the food with food allergens.

11. Individuals with life-threatening food allergies should be provided with a special food allergy menu to use for self-selecting menus. This menu may exclude the 8 allergy foods noted above, and include whole foods and foods with limited ingredients.

12. For cafeteria service, foods containing any of the 8 food allergens noted above should be marked clearly to identify the food allergen.

Resources:

Food Allergy and Anaphylaxis Network.
Food Allergy Training Guide for Hospital and Food Service Staff: *A Comprehensive Program for Training Hospital Staff to Safely Prepare and Serve Food to Patients With Food Allergies*
http://www.foodallergy.org/files/media/hospital-guide/Food_Allergy_Training_Guide%5B1%5D.pdf

©2013 Becky Dorner & Associates, Inc.

Ice

Policy:

Ice will be produced and handled in a manner to keep it free from contamination.

Procedure:

1. Ice will be made from potable water.

2. Ice machines will be maintained in a clean and sanitary condition to prevent ice contamination. (See Cleaning Instructions: Ice Machines and Equipment.)

3. Ice that is used to keep foods cold or to cook foods will not be used for consumption.

4. Staff will wash hands prior to handling ice. Ice will not be handled with bare hands, but rather with a sanitized scoop and container for transport and distribution.

5. Ice containers will be washed and sanitized on a regular basis.

©2013 Becky Dorner & Associates, Inc.

Personal Food Storage

Policy:

Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units will be monitored by designated facility staff for food safety.

Procedure:

1. Individuals will be educated on safe food handling and storage techniques by designated facility staff as needed. Staff will examine food for quality (visual, smell, packaging) to identify potential concerns.

2. Staff will provide information on safe food storage and handling as deemed appropriate. (For suggestions, see Resource: Food Safety for Your Loved One on the following page.)

3. Designated facility staff will be assigned to monitor individual room storage and refrigeration units for food or beverage disposal, using the tips in the Resource: Food Safety for Your Loved One (on the following page).

4. All refrigeration units will have internal thermometers to monitor for safe food storage temperatures. Units must maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Staff will monitor and document unit refrigerator temperatures (see Refrigerator and Freezer Temperatures Sample Forms in this section.)

©2013 Becky Dorner & Associates, Inc.

Resource: Food Safety for Your Loved One

If you plan to bring food into the facility for your loved one, please be sure that the food is handled safely.

Food or beverages should be labeled and dated to monitor for food safety:

- Food or beverages in the original containers marked with manufacturer expiration dates and unopened do not have to be re-labeled for storage.
- Raw eggs or dishes made with raw eggs for consumption (i.e. eggnog, poached eggs) are not permitted.
- Foods or beverages that have past the manufacturer’s expiration date should be thrown away.
- Food or beverage items without a manufacturer’s expiration date should be dated upon arrival in the facility and thrown away three days after the date marked.
- Foods in unmarked or unlabeled containers should be marked with the current date the food item was stored.
- Any suspicious or obviously contaminated food or beverages should be thrown away immediately.
- No food should be shared with others, unless approved by a nurse or food service manager.

Foods should be cooked to safe internal temperatures:

- Ground meats: 155° F for a minimum of 15 seconds.
- Fish, pork and other meats: 145° F for a minimum of 15 seconds.
- Stuffed meat, poultry, fish or pasta: 165° F for a minimum of 15 seconds.
- Eggs: 145° F if cooked for immediate service, 155° F if held for service.
- Food cooked in microwave: 165° F (and let stand for 2 minutes).
- Food that is cooked, cooled and reheated: 165° F for a minimum of 15 seconds.

Foods should be stored at the appropriate temperature to maintain safety:

- Cold foods: Less than 41° F.
- Hot foods: Hold at 140° F or higher.
- Foods that are leftover should be stored promptly and cooled to 41° F or less within 4 hours.
- Foods that are leftover should be reheated to an internal temperature of 165° F for a minimum of 15 seconds.

©2013 Becky Dorner & Associates, Inc.

Providing Food and Supplies for Other Departments

Policy:

The food service department provides other departments with food, snacks, beverages, and/or supplies for special activities and occasions.

Procedure:

1. The department head will request food and supplies at least one week in advance (see Special Events Sample Form on the next page).

2. The administrator decides which department budget incurs the costs for such events.

3. Foods for special meals and picnics that replace the usual meal are usually charged to the food service department.

4. The food service department can usually purchase food and supplies more economically from their purveyors. Thus the food service manager usually places orders and writes up separate purchase orders, indicating which department the purchase order is charged to.

5. Food service staff prepares food items for special meals and events.

6. Department heads assist nursing in bringing individuals to and from the special event site and then with serving the refreshments.

7. Clean up is either an assigned task or all staff help with the clean up.

©2013 Becky Dorner & Associates, Inc.

Special Events Food/Meal Sample Form

Please submit all requests at least 2 weeks in advance of the scheduled event.

Request from (Name/Department) ______________________________

Date of Special Event ____________________ **Time** ________________

Special Event Description:

Meal **Buffet** **Snack** **Coffee/Tea** **Other** ____________

Food Requested
Appetizer:
Entrée/Meat:
Side Dish:
Side Dish:
Salad:
Starch/Bread:
Dessert/Fruit:
Supplies Requested
Dinnerware:
Table Set up:
Linens:
Other:

Event Location:	**Group Attending Event/Estimated Number Attending:**

Comments:

Signature (Name/Title) ______________________________ **Date:** ____________

©2013 Becky Dorner & Associates, Inc.

Floor Stock

Policy:

Limited supplies of food and drink items will be available around the clock from the nursing unit, refrigerator, kitchenette and/or food storage areas.

Procedure:

1. The food service manager will:
   - Determine floor stock items and par levels to be delivered to each area.

2. The food service staff will:
   - Deliver floor stock items daily to the appropriate area, replenishing items according to predetermined par levels
   - Record all stock items issued on the Floor Stock Supply Sheets (see sample form next page).
   - Rotate stock and remove outdated items.
   - Check the temperatures of the refrigerators/freezers in the units daily, document temperatures, and actions taken for any inappropriate temperatures. (See Refrigerator/Freezer Temperatures Sample Form in this section.)

©2013 Becky Dorner & Associates, Inc.

Floor Stock Supply Sample Form

Nursing Station_______________**Date**__________**Personnel**_____________________

Food Item	Par Level	Sun		Mon		Tues		Weds		Thurs		Fri		Sat	
		OH	D	OH	D	OH	D	OH	D	OH	D	OH	D	OH	D
Preparer's Initials															

OH = On Hand D = Delivered

©2013 Becky Dorner & Associates, Inc.

Food Service Problems/Referral to Food Service Manager

Policy:

Food service problems and unusual incidents will be brought to the attention of the food service manager in a timely manner.

Procedure:

1. Staff will notify the food service manager of problems or unusual incidents via verbal and/or written communication.

2. Referrals include, but are not limited to, problems with:
   - Quality of food
   - Recipes
   - Equipment
   - Food preparation
   - Sanitation
   - Resident's/patient's food intake
   - Dining areas
   - Meal delivery and/or service
   - Food safety
   - Food brought in by families or visitors

©2013 Becky Dorner & Associates, Inc.

Reporting a Foodborne Illness (FBI)

Policy:

If a food borne illness outbreak is suspected, facility staff will follow the proper procedure to investigate, document, and report as needed.

Procedure:

1. Staff will report any possible foodborne illness (FBI) incidents to the food service manager. Potential concerns may come from a variety of sources such as nursing staff or a family member reporting a resident/patient with FBI symptoms.

2. The staff and/or food service manager should document the following information:
   a. Date/time of complaint.
   b. Detailed report of possible FBI.
      - Person or individual experiencing symptoms.
      - Details of symptoms, concerns or complaint related to possible FBI.
   c. Specific food suspected and any helpful details such as source of food, description of food handling, product information. Document all details regarding compromise of handling the food at any stage including:
      - Source of the food
      - Condition in which it was received, storage handling procedures including how quickly foods are typically stored after receiving, storage temperatures
      - Preparation and cooking processes, internal cooking temperature procedures, temperatures for holding and service
      - Procedures for cooling, handling leftovers, reheating for service, etc.
      - Document the temperatures of the suspected food at all stages of preparation/service
   d. Details on any other individuals reporting symptoms related to the same FBI report.
   e. Details on whether the incident was reported to the individual's physician, whether the individual was hospitalized, and treatment provided.

   If three or more people report FBI symptoms, it is considered an outbreak and the incident must be reported to the health department. Document the contact information of the health department and staff, date reported and detailed information of the report.

3. Any suspected food should be saved and clearly marked as potentially unsafe with a "do not use" note. The health department may need to test it.

4. The food service manager will follow up as appropriate to resolve any concerns related to the FBI. This may include, but is not limited to:
   a. Conducting staff training.
   b. Implementing new policies and procedures.
   c. Supervising staff closely to assure proper HACCP procedures.
   d. Assuring staff follow proper handwashing procedures, use of gloves or utensils as appropriate.
   e. Assuring proper cleaning and sanitizing procedures throughout the kitchen (form dish room to preparation areas).
   f. Confirming that staff routinely checks and documents food temperatures at all stages of preparation and takes corrective action as needed.
   g. Observing food handling, recording potential cross-contamination issues, mishandling of food, or temperature issues, and taking corrective action as needed.

©2013 Becky Dorner & Associates, Inc.

Reporting a Foodborne Illness (FBI)

h. Assessing employee health concerns to assess presence of illness, cuts, infections, or sores that may be of issue related to FBI.
i. Assuring proper use of sanitizer and sanitizing cloths.
j. Assuring access to clean water supplies, proper disposal systems, and proper waste water and sewage disposal (no cross connections or system back up of waste/waste water).
k. Assessing proper use of toxic chemicals including proper storage, labeling, and handling.

5. Follow facility procedures for reporting the FBI incident to the health department (this may be the responsibility of the administrator, director of nursing, food service manager or other designated staff.

6. Follow the facility's procedures for handling inquiries from staff, family members, concerned citizens, and/or the media.

Resource:

- Centers for Disease Control and Prevention: How to Report a Foodborne Illness: http://www.cdc.gov/outbreaknet/reportillness.html.

©2013 Becky Dorner & Associates, Inc.

Sanitation and Infection Control

- ♦ Food Safety and Sanitation 4-1
- ♦ Food Safety – Food Service Manager's Responsibility 4-3
- ♦ Employee Sanitary Practices 4-4
- ♦ Authorized Personnel in Food Service Department 4-5
- ♦ General Sanitation of Kitchen 4-6
- ♦ Hand Washing 4-7
- ♦ Use of Hand Antiseptic 4-8
- ♦ Bare Hand Contact with Food and Use of Plastic Gloves 4-9
- ♦ Cleaning Dishes/Dish Machine 4-10
- ♦ Resource: Sanitation of Dishes/Dish Machine 4-11
- ♦ Dish Machine Temperature Log 4-12
- ♦ Dish Machine Temperature and Sanitizer Log Sample Form 4-13
- ♦ Resource: Dish Machine Problems and Solutions 4-14
- ♦ Maintenance of Dish Machine 4-15
- ♦ Cleaning Dishes - Manual Dishwashing 4-16
- ♦ Resource: Sanitation of Dishes/Manual Dishwashing 4-17
- ♦ Handling Clean Equipment and Utensils 4-18
- ♦ Bedside Water Containers 4-19
- ♦ Dry Storage Areas 4-20
- ♦ Production, Storage and Dispensing of Ice 4-21
- ♦ Isolation Meals 4-22
- ♦ Kitchen Cloths 4-24
- ♦ Waste Disposal 4-25
- ♦ Pest Control 4-26

©2013 Becky Dorner & Associates, Inc.

Food Safety and Sanitation

Policy:

All local, state and federal standards and regulations are followed in order to assure a safe and sanitary food service department.

Procedure:

1. Food Service Department
   a. The department is routinely inspected by the environmental health services of the public health department. The department follows the Department of Health's standards, regulations, and suggestions. The food service manager should have a copy of the applicable regulations in the office, and should be familiar enough with this information to implement needed policies and procedures.
   b. The department follows other regulations and suggestions that are submitted by other official health agencies and organizations.

2. Employees
   a. All staff will be in good health, will have clean personal habits and will handle all foods safely.
   b. All staff should have physical exams (refer to your facility's policy manual) and a Mantoux test (tuberculin sensitivity test) prior to beginning work. Thereafter, an annual physical exam and Mantoux test are required.
   c. All staff are required to have their hair styled so that it does not touch the collar, and to wear clean aprons, clothes and shoes.
      - Hair restraints are required and should cover all hair on the head.
      - Beard nets are required when facial hair is visible.
      - Please refer to the facility's personnel manual for a more detailed dress code.
   d. All staff will wash their hands just before they start to work in the kitchen and when they have used their hands in an unsanitary way such as smoking, sneezing, using the restroom, handling poisonous compounds, dirty dishes, touching face, hair, other people, etc.
   e. Staff who have symptoms of communicable diseases or open infected wounds are not permitted to work in the kitchen.
      - Any staff member that has a contagious illness (coughing, sneezing, diarrhea, vomiting or open wounds) will report to the supervisor immediately before reporting back to work.
      - Any staff member who has one of the following should report this illness to their supervisor immediately: Hepatitis A, E Coli, Norovirus, Salmonella or Shigella.
      - Anyone who has an abrasion or cut on the hand is required to wear gloves during food preparation.
      - The director of nursing should be notified in the event of a communicable disease exposure at the facility.
   f. Staff are not permitted to use tobacco while preparing food, or while in areas used for equipment washing or food preparation. The use of tobacco may result in contamination of food, equipment, utensils, or other items needing protection.

3. Food Purchasing
   a. All food is purchased from sources that have been approved or are considered satisfactory by the local health department. The purchased food must be clean, wholesome and free from spoilage.
      - Only pasteurized milk is purchased.

©2013 Becky Dorner & Associates, Inc.

- Only eggs with clean and uncracked shells are purchased. Pasteurized liquid or frozen eggs are preferred. For highly susceptible populations, only pasteurized eggs may be used in the preparation of foods such as Caesar salads, hollandaise or Béarnaise sauce, mayonnaise, eggnog, ice cream, and egg-fortified beverages, fried and poached eggs.
- Home-canned or home grown foods are not purchased or used.
- Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food are not used.

4. Food Storage (see Food Production and Food Safety-Food Storage for details)
   a. Food that is stored is protected from contamination and growth of any pathogenic organisms.
   b. Food protection measures that are performed by the food service department include:
      - Foods are refrigerated and stored at or below 41° F.
      - Foods are frozen and stored at a temperature that keeps them frozen solid.
      - Foods are protected from contamination (dust, flies, rodents, and other vermin).
      - Foods stored in the storeroom are placed on clean racks at least 6 inches above the floor, 18" from the ceiling, and 2 inches from the wall (check your state and local regulations for additional information). The room is clean, dry and cool. Temperature range is 50 to 70 degrees.
      - Perishable ingredients are refrigerated when they are not being used.
      - Poisonous and toxic materials including cleaning agents are stored (and secured) outside the storage area for food and paper products.
      - All time and temperature control for safety (TCS) leftovers are labeled, covered, and dated when stored. They are used within 72 hours (or discarded).
      - Note: ServSafe guidelines allow 7 days for food safety with the day of preparation counted as day 1 of the 7 days, and then food is discarded. Check your local and state regulations and determine which guideline your facility will follow.
      - Foods with expiration dates are used prior to the use by date on the package.
      - Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer's guidelines.

Note: In order to assure that the dietary needs of the patients/residents are being met and that each facility maintains sanitary conditions, all food and dining areas should be inspected on a regular basis. See the quality assurance/improvement section of this manual for sample audit forms.

©2013 Becky Dorner & Associates, Inc.

Food Safety – Food Service Manager's Responsibility

Policy:

The food service manager is responsible for providing safe foods to all individuals.

Procedure:

The food service manager assures all of the following:

1. Good sanitary food handling practices.

2. Sanitary conditions are maintained in the storage, preparation and serving areas.

3. Dishwashing guidelines and techniques are understood by staff and carried out in compliance with the state and local health codes.

4. Proper waste disposal methods are used.

5. All refrigerated and frozen foods are stored and handled properly. All dry and staple food items are stored properly.

6. Personnel follow sanitary practices and good personal hygiene at all times.

7. All personnel follow proper cleaning and sanitizing instructions for all kitchen equipment. Cleaning schedules are posted and followed.

8. All personnel, when hired, must have a medical report from their physician, including a yearly Mantoux test. Personnel having or suspected of having infections are not permitted to work.

9. Regular inspections are made by the food service manager or designee to assure food safety.

10. All HACCP procedures are followed.

©2013 Becky Dorner & Associates, Inc.

Employee Sanitary Practices

Policy:

All kitchen employees will practice standard sanitary procedures.

Procedure:

All employees shall:

1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. Note: This does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils and linens; and unwrapped single-service and single-use articles.

2. Wash hands before handling food. Pay close attention to finger nails. Finger nails should be clean and neat. Acrylic or painted nails must be covered when handling or serving food. Gloves must be worn if raw food is handled.

3. Jewelry is kept at a minimum. Only a plain band ring such as a wedding band is allowed to be worn. Facial piercings are to be removed or covered. Medical alert bracelets may not be worn per Food Code 2009.

4. Use utensils to handle food.

5. Avoid touching mouth or face while preparing food (and wash hands if contaminated).

6. Use clean cloths in handling hot utensils.

7. Use clean spoons when tasting food and do not return them to the food.

8. Clean and sanitize equipment and work units after use.

9. Use these guidelines in handling clean dishware, glasses and silverware:
   - Use clean hands.
   - Pick silverware and cups up by their handles.
   - Pick dishes up by their rims.
   - Pick glasses up by their base.
   - Store clean dishes inverted, in enclosed cabinets or storage units.
   - Store glasses and cups on a clean, sanitary surface - bottoms up.

Note: Follow all federal, state and local requirements.

©2013 Becky Dorner & Associates, Inc.

Authorized Personnel in Food Service Department

Policy:

The food service department is restricted to food service personnel only.

Procedure:

1. Only food service personnel are allowed in the food service department. This includes the food preparation, food service areas and dish room.

2. Signs indicating "Food Service Staff Only" should be posted on the kitchen door.

3. All requests for food/beverages should be made via phone, written communication or from the kitchen door.

4. The food service manager or designee will be responsible for enforcing this requirement.

©2013 Becky Dorner & Associates, Inc.

General Sanitation of Kitchen

Policy:

The staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.

Procedure:

1. Cleaning and sanitation tasks for the kitchen will be recorded.

2. Tasks will be assigned to be the responsibility of specific positions.

3. Frequency of cleaning for each task will be defined.

4. The method and agents to be used for cleaning/sanitizing will be written for each task.

5. A cleaning schedule will be posted. Employees will be trained on the cleaning schedule and how to perform duties. Employees will initial and date tasks when completed. (Refer to Sample Cleaning Schedule and Forms in the Cleaning Instructions Section of this manual.)

6. Staff will wear rubber gloves and an apron to protect hands and clothing while cleaning the kitchen. Protective eyeglasses will be worn as appropriate.

7. The Materials Safety Data Sheets (MSDS) will be available for all chemicals used by the food service staff. Staff will be inserviced on the proper use of chemicals and the MSDS Sheets.

©2013 Becky Dorner & Associates, Inc.

Hand Washing

Policy:

Staff will wash hands as frequently as needed throughout the day following proper hand washing procedures (and surrogate prosthetic devices washing procedures as appropriate). Hand washing facilities should be readily accessible and equipped with hot and cold running water, paper towels, soap, trash cans and signage notifying employees to wash hands. Encourage hand washing instead of the use of chemical sanitizing gels or lotions. If chemical sanitizing gels are used, staff must first wash hands as stated below.

Procedure:

Clean hands and exposed portions of arms (or surrogate prosthetic devices) immediately before engaging in food preparation including working with exposed food.

1. When to Wash Hands:
   - After touching bare human body parts other than clean hands and clean, exposed portions of arms.
   - After using the restroom.
   - After caring for or handling service animals or aquatic animals.
   - After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking.
   - After handling soiled equipment or utensils.
   - During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.
   - When switching between working with raw food and working with ready to eat food.
   - Before donning gloves for working with food.
   - After engaging in other activities that contaminate the hands.

2. How to Wash Hands:
   - Turn on the faucet using a paper towel to avoid contaminating the faucet.
   - Wet hands and forearms with warm water (minimum 110° F) and apply an antibacterial soap.
   - Scrub well with soap and additional water as needed, scrubbing all areas thoroughly. Pay close attention to the fingernails using a brush as needed. Scrub for a minimum of 10 to 15 seconds within the 20-second hand washing procedure. Apply vigorous friction between the fingers and fingertips. Rinse with clean, running warm water.
   - Rinse thoroughly.
   - Dry hands with paper towel. Turn the faucet off with the paper towel. Or use a hand blow drier.
   - Use the towel to open the door if needed, and then discard the towel.

3. Application of hand lotion is not advised because of the frequency of bacterial contamination found in this solution.

4. Staff is educated on the importance of hand washing and retrained and reminded as necessary on the above philosophy/guidelines.

5. Hand washing procedures are posted by each hand washing sink.

Resource:

- Poster on How to Wash Hands from the World Health Organization: http://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf

©2013 Becky Dorner & Associates, Inc.

Use of Hand Antiseptic

Policy:

Any hand antiseptic used by staff as a hand dip or wash will be limited to situations that involve no direct contact with food by the bare hands. Hand antiseptic may be applied between washing hands twice before full hand washing must be completed.

Procedure

1. The hand antiseptic must comply with 2-301.16 (A) of the 2009 Food Code. Hand antiseptic solution used as a hand dip shall be maintained clean and at a strength equivalent to at least 100 mg/L chlorine.

2. Hand antiseptics are not to take the place of hand washing. Refer to hand washing policy and procedure for instructions regarding when hands must be thoroughly washed.

3. Hand antiseptics may be used after hand washing, and between hand washing as long as hands are not soiled.

4. Hand antiseptic use should be limited to situations where direct contact of food with bare hands does not occur.

5. Use an alcohol based hand rub. Apply to the palm of one hand and rub to cover all areas of the hands until dry. Rub between fingers, finger tips, back of fingers and hands. Volume of hand sanitizer used is based on the manufacturer's recommendations.

Resources:

- Centers for Disease Control. Hand Hygiene in Healthcare Settings. http://www.cdc.gov/HandHygiene/index.html. Accessed September 5, 2012.
- Hand Antiseptics. Food Code 2009, Section 2-301.16. http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/ucm181242.htm. Accessed September 5, 2012.
- Hand Rub Poster from the World Health Organization: http://www.who.int/gpsc/5may/How_To_HandRub_Poster.pdf

©2013 Becky Dorner & Associates, Inc.

Bare Hand Contact with Food and Use of Plastic Gloves

Policy:

Single-use gloves will be worn when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited.

Procedure:

1. Staff use good hygienic practices and techniques with access to proper hand washing facilities (available soap, hot water and disposable towels and/or heat/air drying methods). Antimicrobial gel is not used in place of proper hand washing techniques.

2. Staff use clean barriers such as single-use gloves, tongs, deli paper and spatulas to prevent food borne illness.

3. Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.

4. Hands are to be washed when entering the kitchen and before putting on the single-use gloves.

5. Clean barriers such as single-use gloves are to be used when:
   - Handling ready-to-eat foods.
   - Working with raw meat, poultry, raw eggs, fish and shellfish.
   - Making foods such as meatloaf or meat salads.
   - Hand tossing salad, mixing coleslaw, potato or macaroni salad.
   - Bagging bread or cookies.
   - Removing frozen foods from boxes.
   - Anytime hands would otherwise touch food DIRECTLY.

6. **Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be <u>changed.</u>**
   - After coughing or sneezing into hands, using a handkerchief or tissue, using tobacco or touching hair or face.
   - After handling garbage or garbage cans.
   - After handling soiled trays or dishes.
   - After handling anything soiled.
   - After handling boxes, crates or packages.
   - After picking up any item from the floor.
   - During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.
   - When switching between working with raw food and working with ready-to-eat food.
   - After engaging in other activities that may possibly contaminate the hands with bodily fluids.
   - After using the rest room.
   - After caring for or handling service animals or aquatic animals.
   - Any time a contaminated surface is touched.

7. Wash hands after removing the gloves.

©2013 Becky Dorner & Associates, Inc.

Cleaning Dishes/Dish Machine

Policy:

All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation.

Procedure:

1. Prior to use, run the machine until verification of proper temperatures and machine function is made. Verify that soap and rinse dispensers are filled and have enough cleaning product for the shift.

2. Scrape dishes clean into a wastebasket and/or garbage disposal. Note: Do not put eggshells, onion peels, citrus rinds, bones, potato peels, etc, into the garbage disposal.

3. Rinse dishes thoroughly in the sink, using hot, soapy water if needed. Scrub pots and pans with a non-metallic scouring pad when necessary, and rinse in the sink.

4. Load dishwasher safe items into the dishwasher. Avoid overloading and nesting.

5. Load the dish racks into dishwasher.

6. Add detergent according to manufacturer's directions. The person loading dirty dishes should not handle the clean dishes unless they change into a clean apron and wash hands thoroughly before moving from dirty to clean dishes.

7. Set all controls for operation of the dish machine. Press the start button, and allow the dishwasher to run full cycle. (Follow manufacturer's directions.)

8. During the unloading process, visually inspect all items for cleanliness. If the dishes are not clean, repeat steps 2 thru 8.

9. Allow the dishes to air dry on the dish racks. Do not dry with towels.

10. Remove the dishes, inspect for cleanliness and dryness, and put them away if clean (be sure clean hands or gloves are used).

11. Flatware should be pre-soaked prior to washing, and loaded into cylinders with mouth piece exposed. Flatware should be washed twice, with the mouth piece down during the second washing. Staff should assure that silverware is not nested prior to washing in cylinders.

Note: Staff should check the dish machine gauges throughout the cycle to assure proper temperatures for sanitation. Thermal strips may be used as verification that the temperature is adequately hot, but cannot verify actual temperatures. Those machines installed after the Food Code 2001 was implemented must automatically dispense detergents and sanitizers, and must incorporate visual means or other visual audible alarm to alert the user to any concerns (such as the soap or sanitizer not dispensing properly).

©2013 Becky Dorner & Associates, Inc.

Resource: Sanitation of Dishes/Dish Machine

Type of Dish Machine	Wash Temperature	Final Rinse Temperature or Sanitization
High Temperature Dishwasher	**150 to 165° F**	**180° F**
Spray Type Dish Machines Using Hot Water to Sanitize		
• Stationary rack, single temperature machine		**165° F**
• Stationary rack, dual temperature machine		**150° F**
• Single tank, conveyor, dual-temperature machine		**160° F**
• Multi-tank, conveyor, multi-temperature machine		**150° F**
Low Temperature Dishwasher **Spray Type Dish Machines Using Chemicals to Sanitize**	**120° F**	**50 PPM Hypochlorite**
Mechanical Dish Machine Using Hot Water to Sanitize		
• Hot water sanitizing rinse as it enters the manifold may not be more than or less than		**194° F**
• For a stationary rack, single temperature machine		**165° F**
• For all other machines		**180° F**

Sources:

1. Food Code 2009, US Dept. HHS, Public Health Service, FDA, Washington, D.C. http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/. Accessed September 5, 2012.
2. CMS State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities. F 371. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Dish Machine Temperature Log

Policy:

Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes.

Procedure:

1. The food service manager will provide the dishwashing staff with a log to be posted near the dish machine. (See sample form next page.)

2. The food service manager will train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process.

3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal.
    a. The food service manager will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures.

4. Dishwashing staff will be trained to report any problem with the dish machine to the food service manager as soon as they occur.

5. The food service manager will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes.

©2013 Becky Dorner & Associates, Inc.

Dish Machine Temperature and Sanitizer Log Sample Form

Facility:______________________________ **Month:**_______________ **Year:**______

Date	Meal	Wash	Final Rinse	Sanitizer Concentration (PPM)	Thermal Strip	Corrective Action If needed	Initials
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						

Directions: **Insert your dish machine instructions here:**	**Temperature Standards for Your Type of Machine & Sanitizer** 1. Wash temperature: _____°F 2. Final rinse temperature: _____°F 3. Sanitizer concentration: _____ PPM

Note: Maintain this log for each month. **PPM** = Parts per million of sanitizing solution (used in low temp dish machines).

Report any inappropriate temperatures or sanitizing issues to the supervisor immediately for corrective action.

©2013 Becky Dorner & Associates, Inc.

Resource: Dish Machine Problems and Solutions

Problems	Reasons	Possible Solutions
Scale in machine	Water hardness Wrong kind or amount of detergent	Soften water Select detergent better for your situation (consult supplier) De-lime the machine
Greasy film	Poor cleaning guidelines; Water not hot enough Not enough detergent	Improve job of cleaning Check that wash and rinse cycle temperature is appropriate Use additional detergent
Cloudy film on glasses; dirty soap film on dishes	Final rinse jets clogged	Be sure jets are clean and that the spray reaches all dishes Be sure scrap traps are emptied and cleaned often
Water spots and film on glasses and dishes	Too short a rinse time Pressure of rinse Water hardness Drying time	Lengthen time: If time is too short, soil is not removed Adjust pressure: If pressure is too low, the rinse is poor If pressure is too high, dishes tend to fog Soften water If drying time is too long, water remaining will cause spots A rinse additive would be indicated to produce “sheeting off” of the rinse water to produce a dry dish

©2013 Becky Dorner & Associates, Inc.

Maintenance of Dish Machine

Policy:

Dish machine will be maintained to assure proper functioning.

Procedure:

1. The dish machine will be regularly cleaned and de-limed as needed.

2. Clean according to the manufacturer's directions. The dish machine should be cleaned at least once per week. General guidelines are as follows:
   - Turn the heat off on the wash and rinse tanks, and drain the water from the tanks.
   - Remove any removable parts, and any loose food particles from the scrap traps.
   - Check and clean the final rinse sprays if needed.
   - Close the tank drain, refill the tank, flush out the pump and lines, running machine at least one minute, and then drain.
   - Replace the scrap traps, wash and rinse the removable parts.
   - Leave all the doors open.
   - Clean and refill the detergent dispenser.
   - Check the filler opening, final rinse, and pump for leaks.
   - Clean the dish tables with detergent, sanitizer solution, rinse, and dry.

3. De-lime as needed and according to the manufacturer's directions.

Note: Consider contracting with the dish machine company to conduct a monthly maintenance check.

©2013 Becky Dorner & Associates, Inc.

Cleaning Dishes - Manual Dishwashing

Policy:

Dishes and cookware will be washed after each meal to assure that all dishes are clean and sanitary.

Procedure:

1. Scrape dishes into a wastebasket and/or garbage disposal.
2. Rinse dishes off and stack them carefully. Pre-soak items as needed.
3. Prepare the sinks according to the chart below. All sinks should be cleaned and sanitized prior to beginning.
4. Place a few dishes at a time into the sink. Wash thoroughly with a clean cloth or sponge. Scrub items as needed using a scouring pad. Rinse in sink 2, and sanitize in sink 3 following the directions below.
5. After dishes are done, sinks and faucets will be cleaned and sanitized.
6. Check sanitation sink often using a test strip to assure the level of sanitizing solution is appropriate.

Sink 1: Wash	Sink 2: Rinse	Sink 3: Sanitize
Wash dishes in detergent and warm water to remove all soil: 1. Prepare the clean sink by measuring the appropriate amount of water into the sink and marking the sink with a water line. 2. Determine the appropriate amount of detergent to be used, and follow the manufacturer's directions for use. 3. Water should be about (120 to 125° F). 4. Change water frequently to assure effective cleaning of dishes.	Rinse dishes in clean, warm water: 1. Prepare the clean sink with hot water (120 to 140° F). 2. Rinse the dishes thoroughly before placing in the sanitizing sink.	Sanitize dishes: 1. Measure the appropriate amount of sanitizing chemical into the appropriate amount of water (following the manufacturer's guidelines). 2. Test the sanitizing solution in the sink using the manufacturer's suggested test strips to assure appropriate level. 3. Place the dishes in the sanitizing sink. Allow to stand according to the manufacturer's guidelines for sanitizer (or see chart below). 4. Allow dishes to air dry. Invert dishes in a single layer to air dry. Check all dishes to be sure they are clean and dry prior to storing. **Note:** If hot water is used as the sanitizing method, water must be at least 171° F and dishes must be immersed for at least 30 seconds.

Sanitize all dishes by immersion in one of the following:

Disinfectant	Strength	Minimum Temperature	Contact Time
Hot Water	N/A	171° F	30 seconds
Chlorine	50 to 100 PPM	75° F	10 seconds
Quaternary Ammonium	150 to 200 PPM	75° F	Per manufacturer
Iodine	12.5 PPM	75° F	30 seconds

Source: CMS State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities. F 371, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Sanitation of Dishes/Manual Washing

	Temperature
Manual Washing Using Hot Water to Sanitize • For sanitizing using immersion in hot water, water must be maintained at	**171° F for 30 seconds**
Manual Washing Using Chemicals to Sanitize • An exposure time of at least 10 seconds for a chlorine solution of 50 mg/L that has a pH of 10 or less and a temperature of at least • Or a pH of 8 or less and a temperature of at least • An exposure time of at least 30 seconds for other chemical sanitizing solutions	**100° F** **75° F** **Per Manufacturer**

Chlorine Solutions

Chlorine solutions must have a minimum temperature based on concentration and pH of the solution.

Minimum Concentration Mg/L	Minimum Temperature in ° F pH 10 or Less	pH 8 or Less
25	120	120
50	100	75
100	55	55

Iodine Solutions
• Minimum 68° F • pH of 5.0 or less or pH no higher than level specified by the manufacturer • Concentration between 12.5 mg/L and 25 mg/L

Quaternary Ammonium Compound Solutions
• Minimum 75° F • Concentration as indicated by manufacturer • Used only in water with 500 mg/L hardness or less, or in water with a hardness no greater than specified by the manufacturer

Source: Food Code 2009, 4-501.114. US Dept. HHS, Public Health Service, FDA, Washington, D.C. http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/FoodCode2009/. Accessed September 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Handling Clean Equipment and Utensils

Policy:

Clean equipment and utensils will be handled to prevent contamination.

Procedure:

1. When handling cleaned and sanitized equipment and utensils, staff will avoid touching the parts that will come in contact with the food or the mouth (especially with silverware).

2. Clean equipment and utensils will be stored in a clean, dry location in a way that protects them from splashes, dust, or other contamination. Stationary equipment will also be protected from contamination.

3. Glasses and cups will be stored in an inverted position on a clean sanitary surface.

4. Stored utensils should be covered or inverted wherever possible.

5. Flatware will be handled by the hand piece, and should be stored accordingly.

©2013 Becky Dorner & Associates, Inc.

Bedside Water Containers

Policy:

The facility will provide individuals with fresh drinking water on a regular basis.

Procedure:

1. Each individual should have two complete water container sets for water at the bedside.

2. The night shift is responsible for collecting the complete set and replacing it with a clean set, filled with fresh water and ice on a daily basis.

3. The soiled set will be taken to the dietary department dish room to be washed and sanitized the next day.

4. The clean water containers will be returned to the unit the following day.

5. Store water sets inverted in the kitchen until needed.

6. This procedure is to be followed on a daily basis.

Note: Facilities may choose to use bottled water instead of refilling and cleaning/sanitizing containers. In this case, water is supplied multiple times each day based on the need of each individual. If this method is used, bottles are recycled.

©2013 Becky Dorner & Associates, Inc.

Dry Storage Areas

Policy:

Dry storage areas will be kept in a condition which protects stored foods from infestation.

Procedure:

1. All items must be stored at least 6 inches off the floor. Shelving should be built at least 2 inches from walls and 18 inches from the ceiling. There must be adequate space on all sides of stored items to permit ventilation.

2. The floors, walls, shelves and other storage areas are kept clean.

3. Any porous surfaces must be sealed with paint or other substances to prevent accidental food leakage from being absorbed. Metal shelves must be coated to prevent oxidation.

4. Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods.

5. No smoking is allowed in storage rooms.

6. Storerooms must be well lighted.

7. The storeroom is sprayed and/or treated on a regular schedule to keep it pest and rodent free.

8. Ceilings must be free from water and heating pipes to protect the food from leaking pipes, heat, or contamination.

9. Storeroom temperature should be 50° to 70° F. A thermometer is present in the storeroom, and is monitored on a regular basis.

10. Containers with tight-fitting covers should be used for storing cereal, grain products, dried vegetables and broken lots of bulk food.

11. Poisonous and toxic material should be stored outside the food storage and preparation area or in cabinets, which are used for no other purpose. Bactericides, cleaning compounds, insecticides and other poisonous materials should not be stored in the same area.

Care of the Storeroom

12. The staff will maintain care of the storeroom according to the following directions.
    a. All foods are arranged in the storeroom according to type.
    b. New stock is placed in back of previously delivered items so that older stock will be issued first.
    c. Refrigerated and frozen foods are dated upon delivery. Foods with expiration dates are used prior to the date on the package. Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer's guidelines. Canned goods should be dated and staff should use the FIFO (first in/first out) method to rotate foods.
    d. The storeroom is cleaned on a regular basis. Floors are swept and mopped at least weekly and more often as needed. Refer to the cleaning schedule for details.

©2013 Becky Dorner & Associates, Inc.

Production, Storage and Dispensing of Ice

Policy:

Ice will be produced, stored and dispensed in a manner to avoid contamination.

Procedure:

1. The ice dispenser is cleaned and sanitized at least monthly, and/or as needed. Inside and outside of machine are cleaned. The area around the machine is also cleaned.*

2. Ice scoops are stored outside of the dispenser in a closed, clean container. Ice scoops are cleaned and sanitized daily.

3. Ice is dispensed into properly sanitized (dish machine or 3 sink method) receptacle.

4. Ice scoops are used to dispense ice. Ice is distributed only to clean, sanitized containers or glasses.

5. Use clean fresh ice only. Do not re-use ice that has been used for other things (such as ice used to chill milk or juice containers).

*Also see Cleaning Instructions: Cleaning Ice Machines and Equipment.

©2013 Becky Dorner & Associates, Inc.

Isolation Meals

Policy:

Meals, dishes and utensils will be handled properly to prevent any contamination. Universal precautions are followed.

Procedure:

1. The nursing staff will inform the food service manager that an isolation meal is to be provided. Nursing will specify whether disposable dishes, utensils and single service items are needed.

2. The isolation meal will be delivered to the appropriate staff to assure the meal reaches the appropriate individual.

3. The isolation meal tray will be returned back to the kitchen to be handled with universal precautions (apron, single-use gloves) and dish machine temperature appropriate for destroying bacteria/micro-organisms.

4. For individuals needing disposable items, only single use items will enter the room. If a tray is used to carry the food items to the isolation room; unless disposable, the tray itself will not enter the room. All leftover food, dishes and utensils will be disposed of in the isolation room in a disposable plastic bag as defined by nursing isolation techniques. No leftover food, dishes, or utensils will be returned to the kitchen.

©2013 Becky Dorner & Associates, Inc.

Isolation Meals

Insert your facility's isolation meal policy here.

©2013 Becky Dorner & Associates, Inc.

Kitchen Cloths

Policy:

Kitchen cloths will be clean and available as needed.

Procedure:

1. There will be enough clean kitchen cloths available so that each task can be started with a clean cloth.

2. Cloths will be rinsed to remove excess dirt after each use. Unless disposable, soiled cloths will be sent to the laundry and replaced with clean cloths.

3. Recyclable kitchen cloths will be laundered separately from other laundry. They will be dried, folded, and returned to the kitchen, and stored in a clean area.

4. Terry cloth towels will not be used, as terry loops may harbor bacteria.

5. Kitchen towels are not used to dry dishes, cups, glasses, utensils or cooking equipment. All of these items must be washed, sanitized, rinsed and allowed to air dry.

6. Cloths that are used for cleaning purposes should be stored in sanitizing solution between uses. (See Cleaning Instructions: Cleaning Cloths, Pads, Mops and Buckets.)

©2013 Becky Dorner & Associates, Inc.

Waste Disposal

Policy:

All garbage will be disposed of daily and as needed throughout the day.

Procedure:

1. Prior to disposal, all waste shall be kept in leak-proof, non-absorbent, fireproof containers that are kept covered.

2. These containers are emptied as often as necessary throughout the day. Trash bags shall be sealed prior to removing them from the facility. Trash will be deposited into a sealed container outside the premises.

3. Each container shall be cleaned after emptying as needed.

4. Each container will be cleaned thoroughly at least every 2 to 4 weeks as follows:
   - Rinse the can and lid with cold water.
   - Wash/scrub the can and lid, inside and out with hot soapy water.
   - Rinse the can and the lid with water.
   - Sanitize the can and lid with prepared sanitizing solution.
   - Invert to drain and air dry.
   - Fit the can with clean plastic liners and return to the kitchen.
   - Report any leaks, cracks or dents in the can or lid to the food service manager or designee.

©2013 Becky Dorner & Associates, Inc.

Pest Control

Policy:

If pests are seen in the kitchen, the food service manager or appropriate staff shall be informed, describing where the pest was seen and when. Appropriate action will be taken to eliminate any reported pest situation in the department.

Procedure:

1. An appropriate pest control contractor comes in to complete preventative spray treatments at prescheduled appointed times.

2. If a pest situation is reported, the contractor comes in as soon as possible to spray at the appointed times.

3. The contractor will document all visits along with actions taken.

4. If the contractor chemically treats the kitchen, all dishes, pots, pans, toasters, blenders, food processors, and other equipment must be covered. If these items are not covered during treatment, they must be washed and sanitized prior to use.

5. The contractor chemically treats the kitchen only after receiving consent from the food service manager.

6. Any pest traps that are in the kitchen area will be monitored every shift and disposed of according to the contractor's specifications.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions

- ♦ Cleaning and Sanitation of Dining and Food Service Areas 5-1
- ♦ Sample Cleaning Schedule 5-2
- ♦ Daily Cleaning Schedule Sample Form 5-3
- ♦ Weekly Cleaning Schedule Sample Form 5-4
- ♦ Monthly Cleaning Schedule Sample Form 5-5
- ♦ Resource: Infection Control Cleaning Agents 5-6
- ♦ Material Safety Data Sheets 5-7
- ♦ Cleaning Instructions
  - Broilers 5-9
  - Cabinets and Drawers 5-10
  - Can Opener 5-11
  - Cleaning Cloths, Pads, Mops and Buckets 5-12
  - Coffee, Beverage, Juice, Frozen Yogurt or Ice Cream Machines 5-13
  - Counter Space 5-14
  - Cutting Boards 5-15
  - Floors, Tables and Chairs 5-16
  - Food Carts 5-17
  - Food Preparation Appliances 5-18
  - Freezers 5-19
  - Fryers 5-20
  - Garbage Disposals 5-21
  - Hoods and Filters 5-22
  - Ice Machine and Equipment 5-23
  - Microwave Oven 5-24
  - Ovens 5-25

©2013 Becky Dorner & Associates, Inc.

Ranges **5-26**

Refrigerators **5-27**

Slicers **5-28**

Steam Tables **5-29**

Toasters **5-30**

Cleaning and Sanitation of Dining and Food Service Areas

Policy:

The food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule.

Procedure:

1. The food service manager will record all cleaning and sanitation tasks needed for the department.

2. Tasks shall be designated to be the responsibility of specific positions in the department. (See sample forms on the following pages.)

3. All staff will be trained on the frequency of cleaning necessary.

4. The method and guidelines to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. (See sample forms on the following pages.)

5. A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed. (See sample Cleaning Schedules on the following pages.)

6. Staff will be held accountable for cleaning assignments.

Note: Include copies of specific equipment manufacturer's cleaning/sanitizing procedures in this manual.

©2013 Becky Dorner & Associates, Inc.

Sample Cleaning Schedule

After Each Use:

- All small equipment, utensils and appliances
- Counters
- Can openers
- Cutting boards
- Mixers
- Processors
- Coffee machines
- Toasters
- Stove tops (Range)
- Dishes
- Pots and pans
- Dining room tables
- Dining room chairs
- Dining room floors
- Kitchen floors, as needed

Daily:

- Kitchen towels and cloths
- Floors
- Exterior of dishwashers and other appliances
- Kitchen sinks and faucets

Weekly:

- Interior of dishwasher(s)
- Storeroom floors
- Sanitize dining room chairs
- Garbage containers
- Windows
- Garbage disposal(s)
- Refrigerators

Twice Per Month:

- Ice Machines
- Ovens
- Kitchen cabinets and drawers

Monthly:

- Stove hood and filters
- Freezers
- Clean behind and under major appliances
- Vacuum and dust back of appliances
- Drawers
- Shelves
- Refrigerator condenser pans
- Refrigerator condenser coils
- Freezer condenser pans
- Freezer condenser coils

Refer to Housekeeping:

- Walls
- Ceilings
- Doors
- Fixtures
- Waxing Floors

©2013 Becky Dorner & Associates, Inc.

Daily Cleaning Schedule Sample Form

		Initials and Dates							
Item	Responsible Party	Mon	Tue	Wed	Thu	Fri	Sat	Sun	FSM

FSM = Food Service Manager or designee (initial here after checking to assure work was done satisfactorily)

©2013 Becky Dorner & Associates, Inc.

Weekly Cleaning Schedule Sample Form

		Initials and Dates					
Item	Responsible Party	Week 1	Week 2	Week 3	Week 4	Week 5	FSM

FSM = Food Service Manager or designee (initial here after checking to assure work was done satisfactorily)

©2013 Becky Dorner & Associates, Inc.

Monthly Cleaning Schedule Sample Form

Item	Responsible Party	Initial and Dates											
		January	February	March	April	May	June	July	August	September	October	November	December

Food Service Manager or designee: Check to assure work was done satisfactorily.

©2013 Becky Dorner & Associates, Inc.

Resource: Infection Control Cleaning Agents

Agents used are:

	Agent	Use
1.	___________________________________	Sanitizer for use in final rinse sink
2.	___________________________________	Used for cleaning all appliances, countertops
3.	___________________________________	Used for washing all pots and pans, and other items washed by hand
4.	___________________________________	Used for mopping floors
5.	___________________________________	Used for cleaning ovens
6.	___________________________________	Used on all stainless steel after it has been cleaned
7.	___________________________________	Used to clean walls, ceilings, doors, etc.
8.	___________________________________	___________________________________
9.	___________________________________	___________________________________
10.	___________________________________	___________________________________
11.	___________________________________	___________________________________
12.	___________________________________	___________________________________

Note: Material Safety Data Sheets (MSDS) for the above products should also be included in this manual and staff should be inserviced on the potential hazards and on safe use of these products.

©2013 Becky Dorner & Associates, Inc.

Material Safety Data Sheets

Policy:

Staff is trained on the safe use of chemicals. Material Safety Data Sheets (MSDS) are readily available for staff use.

Procedure:

1. The food service manager arranges for staff to be inserviced on any chemicals in use in the department at least yearly and more frequently if changes are made.

2. The MSDS are readily available to staff for reference.

3. Staff is trained on safe use of chemicals as part of their orientation and yearly review.

4. Staff is trained on what to do in an emergency if someone is hurt by the chemicals while using them in the department.

5. MSDS sheets are updated any time the manufacturer revises them. The food service manager should check for changes in MSDS sheets every 1 to 3 months for quality assurance and safety purposes.

6. Staff are informed of changes in the MSDS sheets as they occur.

©2013 Becky Dorner & Associates, Inc.

Material Safety Data Sheets

Please insert your material safety data sheets (MSDS) here.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Broilers

Policy:

Broilers will be cleaned on a regular basis and cared for in a way to maintain optimum production.

Procedure:

1. Be sure the broiler has cooled completely prior to cleaning.

2. Use a stiff brush to scrape away all dried and cooked on food particles. Most manufacturers recommend the appropriate brushes to clean broilers properly.

3. Remove the broiler grills. Scrub the broiler grills thoroughly (top and underneath). Scrub the sides and bottom of the broiler according to manufacturer's directions.

4. Sanitize the broiler and grills according to manufacturer's directions. Air dry.

5. Reassemble the broiler to prepare it for the next use.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Cabinets and Drawers

Policy:

Cabinets and drawers will be free of food particles and dirt. They should be cleaned at least twice a month. Cabinets and drawers are cleaned as needed when spills occur.

Procedure:

1. Remove food, utensils, equipment, and other articles from cabinets and drawers.
2. Remove drawers, if possible.
3. Shelves and drawers will be washed with a clean cloth soaked in mild detergent and water.
4. Rinse with water and air dry.
5. Wash and sanitize, or wipe off articles if needed before replacing.
6. Replace drawers, food, utensils, and other articles.

Note: Shelf liner should not be used in drawers, cabinets or on storage shelves.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Can Opener

Policy:

The can opener will be cleaned after each use.

Procedure:

1. Guidelines for cleaning hand held can openers:
   - Remove the can opener shaft from the base.
   - Wash in the sink filled with soapy water. Pay special attention to the blade and moving parts.
   - Rinse
   - Sanitize
   - Air dry
   - Wash the base thoroughly with hot detergent water. Be sure to remove all food particles from the blade and base.
   - Sanitize
   - Air dry
   - Reassemble
   - Repeat guidelines after each use

2. Guidelines for cleaning electric can openers:
   - Unplug the appliance.
   - Wipe all parts carefully with a clean cloth soaked in sanitizing solution. Pay special attention to the blade and moving parts. If the blade can be removed, wash and sanitize thoroughly.
   - Air dry

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Cloths, Pads, Mops and Buckets

Policy:

Cleaning tools will be maintained in clean, fresh, odor-free condition.

Procedure:

1. Cleaning cloths and pads will be washed separately from other items in hot detergent water and rinsed in clean hot water to which a sanitizer has been added. This will be done on a daily or as needed basis through the laundry department.
   - Cleaning cloths should be kept in a container of clean sanitizing solution between uses.
   - Periodically test the sanitizing solution to assure that it maintains the correct concentration.

2. Mops will be rinsed thoroughly after each use in fresh, hot water to which a sanitizer has been added. Mops will be washed in the laundry on a daily basis, and separately from other items. Start with fresh mop heads each day.

3. Mop buckets and wringers will be washed out after each use, and stored inverted to allow for proper drainage. Keep mops, wringers and buckets in an appropriate area away from food and food preparation.

4. Mops should be hung inverted between uses, and stored separately from food areas.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Coffee, Beverage, Juice, Frozen Yogurt or Ice Cream Machines

Policy:

Coffee makers, urns, juice machines, frozen yogurt and/or ice machines will be cleaned thoroughly following the manufacturer's instructions. If no manufacturer's instructions are available, follow the instructions below.*

Procedure:

Coffee Machines:

1. Rinse the coffee maker with clear hot water.
2. Baking soda or urn cleaner should be used to clean the liner, gauges, faucets, and glass pots.
3. Rinse very carefully, first with hot and then cold water. Invert glass pots to air dry.
4. Use a brush to de-scale the inside of the coffee maker.
5. Gauges should be cleaned every other day.
6. The inside of the coffee urn must be clean and free from stains and sediment.
7. Clean all exterior parts with warm detergent water. Rinse and dry.

*Follow the manufacturer's instructions for more specific cleaning details.

Beverage, juice, frozen yogurt and ice cream machines:

1. Follow the manufacturer's instructions.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Counter Space

Policy:

Counter space will be wiped and sanitized prior to and following food preparation and meal service, and as needed.

Procedure:

1. Spills will be wiped up as needed using a clean cloth and warm water.

2. To sanitize:
   - Remove small appliances and other items from the counter.
   - Wipe off debris.
   - Spray the counter with sanitizing solution and wipe with a clean cloth.
   - Wipe the outer surfaces of small appliances.
   - Allow countertops and small appliances to air dry.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Cutting Boards

Policy:

Cutting boards will be cleaned and sanitized after each use. No wooden cutting boards, counters, or tables are used for cutting foods. Acrylic cutting boards are used for cutting foods. Separate cutting boards are used for raw meat, fish and poultry; and for raw fruits, and vegetables. (Color coded cutting boards may be helpful to guarantee proper use. A posted chart explaining which color cutting board is used for which food is also helpful.)

Procedure:

1. Keep cutting boards separate for raw versus cooked or ready to serve foods.

2. After each use, wash cutting boards in hot soapy water.

3. Rinse and sanitize.

4. Air dry.

Note: Cutting boards may be washed in dishwasher if dishwasher safe.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Floors, Tables and Chairs

Policy:

Kitchen and dining room floors, tables and chairs will be kept clean and sanitary.

Procedure:

1. Kitchen floors will be swept and cleaned after each meal. A thorough cleaning using a disinfectant will be done at least daily. Major appliances will be moved at least once a month (as appropriate) in order to facilitate cleaning behind and underneath them.

2. For carpeted areas, vacuum after each meal. Clean carpets as needed to maintain a healthy and clean atmosphere.

3. Dining room tables will be cleaned and sanitized after each meal.

4. Dining room chairs will be wiped off (as appropriate) after each meal using a clean cloth and clean, hot soapy water. Cloth covered chairs may be brushed off or vacuumed.

5. Dining room chairs (wooden or metal legs, arms, etc.) should be cleaned at least once a week (or more often as needed) using a sanitizing solution.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Food Carts

Policy:

Food carts will be cleaned and sanitized immediately after each use.

Procedure:

1. Each day, the inside and outside of all food carts will be cleaned and sanitized.
2. Wheels on the food carts should be cleaned as often as needed.
3. The outsides of the food carts may be polished with stainless steel polish on occasion if applicable.
4. Food carts are cleaned at least weekly (preferably daily) in a designated area using a power washer as available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Food Preparation Appliances

Policy:

Small appliances (such as mixers and food processors) will be cleaned and sanitized after each use.

Procedure:

1. Disconnect the electric power and empty all food from the appliance.
2. Remove all removable parts.
3. Scrape solid food from the parts into a garbage container.
4. Rinse the parts with warm water and place in the dishwasher or sink. Wash and rinse following the guidelines for automatic or hand dish washing.
5. Air dry.
6. Clean the outer surface of the appliance with a clean cloth that has been moistened with hot, soapy water. Follow with a hot water rinse. Do not immerse the bases of electrical appliances in water.
7. Allow to air dry.
8. Reassemble the equipment.
9. Return the equipment to the appropriate area.

Note: If available, follow specific manufacturer's directions for cleaning.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Freezers

Policy:

Freezers will be defrosted as needed (when frost is $\geq$ ¼ inch thick, the freezer should be defrosted), or per the manufacturer's instructions.

Procedure:

1. Remove all food from the freezer. Sort out and throw away all that is not usable. Store good food in another freezer (or if unavailable, store food in a refrigerator or cooler) until the freezer is cleaned.

2. Turn the freezer off about 30 to 60 minutes (or more depending on size) prior to cleaning. Walk-in freezers will need longer to defrost.

3. Let the freezer stand until the ice has melted. Be sure that the drain plug is free so that water can flow freely. Do not scrape ice off with any sharp objects.

4. Wash the shelves and walls with warm sudsy water. Rinse and sanitize using a sanitizing solution. Allow to air dry.

5. Turn the freezer on.

6. Replace freezer inventory, placing older inventory to the front of the shelves.

7. For walk-in freezers, mop floors, wash walls and ceilings as needed. Store all foods at least 6 inches from the floor and 18 inches from the ceiling. Allow room between food items for air circulation.

Note: Frostless freezers do not need to be defrosted. Follow manufacturer's instructions, or if unavailable, follow steps 4 thru 7.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Fryers

Policy:

Fryers will be cleaned on a regular basis and cared for in such a way to maintain optimum production.

Procedure:

1. Be sure the fryer has cooled completely prior to removing all oil from the fryer.

2. Check to be sure the drain is running freely and is free from clogs.

3. Scrub down the sides and bottom of the deep fryer according to manufacturer's directions. Most fryer manufacturers have special deep fryer brushes to clean fryers properly.

4. Sanitize the fryer using the manufacturer's directions.

5. Check with maintenance on the proper disposal of used oil. Do not poor oil down the sink drains.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Garbage Disposals

Policy:

Garbage disposals will be cleaned at least once per week, and more often if needed due to heavy use.

Procedure:

1. Rinse the garbage disposal with cold water after each use.
2. Check to see that the disposal is in the “off” position.
3. Inspect for any paper, plastic or metal objects left in the disposal and remove carefully.
4. Wash down the disposal and surrounding area with detergent solution.
5. Rinse with sanitizing solution.

Note: Follow manufacturer’s instructions for cleaning and sanitizing if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Hoods and Filters

Policy:

Stove hoods and filters will be cleaned according to the cleaning schedule, or at least monthly.

Procedure:

1. Remove the screens from the hoods.
2. Place the screens in soapy water in the sink. Scrub thoroughly. Rinse. (Or run through the dish machine if appropriate.)
3. Remove the screens to air dry.
4. Replace the screens into the hoods.
5. To clean the interior and exterior of the hood, use a clean cloth soaked in soapy detergent water. Rinse thoroughly and air dry. A more abrasive cleaning agent may be needed in some cases. A cleaning agent that can handle grease may be needed.
6. Hoods and filters should be cleaned professionally at least yearly.

Note: Follow manufacturer's instructions for cleaning if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Ice Machine and Equipment

Policy:

The ice machine and equipment (scoops, etc.) will be cleaned on a regular basis to maintain a clean, sanitary condition. If available, follow the manufacturer's cleaning and sanitizing procedures.

Procedure:

1. Unplug the ice machine and remove the ice.

2. Wash the interior thoroughly using a detergent solution. Rinse and drain the interior with clean hot tap water.

3. Sanitize.

4. Air dry.

5. Turn the machine on.

6. Clean the exterior of the machine with a detergent solution. Rinse and allow to air dry. Clean the area underneath and around the machine. The exterior of machine should be cleaned daily.

7. The ice scoop and any other removable parts will be washed and sanitized at least weekly or as needed in the dishwasher and allowed to air dry.

8. Store the ice scoop beside or on top of the machine in a clean non-porous container that allows the water to drain off (and not pool around the scoop).

Note: Follow manufacturer's cleaning and sanitizing instructions if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Microwave Oven

Policy:

The microwave oven will be kept clean, sanitized and odor free. The microwave oven interior should be cleaned after each use as needed, and at minimum, after each meal service.

Procedure:

1. Remove the trays or shelves from inside the microwave oven.
2. Wash, rinse, sanitize and allow to air dry, if applicable.
3. Remove any food particles from the interior of the microwave oven with a clean, wet cloth.
4. Wipe the interior with hot sudsy water.
5. Rinse with clear water.
6. Sanitize.
7. Leave the door ajar until the interior dries.
8. Wipe the exterior including the selection panel or keypad with a clean, wet cloth. Wipe dry. Clean the area underneath and around the machine.
9. Clean the exterior of the glass door with an approved glass cleaner.
10. Replace the trays or shelves (if applicable).

Note: Follow manufacturer's cleaning and sanitizing instructions if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Ovens

Policy:

Ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). Spills and food particles will be removed after each use.

Procedure:

1. Remove the oven racks, and place on a newspaper in a ventilated area.
2. Apply the oven cleaner and let the racks stand per the oven cleaner directions.
3. Wipe off any loosened grease and particles with paper towels. Place the racks in a sink with the drain open.
4. Run water over the racks to remove the oven cleaner, dirt, grease and grease particles. Let the water run down the drain.
5. Wash and rinse the racks. Air dry.
6. Remove large particles from the inside of the oven. Apply the oven cleaner to the inside of the oven and oven door. Let it stand per oven cleaner directions.
7. Wipe off any loosened grease and particles from inside the oven and the oven door.
8. Rinse thoroughly.
9. Replace the racks inside the oven.
10. Remove spills and food particles after each oven use as needed (before re-heating the oven).

Note: For self-cleaning ovens, please follow the manufacturer's cleaning instructions.

Caution: Read the manufacturer's directions for use on the oven cleaner label to determine the proper clothing and skin protection to be worn as oven cleaner is usually a very caustic substance. Do not get oven cleaner on the heating elements.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Ranges

Policy:

The cook on each shift is responsible for keeping the range as clean as possible during the preparation of the meal. The range will be cleaned after each use. Spills and food particles will be wiped up as they occur.

Procedure:

1. Turn the range off and allow it to cool.

2. Scrape burned particles and grease off using proper cleaning items (a non-metal scouring pad may be needed for metal surfaces). Wipe the surface with a clean cloth soaked in soapy water.

3. Wipe the outside surface of the appliance using a sanitizing solution.

4. Wash the drip pans as needed and/or according to the cleaning schedule.

5. Spills should be cleaned up as they occur.

Note: Follow manufacturer's cleaning and sanitizing instructions if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Refrigerators

Policy:

The refrigerators will be washed thoroughly inside and outside with a detergent and followed by a sanitizer at least once every month, or as needed. Spills and leaks will be cleaned as they are noticed.

Procedure:

1. Remove all food from the refrigerator. Sort out and throw away all that is not usable. Store good food in another refrigerator or cooler until the refrigerator is cleaned.

2. Remove the shelves, drawers and other removable parts. Wash the parts in the sink using the hand dishwashing method.

3. Wash the walls and base of the refrigerator with warm detergent water.

4. Rinse and sanitize. Allow to air dry.

5. Wipe the exterior of the refrigerator with an approved cleaner or clean cloth, moistened with sanitizing solution.

6. Replace the removable parts and food into the refrigerator.

7. For walk-in refrigerators, also mop the floors, clean the drains and wash the walls and ceilings monthly. Store all foods at least 6 inches from the floor and 18 inches from the ceiling.

8. Spills should be cleaned at the time they occur.

Note: The maintenance department should clean the condenser coils and the condensation pans on a regular basis.

Note: Follow manufacturer's cleaning and sanitizing instructions if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Slicers

Policy:

The slicer will be cleaned and sanitized after each use.

Procedure:

1. Turn off the machine and disconnect it from the electrical power.
2. Remove the food tray by loosening the screw located at the lower side.
3. Remove the rectangular glide by lifting it out.
4. Remove the shield.
5. Wash all removable parts in the pot and pan sink.
6. Sanitize all parts in a chemical sanitizer, immersing for the appropriate amount of time to sanitize.
7. Carefully wash the remaining parts with hot detergent water, rinse and dry. Pay special attention to any moveable parts, being very careful when cleaning blade. Always wear safety gloves when cleaning the slicer blade.
8. Reassemble and cover the machine.
9. Wash and sanitize the counter top on which the slicer is located.

Note: Use extreme caution when removing parts around the blade and when cleaning the blade. If the slicer comes with manufacturer's cleaning instructions, please use them instead of the above.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Steam Tables

Policy:

Steam tables will be maintained in a clean and sanitary condition. Steam tables should be cleaned after each use and thoroughly cleaned at least once per day.

Procedure:

1. Unplug the unit from electrical outlet.

2. Remove the serving pans and wash according to the guidelines for pots and pans. Send the serving pans through the dish machine for final cleaning and rinsing if needed.

3. Clean the inside and outside of each unit of the steam table. Use hot water and a detergent. Rinse and dry thoroughly.

4. If the unit is heated by steam, drain the water and remove the top section to clean. Water should be drained out and the tank cleaned at least once a day. De-limer may be needed to remove lime deposits.

5. If units are heated by electricity, be careful not to get water into the sockets.

6. Carefully clean around the electrical elements weekly.

Note: Follow manufacturer's cleaning and sanitizing instructions if available.

©2013 Becky Dorner & Associates, Inc.

Cleaning Instructions: Toaster

Policy:

The toaster will be cleaned after each use.

Procedure:

1. Unplug the toaster from the electrical outlet.
2. Empty crumbs into a garbage container.
3. Remove the crumb tray and wash in warm soapy water. Wash, rinse, and sanitize. Allow to air dry.
4. Move the toaster and wash the counter surface underneath.
5. Wash the outside with appropriate cleaner and sanitizer. Air dry.
6. Replace the crumb tray.

Note: Follow manufacturer's cleaning and sanitizing instructions if available.

©2013 Becky Dorner & Associates, Inc.

Safety

- Safety Guidelines 6-1
- Safety in Food Preparation 6-3
- Equipment Safety 6-4
- Knife Safety 6-5
- Dishware and Glassware Safety 6-6
- Dish Clearing and Cleaning Safety 6-7
- Receiving and Storage Safety 6-8
- Lifting Techniques 6-9
- Floor Safety 6-10
- Fire Prevention 6-11
- Fire Plan for Food Service Department 6-12
- Fire Safety Rules 6-13
- Resource: How to Contain Food Service Department Fires 6-14
- Facility Specific Policy and Procedure for Fires 6-15
- Resource: Emergency First Aid 6-16
- Emergency Eye Wash 6-17
- Incident Report 6-19
- Malfunctions and Repairs 6-21

©2013 Becky Dorner & Associates, Inc.

Safety Guidelines

Policy:

The food service department is equipped with safety equipment. Staff is trained on safety precautions to maintain a safe working environment. Safe procedures are followed in daily work routines and equipment operations.

Procedure:

1. Staff will be well trained on general safety guidelines. Safety is an important aspect of food service. Staff must be familiar with practicing all safety precautions.

2. The food service manager shall stress safe techniques during the orientation of new employees, and on a daily basis with all workers.
   a. Instructions for operating equipment should be readily available. Staff must be trained to ask for help if they are not sure how to use a piece of equipment. Thorough training on equipment use and handling will help prevent accidents.
   b. Equipment should meet the standards set by the National Sanitation Foundation.
   c. Precaution should be exercised in handling hot equipment to guard against burns. Dry flame-proof pot holders are used to handle hot pots and pans. Handles of pans are turned away from the edge of the stove to prevent accidental spilling. Prevent burns by turning appliances off immediately after you are finished using them.
   d. Glassware and dishes are handled with care. Chipped or cracked pieces are discarded.
   e. Spills are wiped up immediately to help prevent falls.
   f. Prevent back strain when lifting by using leg muscles instead of back muscles (squat to lift with your legs). Heavy boxes should be lifted properly to prevent injury. Two or more employees should lift heavy articles when necessary, or utilize the proper equipment for lifting.
   g. Wear gloves when using bleach, oven cleaner, abrasive cleaner, or other harsh chemicals. Safety glasses are required when using some chemicals used to clean some equipment.
   h. Never use a box, crate, or chair to stand on. Be certain that stepladders are steady and sturdy.
   i. Extreme caution should be utilized with swinging doors.
   j. Use appropriate cleaners to avoid slippery areas on the floors. Use “wet floor” signs in appropriate areas to avoid falls.
   k. All personnel should observe warning signs, such as “wet floor” signs.
   l. Walk, don’t run.
   m. Wear flat shoes with skid guard (rubber) soles and closed toes.
   n. Keep traffic areas free from debris and clutter.

3. Equipment should be kept in proper working order. Malfunctions should be reported to the food service manager immediately.
   a. Employees should familiarize themselves with work procedures and safe practices to be followed.
   b. Employees should immediately report any unsafe conditions to the food service manager.
      i. Any broken lights, broken chairs, frayed electrical cords, damaged plugs, defective equipment, leaky faucets, broken china or glass, or other unsafe items should be reported to the food service manager.
      ii. Employees shall report to the food service manager any accident, injuries, burns, cuts, sores, respiratory or gastrointestinal infections. Every accident must be

©2013 Becky Dorner & Associates, Inc.

reported and an incident form completed. Injured employees or visitors will receive immediate medical attention.

4. Train all staff on the material safety data sheets (MSDS) for the chemical products in use in the facility.

5. Monitor and log water temperatures on a regular basis in all areas accessible to residents/ patients as part of routine maintenance procedures.
   - Monitor hot beverages and food temperatures on a regular basis at the point they are served. Appropriate supervision must be provided to any individual demonstrating decreased safety awareness and/or anyone who is at risk for burns or scalds per clinical assessments.

   The chart below shows the estimated time for persons to receive second and third degree burns at various temperatures.

Water Temperature	Time to Receive Second Degree Burn	Time to Receive Third Degree Burn
120 degrees	8 minutes	10 minutes
124 degrees	2 minutes	4 minutes
131 degrees	17 seconds	30 seconds
140 degrees	3 seconds	5 seconds
150 degrees	< 1 second	1 second

Source: Michigan Department of Health, 2006.

6. Follow fire safety procedures if a kitchen or facility fire occurs.

©2013 Becky Dorner & Associates, Inc.

Safety in Food Preparation

Policy:

Food shall be prepared in a safe manner to prevent employee injury.

Procedure:

Staff will be trained on the following:

1. Only heavy, dry mitts or pot holders will be used when handling hot utensils (wet cloths conduct heat more rapidly). These will be readily available for use. Towels and mitts will not be placed on the stove top.

2. Cook food in appropriate size containers to avoid boiling over. When the food reaches the boiling point, reduce heat to prevent boil over.

3. Remove pot and pan covers slowly and by lifting sideways and away from face and body to assure that steam escapes without scalding hands or face.

4. Turn the handles of cooking utensils away from the edge of the stove so utensils will not be accidentally bumped off. Handles are not positioned over an open flame.

5. Have adequate assistance prior to removing heavy containers from the stove. Make certain the work area is clear prior to moving hot containers.

6. Regard all pots, pans and any cooking equipment as hot and handle with the proper utensils or suitable hot pads to avoid burns and other accidents.

7. Avoid splashing grease on top of the range (grease will ignite quickly, causing a dangerous fire). Avoid overheating fat. Do not allow grease to build up on equipment (including the hoods).

8. Avoid over-filling food containers. Ladle foods into other containers to transfer instead of pouring to prevent spills and burns.

9. Do not store dishes, glassware or articles on shelves or tables where food is prepared.

10. Poisonous and toxic materials must be labeled and used only under conditions that will not contaminate food. They must be stored in locked cabinets in their original containers-outside of the food storage, preparation, equipment and utensil storage areas.

11. Easily shredded, abrasive materials, such as steel wool or sponges will not be used to clean food preparation equipment or utensils.

©2013 Becky Dorner & Associates, Inc.

Equipment Safety

Policy:

Safety precautions will be followed when electrical equipment is utilized.

Procedure:

Employees will be trained in the use of the machines they will use on the job.

1. Be sure hands are dry prior to touching an electrical appliance, plug or electrical outlet.

2. Be sure all safety devices are firmly attached and in place prior to using the machine (guards, attachments, etc.)

3. Keep fingers, hands, spoons, knives, etc. away from moving parts. Do not remove food until the machine has stopped.

4. Be sure the machine is in the “off” position prior to plugging the machine into the electrical outlet.

5. Turn the switch to “off” and unplug it from the electrical outlet prior to cleaning or adjusting the machine.

6. Clean all equipment properly, following the instructions in the equipment manual.

7. Mixing machines should not be started until the bowl is properly placed and the “beater” is securely fastened.

8. Always use a spatula or other appropriate tool to push food into a mixer, grinder, blender, or food processor.

9. Equipment should not be left on when unattended.

10. Do not use extension cords.

11. All electrical plugs manufactured with 3 prongs must be maintained as such.

12. Always use the safety guard and food holder on the slicer – do not use your hands to push the food down to the blade. Always turn the slicer off and return the slicer blade to zero (0) when finished slicing or walking away from the machine.

©2013 Becky Dorner & Associates, Inc.

Knife Safety

Policy:

Knives will be handled in a safe manner to prevent employee injury.

Procedure:

Employees must be trained to pay special attention to their work when using knives.

1. Knives are utilized only for the operation for which they are intended.
2. Knives are pointed away from the body and away from other staff.
3. Point the sharp edge away from the body and away from others when cleaning, drying or wiping knives.
4. Knives are stored safely and neatly with handles easily accessible to prevent cuts.
5. Remove steel particles from knives after they are sharpened.
6. Knives are not placed in a sink full of soapy water, or other locations where they are not obviously visible.
7. Do not try to catch a falling knife.
8. Knives are to be picked up by the handle, not the blade.
9. Knives are kept sharpened for ease of use. Knife sharpening should only be done by trained personnel in the facility or by an outside source.

©2013 Becky Dorner & Associates, Inc.

Dishware and Glassware Safety

Policy:

Dishware and glassware are handled in a safe manner.

Procedure:

1. Chipped or cracked drinking glasses or china are discarded immediately.

2. Do not pile or stack dishes and glassware too high or too tightly.

3. Use caution when transporting glass and china. Maintain complete control of the load at all times.

4. Push meal carts slowly. Do not place meals on the extreme top of the food carts. Place food carts along a wall and away from hallway intersections.

5. Glass and china are not placed in a soapy pot and pan sink where they are difficult to see. Place them on the counter instead.

6. Use a pan and broom to sweep pieces of broken glass. Use a dampened towel for cleaning slivers of glass. (Never reach blindly into a wastebasket or can.)

7. When there is a broken glass or dish in soapy water, the water is drained first and then the glass pieces are removed carefully. Do not reach into a filled sink with bare hands.

8. Glassware is not used to form or prepare food (such as cutting biscuits or ladling liquids).

©2013 Becky Dorner & Associates, Inc.

Dish Clearing and Cleaning Safety

Policy:

Dishes will be cleared and cleaned in a safe manner to prevent employee injury.

Procedure:

1. Carts will not be overloaded with dishes and trays. Employees should always be able to see where they are going.

2. Meal carts are pushed, never pulled.

3. Meal carts that are in poor repair are removed from service.

4. Care is taken in stacking dishes or trays and when removing them from tables.

5. Any broken or chipped dishes or glassware will be carefully removed from service and discarded.

6. Staff will be trained to take time in cleaning and stacking dishes and glassware to prevent breakage.

7. Cart wheels will need to be checked frequently for proper movement and to assess the need for replacement.

©2013 Becky Dorner & Associates, Inc.

Receiving and Storage Safety

Policy:

Safety precautions should be followed when delivery containers, crates, or boxes are opened, and when food and supply items are stored.

Procedure:

1. When opening boxes, cartons, barrels, crates, etc., remove nails or staples carefully.

2. When storing materials on shelves, always locate the heavier and bulkier materials on lower shelves. Avoid storage on top shelves or other high storage units.

3. All containers will be clearly labeled.

4. All supplies will be stored on well-constructed shelves and floor racks.

5. Arrange heavy supplies on floor racks or on lower shelves.

6. Odd shaped, sharp-edged objects will be placed where they are readily visible, never on top shelves.

7. Safe and sturdy step stools are available and used for reaching high shelves.

©2013 Becky Dorner & Associates, Inc.

Lifting Techniques

Policy:

Correct procedures will be followed when lifting objects. Staff will be well trained on proper lifting techniques.

Procedure:

All staff will be trained on proper lifting as follows. Staff will be able to demonstrate proper lifting at the end of the training.

1. Determine the Load Size and Details
   - If the item is large, bulky, awkward or heavy, ask for assistance with the object or use a hand truck if available.
   - Check for any exposed hazardous surfaces such as nails, wood splinters, etc. and use gloves if needed to lift the object.
   - Be sure there is a clear path to where the object is to be moved.

2. Lift the Object
   - If lifting by hand, bring the object as close to the body as possible before lifting.
   - Squat or bend the knees, keeping back straight.
   - Take a firm grip on the object and divide the weight of the object between both hands.
   - Take a firm footing before lifting the object.
   - Use leg and thigh muscles rather than the back for lifting.
   - Keep the back straight when lifting and keep the object close to the body.

3. Moving the Object
   - Keep the object close to the body and continue to evenly distribute weight between both hands.
   - Have a clear vision of the path for moving the object.
   - Shift your feet if turning (do not twist at the waist).

4. Lower the Object
   - Be sure the way is clear for the object to be set down.
   - Set the object down by bending at the knees and keeping the back straight.
   - Be sure fingers and toes are clear before putting the object down.

Note: Do not lift heavy articles above your height. Do not strain to lift an object that is too heavy for you to lift alone. Ask for help.

©2013 Becky Dorner & Associates, Inc.

Floor Safety

Policy:

Floors will be maintained in a safe manner.

Procedure:

Staff will be trained and supervised to assure the following:

1. Floors will be kept clean and dry.

2. When cleaning floors, one area should be mopped at a time. Use “wet floor” signs to caution others to be careful. Keep mops and cleaning equipment out of the line of traffic. Choose a cleaning agent that does not leave floors slippery after cleaning and drying.

3. Employees should walk across floors, never run, and always look carefully where they are going.

4. Clear traffic lanes will be maintained. Objects should be kept off the floor and out of the aisles and doorways.

5. When operating electrical equipment, do not stand on a wet floor.

6. Any spills should be cleaned immediately.

7. Be sure the floor around all dishwashing areas has a special surface to prevent slipping. Placing rubber mats beside the dishwasher is acceptable. However, mats must be removed each day (or as needed) in order to mop and clean the floor in that area.

©2013 Becky Dorner & Associates, Inc.

Fire Prevention

Policy:

The facility should be constructed, equipped, and maintained to protect the health and safety of residents/patients, personnel and the public. Personnel will be trained on fire safety and fire prevention.

Procedure:

1. A copy of the facility's disaster plan should be posted in the food service department.

2. Staff should be familiar with the location and use of fire extinguishers and the fire reporting system. Inservice training sessions should be conducted to familiarize staff with the location and use of fire extinguishers and this should be documented in the annual inservice records.

3. Personnel will be made aware of procedures to follow in case of fire, including reporting to the fire control center for specific assignments.

4. Hoods, fans, vents, grills and other equipment will be kept free of grease and dust accumulation.

5. A routine cleaning schedule should be posted and enforced for all equipment where grease or dust accumulates.

6. Smoking, if allowed at all, is only allowed in designated areas. It is not permitted in the kitchen, storeroom, restrooms, or residents'/patient's rooms.

7. All employees will participate in routine fire drills.

8. All fire doors, exits, and stairways will be maintained to be clean of material and equipment.

Note: Check your state fire authority, or local or county health department regulations for details in your area.

Resources

- National Fire Safety Association, Free Safety Tip Sheets
  http://www.nfpa.org/itemDetail.asp?categoryID=1979&itemID=46567&URL=Safety%20Information/Safety%20tip%20sheets

©2013 Becky Dorner & Associates, Inc.

Fire Plan for Food Service Department

Policy:

All food service employees follow the fire plan for the department. Staff will be well trained on fire safety.

Procedure:

1. Fire extinguishers are checked monthly. (This is usually done by maintenance.)

2. Staff will be trained on procedures to follow in the event of a fire.
   a. In the event of a fire, never yell “Fire!” Be as calm as possible. Do not panic.
   b. Call 9-1-1. Report the fire, and provide the exact location of the fire(s). Or notify others nearby, and they can call 9-1-1 to report the fire so you can attend to emergency needs.
   c. Notify the person in charge who will alert other employees of the fire as needed.

3. Procedures to follow for different types of fires:
   a. Never put water on a grease fire.
   b. Small fires may be fought with fire extinguishers located in the kitchen. Do not fight the fire if it becomes dangerous to your safety.
   c. If a fire is large and uncontrolled and exists in range area or hoods, use overhead fire extinguishers.

4. Other food service employees are to turn off lights in storage areas and close storage area doors.
   a. The cook on duty will turn off all electrical and gas cooking equipment, ventilators and air conditioners.
   b. The supervisor or person in charge is the last person to leave the food service area. As he or she leaves, it is a good idea to take the posted schedule. This will serve as a reference for head count.
   c. After employees are in a safe area, supervisor will turn off main light switch and close all outside doors.

5. Stay Calm! Be ready to assist with evacuation if it becomes necessary.

©2013 Becky Dorner & Associates, Inc.

Fire Safety Rules

Policy:

All employees should be aware of rules to follow in a fire emergency.

Procedure:

1. In the event of a small fire, locate and use the nearest hand fire extinguisher.

2. If the fire is small and confined to a burner or a pan skillet fire, smother by covering with a pan lid or using baking soda.

3. DO NOT use water as a means of extinguishing any fire that involves grease.

4. Report the fire to the administrator or person in charge.

5. In the event that the fire is large, pull the nearest fire alarm box.

6. In the event that the fire is large, call the emergency number or the local fire department and report the fire. The following information should be given:
   - Name of facility
   - Address
   - Telephone number
   - Location of fire
   - Name of employee making the phone call and the department they represent

   Next, notify your supervisor who will notify other staff in the facility as appropriate.

7. When a fire breaks out, shut off all exhaust fans; turn off all gas and electrical equipment, and close all doors and windows in the dietary department.

8. In the event of extensive smoke, evacuate the kitchen and close all kitchen doors.

9. Food service personnel on duty during the occurrence of a fire shall assist in evacuating residents/patients from the dining room and other areas as directed.

©2013 Becky Dorner & Associates, Inc.

Resource: How to Contain Food Service Department Fires

1. Oven Fire
   a. Turn off gas or electric.
   b. Close oven door.
   c. If it is a small fire, use the fire extinguisher as needed.

2. Stove Fire
   a. Turn off gas or electric.
   b. Smother with a lid if the fire is contained to a pan.
   c. If it is a small fire, use the fire extinguisher as needed.
   d. Use range hood extinguisher if needed.

3. Electrical Equipment Fire
   a. Shut off the breaker.
   b. If it is a small fire, use the fire extinguisher as needed.

4. Trash Container Fire
   a. Smother with a lid if the fire is contained within a trash container.
   b. If it is a small fire, use the fire extinguisher as needed.

5. Clothing Fire
   a. Smother with an apron or blanket.
   b. **Stop** moving.
   c. **Drop** to ground or floor.
   d. **Roll** on the floor to smother the fire.
   e. Call emergency services for immediate medical attention.

6. Know the location and use of the:
   a. Fire extinguisher.
   b. Fire alarm pull station.
   c. Range hood extinguisher.
   d. Electrical breaker panel.
   e. Fire blanket.
   f. Phone for emergency calls.

Note: These procedures should be discussed with maintenance, safety officer and/or fire department and adjusted to reflect their input and the facility's procedures.

©2013 Becky Dorner & Associates, Inc.

Facility Specific Policy and Procedure for Fires

Insert your facility fire policy and procedure here.

©2013 Becky Dorner & Associates, Inc.

Resource: Emergency First Aid

For any of the following concerns, call the nursing staff or 911 immediately for assistance.

1. Burns
   a. Run under cold water.

2. Cuts
   a. Apply direct pressure to control bleeding.

3. Severed limb or digit
   a. Apply direct pressure to control bleeding of a stump.
   b. Place severed limb or digit on ice.

4. Falls
   a. Do not move.

5. Chemicals
   a. Proceed according to product label - be familiar with material safety data sheets (MSDS).
   b. Know where and how to use eye wash station if chemicals are in eyes and washing is appropriate according to MSDS sheets.

©2013 Becky Dorner & Associates, Inc.

Emergency Eye Wash

Policy:

If an eye wash station is available, all staff will be trained on its use.

Procedure:

1. If an eye wash station is available, all staff are inserviced at least upon orientation and yearly thereafter on:
   a. Location of the eye wash station.
   b. Operation of the eye wash station.
   c. Appropriate use of the eye wash.

2. Operation and use of the eye wash station is part of the departmental orientation for newly hired employees.

Note: Follow manufacturer's instructions for use of eye wash/eye wash station.

©2013 Becky Dorner & Associates, Inc.

Emergency Eye Wash

Insert a copy of your eye wash/station instructions here.

©2013 Becky Dorner & Associates, Inc.

Incident Report

Policy:

All accidents and incidents will be reported and documented.

Procedure:

1. Any accident or incident involving an injury that occurs in the kitchen or dining area should be reported to the food service manager.

2. The director of nurses or nursing staff may be contacted for necessary first aid.

3. Physicians or emergency services may be contacted as needed.

4. Thoroughly document the accident or incident on the appropriate facility form.

5. Any accident or incident should be reported whether an injury occurred or not, and provided to the appropriate person according to facility policy.

©2013 Becky Dorner & Associates, Inc.

Incident Report

Insert a copy of your facility's incident report here.

©2013 Becky Dorner & Associates, Inc.

Malfunctions and Repairs

Policy:

All malfunctions and repairs are reported to the food service manager and maintenance department.

Procedure:

1. When a piece of equipment malfunctions, the food service manager is notified.

2. The food service manager notifies the maintenance department by phone or in writing if needed, letting them know how quickly that piece of equipment is needed.

3. If repairs require outside help or the purchase of parts, this must be approved per facility policy.

©2013 Becky Dorner & Associates, Inc.

Malfunctions and Repairs

Insert a copy of your facility's maintenance work order here.

©2013 Becky Dorner & Associates, Inc.

Malfunctions and Repairs

Insert your facility's policy and procedure for repairs that involve use of companies outside of your facility here.

©2013 Becky Dorner & Associates, Inc.

Personnel/Training

♦ Personnel - General 7-1

♦ Food Service Supervision 7-2

Line of Authority 7-3

Staffing the Food Service Department 7-4

Interview Sample Questions 7-5

Employee Physical Sample Form 7-6

Mantoux Test Sample Form 7-8

Reference Check Sample Form 7-10

Employee Information Sample Form 7-12

♦ Training/Orientation 7-13

♦ Nursing Homes: Resident's Rights Training 7-15

♦ Hospitals: Patient's Rights Training 7-16

♦ Training/Orientation Sample Form 7-17

♦ Health Insurance Portability and Accountability Act of 1996 (HIPAA) 7-18

♦ Personal Hygiene Training 7-19

♦ Inservice Training 7-20

♦ Resource: Inservice Training 7-21

♦ Inservice Training Report Sample Form 7-22

♦ Inservice Sign In Sheet Sample Form 7-23

♦ Evaluating Food Service and Clinical Nutrition Personnel 7-24

♦ Employee Evaluation Forms 7-25

♦ Vacation/Leave Request Sample Form 7-26

♦ Employee Request for Leave Sample Form 7-27

©2013 Becky Dorner & Associates, Inc.

Personnel - General

Policy:

The food service department will be staffed to assure that sufficient, competent, supportive personnel carry out the functions of the food service department.

Procedure:

1. The food service department will have an adequate number of staff.
2. Food service staff will be on duty for a period of no less than 12 hours. A food service employee shall be present in the kitchen during hours of operation. (See Hours of Operation in the Food Production and Food Safety Section.)
3. A clearly written job description for each position will be on file in this policy and procedure manual.
4. Food service staff will be trained to perform assigned duties and will be expected to participate in inservice programs. These programs are to be conducted by the food service manager and/or designee.
5. Work schedules will be posted two weeks in advance. Weekly work schedules shall include all dietary personnel including management and/or professional staff.
6. Work schedules will be maintained on file for a minimum of one year.
7. A food service employee should not be assigned duties outside the department, except in an emergency. These duties must not interfere with the sanitation, safety, or time required for work assignments.
8. Meal and break times will be clearly stated on the work schedule. All exceptions need to be approved by the food service manager or designee.
9. Overtime hours must be preapproved by the food service manager or designee.

©2013 Becky Dorner & Associates, Inc.

Food Service Supervision

Policy:

The food service manager is responsible for the safe, sanitary, economical, and nutritional operation of the food service department.

Procedure:

1. The food service manager is hired by the administrator, or the food service manager's immediate supervisor.

2. The food service manager is qualified according to the position's job description.

3. The food service manager carries out his or her duties according to the job description and work schedule (list of duties).

4. The food service manager or designee is considered the immediate supervisor of the cooks and other food service.

5. The food service manager cooperates with other department heads and other professionals for the health and welfare of the residents/patients.

6. The food service manager should participate in:
    - Regular meetings with the administrator
    - Regular meetings with the food service staff
    - Department head meetings
    - Care plan meetings as appropriate
    - Infection control committee meetings and activities
    - Regular meetings with the registered dietitian or designee

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Line of Authority

Policy:

When the food service manager is not available, temporary management of the food service department is assigned in the following order:

1. Assistant food service manager
2. Head cook
3. Cook

Procedure:

1. In the absence of the food service manager, the next available staff member is in charge of the kitchen per shift assigned.

2. When another person acts as food service manager, he or she is responsible for performing his or her usual duties as well as:
   - Inserting new or temporary meal identification (ID) cards/tickets for new or readmitted residents/patients.
   - Completing diet changes to assure that all residents/patients receive their diets as ordered.
   - Supervising meal preparation and service.
   - Placing orders for food supplies.
   - Rescheduling staff as needed.
   - Assuring safe and sanitary service and clean-up.
   - Assuring accuracy of therapeutic diets
   - Assuring timeliness of meal service
   - Managing disciplinary problems.
   - Contacting the administrator or assigned representative in their absence in cases of emergency that the cook is not authorized to handle.

3. The food service manager has the responsibility of being prepared and up-to-date prior to his or her planned absence (i.e., scheduling of staff, planning food/beverage orders, completing scheduled nutrition care documentation, reviewing menus and preparation with the staff, as well as other routinely scheduled supervisory duties).

4. In the food service manager's absence, the temporary manager does not hire, discipline, or fire. Temporary managers do not chart in the permanent medical record or participate in care plan meetings unless trained to do so.

5. In the food service manager's absence, the temporary managers confer with the administrator and registered dietitian (RD) or designee, plan and prepare food orders, record food preferences, and make note of other pertinent information for the food service manager to follow-up on upon his or her return.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Staffing the Food Service Department

Policy:

The food service manager is responsible for hiring and scheduling food service staff, with recommendation, consultation and direction from the administrator.

Procedure:

1. Open position advertisements are placed with the assistance of the personnel director or administrator.

2. Applications are reviewed.

3. Interviews are scheduled by the food service manager. (See sample interview questions.)

4. All proper hiring procedures are followed as outlined by facility policy. This may include, but is not limited to:
   - Background check
   - Mantoux screening
   - Reference check
   - Physical exam

   (Insert appropriate forms or policies on the following pages.)

5. The most qualified applicants are hired by the food service manager, with input from administration as appropriate.

6. Schedules are completed by the food service manager for a minimum of two weeks at a time.

©2013 Becky Dorner & Associates, Inc.

Interview Sample Questions

Interviewee name: ________________________ Position applied for: ___________________

Interview conducted by: ___________________________________ Date: _______________

1. Why do you want to work as a _________________?

2. What are your long-term work goals?

3. What unique skills or qualities can you offer our department? (What are your greatest strengths?

4. What do you consider to be your greatest weaknesses?

5. What motivates you to put forth your greatest effort?

6. Describe the qualities of your ideal supervisor. Can you tell me about a supervisor who had these qualities and how it made for a good working environment?

7. Why do you qualify for this position? (Ask specific questions related to the job such as cooking abilities, ability to run certain equipment, etc.)

8. What do you want from this job that is lacking in your present job?

9. Describe a situation when you had several deadlines to meet, and explain how you handled it.

10. Describe a time when the quality of your work was not up to standards. Explain what happened and how you handled the situation.

11. Describe a situation when you had to respond to a customer request or complaint.

12. Why do you want to make a job change?

13. What are your salary expectations? Benefits?

14. What is your availability? (Current job notice, etc.)

©2013 Becky Dorner & Associates, Inc.

Employee Physical Sample Form

Name ______________________________________ **Age** __________ **Gender** __________

Allergies ____

Illnesses ____

Medications ____

Smoking __________________ Alcohol ___________________ Drugs ___________________

Weight ______lbs Height ______ BP _______ Pulse ______ Hearing (L) ______ (R) ______

HEENT: NL/ABN ____ Bruits: Yes / No

Lymph nodes: Cervial _______________ Axilary ______________ Inguinal ______________

Lungs: Clear/ABN ____

Heart: RR w/o M, G, R/ABN ____

Abdomen: NL/ABN ____

Extremities: NL/ABN ____

Peripheral Pulses: Carotids __________ Femorals _________ Dorsal Pedals ____________

Genitalia: NL/ABN ______________________________________ Hernia: Absent / Present

Neurologic: Pupils ERL/ABN EOM's Intact / ABN Cranial Nerves Intact / ABN

Sensory Intact / ABN _______________ Motor Intact / ABN ____________________

DTR's NL / ABN Romberg NL / ABN Mental Status NL / ABN

Assessment ____

____

____

____

____

____

Date _______________ **Physician** ____

©2013 Becky Dorner & Associates, Inc.

Employee Physical Form

Insert your physical form here.

©2013 Becky Dorner & Associates, Inc.

Mantoux Test Sample Form

Name ____

Date Given ____________________ Signature ______________________________

Date Read _____________________ Signature ______________________________
(48 hours after dose)

(+) Significant:	___________________	10 mm or greater
Inconclusive:	___________________	5 to 9 mm
(-) Non-significant:	___________________	0 to 4 mm

Date Given __________________ Signature ______________________________
(7 days after first dose if negative reading)

Date Read ___________________ Signature:_____________________________
(48 hours after dose)

(+) Significant:	___________________	10 mm or greater
Inconclusive:	___________________	5 to 9 mm
(-) Non-significant:	___________________	0 to 4 mm

©2013 Becky Dorner & Associates, Inc.

Mantoux Test Form

Insert your Mantoux test form here.

©2013 Becky Dorner & Associates, Inc.

Reference Check Sample Form

For ____

Name of Reference _________________________________ Date _____________

1. Would you re-hire this person?

2. What type of performance did they have?

   Excellent Good Fair Poor

3. Did they interact well with:

   - Other staff members? Yes/No
   - Supervisors? Yes/No

4. If you had any suggestion for improvement, what would they be?

5. Was this person dependable? Yes/No

6. Were there any concerns that you can tell me regarding this person's employment?

Signature/Title ______________________________________ Date ____________

©2013 Becky Dorner & Associates, Inc.

Reference Check

Insert your reference check form here.

©2013 Becky Dorner & Associates, Inc.

Employee Information Sample Form

Employee Name ________________________________ Phone ____/ ____________________

Date of Birth ___________________________________ Hire Date _______________________

Home Address ____

___________________/ _________________________/ ___________________/ ____________

City County State Zip

Pertinent Medical Information ____

____

Person to Contact in Case of Emergency:

1) Name Phone

____ _____/ ________________________

Address

____

____

2) Name Phone

____ _____/ ________________________

Address

____

____

Physician Name Phone

____ _____/ ________________________

Address

____

____

Hospital Preference ____

©2013 Becky Dorner & Associates, Inc.

Training/Orientation

Policy:

All staff involved in food service are adequately trained to perform assigned duties and are required to participate in regularly scheduled inservice training sessions. Upon completion of initial training, each employee will be trained in all food service areas that are related to the job. The food service manager is responsible for orientation and training of new staff.

Procedure:

Train staff on the following: (For nursing homes, include a thorough review of resident's rights; and for hospitals, include a thorough review of patient's rights.)

1. **Overview of Food Service**
   Goal: To introduce dietary work and the general responsibilities of the employee.
   - Organization charts
   - Job descriptions
   - Reference materials (menus, recipes, diet/nutrition care manual, policy manual, etc.)
   - Records
   - Communication with other departments
   - Customer service training
   - Waiter/waitress/hostess training if applicable
   - Meal service training
   - Health Insurance Portability and Accountability Act (HIPAA)

2. **Introduction to Food Service**
   Goal: To give proper procedures for maintaining an efficient operation, practicing mechanical safety, and performing general cleaning.
   - Purchasing
   - Receiving
   - Storing
   - Equipment
   - Cleaning

3. **Sanitation**
   Goal: To impress the importance of maintaining a high degree of cleanliness. To give specific information on food protection, care and cleaning of dishes and equipment.
   - Personal hygiene
   - Equipment
   - Pest control
   - Dishwashing – machine pot and pan washing
   - Cleaning schedules and procedures
   - Infection control
   - Facility pets (not allowed in food service/storage areas or in dining areas during meal times)

4. **Safety**
   Goal: To give rules and guidelines for safety.
   - General safety guidelines
   - Material safety data sheets (MSDS) for chemical products in use in the department
   - Knife skills and safety
   - Equipment safety

©2013 Becky Dorner & Associates, Inc.

- Fire safety
- Emergency plans

5. **Food Preparation and Food Safety**
   Goal: To teach methods of hot and cold food preparation.
   - Hot foods and cold foods
   - Methods of cooking
   - Food safety/Preventing foodborne illness
   - Temperature protection (internal cooking temperatures, holding, storage, reheating and cooling temperatures)

6. **Standard Measurements**
   Goal: To provide standards of food preparation and service.
   - Standardized recipes
   - Weights and measures
   - Tools and utensils
   - Portion control
   - Tasting and temperature testing

7. **Nutrition**
   Goal: To provide basic information about the importance of nutrition, the function of food, and the results of deficiency.
   - Basic nutrition and malnutrition
   - Role of vitamins, minerals, protein, carbohydrate, fat, and water
   - Food habits and needs: evaluating eating habits

8. **Therapeutic Diets**
   Goal: To give information on the types of menus and therapeutic diets offered.
   - Diet/nutrition care manual
   - Review of basic therapeutic diets
   - Review menus and recipes
   - Menu extensions for therapeutic diets
   - Meal identification (ID) cards/tickets
   - Review of therapeutic diets offered
   - Consistency modifications

9. **Review of Policies and Procedures**
   Goal: To provide a basic overview of the department’s policies and procedures.
   - Documentation in the food service department
   - Menus and therapeutic diets
   - Meal service
   - Sanitation and infection control
   - Cleaning instructions
   - Food production
   - Food safety
   - Personnel/training
   - Quality assurance

(See Training/Orientation Documentation Form to record each new employee’s training.)

©2013 Becky Dorner & Associates, Inc.

Nursing Homes: Resident's Rights Training

Policy:

All staff working in Nursing Homes will be made aware of Resident's Rights.

Resources:

- Information from CMS: http://www.medicare.gov/nursing/residentrights.asp
- Sample Nursing Home Resident Bill of Rights: http://www.amerilawyer.com/nh_bill_of_rights.htm

Insert a copy of your nursing home Nursing Home Resident's Rights Document here.

©2013 Becky Dorner & Associates, Inc.

Hospitals: Patient's Rights Training

Policy:

All staff working in the Hospital System will be made aware of Patient's Rights.

Note: The American Hospital Association (AHA) has changed from Patient's Rights to "The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities". For more information visit AHA's website at http://www.aha.org/aha/issues/Communicating-With-Patients/pt-care-partnership.html.

Insert a copy of your hospital's patient's rights information.

©2013 Becky Dorner & Associates, Inc.

Training/Orientation Sample Form

Name ________________________ Position __________________ Date of Hire ____ _ _____

Subject	Date	Instructor Initials	Employee Initials	Review Date	Instructor Initials	Employee Initials
Resident's or Patient's Rights						
Overview of Food Service						
Introduction to Food Service						
Sanitation						
Safety						
Food Preparation						
Standard Measurements						
Nutrition						
Therapeutic Diets						
Review of Policies and Procedures						

I have been oriented to the department, and the subjects listed above have been explained to me.

______________________________ ____________ ________________________________

Employee Signature Date Food Service Manager's Signature

©2013 Becky Dorner & Associates, Inc.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Policy:

The food service and nutrition department will abide by policies and procedures to maintain HIPAA compliance. The department staff will keep confidential all health information collected to deliver care and services to maintain acceptable parameters of nutritional health.

Procedure:

1. All new food and nutrition department staff will obtain training or pertinent HIPAA information during their orientation.

2. All current food and nutrition department staff will be in-serviced on HIPAA compliance upon hiring and no less than yearly.

3. The food and nutrition department staff will collect data from the individual's medical record to maintain acceptable parameters of nutritional health. This may include height, weight, age, diet order, diagnosis, laboratory values, food and fluid intake records, medical history, nutritional history, food preferences, cultural preferences, and interdepartmental documentation.

4. Protected health information will be kept confidential by department staff as required by HIPAA.

5. Meal identification (ID) cards/tickets that require protected health information to provide physician ordered diets will be held and updated by the department and destroyed as needed per HIPAA policy.

6. No dietary employee will utilize any protected health information for any purpose other than the provision of nutrition care and food service.

7. The food and nutrition department will follow all procedures for HIPAA compliance.

©2013 Becky Dorner & Associates, Inc.

Personal Hygiene Training

Policy

All dietary employees will be trained on personal hygiene.

Procedure

1. Wear clean clothing and apron daily.

2. Jeans, street clothes, shorts, tank tops and other sleeveless apparel is not permitted. “Casual days” are not an exception.

3. Wear comfortable, leather or leather-like closed-toe shoes with non-slick soles at all times while on duty.

4. Keep hair neat and clean. Wear a hair restraint when around exposed foods, in the kitchen or food service areas including dining areas.

5. Keep beards and mustaches closely cropped and neatly trimmed. When around exposed foods, keep beards restrained.

6. Keep fingernails clean, trimmed. Wear gloves if nail polish is used.

7. Jewelry shall be kept to a minimum, such as small earrings, wedding band and watch.

8. Store street clothing, coats, purses, packages, and other personal effects in employee lockers and not in the kitchen.

9. Wash hands in the sink designated for employee hand washing. Refer to the handwashing policy for more information.

10. Do not report to work if ill. Call in and explain the nature of your illness and the length of time expected to be absent. A medical note is needed to return to work, for the following conditions:
    Shigellosis
    Hepatitis A
    Norovirus
    Hemorrhagic Colitis (E. Coli)
    Salmonellosis
    Fever and sore throat
    Diarrhea lasting over 24 hours
    Vomiting lasting over 24 hours

I have received a copy of the personal hygiene requirements and understand what is expected of me.

______________________________________ ____________________
Signature Date

Adapted with permission from Nutrition Alliance, LLC.

©2013 Becky Dorner & Associates, Inc.

Inservice Training

Policy:

Inservice training will be offered on a regular basis to update employees' knowledge.

Procedure:

1. A yearly inservice schedule should be developed so that employees receive training on a regular basis.

2. Employees will be notified of the inservice at least one week in advance.

3. Inservicing will cover a range of topics, including, but not limited to:
   - Documentation in the food service department
   - Menus and therapeutic diets
   - Meal service
   - Sanitation and infection control
   - Cleaning instructions
   - Emergency meal plan
   - Food production (including maintenance of equipment)
   - Food safety (including food temperature records from the tray line, refrigerator/freezer temperature records, dishwasher records and infection control procedures especially related to potential food borne illness outbreaks)
   - Personnel/training
   - Safety
   - Quality assurance
   - Survey readiness

   (Also see Sample Inservice Topics in this section)

4. Mandatory inservices will also be scheduled to cover the following topics:
   - Fire/Disaster Preparedness (including natural emergencies, such as flooding, hurricanes, tornadoes)
   - Residents'/Patients' Rights
   - Infection Control
   - Material Safety Data Sheets (MSDS)
   - Health Insurance Portability and Accountability Act of 1996 (HIPAA)

5. All employees attending the inservice must sign the attendance sheet, which is completed by the person conducting the inservice. (See Inservice Sign in Sheet Sample Form in this section.)

6. Records of each inservice will be kept on file for a period of 3 years.

7. Records of inservice attendance should be kept for each employee in their employee file. (See Inservice Training Sample Report Form in this section.)

©2013 Becky Dorner & Associates, Inc.

Resource: Inservice Training

Introduction
- Organizational charts
- Employee policy manual
- Job descriptions
- References
- Records
- Communication with nursing department
- Residents'/Patients' Rights**
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- Survey preparedness*

Sanitation
- Infection control**
- Personal hygiene/hand washing*
- Equipment
- Food safety*
- Food preparation
- Prevention of food borne diseases
- Pest control
- Dishwashing - hand and machine
- Pot and pan washing
- Facility pets*

Safety
- General safety guidelines
- Fire safety and procedures**
- Disaster plan**
- Material safety data sheets**
- Knife safety
- Equipment safety

Nutrition
- Basic nutrition
- Food and it's role in health
- Role of vitamins, minerals, protein, carbohydrates, fat and water
- Malnutrition
- Geriatric food habits and needs
- Evaluating eating habits

Therapeutic Diets
- Diet manual
- Review of special diets*
- Menus/standardized recipes*
- Kardex or computer system
- Tray cards
- Consistency altered diets

Introduction to Food Service
- Purchasing
- Receiving
- Storing
- Equipment
- Operating equipment
- Cleaning equipment
- Motion economy

Standard Measures
- Weights and measures
- Tools and utensils
- Portion control*
- Tasting and temperature testing
- Cost control*

Food Preparation
- Meats, fish, poultry
- Salads/vegetables
- Sandwiches
- Juices
- Desserts/fruits
- Methods of cooking
- Temperature protection

Survey Readiness
- Survey process*
- Survey questions and responses*
- Common food service deficiencies*

**Mandatory Annual Inservices
*Recommended Annually

©2013 Becky Dorner & Associates, Inc.

Inservice Training Report Sample Form

Department: ____

Date: ____________________ Time: ____________________

Employee Group(s) Present: __________________________________

Total Number of Employees in Group: ____________________________

Number Present: ______________ Number Not Present: ______________

Method of Presentation: ____________________________________

Subject(s) Covered:

____

____

____

____

____

____

____

____

Recommendations/Follow-Up:

____

____

____

____

____

____

____

____

____

____

____
Conducted by

____
Title

©2013 Becky Dorner & Associates, Inc.

Inservice Sign in Sheet Sample Form

Date:_____________ Time:_________ Inservice Title: ___________________________________

Name	Title/Position	Shift

©2013 Becky Dorner & Associates, Inc.

Evaluating Food Service and Clinical Nutrition Personnel

Policy:

Periodic written evaluations for food service staff are completed by the food service manager. Clinical staff should be evaluated using a competency based assessment. The registered dietitian (RD) should evaluate nutrition support staff, and the RD should be evaluated by an appropriate supervisor or peer.

Procedure:

Food Service Personnel:

1. The first evaluation should be done at the end of 30 days, the second at the end of 60 days, and the third at the end of the probationary period, 90 days.

2. Subsequent evaluations should be done at least annually.

3. Competency based evaluations are recommended. All evaluations should include a list of suggestions for improvement, education resources for action, and recommended completion dates.

4. The food service manager should review evaluations with the administrator.

5. The food service manager then reviews the evaluation with the employee.

6. A copy of the evaluation should be given to the employee and the original should be placed in the employee's file.

Clinical Staff:

1. The registered dietitian (RD) will perform the nutrition support staff's first evaluation at the end of 30 days after hiring, the second at the end of 60 days, and the third at the end of the probationary period, 90 days.

2. Subsequent evaluations should be done at least annually.

3. The RD uses guidance from the Academy of Nutrition and Dietetics Scope of Practice and Standards of Professional Performance to assess competency of the nutrition support staff.

4. The RD uses guidance from the Association of Nutrition and Food Service Professionals Scope of Practice to assess the competency of the certified dietary manager (CDM).

5. Competency based evaluations are recommended. All evaluations should include a list of suggestions for improvement, education resources for action, and recommended completion dates.

6. The RD should share evaluation with administration as appropriate and/or per facility policy.

7. A copy of the evaluation should be given to the employee and the original should be placed in the employee's file.

©2013 Becky Dorner & Associates, Inc.

Employee Evaluation Forms

Insert your employee evaluation forms and employee coaching or discipline forms here.

©2013 Becky Dorner & Associates, Inc.

Vacation/Leave Request Sample Form

Employee ________________________________ Request Date _____________

Position _________________________________

This is for vacation (4) _______________ Leave of absence (4) _______________

1. Date(s) Requested:

   From _____________________________ to ______________________________

2. Alternate Dates Acceptable:

   From _____________________________ to ______________________________

   From _____________________________ to ______________________________

3. Reasons (for leave of absence):

   ____

   ____

   ____

   ____

4. Comments:

   ____

   ____

   ____

   ____

____
Employee

____ Date _____________________
Approved by

Supervisor: Please send copy of approved request to payroll.

©2013 Becky Dorner & Associates, Inc.

Employee Request for Leave Sample Form

Name____ Date _______________________

I request the following time off:

Type **Date(s)**

Vacation ____

Other ____

Approved ____ Date ________________________

Name____ Date _______________________

I request the following time off:

Type **Date(s)**

Vacation ____

Other ____

Approved ____ Date ________________________

©2013 Becky Dorner & Associates, Inc.

Employee Request for Leave Form

Insert your vacation and leave request forms here.

©2013 Becky Dorner & Associates, Inc.

Clinical Documentation

- Right to Deviate from Clinical Policy and Procedure 8-1
- Philosophy and Standards of Clinical Care 8-2
- Documenting in the Medical Record 8-3
- Diet History 8-4
- Food Preferences Sample Form 8-5
- Alternates for Food Dislikes 8-6
- System for Recording Food Preferences 8-7
- Recording Food Preferences 8-8
- Recording Percent of Meal Consumed 8-9
- Alternate Meal Recording System 8-10
- Food Intake Record/Total Meal Percentage Sample Form 8-11
- Food Intake Record/Point System Sample Form 8-12
- Food Intake Record 8-13
- Nutrient Intake Study 8-14
- Food Intake Study Sample Form 8-15
- Individuals Who Do Not Drink Milk 8-16
- Nutrition Screening for Referrals to the Registered Dietitian 8-17
- Referrals for Registered Dietitian Sample Form 1 8-19
- Referrals for Registered Dietitian Sample Form 2 8-20
- Nutrition Screening Sample Form 8-21
- Letter to Physician Sample Form 8-22
- MNA Physician Communication Mini Nutritional Assessment Report for Malnutrition 8-23
- Medical Nutrition Therapy Documentation 8-24
- Comprehensive Medical Nutrition Therapy Assessment 8-28

©2013 Becky Dorner & Associates, Inc.

Clinical Documentation

- ♦ Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment 8-31
- ♦ Comprehensive Care Plan 8-34
- ♦ Resource: Weight-Related Nutrition Interventions 8-36
- ♦ Medical Nutrition Therapy Documentation Forms (Hospital) 8-39
- ♦ Nutrition Care Process Medical Nutrition Therapy Assessment Forms
  - Medical Nutriton Therapy Abbreviations 8-40
  - Medical Nutrition Therapy Assessment Sample Form 8-41
  - Medical Nutrition Therapy Notes Sample Form 8-42
  - Worksheet for MDS 3.0 Section K Swallowing/Nutrition Status Sample Form 8-43
  - Medical Nutrition Therapy Re-Assessment Sample Form 8-44
  - Medical Nutriton Therapy Care Plan Sample Form 8-45
- ♦ Medical Nutrition Therapy Documentation Forms 8-46
- ♦ Medical Nutrition Therapy Recommendations 8-47
- ♦ Nutrition Recommendations Sample Form 8-48
- ♦ Communication of Nutritional Concerns 8-49

Note: Also see sample job descriptions and competency evaluations available from Becky Dorner & Associates, Inc. at www.beckydorner.com.

©2013 Becky Dorner & Associates, Inc.

Right to Deviate from Clinical Policy and Procedure

These policies and procedures represent the expected standard of practice for medical nutrition therapy services. These policies and procedures are based on industry wide standards of practice. Some cases will fall outside of standard policy and procedure and will need to be addressed as deviations from the policy and procedure. The registered dietitian (RD) has the right to deviate from policy and procedure when warranted due to changes in practice standards, new evidence based research or other circumstances that warrant professional judgment.

Note: Physician's orders must be followed according to state and federal law. The RD may request recommended changes to physician orders as appropriate.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Philosophy and Standards of Clinical Care

Policy:

Medical nutrition therapy (MNT) is defined and supported by well known and current standards of practice. Current standards of practice are based on evidence-based research where available or upon expert consensus if evidence is not available. Standards of practice are found in current manuals, textbooks or publications that are accepted, adopted or promulgated by recognized professional organizations or national accrediting bodies such as the Academy of Nutrition and Dietetics.

Procedure:

Medical nutrition therapy (MNT) is provided based on current standards of practice, evidence based research and clinical outcome studies. The registered dietitian (RD) and designees will follow accepted standards of clinical practice which include:

1. Compliance with federal, state, local regulations and/or Joint Commission standards as applicable.

2. All MNT care is documented in the medical record in accordance with facility policy. Timely and periodic assessments of individuals' nutritional status and needs will be completed.

3. The RD or designee will:
   - Assess the nutrition status of all referrals, and for any individuals who are identified "at risk".
   - Communicate to the health care team any information that impacts care.
   - Participate in quality assurance and performance improvement efforts related to MNT care.
   - Provide education/guidance per physician order and/or as deemed appropriate by the RD or designee including those being discharged.
   - Function as a nutrition educator and resource to individuals and their families, the medical and nursing staff, food service and other facility staff, students and community organizations as appropriate.
   - Provide input to assure compliance to standards in nutrition care.
   - Provide input to assure compliance to standards in food purchasing, food production, food safety and food service as appropriate.

4. The facility staff will take a systematic approach to optimize the individual's nutritional status. The RD will:
   - Participate in the nutrition care process: nutrition assessment, nutrition diagnosis, nutrition intervention, nutrition monitoring and evaluation.
   - Identify and assess each individual's nutrition status and risk factors.
   - Evaluate and analyze the assessment information for nutrition diagnosis as appropriate.
   - Develop and consistently implement pertinent food and nutrition interventions.
   - Monitor and evaluate the effectiveness of nutrition interventions and revise them as necessary.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified detary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Documenting in the Medical Record

Policy:

All information regarding medical nutrition care (MNT) will be documented in the individual's medical record utilizing an accepted form of documentation.

Procedure:

The registered dietitian (RD) or designee shall:

1. Document all pertinent information regarding medical nutrition therapy (MNT) in the medical record: screening information, assessments, progress notes and/or care plans.

2. Document each event as soon as possible after its occurrence.

3. Sign all entries with name and professional qualifications.

4. Date (and record the time, if appropriate) of the documentation.

5. Implement and utilize validated or proven nutrition screening tools and MNT assessment and reassessment forms. Progress notes may be used for intermittent documentation as needed. The care plan is based on the facility system, and follows state and federal regulations and Joint Commission Standards as applicable.

6. If an error is made in the medical record, follow the facility policy on correcting errors. The appropriate information will then be recorded for correction. (Example: One line is drawn through the incorrect statement. Above the line, the entry is initialed and dated. The correct information is documented, signed and dated.)

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Diet History

Policy:

Information will be gathered upon admission to inform the food service department of the individual's food preferences and diet history.

Procedure:

1. Upon admission and periodically as needed, the food service manager or designee will interview the individual for the following information using the Food Preferences Form (Sample form on the following page):
   - Understanding and acceptance of the diet order
   - Food preferences, intolerances, allergies
   - Cultural and/or religious preferences
   - Location where the meals are to be served
   - Preferred portion sizes for each meal
   - Select menu preference (if applicable)
   - Beverage preferences

2. When interviewing an individual for food preferences, the food service manager or designee will offer the names of foods as needed (some individuals may have a difficult time with open ended questions). The Food Preferences Sample Form on the following page provides a good guideline to follow:

3. A Food Preferences Form may be distributed to the family or significant other upon admission.

4. Each individual will be visited by the food service manager or designee for a personal interview to obtain food preferences within 48 to 72 hours of admission.

5. The information is kept on file in the food service department and used to assure that each individual's needs and desires for food are met.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Food Preferences Sample Form

Name ____________________________ Admission Date______________________________

Diet Order ______________________ Food Allergies/Intolerances_________________________

Meal Location Room: B L D Dining Room: B L D Preferred Portions: Lg Avg Sm

Is food available from outside sources? Yes No Source:____________________________

Would you like a select menu? Yes No

Beverage Preference (Circle)

Breakfast	Juice	Milk	Coffee	Reg/Decaf	Hot Tea	Reg/Decaf	Water	Soda Pop	Iced Tea
Lunch	Juice	Milk	Coffee	Reg/Decaf	Hot Tea	Reg/Decaf	Water	Soda Pop	Iced Tea
Dinner	Juice	Milk	Coffee	Reg/Decaf	Hot Tea	Reg/Decaf	Water	Soda Pop	Iced Tea

Food Dislikes (Circle)

Meat/Substitutes	Vegetables	Fruits	Starches	Cereal
Bacon Beef Liver Beef Patty Cheese Chicken Chicken Liver Chili Cottage Cheese Eggs Enchiladas Fish Ground Beef Ham Lamb Luncheon Meat Nuts Pork Loin Pork Chop Roast Sausage Link Sausage Patty Shellfish Shrimp Soy Burgers Tofu Tuna Turkey	Beets Broccoli Brussels Sprouts Cabbage Carrots Corn Coleslaw Green Beans Green Peas Greens Lettuce Lima Beans Okra Onions Peas Sauerkraut Spinach Tomatoes Yellow Squash Wax Beans Zucchini **Soups** Bean Beef Noodle/Veg. Broth Lentil Potato Split Pea Tomato Vegetable Cream Soups	Apples Applesauce Apricots Bananas Cantaloupe Grapefruit Mango Oranges Papaya Peaches Pears Pineapple Plums Prunes Tangerines Watermelon **Juices** Apple Cranberry Grape Grapefruit Orange Prune Tomato Vegetable **Spicy Foods** Chili Sauce Tacos Tomato Sauce	Baked Beans Black-eyed Peas French Fries Lima Beans Macaroni Mashed Potatoes Navy Beans Noodles Pancakes Pinto Beans Potatoes Rice Sweet Potatoes Tator Tots Waffles **Bread** Bagels Biscuits Cornbread Crackers Coffee Cake Muffins Pancakes Pita Bread Raisin Bread Rolls Rye Bread Toast Tortillas Wheat Bread White Bread	Cream of Wheat Grits Malt-O-Meal Oatmeal Dry Cereal: **Milk/Dairy** 1% 2% Skim Whole Buttermilk Chocolate Milk Kefir Rice Milk Soymilk Yogurt **Desserts** Cakes Cookies Fruit Crisp Gelatin Ice Cream Pudding Pie Sherbet

Special meal preferences or pattern if different from menu (including cultural/religious preferences):

©2013 Becky Dorner & Associates, Inc.

Alternates for Food Dislikes

Policy:

Appropriate alternate foods will be prepared and substituted for food dislikes, allergies and/or intolerances.

Procedure:

1. Individual food preferences, allergies and/or intolerances are obtained upon admission, and updated as needed.

2. The food service manager or designee is responsible for planning, ordering and scheduling the preparation of appropriate alternate foods to replace food dislikes, allergies or intolerances.

3. The food service manager is responsible for recording planned alternates on the menu extension sheets and for notifying the food service staff for production counts.

4. Menu alternates should be planned in advance and posted with the menu for each meal.

5. The food service staff is responsible for preparing and serving the alternates, and recording them as appropriate.

6. The food service staff will use the menu substitution lists as a guideline for appropriate, nutritionally balanced substitutions. Examples of appropriate alternates include:
   - Substituting another meat or protein food for disliked meat or protein food
   - Substituting another vegetable, fruit, or juice in place of disliked vegetable or fruit

7. If a majority of individuals dislike a certain food item as noted by plate waste studies, it should be removed from the regular menu.

Note: Plan carefully to avoid alternates that may be disliked by the majority of people and to avoid preparing the same foods for multiple meals in a row.

©2013 Becky Dorner & Associates, Inc.

System for Recording Food Preferences

Policy:

Food preference notes may be kept on file, recorded on the meal identification (ID) card/ticket, or may be computerized.

Procedure:

For meal identification cards:

1. Note the food preferences on the individual's meal ID card/ticket.
2. Utilize the meal ID cards/tickets for production counts of food substitutions as appropriate.
3. File the meal ID cards/tickets by unit and room number.
4. Review the meal ID cards/tickets as needed each day and use for food production and meal service.
5. Update the meal ID cards/tickets on a daily or as needed basis.

By Computer:

Follow the general guidelines above and also:

1. Computer files are updated upon admission, readmission, or upon learning of new or changed information.
2. Follow directions according to the computer software manual.

Maintaining Records:

When possible, documentation of food preferences should be maintained on file for at least one year (paper or electronic as appropriate).

©2013 Becky Dorner & Associates, Inc.

Recording Food Preferences

Insert a sample of your food preference form and/or meal identification (ID) card here if applicable.

©2013 Becky Dorner & Associates, Inc.

Recording Percent of Meal Consumed

Policy:

Staff will document the percentage of each meal consumed for each individual on a daily basis. The registered dietitian (RD) or designee will provide the form to be used, and specify how the data is to be kept. (See Food Intake Record/Total Meal Percentage Sample Form.)

Procedure:

The documentation of a total meal will be based on basic food groups: milk, meat, fruit and vegetables, and grains.

0% Consumption of **no** basic food items or bites only (but less then 25%).

25% Consumption of **1/4** of all items on the tray and/or all of one of the basic four items.

50% Consumption of **1/2** of all of the items on the tray and/or all of two of the basic four items.

75% Consumption of **3/4** of all of the items on the tray and/or all of three of the basic four items.

100% Consumption of **total tray** and all of the food basic groups.

Note: There are numerous systems for documenting food and fluid intake. This is just one example. An alternate system is provided on the next page.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Alternate Meal Recording System

Policy:

Staff will utilize the food intake percentage system as designated by the registered dietitian (RD). The point system for recording meal intake percentages may be used as an alternative to the total meal intake percentage system previously described. (See Food Intake Record – Point System Sample Form.)

Procedure:

1. Staff will be trained to utilize the following food intake percentage system:

   Point System:
   Each food item served = 1 point
   ¾ of a food item = 1 point
   ½ of a food item = 0.5 points
   ¼ of a food item = 0 points

   Liquid Measurements:
   8 ounce Cup = 240 mL
   6 ounce Cup = 180 mL
   4 ounce Cup = 120 mL
   1 ounce Cup = 30 mL

   Ex. Breakfast:
   Juice, cereal, milk, bread butter, coffee = offers a total of 4 Points

   Consumes all 4 items = 100%.
   Consumes 2 of 4 items = 50%.

   Total points consumed X100. Divide by number of points for that meal.

   Ex. 3 points consumed divided by 4 points provided = 75%

2. Intake percentage will be recorded directly on the form provided. (See Food Intake Record/Point System Sample Form.)

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Food Intake Record/Total Meal Percentage Sample Form

		Breakfast						Lunch						PM Snack						Dinner						H.S. Snack							
Rm	Name	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	Total Fluid mLs	Comments

0%	- Refused
25%	- Poor
50%	- Fair
75%-100%	- Good

Comments can include meal replacement, preferences, etc.

A = Accepted
R = Refused

©2013 Becky Dorner & Associates, Inc.

Food Intake Record/Point System Sample Form

Date ____________________

		Breakfast	Fluids	Lunch	Fluids	2:00pm	Fluids	Dinner	Fluids	HS	Fluids
Rm	Name	Points	mLs	Points	mLs	Points	mLs	Points	mLs	Points	mLs

©2013 Becky Dorner & Associates, Inc.

Food Intake Record

Insert a sample of your food intake record here if applicable.

©2013 Becky Dorner & Associates, Inc.

Nutrient Intake Study

Policy:

Staff will conduct individual nutrient intake studies as deemed necessary by the registered dietitian (RD) or designee, the interdisciplinary team, or as ordered by the physician. The RD will provide the form and the study will be conducted for 3 to 7 days or as ordered. Individuals identified to have a poor food/fluid intake or those at risk for development of unintended weight loss, undernutrition, dehydration, or pressure ulcers may be candidates for a nutrient intake study.

Procedure:

1. The RD or designee provides the appropriate number of forms for the number of days the nutrient study is to be conducted. The RD or designee writes in the food items and amounts served in the appropriate column and provides the forms to the staff who will record the actual intake study.

2. Staff observes the individual's food/fluid intake at each meal, and checks the percentage of each food/fluid item consumed at each meal and snack.

3. If a **small** amount (1/4) of the food was eaten, record **25%**.
   If **half** of the food item (1/2) was eaten, record **50%**.
   If **almost all** (3/4) of the food item was eaten, record **75%**.
   If the **entire** (all) food item was eaten, record **100%**.
   If very little (none) of the food was consumed or if the food was **refused**, record **0**.

   Sample:

   Lunch

Food Item and Amount Served	Amount Eaten	Initials
3/4 c Macaroni and Cheese	50%	JM
2 oz Sausage Patty	75%	
1/2 c Stewed Tomatoes	100%	
1/1 Bread and Butter	25%	
1/2 c Milk	0	

   2:00 Snack or Supplement

1/2 c Pudding	100%	JM
1/2 c Milk	50%	

4. Staff submits the completed form to the RD or designee for evaluation.

5. The RD or designee calculates the number of calories and protein (and fluids if appropriate) consumed, and documents in the medical record accordingly. Specific interventions will be determined based on the MNT assessment or re-assessment and the nutrient intake study.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Food Intake Study Sample Form

Name_________________________ **Date**_______________

Food Item and Amount Served	Amount Eaten							For Dietitian		
	0	25%	50%	75%	100%	Fluids mLs	Initials	Calories	Protein	Fluids
Breakfast:										
10:00 AM Snack or Supplement:										
Lunch:										
2:00 PM Snack or Supplement:										
Dinner:										
HS Snack or Supplement:										
Totals										

Instructions:

1. Food Service - Write in the menu items served and give the form to the appropriate nursing staff.
2. Nursing - Check the appropriate column for percentage eaten. Return the completed form to food service.
3. Food Service – Provide the completed form to registered dietitian (RD) or designee for computation of calorie and protein intake.

©2013 Becky Dorner & Associates, Inc.

Individuals Who Do Not Drink Milk

Policy:

Substitutions are made for individuals who do not drink milk (i.e. dislikes, allergies or intolerances) to assure provision of adequate calcium.

Procedure:

1. The facility staff and food service manager or designee are responsible for identifying individuals who do not like milk, are allergic to or intolerant to milk and/or milk products.

2. The facility staff is responsible for advising the food service manager or designee when an individual refuses to drink milk or consume milk products.

3. The food service manager or designee is responsible for making the appropriate substitutions.

4. The food service manager or designee is responsible for making necessary changes on the meal identification card indicating what should be provided in place of milk and milk products. This is determined using guidance provided by the registered dietitian (RD) and/or the diet manual along with the individual's preferences. (Also see number 7 below.)

5. The food service manager or designee is responsible for informing the registered dietitian (RD) so that this can be included on the individual's care plan.

6. This information should be communicated to nursing to share with the doctor, so that a calcium supplement with vitamin D may be prescribed if needed.

7. Milk alternatives:
   These foods provide approximately the same amount of calcium as one cup of milk, which has 291 mg of calcium.
   - 1 cup yogurt
   - 1 1/2 ounces of cheese
   - 1 cup pudding
   - 1 3/4 cup ice cream
   - 2 cups cottage cheese
   - 8 to 9 ounces calcium-fortified juice
   - 8 ounces lactose free milk (lactose intolerance only, not appropriate for milk allergy or milk intolerance)
   - 8 ounces of soy milk, rice milk or almond milk (check individual label to assure calcium requirements are met)

   The calorie and protein levels of the above items are not equal and cannot be used for certain therapeutic diets. Those on therapeutic diets should be referred to the RD or designee to assess the need for diet alterations, or for recommendations for protein, calcium and/or vitamin D supplementation.

©2013 Becky Dorner & Associates, Inc.

Nutrition Screening for Referrals to the Registered Dietitian

Policy:

Facility staff will screen individuals for nutrition risk on admission, at regular intervals, or whenever a change in condition warrants, using a validated nutrition screening tool and approved process.

Procedure:

1. Staff will use a validated screening tool, such as the Mini Nutritional Assessment (MNA®), to determine the presence or risk for malnutrition or undernutrition. The screening process may also include additional criteria associated with other nutritional risk(s).

   Note: In the outpatient setting, the MNA-Self Assessment may be used. This form can be found at www.mna-elderly.com/forms/self-mna-pdf.

2. The facility will designate responsibility for completing the nutrition screening form. The nutrition screen may be completed by nursing staff during initial assessment, or by nutrition support staff during the initial visit to obtain food preferences and determine needs and concerns.

3. Facility staff will follow directions to complete the validated screening form upon admission quarterly, annually, after readmission following a hospital stay, and/or with any significant change in status health.

4. Staff will communicate the results of the nutrition screening process with the RD or designee. Staff will notify the RD or designee and provide information for individuals with:
   - Malnutrition as indicated by the screening tool (MNA® scores 7 or less)
   - Risk for malnutrition or (as indicated by MNA® screening score of 8-11)
   - Other criteria as determined by the specific screening tool if other than MNA® facility (see number 6 below)

   The facility RD, nutrition support staff and/or nurse manager will initiate appropriate interventions, as necessary, for the individual resident/patient. The RD or designee will complete a comprehensive nutrition assessment and determine appropriate nutrition interventions.

5. The RD or designee will notify the physician in writing, when an individual's nutrition screening indicates malnutrition (MNA® score of 7 or less). The physician will review the information during the next scheduled visit and indicate a diagnosis of malnutrition if appropriate.

6. The nutrition support staff or director of nursing or designee will provide the RD or designee with a list of the individuals no less than monthly including:
   - New or re-admissions to the facility
   - Physician ordered consult
   - Malnutrition risk score on MNA® of 11 or less, or as determined by the specific nutrition screening tool
   - Others as determined by the facility may include:

©2013 Becky Dorner & Associates, Inc.

- Enteral/parenteral feedings
- Significant weight changes (loss or gain)
- Insidious weight loss (unplanned gradual weight loss)
- Pressure ulcers and other wounds
- Dehydration risk
- Dialysis or renal diets
- Terminal condition
- Need for nutrition education
- Poor food/fluid intake
- Poorly controlled diabetes
- Chewing, swallowing or gastrointestinal problems
- Diet orders not available on the menu

(See Referrals for RD Sample Form)

7. Facility staff will use the referral form provided to notify the RD or designee of any problems as they arise. If the problem is urgent, facility staff will notify the RD or designee of the problem by phone and provide information.

8. Facility staff will leave the referral form at a pre-agreed upon location in the facility, or communicate this information using a secure means. Facility staff should complete the referral form weekly or more often if needed, and provide it to the RD or designee.

Note: The MNA® is a validated tool to identify malnutrition, or undernutrition, in adults age 65 and older. The MNA® and the 2012 ASPEN/Academy of Nutrition and Dietetics consensus characteristics of adult malnutrition address many similar issues including inadequate intake and loss of weight, muscle mass, and functionality. The MNA®-SF also addresses psycho-social issues that increase malnutrition risk for older adults; it does not address inflammation.

Refer to the following pages for copies of the MNA® and MNA®-Self Assessment Forms, Sample Letter to the Physician, and Sample Malnutrition Report Form for the Physician which can help implement this system.

Note: Nutrition support staff work under the supervision of the registered dietitian (RD). Nutrition support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Referrals for Registered Dietitian Sample Form 1

Facility:_________________________ **Date:**__________________

Referral Date	Completed	Room Number	Name	New/ Re-admit	Screened for Referral (MNA® Score of 11 or less)	Physician ordered consult	Enteral / Parenteral Feeding	Significant Weight Loss or Gain (or insidious s loss)	Pressure Ulcer or Wound	Dehydration risk	Dialysis or renal diet	Terminal Condition	Annual assessments	Needs nutrition education	Other	Comments

©2013 Becky Dorner & Associates, Inc.

Referrals for Registered Dietitian Sample Form 2

Facility:________________________ **Date:**_________________

Room/Name		New/ Re-admit	MD Consult Order	Significant Weight Loss/Gain	Pressure Ulcer or Wound	Risk of or Resolving Dehydration	Terminal Condition	Enteral/ Parenteral Feeding	Needs Nutrition Education	Other	Comments

©2013 Becky Dorner & Associates, Inc.

Nutrition Screening Sample Form

Mini Nutritional Assessment MNA®

Last name: First name:

Sex: Age: Weight, kg: Height, cm: Date:

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

Screening

A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
0 = severe decrease in food intake
1 = moderate decrease in food intake
2 = no decrease in food intake ☐

B Weight loss during the last 3 months
0 = weight loss greater than 3 kg (6.6 lbs)
1 = does not know
2 = weight loss between 1 and 3 kg (2.2 and 6.6 lbs)
3 = no weight loss ☐

C Mobility
0 = bed or chair bound
1 = able to get out of bed / chair but does not go out
2 = goes out ☐

D Has suffered psychological stress or acute disease in the past 3 months?
0 = yes 2 = no ☐

E Neuropsychological problems
0 = severe dementia or depression
1 = mild dementia
2 = no psychological problems ☐

F1 Body Mass Index (BMI) (weight in kg) / (height in m^2)
0 = BMI less than 19
1 = BMI 19 to less than 21
2 = BMI 21 to less than 23
3 = BMI 23 or greater ☐

IF BMI IS NOT AVAILABLE, REPLACE QUESTION F1 WITH QUESTION F2.
DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

F2 Calf circumference (CC) in cm
0 = CC less than 31
3 = CC 31 or greater ☐

Screening score (max. 14 points)

12 - 14 points: Normal nutritional status
8 - 11 points: At risk of malnutrition
0 - 7 points: Malnourished ☐☐

References
1. Vellas B, Villars H, Abellan G, *et al.* Overview of the MNA® - Its History and Challenges. *J Nutr Health Aging*. 2006;**10**:456-465.
2. Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J. Geront.* 2001; **56A**: M366-377
3. Guigoz Y. The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us? *J Nutr Health Aging*. 2006; **10**:466-487.
4. Kaiser MJ, Bauer JM, Ramsch C, et al. Validation of the Mini Nutritional Assessment Short-Form (MNA®-SF): A practical tool for identification of nutritional status. *J Nutr Health Aging*. 2009; **13**:782-788.

® Société des Produits Nestlé, S.A., Vevey, Switzerland, Trademark Owners © Nestlé, 1994, Revision 2009. N67200 12/99 10M

For more information: www.mna-elderly.com

Letter to Physician Sample Form

Date

Dear Doctor _______________________,

__________________________ (facility name) has adopted the Mini Nutritional Assessment - (MNA®) to screen for malnutrition in the elderly. The MNA® is the most well validated nutrition screening tool for older adults and identifies geriatric patients who may be malnourished or at risk of malnutrition. Staff will complete the nutrition screen within the first 14 days of admission, and quarterly thereafter. Additional screenings may be necessary, depending on the status of the patient.

Research has shown that a score of ***0-7 points*** on the MNA® is consistent with a diagnosis of ***<u>Malnutrition</u>***. For individuals who score ***0-7 points,*** the facility will complete and place a *Physician's Notification of Malnutrition* form in your mailbox for your review during your next facility visit. Should you choose to make a diagnosis of malnutrition, a low MNA® score provides support for such a diagnosis. If you confirm a diagnosis of Malnutrition, the new diagnosis will be communicated to the appropriate personnel.

As always, we will provide the patient appropriate nutrition intervention based on the results of the screen and full nutritional assessment. We will also closely monitor their response to therapy.

Our goal is to provide each resident with the most appropriate nutritional care. The MNA® will help guide us in that direction.

If you have any questions, please feel free to contact me at ________________.

Sincerely,

____
Registered Dietitian
Director of Nutrition Services

Note: Attach a copy of MNA® Form and MNA® Physician Communication Form.

©2013 Becky Dorner & Associates, Inc.

MNA Physician Communication
Mini Nutritional Assessment Report for Malnutrition

Facility ______________________________ Physician ____________________________

Room #	Patient Name	Review Date	*MNA Score	Intervention(s)	Physician Initials

*Score of 0-7 indicates patient has triggered ‘Malnourished”

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Documentation

Policy:

Documentation of each individual's medical nutrition therapy (MNT) is the responsibility of the registered dietitian (RD) with assistance as assigned to the nutrition support staff (i.e. nutrition associate, dietetic technician registered or DTR, and/or certified dietary manager or CDM), as appropriate within each professional's scope of practice and competency level. The facility will:

- Provide nutrition care and services to each individual, consistent with the individual's comprehensive assessment.
- Recognize, evaluate and address the needs of every individual, including but not limited to the individual at risk or already experiencing impaired nutrition.

All documentation will be in accordance with state and federal regulations.

Note: The MNT documentation should follow the Academy of Nutrition and Dietetics (The Academy) Nutrition Care Process of:

1. Nutrition Assessment
2. Nutrition Diagnosis
3. Nutrition Intervention
4. Nutrition Monitoring and Evaluation

Facilities and RDs are in various stages of implementing the Academy's Nutrition Care Process, however, the Academy encouraged full implementation by 2012. For more information on the Academy Nutrition Care Process, visit www.eatright.org.

Procedure:

1. **Initial Assessment**

   The focus of the comprehensive medical nutrition therapy (MNT) assessment is to identify risk factors that may contribute to undernutrition, protein energy malnutrition, dehydration, unintended weight loss, pressure ulcers and other nutrition problems, as well as identifying other nutritional needs.

   For Medicare patients/residents, the initial MNT assessment for a new or re-admitted individual is generally initiated and/or completed within 5 days of admission. Re-assessments and/or progress notes are then completed at 14, 30, 60 and 90 days and a minimum of every quarter thereafter. For non-Medicare individuals, the initial MNT assessment may be completed within 14 days of admission and re-assessments or progress notes are completed a minimum of every quarter or more often as needed. (See Resource: Comprehensive Medical Nutrition Therapy Assessment and Nutrition Assessment: Components of a Comprehensive Nutrition Assessment.)

   Information for the MNT assessment will be gathered through interviews with individuals, family and staff, observations, and review of the medical record. The completed form is reviewed by the RD and/or designee. The assessment form is filed in the medical record. A new or re-assessment is completed each time an individual is re-admitted, has a significant change in condition, and as deemed necessary by federal and state guidelines or the RD or designee.

   MNT re-assessments will be completed according to federal guidelines, at a minimum of quarterly, upon identification of significant change, or at a minimum of yearly intervals.

©2013 Becky Dorner & Associates, Inc.

2. **Plan of Care**
   Each time an MNT assessment or re-assessment is completed, a care plan or care plan revision should be completed as appropriate.

   The care plan is based on the MNT assessment, the identified risk factors and nutritional needs. Problems, risk factors, or concerns are described along with nutrition interventions and goals for improvement. Care plans are to be completed within 7 days of completion of the assessment, and updated according to the facility's policy, state and federal guidelines, and as needed due to any significant changes (i.e. weight status, food intake, diet order, etc). Specific and measurable goals should be stated to maintain or achieve optimal nutritional status. Goals and approaches (interventions) should be individualized and should be coordinated with the interdisciplinary team.

   Each time a care plan is updated, a re-assessment or progress note should be completed or revised as appropriate.

3. **MNT Re-Assessments/Progress Notes**
   The MNT re-assessment/progress notes reflect progress made on care plan goals, so the RD and /or designee must review the previous care plan to assess progress. If goals are not met for the problems on the care plan, the approach or goal should be changed. If not changed, then the reasons for little or no progress should be documented. Care plan approaches should be revised based on the individual's outcomes, needs and choices.

   Progress notes should include information from mealtime visitation, discussion with the individual and with the care givers, review of the medical record, evaluation of the care plan, weight status, food intake, physician order or condition changes, lab values, medication, etc. Progress notes should reflect progress made to meet care plan goals.

   Progress notes are completed according to facility policy and state and federal guidelines. When significant changes occur, notes should be updated. Significant changes can include but are not limited to changes in condition, diet order, food intake and weight. Generally progress notes are written a minimum of every 90 days; and with each significant change in status. Individuals with high-risk conditions will need to be reviewed more frequently.

   Each time a re-assessment or progress note is completed, the care plan should be updated.

Summary for Nursing Faciltiies:

- The initiation of the nutrition assessment is completed within 5 days of admission for Medicare residents and within 14 days of admission for all residents.
- The Initial care plan is completed within 7 days after completion of the assessment.
- Progress notes and care plan updates are completed according to state and federal guidelines (generally a minimum of every 90 days and with any significant change).
- A re-assessment and care plan revision is completed each time an individual is re-admitted, quarterly, upon significant change in condition and as deemed necessary by the facility or the RD.

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Documentation

Role Delineation (Division of Responsibility for Documentation):
Role delineation is dictated by the current Standards of Practice and Standards (SOP) of Professional Performance (SOPP) of the Academy of Nutrition and Dietetics (Academy) along with individual State Dietetic Licensing or Certification Boards, and to some extent, by the Academy Dietetic Practice Groups and the Association of Food and Nutrition Professionals (ANFP). This policy covers general guidelines. More detailed guidelines may need to be developed based on individual state laws (dietetic licensing or certification boards).

- **The Certified Dietary Manager (CDM) or trained Food Service Manager** may gather information for the food preferences and gather facts for the MNT assessment and/or progress notes. The initial food preferences and information gathering for the MNT assessment should be completed within 48 hours of admission. This includes food preferences, pertinent data such as food allergies or intolerances, chewing and swallowing abilities and other relevant information. The CDM or food service manager may write progress notes by stating factual information such as diet order, percent of food intake, as noted by nursing, height, weight, usual body weight, lab values, medications, etc. The CDM or food service manager's role is to collect the factual data for documentation, communicate pertinent information to the RD or designee and the interdisciplinary team, and implement the physician's diet and supplement orders as applicable. The CDM or food service manager also communicates and implements the RD or designee recommendations as appropriate.
- **The Dietetic Technician Registered, Nutrition Associate, and/or Registered, Licensed Dietitian** complete the MNT assessment and initial care plan, and revise all care plans when additional problems, approaches and goals are added. These nutrition professionals may also write progress notes as needed. The RD guides nutritional care of each resident/patient and provides information and guidance for facility wide systems for nutrition care. As support staff, the DTR and Nutrition Associate work under the supervision of the RD. The Academy SOP/SOPP for RDs and DTRs should be reviewed and implemented at the facility level.

Per state licensure laws, the licensed dietitian may delegate certain tasks to the support staff (including CDM). Review your state licensure laws and the scope of practice for each professional to assure appropriate delegation. This policy should be adjusted according to specific state regulations. Every state is different so review individual state laws to assure compliance. The RD is ultimately responsible for the direction of nutrition care.

Summary:
- The CDM or trained food service manager gathers information to initiate assessments and progress notes.
- The RD or designee assesses the nutritional status and completes the nutrition care process.

Resources for this policy:
1. Individual State Dietetic Licensure or Certification Board.
2. Academy of Nutrition and Dietetics (Academy) Standards of Practice and Standards of Professional Performance, and Dietetics in Health Care Communities (DHCC), an Academy dietetic practice group Standards of Practice and Standards of Professional Performance available at www.eatright.org.
3. Unintended Weight Loss in Older Adults Toolkit (includes guidelines and sample forms for the Nutrition Care Process for RDs). Available for purchase at http://www.adaevidencelibrary.com/store.
4. Becky Dorner & Associates, Inc. continuing education programs on Nutrition Care Process and MDS. Available at www.beckydorner.com .
5. Association of Food and Nutrition Professionals:

©2013 Becky Dorner & Associates, Inc.

a. CDM scope of practice: http://www.anfponline.org/Training/CDM_CFPP.shtml
b. ANFP Practice Standard: Documenting in the Medical Record: http://www.anfponline.org/Resources/DMAResources/standard02.shtml
c. CDM Nutrition Care Self-Assessment tool: http://www.anfponline.org/Extras/Self_Assessment_Tool.pdf

©2013 Becky Dorner & Associates, Inc.

Comprehensive Medical Nutrition Therapy Assessment

Policy:

The facility will complete a comprehensive medical nutrition therapy (MNT) assessment for each individual that is referred or identified for assessment. *"Nutritional assessment is a systematic process of obtaining, verifying and interpreting data in order to make decisions about the nature and cause of nutrition-related problems."* (1,2)

Note: Nursing facilities use the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) for basic assessment (section K covers nutrition). The majority of residents will also need a comprehensive medical nutritional assessment as well.

Procedure:

1. The interdisciplinary team clarifies nutrition issues, needs, and goals in the context of the individual's overall condition. This is accomplished by using observation, and gathering and considering information relevant to each individual's eating and nutrition status. The team should interview the individual and/or their representative, and review information from other sources e.g., past history of eating patterns, weight history and a summary of any recent hospitalizations.

2. The facility identifies key individuals who should participate in the assessment of nutrition status and related causes and consequences.
   - Nursing staff provides details about the individual's nutrition intake.
   - Health care practitioners (e.g., physicians and nurse practitioners) help define the nature of the problem, identify causes nutrition problems (i.e. anorexia and weight loss), tailor interventions to the individual's specific causes and situation, and monitor the continued relevance of those interventions.
   - The registered dietitian (RD) and/or designee helps identify nutritional risk factors and recommends nutrition interventions based on each individual's medical condition, needs, desires, and goals. (See Referrals to the Registered Dietitian).
   - Consultant pharmacists can help the staff and practitioners identify medications that affect nutrition by altering taste or causing dry mouth, lethargy, nausea, or confusion.

3. A more in-depth medical nutrition therapy (MNT) assessment may be needed to identify the nature and causes of impaired nutrition and nutrition-related risks (in addition to the RAI in long term care). The in-depth MNT assessment may utilize existing information from sources such as assessments from other disciplines, observations, and individual and family interviews. (See Resource: Nutrition Assessment: Components of a Comprehensive Nutrition Assessment).

4. Goals, prognosis and projected personal and clinical outcomes take into account the individual's preferences (e.g., willingness to participate in weight management interventions or desire for nutritional support at end-of-life), the anticipated course of a individual's overall condition and progression of a disease (e.g., end-stage, terminal, or other irreversible conditions affecting food intake, nutritional status, and weight goals), and by the individual's willingness and capacity to permit additional diagnostic testing, monitoring and treatment.

5. The facility uses laboratory tests as appropriate to help identify underlying causes of impaired nutrition or when the clinical assessment alone is not enough to define someone's nutritional status. Abnormal laboratory values may, but do not necessarily, imply that treatable clinical problems exist or that interventions are needed. The facility confirms the

©2013 Becky Dorner & Associates, Inc.

likelihood of nutrition issues through additional clinical evaluation and evidence such as food intake, underlying medical condition, etc.

- Example: Serum albumin may help establish prognosis but is only sometimes helpful in identifying impaired nutrition or guiding interventions. Serum albumin may drop significantly during an acute illness for reasons unrelated to nutrition; therefore, albumin may not improve, or may fall further, despite consumption of adequate amounts of calories and protein. The decision to order laboratory tests, and the interpretation of subsequent results, is best done in light of a individual's overall condition and prognosis. Although laboratory tests such as albumin and pre-albumin may help in some cases in deciding to initiate nutritional interventions, there is no evidence that they are useful for the serial follow-up of undernourished individuals (3,4).
- Before ordering laboratory tests it is appropriate for the health care practitioner to determine and indicate whether the tests would potentially change the individual's diagnosis, management, outcome or quality of life or otherwise add to what is already known.

Note: If laboratory tests were done prior to or after admission to the facility and the test results are abnormal, the physician or other licensed health care practitioner, in collaboration with the interdisciplinary team, reviews the information and determines whether to intervene or order additional diagnostic testing.

6. The facility conducts the nutrition analysis using the information from multiple sources. These include, but are not limited to, the RAI and additional nutritional assessments as indicated to determine an individual's nutritional status and develop an individualized care plan.

7. The facility develops the specification of the nutrition concern (Nutrition Diagnosis determined by the RD) which is a clear statement that provides the basis for individual-specific interventions. For example:
   a. Inadequate oral food and fluid intake
      - Related to oral intake <50%
      - As evidenced by ≥ 5% weight loss the past 30 days
   b. Increased energy needs
      - Related to energy needs greater than calculated needs
      - As evidenced hyper-metabolic state associated with infection with fever
   c. Swallowing difficulty
      - Related to neuromuscular disorder affecting ability to eat and swallow
      - As evidenced by need for pureed diet

Note: The Academy of Nutrition and Dietetics encourages all RDs to adopt the Nutrition Care Process of Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention and Nutrition Monitoring and Evaluation.

References for this policy:

1. Kieselhorst, K.J., Skates, J., & Pritchett, E. (2005). American Dietetic Association: Standards of practice in nutrition care and updated standards of professional performance. Journal of the American Dietetic Association, 105(4), 641-645.
2. Lacey, K. & Pritchett, E. (2003). Nutrition care process and model: ADA adopts road map to quality care and outcomes management. Journal of the American Dietetic Association, 103(8), 1061-1072.
3. Covinsky KE, Covinsky MH, Palmer RM, & Sehgal AR. (2002). Serum albumin concentration and clinical assessments of nutritional status in hospitalized older people:

©2013 Becky Dorner & Associates, Inc.

Different sides of different coins? Journal of the American Geriatrics Society, 50(4) 631-637).
4. Fuhrman MP, Charney P and Mueller CM. (August 2004). Hepatic proteins and nutrition assessment. Journal of the American Dietetic Association, 104(8), 1258-64.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment

The in-depth medical nutrition therapy (MNT) assessment may include the following information:

1. **Nutrition History:**
   - Usual body weight, a history of reduced appetite or a history of progressive weight loss or gain prior to admission, medical conditions, and events such as recent surgery, which may have affected an individual's nutritional status and risks.

2. **General Appearance:**
   Findings that may affect or reflect nutritional status:
   - Robust, thin, obese, or cachectic
   - Level of consciousness, responsiveness, affect
   - Oral health and dentition
   - Ability to use the hands and arms
   - Condition of hair, nails, and skin

3. **Height:**
   - Refer to Policy and Procedure on Obtaining Accurate Heights and Resource: How to Obtain Accurate Heights in the Anthropometrics Section.

4. **Weight:**
   - Significant unintended changes in weight (loss or gain) or insidious weight loss may indicate a nutritional problem.
   - See Policies and Procedures and Resources on Accurate Weights, How to Obtain Accurate Weights, Adjusting Weights for Amputees, Significant Weight Changes, Tracking Weight Changes, Significant Weight Loss and Significant Weight Gain, Sample Forms and Charts, etc. in the Anthropometrics Section.

5. Food and Fluid Intake:
   - Estimate of calorie, nutrient and fluid needs, and whether intake is adequate to meet those needs.
   - The route (oral, enteral or parenteral) of food and/or fluid intake.
   - Any special food formulation, meal and snack patterns (including the time of supplement or medication consumption in relation to the meals).
   - Dislikes and preferences (including ethnic foods and form of foods such as finger foods).
   - Meal/snack patterns and preferred portion sizes.
   - Participation in select menus, buffet-style dining, or open dining.
   - Ability to make food choices.

6. **Fluid Loss or Retention:**
   - Much of an individual's daily fluid intake comes from meals; therefore, when a individual has decreased appetite, it can result in fluid/electrolyte imbalance.
   - Abrupt weight changes, change in food intake, or altered level of consciousness are some of the clinical manifestations of fluid and electrolyte imbalance.
   - Laboratory tests (e.g., electrolytes, BUN, creatinine and serum osmolality) can help greatly to identify, manage, and monitor fluid and electrolyte status (1).

7. **Altered Nutrient Intake, Absorption, and Utilization:**
   Poor intake, continuing or unabated hunger, or a change in the individual's usual intake that persists for multiple meals, may indicate an underlying problem or illness. Assess for possible causes such as:

©2013 Becky Dorner & Associates, Inc.

- Inability to consume meals provided (possibly due to the form or consistency of food/fluid, cognitive or functional decline, arthritis-related impaired movement, neuropathic pain, or insufficient assistance).
- Insufficient availability of food and fluid (e.g., inadequate amount of food or fluid or inadequate tube feedings).
- Environmental factors affecting food intake or appetite (e.g., comfort and level of disruption in the dining environment).
- Adverse consequences related to medications.
- Diseases and conditions such as cancer, diabetes mellitus, advanced or uncontrolled heart or lung disease, infection and fever, liver disease, hyperthyroidism, mood disorders, and repetitive movement disorders (e.g., wandering, pacing, or rocking).

8. **Diuretics:**
   The use of diuretics and other medications may cause weight loss that is not associated with nutritional issues, but can also cause fluid and electrolyte imbalance/dehydration that causes a loss of appetite and weight.

9. **Gastrointestinal (GI) Disorders:**
   - Various GI disorders such as pancreatitis, gastritis, motility disorders, small bowel dysfunction, gall bladder disease, and liver dysfunction may affect digestion or absorption of food.
   - Prolonged diarrhea or vomiting may increase nutritional requirements due to nutrient and fluid losses.
   - Constipation or fecal impaction may affect appetite and excretion.

10. **Wounds and Other Health Impairments:**
    Pressure ulcers and some other wounds and health impairments may also affect nutritional requirements.
    - A hypermetabolic state results from an increased demand for energy and protein and may increase the risk of weight loss or undernutrition. Examples of causes include advanced chronic obstructive pulmonary disease (COPD), pneumonia and other infections, cancer, hyperthyroidism, and fever. Early identification of these factors, regardless of the presence of any associated weight changes, can help the facility choose appropriate interventions to minimize any subsequent complications.
    - Often, several of these factors affecting nutrition coexist (2).

11. **Chewing Abnormalities:**
    Many conditions of the mouth, teeth, and gums can affect the individual's ability to chew foods. For example, oral pain, dry mouth, gingivitis, periodontal disease, ill-fitting dentures, and broken, decayed or missing teeth can impair oral intake.

12. **Swallowing Abnormalities**
    Various direct and indirect causes can affect the individual's ability to swallow. These include but are not limited to stroke, pain, lethargy, confusion, dry mouth, and diseases of the oropharynx and esophagus.
    - Swallowing ability may fluctuate from day to day or over time. In some individuals, aspiration pneumonia can complicate swallowing abnormalities.

    Note: Swallowing studies are not always required in order to assess eating and swallowing; however, when they are indicated, it is essential to interpret any such tests in the proper

©2013 Becky Dorner & Associates, Inc.

context. A clinical evaluation of swallowing may be used to evaluate average daily oral function (3).

13. **Functional Ability:**
The ability to eat independently may be helped by addressing factors that impair function or by providing appropriate individual assistance, supervision, or assistive devices.
    - Conditions affecting functional ability to eat and drink include impaired upper extremity motor coordination and strength or reduced range of motion (any of which may be hampered by stroke, Parkinson's disease, multiple sclerosis, tardive dyskinesia, or other neuromuscular disorders or by sensory limitations (e.g., blindness).
    - Cognitive impairment may also affect a individual's ability to use a fork, or to eat, chew, and swallow effectively.

14. **Medications:**
Medications and nutritional supplements may affect, or be affected by the intake or utilization of nutrients (e.g., liquid phenytoin taken with tube feedings or grapefruit juice taken with some antihyperlipidemics) (4).
    - Medications from almost every pharmaceutical class can affect nutritional status, directly or indirectly; for example, by causing or exacerbating anorexia, lethargy, confusion, nausea, constipation, impairing taste, or altering gastrointestinal function.
    - Inhaled or ingested medications can affect food intake by causing pharyngitis, dry mouth, esophagitis, or gastritis. To the extent possible, consideration of medication/nutrient interactions and adverse consequences should be individualized.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

References for this policy:

1. Thomas DR, Tariq SH, Makhdomm S, Haddad R, & Moinuddin A. (2003). Physician misdiagnosis of dehydration in older adults. Journal of the American Medical Directors Association, 4(5), 251–254. And Thomas D R, Cote T R, Lawhorne L, Levenson S A, Rubenstein L Z, Smith D.A, et al. (2008). Understanding clinical dehydration and its treatment. Journal of The American Medical Directors Association, 9(5), 292-301.)
2. Wilson, M.G., Thomas, D.R., Rubenstein, L.Z., Chibnall, J.T., Anderson, S., Baxi, A., Diebold, M., & Morley, J.E. (2005). Appetite assessment: Simple appetite questionnaire predicts weight loss in community-dwelling adults and nursing home individuals. American Journal of Clinical Nutrition, 82(5), 1074-1081.
3. Chouinard, J. (2000). Dysphagia in Alzheimer's disease: A review. Journal of Nutrition, Health and Aging, 4(4), 214-217.
4. Pronsky ZM, Crowe JP, Young VSL, Elbe D, Epstein S, Roberts W, Ayoob KT.. Food-medication interactions, 16th Edition. Food Medications Interactions 2010.

©2013 Becky Dorner & Associates, Inc.

Comprehensive Care Plan

Policy:

The facility will develop a comprehensive care plan following the most current regulatory requirements available. As applicable, this includes a comprehensive nutrition care plan which is based on the comprehensive medical nutrition therapy (MNT) assessment.

Procedure:

1. Based on information generated by the comprehensive assessment and any pertinent additional MNT assessment, the interdisciplinary team develops an individualized care plan with input from the resident/patient and/or representative.

2. The care plan addresses, to the extent possible, identified causes of impaired nutrition status. The care plan reflects the individual's goals and choices, and identifies individual-specific interventions. It includes a time frame in which goals are achieved and parameters for monitoring progress.

3. The care plan is updated as needed: e.g., as conditions change, goals are met, interventions are determined to be ineffective, or as specific treatable causes of nutrition-related problems (anorexia, impaired chewing, etc.) are identified.
   - If nutrition goals are not achieved, new or additional pertinent approaches are considered and implemented as indicated.
   - Pertinent documentation can help identify the basis (e.g., current individual status, comorbid conditions, prognosis, and individual choices) for nutrition-related goals and interventions.

4. Allow each individual or individual's representative to make informed choices about accepting or declining care and treatment.
   - Help the individual exercise the right of individual choice effectively by discussing the individual's condition, treatment options (including related risks and benefits, and expected outcomes), personal preferences, and any potential consequences of accepting or refusing treatment. If the individual declines specific interventions, the facility must address the individual's concerns and offer relevant alternatives.
   - The care plan reflects an individual's choices, either as offered by the individual directly or via a valid advance directive, or based on a decision made by the individual's representative in accordance with state law.
     - The presence of care instructions such as an advance directive, or declining some interventions does not necessarily imply that other support and care was declined or is not pertinent.
     - When preferences are not specified beforehand, decisions related to the possible provision of supplemental or artificial nutrition should be made in conjunction with the individual or individual's representative in accordance with state law. This decision should take into account relevant considerations such as the individual's condition, prognosis, and known values and choices.

   Note: The presence of a "Do Not Resuscitate" (DNR) order does not by itself indicate that the individual is declining other appropriate treatment and services. It only indicates that the individual has chosen not to be resuscitated if cardiopulmonary functions cease. Comfort, palliative or hospice care status indicates that the individual is declining aggressive treatment such as tube feeding. An appropriate care plan should be written based on the individual's current condition and wishes.

©2013 Becky Dorner & Associates, Inc.

5. Use a variety of interventions to meet the individuals' nutritional needs based on many factors including, but not limited to current food intake, the degree of nutritional impairment or risk, individual choices, the response to initial interventions, and the feasibility of addressing underlying conditions and causes.
   - Basic energy needs can generally be met by providing a diet that includes sufficient calories to stabilize current body weight. Adjustments may be necessary when factors exist such as food allergies/intolerances, the need for a therapeutic diet, or hypermetabolic states (e.g., fever, hyperthyroidism, acute wounds, or heart or lung disease). Energy needs should be met to avoid having the body use lean body mass for energy and wound repair.

6. Monitor outcomes after care plan implementation for individuals with impaired or at-risk nutritional status, as well as for those whose current nutritional status is stable. Review the individual-specific factors identified as part of the latest comprehensive individual assessment and any supplemental MNT assessment.
   - Identify and report information about the individual's nutritional status and related issues such as level of consciousness and function. (Nursing assistants may be most familiar with the individual's habits and preferences, symptoms such as pain or discomfort, fluctuating appetite, and nausea or other gastrointestinal symptoms).
   - More intensive and frequent monitoring may be indicated for individuals with impaired or at-risk nutritional status than for those who are currently nutritionally stable. Monitoring includes, but is not limited to:
     – Observe for and recognize emergence of new risk factors (e.g., acute medical illness, pressure ulcers, or fever).
     – Evaluate consumption of between-meal snacks and oral nutritional supplements.
     – Review the continued relevance of any current nutritional interventions (e.g., therapeutic diets, tube feeding orders or oral nutritional supplements).

7. Evaluate the care plan to determine if current interventions are being followed and if they are effective in attaining identified nutrition and weight goals and modify the care plan as needed.
   - Subsequent adjustment of interventions will depend on progress, underlying causes and overall condition.
   - Modify nutrition-related goals as needed based on new information and responses to current interventions.
     – Modify the current care plan and add new or additional interventions as needed.
     – Explain any decision to continue current interventions when the individual's nutrition status continues to decline (e.g., the goal of care for someone with a terminal, advanced, or irreversible condition has changed to palliation).

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP.http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Weight-Related Nutrition Interventions

Usual Body Weight
For many individuals (including overweight individuals), usual body weight prior to decline or admission rather than ideal body weight (IBW) is the most relevant basis for weight-related interventions.

- Basing interventions on IBW can be misleading, because IBW has not been definitively established for the frail elderly and those with chronic illnesses and disabilities.

Care Plan and Care Area Assessment (CAA)
The care plan includes nutrition interventions that address underlying risks and causes of unplanned weight loss (e.g., the need for eating assistance, reduction of medication side effects, and additional food that the individual will eat) or unplanned weight gain.

- It is important that the care plan address insidious, abrupt, or sudden decline in intake or insidious weight loss that does not trigger review of Care Area Assessment (CAA); for example, by intensifying observation of intake and eating patterns, monitoring for complications related to poor intake, and seeking underlying cause(s).
- Many risk factors and some causes of weight loss can be addressed, at least partially, while others may not be modifiable. In some cases, certain interventions may not be indicated or appropriate, based on individual goals and prognosis.
- Weight stability, rather than weight gain, may sometimes be the most pertinent short-term or long-term objective for the nutritionally at-risk or compromised individual. After an acute illness or as part of an advanced or end-stage medical condition, the individual's weight and other nutrition parameters may not return to previous levels and may stabilize at a lower level, sometimes indefinitely.

Note: There should be a documented clinical basis for any conclusion that nutrition status or significant weight change are unlikely to stabilize or improve (e.g., physician's documentation as to why weight loss is medically unavoidable).

Environmental Factors
Appetite is often enhanced by the appealing aroma, flavor, form, and appearance of food. Practices that may help improve intake include providing a pleasant dining experience (e.g., flexible dining environments, styles and schedules), providing meals that are palatable, attractive and nutritious (e.g., prepare food with seasonings, serve food at proper temperatures, etc.), and making sure that the environment where individuals eat (e.g., dining room and/or individual's room) is conducive to dining.

Anorexia
The facility, in consultation with the interdisciplinary (IDT) team, RD or designee, identifies and addresses treatable causes of anorexia. For example, the practitioner may consider adjusting or stopping medications that may have caused the individual to have dyspepsia or become lethargic, constipated, or confused, and reevaluate the individual to determine whether the effects of the medications are the reasons for the anorexia and subsequent weight loss.

- Where psychosis or a mood disorder such as depression has been identified as a cause of anorexia or weight change, treatment of the underlying disorder (based on an appropriate diagnostic evaluation) may improve appetite. However, other coexisting conditions or factors instead of, or in addition to, depression, may cause or contribute to anorexia. In addition, the use of antidepressants is not generally considered to be an adequate substitute for appropriately investigating and addressing modifiable risk factors or other underlying causes of anorexia and weight loss.

©2013 Becky Dorner & Associates, Inc.

Resource: Weight-Related Nutrition Interventions

Functional Factors

Based on the comprehensive interdisciplinary assessment, the facility provides the necessary assistance to allow the individual to eat and drink adequately. An individual with functional impairment may need help with eating.

- Examples of such interventions may include, but are not limited to: providing proper positioning for eating; participation in a restorative dining program; use of assistive devices/utensils; and prompt assistance (e.g., supervision, cueing, hand-over-hand) during every meal/snack where assistance is needed, ensuring that sensory devices such as eyeglasses, dentures, and hearing aids are in place; providing personal hygiene before and after meals, properly positioning the individual, providing eating assistance where needed, and providing the assistive devices/utensils identified in the assessment (1).

Chewing and Swallowing

- In deciding whether and how to intervene for chewing and swallowing abnormalities, it is essential to take a holistic approach and look beyond the symptoms to the underlying causes. Pertinent interventions may help address the individual's eating, chewing, and swallowing problems and optimize comfort and enjoyment of meals.
  - Examples of such interventions may include providing proper positioning for eating; assuring dentures are clean and in place at mealtime; cutting, chopping, or pureeing food to the proper consistency; assuring proper oral care between meals; participation in a restorative eating program; use of assistive devices/utensils as ordered; and prompt assistance (e.g., supervision, cueing, hand-over-hand) during every meal/snack where assistance is needed.

- Treating medical conditions (e.g., gastroesophageal reflux disease and oral and dental problems) that can impair swallowing or cause coughing may improve a chewing or swallowing problem.
  - Examples of other relevant interventions include adjusting medications that cause dry mouth or coughing, and providing liquids to moisten the mouth of someone with impaired saliva production.

- Excessive modification of food and fluid consistency may unnecessarily decrease quality of life and impair nutritional status by affecting appetite and reducing intake. Many factors influence whether a swallowing abnormality eventually results in clinically significant complications such as aspiration pneumonia (2).

- Identification of a swallowing abnormality alone does not necessarily warrant dietary restrictions or food texture modifications. No interventions consistently prevent aspiration and no tests consistently predict who will develop aspiration pneumonia (3).
  - For example, tube feeding may be associated with aspiration, and is not necessarily a desirable alternative to allowing oral intake, even if some swallowing abnormalities are present (4,5).

- Decisions to downgrade or alter the consistency of diets must include the individual (or the individual's representative), consider ethical issues (such as the right to decline treatment), and be based on a careful review of the individual's overall condition, correctable underlying causes of the risk or problem, the benefits and risks of a more liberalized diet, and the individual's preferences to accept risks in favor of a more liberalized food intake (6,7).

©2013 Becky Dorner & Associates, Inc.

Resource: Weight-Related Nutrition Interventions

Medications

- When an individual is eating poorly or losing weight, the immediate need to stabilize weight and improve appetite may supersede long-term medical goals for which medications were previously ordered. It may be appropriate to change, stop, or reduce the doses of medications (e.g., antiepileptics, cholinesterase inhibitors, or iron supplements) that are associated either with anorexia or with symptoms such as lethargy or confusion that can cause or exacerbate weight loss (8).
- The medical practitioner in collaboration with the staff and the pharmacist should review and adjust medications as appropriate.

Conclusions

- Resultant conclusions may include, but are not limited to:
  - A target range for weight based on the individual's overall condition, goals, prognosis, usual body weight, etc.
  - Approximate calorie, protein, and other nutrient needs.
  - Whether and to what extent weight stabilization or improvement can be anticipated.
  - Whether altered weight or nutritional status could be related to an underlying medical condition (e.g., fluid and electrolyte imbalance, medication-related anorexia, or an infection).
- Based on analysis of relevant information, the facility should identify a clinically pertinent basis for any conclusions that an individual cannot attain or maintain acceptable parameters of nutrition status.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

References for this policy:

1. Alzheimer's Association. (2012). Eating, Retrieved April 24, 2012 from http://www.alz.org/living_with_Alzheimers_eating.asp).
2. Kikawada, M., Iwamoto, T., & Takasaki, M. (2005). Aspiration and infection in the elderly. Drugs Aging, 22 (2), 115-130.
3. Loeb, M.B., Becker, M., Eady, A., & Walker-Dilks, C. (2003). Interventions to prevent aspiration pneumonia in older adults: A systematic review. Journal of the American Geriatrics Society, 51(7), 1018-1022.
4. Feinberg, M.J., Knebl, J., & Tully, J. (1996). Prandial aspiration and pneumonia in an elderly population followed over 3 years. Dysphagia, 11(2), 104-109.
5. Mamun, K., & Lim, J. (2005). Role of nasogastric tube in preventing aspiration pneumonia in patients with dysphagia. Singapore Medical Journal, 46(11), 627-631.
6. Campbell-Taylor, I. (2008). Oropharyngeal dysphagia in long-term care: Misperceptions of treatment efficacy. *Journal of the American Medical Directors Association, 9*, 523–531.
7. Thomas, D. R. (2008). Hard to swallow: Management of dysphagia in nursing home residents. *Journal of the American Medical Directors Association, 9*, 455–457.
8. Pronsky ZM, Crowe JP, Young VSL, Elbe D, Epstein S, Roberts W, Ayoob KT. Food-medication interactions, 16th Edition. Food Medications Interactions 2010.

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Documentation

Hospitals – Insert your medical nutrition therapy documentation policy here. Include policies on nutrition screening, assessment, progress notes and care plans, as applicable and include sample forms.

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Abbreviations

ADL = Activities of Daily Living
ADJ = Adjusted
AEB* = As Evidenced by
Alb = Albumin
ATB = Antibiotic
BMI = Body Mass Index
BS = Blood Sugar
BUN = Blood Urea Nitrogen
BW = Body Weight
C = Nutritional Counseling
CAA = Care Area Assessment
Ca++ = Calcium
CBW = Current Body Weight
CCHO = Consistent Carbohydrate
CDM = Certified Dietary Manager
CHF = Congestive Heart Failure
CHOL = Cholesterol
Cr = Creatine
CRT = Creatinine
C/O = Complaint of
COPD = Chronic Obstructive Pulmonary Disease
CVA = Cerebral Vascular Accident
D/C = Discharge
DM = Diabetes Mellitus
DBW = Desirable Body Weight
DOB = Date of Birth
DR = Dining Room
DTR = Dietetic Technician Registered
DX = Diagnosis
E = Education
EOT = End of Therapy
FF = Free Fluids
G = Gram
GI = Gastro Intestinal
GLU = Glucose
Hct = Hemacrit
HgA1C = Hemoglobin A1C
HGB = Hemoglobin
H/H = Hemoglobin / Hematocrit
HIV = Human Immunodeficiency Virus
Ht = Height
HTN = Hypertension
IBW = Ideal Body Weight
IV = Intravenous
J = J tube or Jejunostomy tube
K+ = Potassium
Kcal = Kilocalorie
Kg = Kilogram
Mech Soft = Mechanical Soft
Meds = Medications
MDS = Minimum Data Set
mL = Milliliters
Mo = Month
MVI = Multi-Vitamin
Na = Sodium
NB* = Behavior Environmental (Knowledge & Beliefs)
NC* = Functional
NCP* = Nutrition Care Process
ND* = Food and/or Nutrient Delivery
NG = Nasogastric
NI* = Intake
N/V = Nausea/Vomiting
OMRA = Other Medicare Assessment Review
PEG = G Tube or Gastrostomy
PES = Problems/Etiology/ Signs & Symptoms
PO = By Mouth
POC = Plan of Care
PPN = Peripheral Parenteral Nutrition
Pre-alb = Pre-albumin
PVD = Peripheral Vascular Disease
Q = Every
RC = Coordination of Nutrition Care
RD = Registered Dietitian
RDI = Recommended Daily Intakes
Reg = Regular
RM = Room
SOB = Shortness of Breath
TF = Tube Feed
TG = Triglycerides
TPN = Total Parenteral Nutrition
S/S = Signs/Symptoms
UBW Usual Body Weight
URI = Upper Respiratory Infection
UTI = Urinary Tract Infection
WBC = White Blood Cell
WNL = Within Normal Limits
Wt = Weight
1 x a day = Once a day
2 x a day = Twice a day
3 x a day = Three Times a Day
4 x a day = Four Times a Day
↑ = Increased or Improved
↓ = Decreased or Poor
= Pounds
> = Greater Than
≥ = Greater Than or Equal to
< = Less Than
≤ = Less Than or Equal to

*__Note:__ Refer to the Academy of Nutrition and Dietetics International Dietetics & Nutrition Terminology (IDNT) Reference Manual (Standardized Language for the Nutrition Care Process) for Nutrition Diagnosis, Second Edition, Chicago, IL. 2009

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Assessment Sample Form

Name **Room/ID No.** **Physician** **Gender** M / F **DOB** **Age**

Assessment Type: Initial / Quarterly / Yearly / Significant change

NUTRITION ASSESSMENT (Problems/Etiology/Signs & Symptoms)

Ht (inches)
□ Actual
□ Estimated
Wt (#) (Date)
UBW (#)
Adj. BW (#)(Amputation)

BMI _______
□ **<18.5 Underweight**
□ 18.5-24.9 Normal Weight
□ 25-29.9 Overweight
□ >30 Obese
□ >40 Extremely Obese

Weight Changes
Wt (#)/(Date) ______ ( ) ↑↓ 5% in 1 mo
Wt (#)/(Date) ______ ( ) ↑ ↓ 10% in 6 mo
Planned Weight Change? Y / N **Comments:**

Diet Order Reg / NAS / Mech Soft / Puree / Other:__________
Food allergies / Intolerances
Location of Meals Rm / DR **Restorative Dining** Y / N
Adaptive Eating Device

Oral Nutrition Supplement / Snacks
Fluid Restriction Y / N _______ mL/day
Food/fluid intake adequate to meet estimated needs? Y/N

Alternate Feeding Orders PPN/ TPN/ IV / Tube feeding (including flush orders):
________mL Formula = _______ Kcals ____ g protein ____% RDI (_____mL FF + _____ mL flush) = ________ Total mL Fluids
Appropriate Y / N **Tolerated** Y / N **Changes Needed** Y / N **Comments:**

Medication Interactions (Circle all that apply)
Antibiotics Cardiac Meds Diuretics Laxatives Psychotropics New Meds / Other:

Labs (Date ______)
H/H ________ HgbA1c ________ Glu ___________ Na _________ K+ _________
Ca++ _______ Alb _____________ Pre-alb ________ BUN _________ Cr _________

Other Pertinent Data
(Date______)

Alteration in Nutrition and/or Hydration Status as Evidenced by (Check/Circle all that apply)

□ Abnormal Labs (Refer to data above)
□ Altered Taste
□ Alternate Feeding: TF / IV / TPN
□ Altered Hydration: Dehydration / Edema / Overhydration / Fluid restriction
□ Anemia
□ Cancer / Chemo / Radiation
□ Cardiovascular: CVD / CVA / TIA / CHF / HTN / PVD
□ Dysphagia/ Chewing/Swallowing Problem
□ Communication Difficulty:
□ Cultural/Religious Food Issues
□ Dementia/Cognitive Decline /Depression
□ Diabetes
□ Failure to Thrive
□ ↑ ↓ Food / Fluid Intake
□ Fracture:
□ GI Issues:
□ Hepatic (Liver) Disease
□ Hunger (Complains of)
□ Infection / Fever / Sepsis /URI/ UTI
□ Kidney Disease / Dialysis
□ Malnutrition / Undernutrition
□ Mobility Issues:
□ Neurological / Muscular Disease:
□ Obesity
□ Pain Affecting Eating
□ Pressure Ulcer Risk Score_____
□ Pressure Ulcers/Wounds / Wound VAC:
□ Pulmonary Condition / COPD
□ Self Feeding Difficulty
□ Significant Weight Change: Loss / Gain
□ Surgery (Recent):
□ Terminal Status
□ **Other:**

Data Gathered by: **Date:**

Nutritional Needs Estimation (Based on CBW)

Total Kcal Needs:	**Protein Needs** (g):	**Fluid Needs** (mL):
Kg Wt X 25 / 30 / 35 +500 cal to gain/ -500 cal to lose	Kg Wt X 0.8 / 1.0 / 1.25 /1.5	Kg Wt X 25mL/ 30mL/ 35 mL / 1 mL/kcal

PES STATEMENT Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention. See Nutrition Diagnosis, Prescription & Intervention

Education Needs

NUTRITION DIAGNOSIS

NUTRITION PRESCRIPTION & INTERVENTION

NUTRITION MONITORING
Weight / Labs / Skin / Diet / TF Tolerance

Proceed to Care Plan Y / N **Proceed to Care Area Assessment** (CAA) Y / N **Comments**

Signature: **Date:**

See Plan of Care for Problems, Goals and Interventions

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Notes Sample Form

Name ____ **Room** ___________
See Plan of Care for Problems, Goals and Interventions

©2013 Becky Dorner & Associates, Inc.

Worksheet for MDS 3.0 Section K Swallowing/Nutrition Status Sample Form

Name ____ **Room** _____________

Assessment Type
Initial / 5 day / 14 day / 30 day / 60 day / 90 day/Q____
Annual_____ / EOT _____ / Significant Change_____ / Discharge_____

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder
_____ A. Loss of liquids/solids from mouth when eating or drinking
_____ B. Holding food in mouth/cheeks or residual food in mouth after meals
_____ C. Coughing or choking during meals or when swallowing medications
_____ D. Complaints of difficulty or pain with swallowing
_____ Z. None of the above

K0200. Height and Weight- While measuring, if the number is X.1-X.4 round down; X.5 or greater round up
_____ A**. Height** (in inches) Record most recent height measure since the most recent admission/entry or reentry
_____ B. **Weigh**t (in pounds) Base weight on most recent measure in last 30 days

K0300. Weight Loss
_____ **Loss of 5% or more in the last 30 days or loss of 10% in last 6 months**
0. No or unknown
1. Yes, on physician prescribed weight-loss regimen
2. Yes, not on physician prescribed weight-loss regimen

K0310. Weight gain
_____ **Gain of 5% or more in last 30 days; or 10% or more in the last 6 months**
0. No
1. Yes, on a physician prescribed weight-gain regimen
2. Yes, not on a physician prescribed weight-gain regimen

K0510. Nutrition Approaches
Check all of the following nutrition approaches that were performed during the last 7 days

1. **While Not a Resident** Performed **while not a resident** of this facility and within the last 7 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank. 2. **While a Resident** Performed **while a resident** of this facility and within the last 7 days	**1. While NOT a Resident**	**2. While a Resident**
	↓Check all that apply↓	
A. Parenteral/IV Feeding		
B. Feeding tube – nasogastric or abdominal (PEG)		
C. Mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)		
D. Therapeutic diet (e.g., low salt, diabetic. Low cholesterol)		
Z. None of the above		

K0700. Percent Intake by Artificial Route- Complete K0700 only if Column 1 and /or Column 2 are checked for K0510A and/or K0510B
_____ **A. Proportion of total calories the resident received through parenteral or tube feeding in the last 7 days**
1. 25% or less
2. 26-50%
3. 51% or more
_____ **B. Average fluid intake per day by IV or tube in last 7 days**
1. 500 cc/day or less
2. 501 cc/day or more

CAA Comments or Updates

Signature____ **Date**___________

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Re-Assessment Sample Form

Name: ______________________________ Physician: __________________ Room: ___________

Ht	UBW	BMI ☐ <18.5 Underweight ☐ 18.5-24.9 Normal Weight ☐ 25-29.9 Overweight ☐ ≥30 Obese ☐ ≥40 Extremely Obese	DOB Age M / F

Estimated Nutritional Needs (Based on CBW)

Total Kcal Needs	Protein Needs (gms)	Fluid Needs (mL)	Dining Needs Location changes:
Kg Wt X 25 / 30 / 35 + 500 kcal to gain / - 500 kcal to lose	1.0 / 1.25 / 1.5	25 / 30 / 35 / 1 mL/kcal consumed	Rehab dining: Y / N Adaptive equipment: Independent / Tray set up / Supervision / Limited Assist/ Total Dependence /Adaptive Equipment:

Date ________________ *Re-admit / MDS update, Q 1 / Q 2 / Q 3 / Y* *Progress Update / Significant Change*	**Date** ________________ *Re-admit / MDS update, Q 1 / Q 2 / Q 3 / Y* *Progress Update / Significant Change*	**Date** ________________ *Re-admit / MDS update, Q 1 / Q 2 / Q 3 / Y* *Progress Update / Significant Change*
New Medical Diagnosis	**New Medical Diagnosis**	**New Medical Diagnosis**
Diet Prescription Reg / Mech Soft / Pureed Other:	**Diet Prescription** Reg / Mech Soft / Pureed Other:	**Diet Prescription** Reg / Mech Soft / Pureed Other:
Oral Nutrition Supplements Calories Protein (gms)	**Oral Nutrition Supplements** Calories Protein (gms)	**Oral Nutrition Supplements** Calories: Protein (gms):
TF / TPN / IV Changes	**TF / TPN / IV Changes**	**TF / TPN / IV Changes**
Food/Fluid Intake Adequate to Meet Needs Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N	**Food/Fluid Intake Adequate to Meet Needs** Y / N
Weights: CBW: _________# ______# ( ) ↓ ↑ **5% past Mo** ______# ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _________# ______# ( ) ↓ ↑ **5% past Mo** ______# ( ) ↓ ↑ **10% past 6 Mo**	**Weights:** CBW: _________# ______# ( ) ↓ ↑ **5% past Mo** ______# ( ) ↓ ↑ **10% past 6 Mo**
Lab Changes Date:______ H/H ______ HbA1c ______ BS ______ Na ______ K+ _______ Ca++ ______ Alb ______ Pre-alb ______ BUN ______ Cr	**Lab Changes** Date:______ H/H ______ HbA1c ______ BS ______ Na _______ K+ _______ Ca++ ______ Alb ______ Pre-alb _______ BUN ______ Cr	**Lab Changes** Date:______ H/H ______ HbA1c ______ BS ______ Na _______ K+ _______ Ca++ ______ Alb ______ Pre-alb _______ BUN ______ Cr
Changes in Care / Condition (Meds, ADLs, physical, diagnosis, etc)	**Changes in Care / Condition** (Meds, ADLs, physical, diagnosis, etc)	**Changes in Care / Condition** (Meds, ADLs, physical, diagnosis, etc)
Signature/Date	Signature/Date	Signature/Date
PES STATEMENT Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)	**PES STATEMENT** Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)	**PES STATEMENT** Compromised nutrition and or hydration status, risk factors and/or complications indicate need for intervention (See Nutrition Prescription & Intervention)
NUTRITION DIAGNOSIS ☐Continue previous ☐Change to:	**NUTRITION DIAGNOSIS** ☐Continue previous ☐Change to:	**NUTRITION DIAGNOSIS** ☐Continue previous ☐Change to:
NUTRITION PRESCRIPTION & INTERVENTION ☐Continue previous ☐Change to:	**NUTRITION PRESCRIPTION & INTERVENTION** ☐Continue previous ☐Change to:	**NUTRITION PRESCRIPTION & INTERVENTION** ☐Continue previous ☐Change to:
Care Plan ☐Continue previous ☐Update	**Care Plan** ☐Continue previous ☐Update	**Care Plan** ☐Continue previous ☐Update
NUTRITION MONITORING Weight / Labs / Skin / Diet / TF Tolerance	**NUTRITION MONITORING** Weight / Labs / Skin / Diet / TF Tolerance	**NUTRITION MONITORING** Weight / Labs / Skin / Diet / TF Tolerance
Signature	Signature	Signature

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Care Plan

Date	Problem/Etiology/Signs/ Symptoms	**Goal** (and Date)	Nutrition Intervention
		□ Improve BMI to_______ □ No weight decline □ Improved lab values □ Gradual weight loss	□ Provide diet and fluids per physician order □ Provide TF and flushes per order
		□ Will tolerate alternate feeding to meet nutrient needs	□ Monitor weight every month/week
			□ Monitor weight every month/week
			□ Monitor all labs as available
			□ Monitor PO food/fluid intake
			□ Oral nutritional supplement as ordered
			□ Monitor pressure ulcer/ wound healing progress
			□ Educate as needed
			□ Medications as ordered
			□ Monitor diet tolerance
			□ Monitor TF tolerance
			□
			□
			□
			□
Intake (NI)	**Nutrition Diagnosis (NI/NB/NC)**		**Nutrition Prescription (ND/E/C/RC)**
	Intake		**ND (Meals/snacks)**
Behavior/ Environ-mental	**Weight/Lifestyle/ Knowledge**		**E (Education)**
			C (Basis/approach)
Functional (NC)	**Swallowing/Chewing Deficit**		
			RC (Care coordination)

See Medical Nutrition Assessment/Re-Assessment and Progress Notes for Details

Resident:_______________________________________ Room/ID#_______________________

Signature:_______________________________________ Date:__________________________

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Documentation Forms

Insert a sample of your blank medical nutrition therapy (MNT) documentation forms here.

©2013 Becky Dorner & Associates, Inc.

Medical Nutrition Therapy Recommendations

Policy:

Medical nutrition therapy (MNT) recommendations from the registered dietitian (RD) or designee will be implemented, or reason for non-implementation will be documented.

Procedure:

1. Any of the RD's or designee's recommendations related to food will be given to the food service manager, who will follow through and implement them in the facility. (Informing staff, making necessary changes on the meal identification (ID) card/ticket, etc.). The food service manager will follow through on these recommendations in a timely manner.

2. Any recommendations, which need nursings' attention or a physician's order will be forwarded in writing to the nursing staff. As nursing addresses the recommendations, comments regarding follow through will be added to the form. Completed forms will be returned to the RD or designee for documentation of actions taken, new orders and follow through. Referrals will be made back to the RD or designee as needed.

3. Routine recommendations will be returned to the RD or designee in a timely manner. Recommendations that are more urgent will be handled and returned within 48 to 72 hours or less.

4. The RD or designee will follow up on returned routine recommendation sheets in a timely manner (within one to two weeks for nursing facilities). If there is an urgent recommendation, the RD or designee may follow up in a shorter period of time. Urgent recommendations or concerns may be handled via phone, secure fax or email.

5. If the physician is not in agreement with recommendation, documentation will be written in the nutrition progress notes.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), Nutrition Associates (four year degree in nutrition/dietetics), Certified Dietary Managers (CDM), Food Service Managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Nutrition Recommendations Sample Form

Facility: **Wing:**

Please complete and return to RD or designee. Thank You!

Name________________________ Room__________ New____ Re-admit____ Update___

Food Service	Nursing	Physician Please Consider
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Comments:	**Comments:**	
Manager's Signature/Date:	Nursing Signature/Date:	

Name__________________________ Room__________ New____ Re-admit____ Update___

Food Service	Nursing	Physician Please Consider
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Comments:	**Comments:**	
Manager's Signature/Date:	Nursing Signature/Date:	

Name__________________________ Room__________ New____ Re-admit____ Update___

Food Service	Nursing	Physician Please Consider
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Comments:	**Comments:**	
Manager's Signature/Date:	Nursing Signature/Date:	

©2013 Becky Dorner & Associates, Inc.

Communications of Nutritional Concerns

Policy:

The registered dietitian (RD) or designee will communicate nutrition concerns to the medical staff.

Procedure:

1. The RD or designee is an active member of the appropriate interdisciplinary (IDT) committees (i.e. JCAHO meetings, nutrition at risk team, pressure ulcer team, weight team, dining team etc.)

2. The RD or designee routinely attends the care plan conferences.

3. Under the direction of the RD or designee, the nutrition support staff may communicate issues of concern to key personnel (RD, physician, nursing staff, therapists, etc.) as appropriate.
   - If authorized, the nutrition support staff will follow through on any duties as appropriate.
   - The nutrition support staff will follow up on communications with the interdisciplinary team to ensure recommendations are considered.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Anthropometrics

- ♦ Obtaining Accurate Heights 9-1
- ♦ Resource: How to Obtain Accurate Heights 9-2
- ♦ Obtaining Accurate Weights 9-3
- ♦ Resource: How to Obtain Accurate Weights 9-4
- ♦ Adjusting Weights for Amputees 9-6
- ♦ Obtaining Measurements for Unweighable Individuals 9-7
- ♦ Measurement Tracking for Unweighable Individuals Sample Form 9-8
- ♦ Resource: Height/Weight Tables for Determining Body Weight Ranges 9-9
- ♦ Body Mass Index 9-10
- ♦ Resource: Body Mass Index Tables 9-11
- ♦ Resource: Significant Weight Change 9-13
- ♦ Significant Weight Change Chart 9-14
- ♦ Tracking Weight Changes 9-18
- ♦ Monthly Weight Record Sample Form 9-19
- ♦ Individual Weight Chart Sample Form 9-20
- ♦ Weekly Weight Record Sample Form 9-21
- ♦ Significant Weight Changes Sample Form 9-22
- ♦ Weight Change Notification and Recommendations Sample Form 9-23
- ♦ Significant Weight Loss Sample Form 9-24
- ♦ Immediate Temporary Interventions for Unplanned Significant Weight Loss 9-25
- ♦ Significant Weight Loss 9-26
- ♦ Significant Weight Gain 9-29

©2013 Becky Dorner & Associates, Inc.

Obtaining Accurate Heights

Policy:

Each individual's height will be determined and documented upon admission to the facility. Height will be remeasured each year or upon a significant change such as double amputation.

Procedure:

1. Nursing will be responsible for the initial determination of each individual's height. This will be included in the initial nursing assessment and/or admission note. Subsequent measurements for height (yearly or upon significant change in height) will be documented on the appropriate designated form or tracked in the computer database.

2. Nursing will remeasure each individual's height yearly. Height will be documented on the individual assessment instrument (MDS for nursing facilities) and in the medical nutrition therapy (MNT) assessment.

3. Staff will follow acceptable procedure to obtain accurate heights.

See Resource: How to Obtain Accurate Heights.

©2013 Becky Dorner & Associates, Inc.

Resource: How to Obtain Accurate Heights

To obtain an accurate height, the following methods may be used:

Standing Height

- To obtain an accurate height, measure the individual without shoes, standing as erect as possible
- If using the measuring bar on the scale, it should be placed flat on the head
- Read the measurement on the bar and record immediately

  If Using a Yardstick
  - Have the individual stand against a wall, as erect as possible
  - Place the yardstick parallel to the floor, on top of the individual's head
  - Mark the wall at the top of the individual's head, using the yardstick as a guide.
  - Measure from the floor to the mark (where the top of the individual's head was)

How to Obtain a Reclining Height

- If unable to stand, lay individual as flat as possible on back with body and legs extended as straight as possible. Mark bed at top of the head and at the heel. Move the individual and using a tape measure, measure between the marks for the estimated height

  Alternate Method (Arm Span Measurement)
  - Arm span measurement is approximately the same as height
  - The individual should lie flat, with 1 arm extended in a 90 degree angle to the torso
  - With arm and hand extended straight out, use a tape measure to measure from the middle of the sternum to the tip of the middle finger
  - Double this number for an approximate height in inches
  - Document as approximate height

Unable to Obtain Accurate Height Measurements

For those who are unmeasurable, an estimate of height should be made.

- Ask the family what the individual's normal height was
- Document that the family provided the height and the reason it was not possible to obtain an accurate height on the individual

©2013 Becky Dorner & Associates, Inc.

Obtaining Accurate Weights

Policy:

Each individual's weight will be determined and documented upon admission to the facility.

Procedure:

Weights:

1. Nursing will be responsible for the initial determination of each individual's weight. This will be included in the initial nursing assessment and/or admission note. Subsequent measurements for weight will be documented on the appropriate designated form or tracked in the computer database.

Weight will be documented on the individual assessment instrument (MDS for nursing facilities), and in the medical nutrition therapy (MNT) assessment. Weight will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly, unless physician's orders or an individual's condition warrants more frequent determinations.

2. The registered dietitian (RD) or designee will be responsible for determining the desirable weight range. This will be documented on the initial MNT assessment and reassessments.

3. Staff will follow acceptable procedure to obtain accurate weights.

See Resource: How to Obtain Accurate Weights.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Resource: How to Obtain Accurate Weights

How to Obtain Accurate Weights:

- Balance the scale back to 0 before and after weighing each time
- Do NOT move scales from place to place
- Record weight immediately after weighing each individual
- Weigh each individual at the same time each month, and record the weight using the documentation system provided by the facility
- Individuals should be weighed at approximately the same time of day each time
- Individuals should be weighed in light clothing, without shoes, prior to breakfast, after voiding, and without catheter bag or with an empty catheter bag (if applicable)
- Prosthetic devices (including braces) should be removed prior to weighing or weigh the prosthetic device itself and subtract its weight from the individual's total weight
- Nursing must document any casts, or appliances such as splints, etc.
- Scales should be calibrated on a regular schedule every 3 months

Standing Scale Weights

- Position the individual standing with feet in the center of the scale (must be able to stand without assistance)
- When the scale is balanced and has stopped its movement, record the weight
- If an individual is unable to stand still and balanced on the scale independently, a wheelchair, chair scale or bed scale should be used
- Balance the scale back to 0 before and after weighing each time

Chair Scale Weights

- Position the individual in the center of the chair, with back resting on the back of chair
- When the scale is balanced and has stopped its movement, record the weight
- Balance the scale back to 0 before and after weighing each time

Wheel Chair Scale Weights

- Be sure the chair is free of extra weight (i.e. side bags, catheter bags, cushions or other items)
- Roll the wheel chair onto the wheel chair scale platform. Center the wheel chair on the scale
- Weigh the wheel chair and record the total weight of the wheel chair and the individual
- Remove the individual from the wheel chair. Weigh the wheel chair by itself
- Carefully subtract the weight of the wheel chair and record the individual's actual weight
- Balance the scale back to 0 before and after weighing each time

Bed Scale Weights

- Follow manufacturer's directions for proper operation of bed scales and lift scales
- Use the bed scale or lift scale sling to lift the individual for weighing
- The individual should be positioned comfortably in the scale sling
- Raise the sling slowly until it is fully suspended and still
- Read and record weight immediately
- Lower the person back onto the bed slowly and gently
- Balance the scale back to 0 before and after weighing each time

Obtaining Measurements for Unweighable Individuals

- For individuals who are unable or unwilling to be weighed, measurements can be taken and tracked for changes
- Measure the abdomen, mid-arm, thigh and calf at least monthly, or more often if needed

©2013 Becky Dorner & Associates, Inc.

Resource: How to Obtain Accurate Weights

- Measure abdominal girth at the widest point. Measure upper arm, calf and thigh at the
- midpoint
- Tape measure should be taut, but not tight. Measurement variations of >1/4" difference from the previous measurement should be remeasured for accuracy
- The registered dietitian (RD) or designee should review these measurements monthly and assess the need for changes in medical nutrition therapy

©2013 Becky Dorner & Associates, Inc.

Adjusting Weights for Amputees

Policy:

To determine adjusted ideal body weight for those with amputations, the percentage of body weight indicated by the chart below is subtracted from the ideal body weight (IBW) range. (See Resource: Height/Weight Tables for Determining Body Weight Ranges.)

Average Weight Percentage of Body Segments	
Lower Arm and Hand	2.3%
Entire Arm and Hand	5.0%
Lower Leg and Foot	5.9%
Entire Leg	16%

Procedure:

1. Using the Height/Weight Tables for Determining Body Weight Ranges to determine the individual's normal IBW for height, locate the percentage weight of the amputated limb and calculate the number of estimated pounds for that limb.

2. Subtract the estimated weight of the limb from the IBW range for an estimated normal IBW after amputation.

   Example:

   Male with below knee amputation (5.9%) – height 5'7"
   - Ideal Body Weight (mean Range) – 145#

   - 145# x .059 (5.9%) = 8.55 pounds
   - Adjusted Ideal Body Weight = 145# - 8.55# = 136.45#

Reference: Krause's Food and The Nutrition Care Process, 13th ed. Mahan, LK, Escott-Stump, S, Raymond JL. Elsevier Saunders, St. Louis MO, 2012.

©2013 Becky Dorner & Associates, Inc.

Obtaining Measurements for Unweighable Individuals

Policy:

Individuals who are unable to be weighed due to inability to stand, sit or inability to weigh on bed scales, will be measured at abdomen, mid-arm, thigh and calf. Measurements will be monitored for change.

Procedure:

1. Measure at least monthly, or more often if needed.

2. Tape measure should be taut, but not tight.

3. Measurement variations of ≥1/4” difference from the previous measurement will be repeated for accuracy.

4. The registered dietitian (RD) or designee will review these measurements monthly and assess the need for changes in medical nutrition therapy (MNT).

5. Measure abdominal girth at the widest point. Measure upper arm, calf and thigh at the midpoint.

See Measurement Tracking for Unweighable Individuals Sample Form for measurement record keeping on the next page.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Measurement Tracking for Unweighable Individuals Sample Form

Body Measurements

Date	Abdominal Girth (Widest Point)	Arm (Mid Point)		Mid-Thigh (Mid Point)		Mid-Calf (Widest Point)	
		R	LT	R	LT	R	LT

Measure abdominal girth at the widest point. Measure upper arm, calf and thigh at the midpoint.

©2013 Becky Dorner & Associates, Inc.

Resource: Height/Weight Tables for Determining Body Weight Ranges

Adult Ideal Weight Ranges 51 + Years

Females:

Height	Weight Range	Mean Weight
4'8"	81-99	90
4'9"	83.5-102	92.5
4'10"	85-105	95
4'11"	87.5-107	97.5
5'0"	90-110	100
5'1"	94-116	105
5'2"	99-121	110
5'3"	104-127	115
5'4"	108-132	120
5'5"	112-138	125
5'6"	117-143	130
5'7"	121-149	135
5'8"	126-154	140
5'9"	130-160	145
5'10"	135-165	150

Males:

Height	Weight Range	Mean Weight
5'0"	95-117	106
5'1"	100-123	112
5'2"	106-130	118
5'3"	111-136	124
5'4"	117-143	130
5'5"	122-150	136
5'6"	127-156	142
5'7"	133-163	148
5'8"	139-169	154
5'9"	144-176	160
5'10"	149-183	166
5'11"	154-189	172
6'0"	160-196	178
6'1"	166-202	184
6'2"	171-209	190

This chart is based on the following formula:

Female:
100 pounds for the first five feet of height plus five pounds for each inch over five feet of height; minus 2½ pounds for every inch under five feet of height; plus or minus 10% to give the range.

Male:
106 pounds for the first five feet of height plus six pounds for each inch over five feet of height; minus 2½ pounds for every inch under five feet of height; plus or minus 10% to give the range.

Reference:
Krause's Food and the Nutrition Care Process, 13th ed. Mahan LK, Escott-Stump S, and Raymond JL. Elsevier Saunders, St. Louis MO, 2012.

©2013 Becky Dorner & Associates, Inc.

Body Mass Index

Policy:

All individuals will be assessed for indicators of nutrition status and decline using body mass index (as one of many factors). Body mass index (BMI) is a measure of body fat based on height and weight which applies to both men and women.

Procedure:

1. BMI will be utilized as an indicator of body fatness and/or ideal body weight. Higher BMI is associated with diabetes and cardiovascular disease. Data suggests that a higher BMI range may be protective in older adults and that the standards for ideal weight (BMI of 18.5 to 25) may be too restrictive in the elderly. A lower BMI may be considered detrimental to older adults due to association with declining nutrition status, potential pressure ulcers, infection and other complications. A BMI of 19 or less may indicate nutritional depletion, while a BMI of 30 or above indicates obesity.

NIH Classification of Overweight and Obesity by BMI*

	Obesity Class	BMI (kg/m2)
Normal		18.5-24.9
Overweight		25.0-29.9
Obesity	I	30.0-34.9
	II	35.0-39.9

*This guideline specifically excludes pregnant woman. Source (adapted from): Preventing and Managing the Global Epidemic of Obesity. Report of the World Health Organization Consultation of Obesity. SHO. Geneva, June 1997.

2. The registered dietitian (RD) or designee will determine the BMI for individuals utilizing the following formula (or by utilizing the BMI charts on the following pages). In some instances, computer programs utilized by the RD or designee will calculate the BMI automatically when weights and heights are recorded.

BMI = weight (kg)/height (meters squared)

Current weight in kilograms divided by the square of the height in meters

OR

BMI = weight (lbs)/height (inches squared) x 705

3. The RD or designee will provide appropriate nutritional interventions for individuals with low or declining BMI or individuals with BMI over 30 as appropriate.

Reference: Krauses's Food and The Nutrition Care Process, 13th ed. Mahan LK, Escott-Stump S, Raymmlond JL., Elsevier Saunders; St Louis MO, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Body Mass Index Tables

To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight. The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off.

BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height (inches)	**Body Weight (pounds)**																
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

Source: National Heart, Lung, and Blood Institute.
http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. Accessed September 10, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Body Mass Index Tables

To use the table, find the appropriate height in the left-hand column labeled Height. Move across to a given weight. The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off.

BMI	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54
Height (inches)	**Body Weight (pounds)**																		
58	172	177	181	186	191	196	201	205	210	215	220	224	229	234	239	244	248	253	258
59	178	183	188	193	198	203	208	212	217	222	227	232	237	242	247	252	257	262	267
60	184	189	194	199	204	209	215	220	225	230	235	240	245	250	255	261	266	271	276
61	190	195	201	206	211	217	222	227	232	238	243	248	254	259	264	269	275	280	285
62	196	202	207	213	218	224	229	235	240	246	251	256	262	267	273	278	284	289	295
63	203	208	214	220	225	231	237	242	248	254	259	265	270	278	282	287	293	299	304
64	209	215	221	227	232	238	244	250	256	262	267	273	279	285	291	296	302	308	314
65	216	222	228	234	240	246	252	258	264	270	276	282	288	294	300	306	312	318	324
66	223	229	235	241	247	253	260	266	272	278	284	291	297	303	309	315	322	328	334
67	230	236	242	249	255	261	268	274	280	287	293	299	306	312	319	325	331	338	344
68	236	243	249	256	262	269	276	282	289	295	302	308	315	322	328	335	341	348	354
69	243	250	257	263	270	277	284	291	297	304	311	318	324	331	338	345	351	358	365
70	250	257	264	271	278	285	292	299	306	313	320	327	334	341	348	355	362	369	376
71	257	265	272	279	286	293	301	308	315	322	329	338	343	351	358	365	372	379	386
72	265	272	279	287	294	302	309	316	324	331	338	346	353	361	368	375	383	390	397
73	272	280	288	295	302	310	318	325	333	340	348	355	363	371	378	386	393	401	408
74	280	287	295	303	311	319	326	334	342	350	358	365	373	381	389	396	404	412	420
75	287	295	303	311	319	327	335	343	351	359	367	375	383	391	399	407	415	423	431
76	295	304	312	320	328	336	344	353	361	369	377	385	394	402	410	418	426	435	443

Source: National Heart, Lung, and Blood Institute.
http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. Accessed September 10, 2012.

©2013 Becky Dorner & Associates, Inc.

Resource: Significant Weight Change

Significant and severe weight change is defined as follows:

Time Interval	Significant Change	Severe Change
1 Week	1-2%	Greater than 1-2%
1 Month	5%	Greater than 5%
3 Months	7.5%	Greater than 7.5%
6 Months	10%	Greater than 10%

Weights should be monitored monthly for significant/severe change and documented accordingly. If the weight is in question, first ask appropriate staff to reweigh the individual to assure an accurate weight.

- For weight loss, follow the Significant Weight Loss policy and procedure.
- For weight gain, follow the Significant Weight Gain policy and procedure.

For continued weight loss, it is extremely important to review the advanced directive statements on the chart. If there is no advance directive in the chart, refer to social services and/or nursing. Document the wishes of the individual and/or family and follow up as appropriate. Documentation may need to be completed monthly, bi-weekly, weekly, or even daily (depending on status).

The following tables are provided to assist with calculation and assessment of significant/severe changes in weight.

©2013 Becky Dorner & Associates, Inc.

Resource: Significant Weight Change Chart

Time Interval	Significant Change	Severe Change
1 Month	5%	Greater than 5%
3 Months	7.5%	Greater than 7.5%
6 Months	10%	Greater than 10%

Weight	5% ↓		5% ↑	7.5% ↓		7.5% ↑	10% ↓		10% ↑
70	66.50	-	73.50	64.75	-	75.25	63.00	-	77.00
71	67.45	-	74.55	65.68	-	76.33	63.90	-	78.10
72	68.40	-	75.60	66.60	-	77.40	64.80	-	79.20
73	69.35	-	76.65	67.53	-	78.48	65.70	-	80.30
74	70.30	-	77.70	68.45	-	79.55	66.60	-	81.40
75	71.25	-	78.75	69.38	-	80.63	67.50	-	82.50
76	72.20	-	79.80	70.30	-	81.70	68.40	-	83.60
77	73.15	-	80.85	71.23	-	82.78	69.30	-	84.70
78	74.10	-	81.90	72.15	-	83.85	70.20	-	85.80
79	75.05	-	82.95	73.08	-	84.93	71.10	-	86.90
80	76.00	-	84.00	74.00	-	86.00	72.00	-	88.00
81	76.95	-	85.05	74.93	-	87.08	72.90	-	89.10
82	77.90	-	86.10	75.85	-	88.15	73.80	-	90.20
83	78.85	-	87.15	76.78	-	89.23	74.70	-	91.30
84	79.80	-	88.20	77.70	-	90.30	75.60	-	92.40
85	80.75	-	89.25	78.63	-	91.38	76.50	-	93.50
86	81.70	-	90.30	79.55	-	92.45	77.40	-	94.60
87	82.65	-	91.35	80.48	-	93.53	78.30	-	95.70
88	83.60	-	92.40	81.40	-	94.60	79.20	-	96.80
89	84.55	-	93.45	82.33	-	95.68	80.10	-	97.90
90	85.50	-	94.50	83.25	-	96.75	81.00	-	99.00
91	86.45	-	95.55	84.18	-	97.83	81.90	-	100.10
92	87.40	-	96.60	85.10	-	98.90	82.80	-	101.20
93	88.35	-	97.65	86.03	-	99.98	83.70	-	102.30
94	89.30	-	98.70	86.95	-	101.50	84.60	-	103.40
95	90.25	-	99.75	87.88	-	102.13	85.50	-	104.50
96	91.20	-	100.80	88.80	-	103.20	86.40	-	105.60
97	92.15	-	101.85	89.73	-	104.28	87.30	-	106.70
98	93.10	-	102.90	90.65	-	105.35	88.20	-	107.80
99	94.05	-	103.95	91.53	-	106.43	89.10	-	108.90
100	95.00	-	105.00	92.50	-	107.50	90.00	-	110.00
101	95.95	-	106.05	93.43	-	108.58	90.90	-	111.10
102	96.90	-	107.10	94.35	-	109.65	91.80	-	112.20
103	97.85	-	108.15	95.28	-	110.73	92.70	-	113.30
104	98.80	-	109.20	96.20	-	111.80	93.60	-	114.40
105	99.75	-	110.25	97.13	-	112.88	94.50	-	115.50
106	100.70	-	111.30	98.05	-	113.95	95.40	-	116.60
107	101.65	-	112.35	98.98	-	115.03	96.30	-	117.70
108	102.60	-	113.40	99.90	-	116.10	97.20	-	118.80
109	103.55	-	114.45	100.83	-	117.18	98.10	-	119.90
110	104.50	-	115.50	101.75	-	118.25	99.00	-	121.00
111	105.45	-	116.55	102.68	-	119.33	99.90	-	122.10
112	106.40	-	117.60	103.60	-	120.40	100.80	-	123.20
113	107.35	-	118.65	104.53	-	121.48	101.70	-	124.30
114	108.30	-	119.70	105.45	-	122.55	102.60	-	125.40
115	109.25	-	120.75	106.38	-	123.63	103.50	-	126.50

©2013 Becky Dorner & Associates, Inc.

Resource: Significant Weight Change Chart

Time Interval	Significant Change	Severe Change
1 Month	5%	Greater than 5%
3 Months	7.5%	Greater than 7.5%
6 Months	10%	Greater than 10%

Weight	5% ↓		5% ↑	7.5% ↓		7.5% ↑	10% ↓		10% ↑
116	110.20	-	121.80	107.30	-	124.70	104.40	-	127.60
117	111.15	-	122.85	108.23	-	125.78	105.30	-	128.70
118	112.10	-	123.90	109.15	-	126.85	106.20	-	129.80
119	113.05	-	124.95	110.08	-	127.93	107.10	-	130.90
120	114.00	-	126.00	111.00	-	129.00	108.00	-	132.00
121	114.95	-	127.05	111.93	-	130.08	108.90	-	133.10
122	115.90	-	128.10	112.85	-	131.15	109.80	-	134.20
123	116.85	-	129.15	113.78	-	132.23	110.70	-	135.30
124	117.80	-	130.20	114.70	-	133.30	111.60	-	136.40
125	118.75	-	131.25	115.63	-	134.38	112.50	-	137.50
126	119.70	-	132.30	116.55	-	135.45	113.40	-	138.60
127	120.65	-	133.35	117.48	-	136.53	114.30	-	139.70
128	121.60	-	134.40	118.40	-	137.60	115.20	-	140.80
129	122.55	-	135.45	119.33	-	138.68	116.10	-	141.90
130	123.35	-	136.50	120.25	-	139.75	117.00	-	143.00
131	124.45	-	137.55	121.18	-	140.83	117.90	-	144.10
132	125.40	-	138.60	122.10	-	141.90	118.80	-	145.20
133	126.35	-	139.65	123.03	-	142.98	119.70	-	146.30
134	127.30	-	140.70	123.95	-	144.05	120.60	-	147.40
135	128.25	-	141.75	124.88	-	145.13	121.50	-	148.50
136	129.20	-	142.80	125.80	-	146.20	122.40	-	149.60
137	130.15	-	143.85	126.73	-	147.28	123.30	-	150.70
138	131.10	-	144.90	127.65	-	148.35	124.20	-	151.80
139	132.02	-	145.95	128.58	-	149.43	125.10	-	152.90
140	133.00	-	147.00	129.50	-	150.50	126.00	-	154.00
141	133.95	-	148.05	130.43	-	151.58	126.90	-	155.10
142	134.90	-	149.10	131.35	-	152.68	127.80	-	156.20
143	135.85	-	150.15	132.28	-	153.73	128.70	-	157.30
144	136.80	-	152.25	133.20	-	154.80	129.60	-	158.40
145	137.75	-	153.30	134.13	-	155.80	130.50	-	159.50
146	138.70	-	154.35	135.05	-	156.95	131.40	-	160.60
147	139.65	-	155.40	135.98	-	158.03	132.30	-	161.70
148	140.60	-	156.45	136.90	-	159.10	133.20	-	162.80
149	141.55	-	157.50	137.83	-	160.18	134.10	-	163.90
150	142.50	-	158.55	138.75	-	161.25	135.00	-	165.00
151	143.45	-	159.60	139.68	-	162.33	135.90	-	166.10
152	144.40	-	160.65	140.60	-	163.40	136.80	-	167.20
153	145.35	-	161.70	141.53	-	164.48	137.70	-	168.30
154	146.30	-	162.75	142.45	-	165.55	138.60	-	169.40
155	147.25	-	163.80	143.38	-	166.63	139.50	-	170.50
156	148.20	-	164.85	144.30	-	167.70	140.40	-	171.60
157	149.15	-	165.90	145.23	-	168.78	141.30	-	172.70
158	150.10	-	168.00	146.15	-	169.85	142.20	-	173.80
159	151.05	-	166.95	147.08	-	170.93	143.10	-	174.90
160	152.00	-	169.05	148.00	-	172.00	144.00	-	176.00

©2013 Becky Dorner & Associates, Inc.

Resource: Significant Weight Change Chart

Time Interval	Significant Change	Severe Change
1 Month	5%	Greater than 5%
3 Months	7.5%	Greater than 7.5%
6 Months	10%	Greater than 10%

Weight	5% ↓		5% ↑	7.5% ↓		7.5% ↑	10% ↓		10% ↑
161	152.95	-	169.05	148.93	-	173.08	144.90	-	177.10
162	153.90	-	170.10	149.85	-	174.15	145.80	-	178.20
163	154.85	-	171.15	150.78	-	175.23	146.70	-	179.30
164	155.80	-	172.20	151.70	-	176.30	147.60	-	180.40
165	156.75	-	173.25	152.63	-	177.38	148.50	-	181.50
166	157.70	-	174.30	153.55	-	178.45	149.40	-	182.60
167	158.65	-	175.35	154.48	-	179.53	150.30	-	183.70
168	159.60	-	176.40	155.40	-	180.60	151.20	-	184.80
169	160.55	-	177.45	156.33	-	181.68	152.10	-	185.90
170	161.50	-	178.50	157.25	-	182.75	153.00	-	187.00
171	162.45	-	179.55	158.18	-	183.83	153.90	-	188.10
172	163.40	-	180.60	159.10	-	184.90	154.80	-	189.20
173	164.35	-	181.65	160.03	-	185.98	155.70	-	190.30
174	165.30	-	182.70	160.95	-	187.05	156.60	-	191.40
175	166.25	-	183.75	161.88	-	188.13	157.50	-	192.50
176	167.20	-	184.80	162.80	-	189.20	158.40	-	193.60
177	168.15	-	185.85	163.73	-	190.28	159.30	-	194.70
178	169.10	-	186.90	164.65	-	191.35	160.20	-	195.80
179	170.05	-	187.95	165.58	-	192.43	161.10	-	196.90
180	171.00	-	189.00	166.50	-	193.50	162.00	-	198.00
181	171.95	-	190.05	167.43	-	194.58	162.90	-	199.10
182	172.90	-	191.10	168.35	-	195.65	163.80	-	200.20
183	173.85	-	192.15	169.28	-	196.73	164.70	-	201.30
184	174.80	-	193.20	170.20	-	197.80	165.60	-	202.40
185	175.75	-	194.25	171.13	-	198.88	166.50	-	203.50
186	176.70	-	195.30	172.05	-	199.95	167.40	-	204.60
187	177.65	-	196.35	172.98	-	201.03	168.30	-	205.70
188	178.60	-	197.40	173.90	-	202.10	169.20	-	206.80
189	179.55	-	198.45	174.83	-	203.18	170.10	-	207.90
190	180.50	-	199.50	175.75	-	204.25	171.00	-	209.00
191	181.45	-	200.55	176.68	-	205.33	171.90	-	210.10
192	182.40	-	201.60	177.60	-	206.40	172.80	-	211.20
193	183.35	-	202.65	178.53	-	207.48	173.70	-	212.30
194	184.30	-	203.70	179.45	-	208.55	174.60	-	213.40
195	185.25	-	204.75	180.38	-	209.63	175.50	-	214.50
196	186.20	-	205.80	181.30	-	210.70	176.40	-	215.60
197	187.15	-	206.85	182.23	-	211.78	177.30	-	216.70
198	188.10	-	207.90	183.15	-	212.85	178.20	-	217.80
199	189.05	-	208.95	184.08	-	213.93	179.10	-	218.90
200	190.00	-	210.00	185.00	-	215.00	180.00	-	220.00
201	190.95	-	211.05	185.93	-	216.08	180.90	-	221.10
202	191.90	-	212.10	186.85	-	217.15	181.80	-	222.20.
203	192.85	-	213.15	187.78	-	218.23	182.70	-	223.30
204	193.80	-	214.20	188.70	-	219.30	183.60	-	224.40
205	194.75	-	215.25	189.63	-	220.38	184.50	-	225.50

©2013 Becky Dorner & Associates, Inc.

Resource: Significant Weight Change Chart

Time Interval	Significant Change	Severe Change
1 Month	5%	Greater than 5%
3 Months	7.5%	Greater than 7.5%
6 Months	10%	Greater than 10%

Weight	5% ↓		5% ↑	7.5% ↓		7.5% ↑	10% ↓		10% ↑
206	195.70	-	216.30	190.55	-	221.45	185.40	-	226.60
207	196.65	-	217.35	191.48	-	222.53	186.30	-	227.70
208	197.60	-	218.40	192.40	-	223.60	187.20	-	228.80
209	198.55	-	219.45	193.33	-	224.68	188.10	-	229.90
210	199.50	-	220.50	194.25	-	225.75	189.00	-	231.00
211	200.45	-	221.55	195.18	-	226.83.	189.90	-	232.10
212	201.40	-	222.60	196.10	-	227.90	190.80	-	233.20
213	202.35	-	223.65	197.03	-	228.98	191.70	-	234.30
214	203.30	-	224.70	197.95	-	230.05	192.60	-	235.40
215	204.25	-	225.75	198.88	-	231.13	193.50	-	236.50
216	205.20	-	226.80	199.80	-	232.20	194.40	-	237.60
217	206.15	-	227.85	200.73	-	233.28	195.30	-	238.70
218	207.10	-	228.90	201.65	-	234.35	196.20	-	239.80
219	208.05	-	229.95	202.58	-	235.43	197.10	-	240.90
220	209.00	-	231.00	203.50	-	236.50	198.00	-	242.00
221	209.95	-	232.05	204.43	-	237.58	198.90	-	243.10
222	210.90	-	233.10	205.35	-	238.65	199.80	-	244.20
223	211.85	-	234.15	206.28	-	239.73	200.70	-	245.30
224	212.80	-	235.20	207.20	-	240.80	201.60	-	246.40
225	213.75	-	236.25	208.13	-	241.88	202.50	-	247.50
226	214.70	-	237.30	209.05	-	242.95	203.40	-	248.60
227	215.65	-	238.35	209.98	-	244.03	204.30	-	249.70
228	216.60	-	239.40	210.90	-	245.10	205.20	-	250.80
229	217.55	-	240.45	211.83	-	246.18	206.10	-	251.90
230	218.50	-	241.50	212.75	-	247.25	207.00	-	253.00
231	219.45	-	242.55	213.68	-	248.33	207.90	-	254.10
232	220.40	-	243.60	214.60	-	249.40	208.80	-	255.20
233	221.35	-	244.65	215.53	-	250.48	209.70	-	256.30
234	222.30	-	245.70	216.45	-	251.55	210.60	-	257.40
235	223.25	-	246.75	217.38	-	252.63	211.50	-	258.50
236	224.20	-	247.80	218.30	-	253.70	212.40	-	259.60
237	225.15	-	248.85	219.23	-	254.78	213.30	-	260.70
238	226.10	-	249.90	220.15	-	255.85	214.20	-	261.80
239	227.05	-	250.95	221.08	-	256.93	215.10	-	262.90
240	228.00	-	252.00	222.00	-	258.00	216.00	-	264.00
241	228.95	-	253.05	222.93	-	259.08	216.90	-	265.10
242	229.90	-	254.10	223.85	-	260.15	217.80	-	266.20
243	230.85	-	255.15	224.78	-	261.23	218.70	-	267.30
244	231.80	-	256.20	225.70	-	262.30	219.60	-	268.40
245	232.75	-	257.25	226.63	-	263.38	220.50	-	269.50
246	233.70	-	258.30	227.55	-	264.45	221.40	-	270.60
247	234.65	-	259.35	228.48	-	265.53	222.30	-	271.70
248	235.60	-	260.40	229.40	-	266.60	223.20	-	272.80
249	236.55	-	261.45	230.33	-	267.68	224.10	-	273.90
250	237.50	-	262.50	231.25	-	268.75	225.00	-	275.00

©2013 Becky Dorner & Associates, Inc.

Tracking Weight Changes

Policy:

Weights will be documented for all individuals, for the purpose of assessing significant and insidious (slow) weight changes.

Procedure:

1. The facility is responsible for obtaining correct weights on a regular basis, and for keeping accurate records. This includes having adequate weight scales, bed scales, lift scales, and/or wheel chair scales as needed.

2. A copy of weight records will be forwarded to the appropriate professional each month: weight team leader, registered dietitian (RD) or designee, nursing supervisor, etc. The RD or designee will review monthly weights and calculate significant change over one, three, and six months. A copy of all significant weight losses and gains will be given to the interdisciplinary care team for appropriate review and documentation.

3. Weight records should also be reviewed for insidious (slow) weight loss over a period of a few months. Weight loss that does not trigger as significant should be addressed by the care plan team because it may be an indicator of other changes in the individual's condition.

4. All individuals with significant weight changes will be reweighed to assure accuracy of the weight prior to reporting this to the staff, physician, or family.

5. The care team will review and document on all insidious and significant weight changes, with appropriate referrals to the physician and RD or designee. The RD or designee will review all significant weight losses, and assess for insidious weight loss as well. The RD or designee will make referrals and take action as necessary (including follow up documentation).

6. The individual, family (or representative), physician and RD or designee will be notified of any individual with an unplanned significant weight change of 5% in one month, 7.5% in three months, or 10% in six months.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Monthly Weight Record Sample Form

Monthly Weight Record for __________ Year **Facility/Wing ____________________**

Room	Name	Ht	UBW	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Ht = Height
UBW = Usual body weight

©2013 Becky Dorner & Associates, Inc.

Individual Weight Chart Sample Form

Name ____________________________ Ht _________ UBW _______ Year _________

Time Interval	Significant Change	Severe Change
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

Month/ Date	Wt	% Wt Change Past Month	% Wt Change Past 3 Months	% Wt Change Past 6 Months	Date Resident, Family, RD & Physician Notified	Comments
Jan						
Feb						
Mar						
April						
May						
June						
July						
Aug						
Sept						
Oct						
Nov						
Dec						

UBW = Usual body weight

Formula to determine weight loss:
Percentage Weight Change:
Previous Weight - Current Weight ÷ Previous Weight x 100

Circle % weight change if significant or severe.

Comments should reflect identified causes and/or interventions implemented for significant weight loss.

©2013 Becky Dorner & Associates, Inc.

Weekly Weight Record Sample Form

Room	Name	Previous Weight/Date	Date															

©2013 Becky Dorner & Associates, Inc.

Significant Weight Changes Sample Form

Facility____________________ Wing__________ **Monthly / Quarterly / Six Month (*Circle Choice)***

Month/Year__________________

Room No.	Name	Previous Month Weight	Present Month Weight	↑ ↓ % Gain or Loss	Re-weigh Required	Re-weigh Weight/ Date	Notified			Comments
							MD	Family	RD	

\+ for significant weight gain of $\geq$ 5%
\- for significant weight loss of $\leq$ 5%

©2013 Becky Dorner & Associates, Inc.

Weight Change Notification and Recommendations Sample Form

Resident/Patient Name ______________________________ Date ______________

Physician ____ Room ID____________

Significant Weight Change	Recommendations

Thank you,

(Signature/credentials) ________________________________

Physician's Response Yes No

New Order ____

Physician Signature ___________________________________ Date ______________

Signature of Nurse Accepting Order __________________________ Date ______________

□ IDT Notified Yes No Date ____________
Notes ____

□ Family Notified Yes No Date _____________
Notes ____

□ RD Notified Yes No Date _____________
Notes ____

Additional Comments

____

____

____

____

____

©2013 Becky Dorner & Associates, Inc.

Significant Weight Loss Sample Form

Name____

Weight loss _____% loss in _____ months   Clinically Unavoidable   Yes   No

Interventions attempted to address weight loss ______________________________________

____

____

Identified Concerns

______ Poor food/fluid intake

______ Advanced disease state: ____

______ Increased nutritional / caloric needs associated with _____________________

______ Prolonged nausea, vomiting or diarrhea not relieved by treatment provided

______ Radiation or Chemotherapy

______ Other: ____

____

Dietary Notes	Nursing Notes	SS Notes	Physician Notes

____________________________________ ________________
RD Signature Date

____________________________________ ________________
RN Signature Date

____________________________________ ________________
SS Signature Date

____________________________________ ________________
Physician Signature Date

©2013 Becky Dorner & Associates, Inc.

Immediate Temporary Interventions for Unplanned Significant Weight Loss

Policy:

Individuals with unplanned significant/severe weight loss will receive immediate nutrition interventions to prevent further weight loss, stabilize weight, and/or assist to regain weight as appropriate

Procedure:

1. The charge nurse will request temporary nutrition interventions as appropriate for significant/severe weight loss. The individual should be interviewed for preference of intervention.

2. These temporary interventions may include:
   - Commercial supplement one to three times a day, between meals or with medication passes.
   - Oral nutritional supplement (house supplement) one to three times a day.
   - Other interventions such as extra milk, pudding or extra portions as appropriate.

3. A diet order slip will be sent to the food service department to request this temporary intervention.

4. The food service staff will change the temporary intervention if it is not appropriate for the individual. For example, if the individual has a lactose intolerance, and nursing has requested a milk-based supplement, this is an inappropriate intervention. The food service manager has the authority to then change this to an appropriate intervention. Other examples of inappropriate interventions might be related to food allergies, intolerances or dislikes that are known to the food service department.

5. The registered dietitian (RD) or designee will review all significant/severe weight losses monthly or more often as needed. As part of this review, nutrition status will be assessed. At that time, the temporary intervention may be changed as needed based on the reassessment process. The RD or designee will document the specific interventions used, and their nutritive value (portion, number of times per day provided, calories and protein).

6. The RD or designee will determine a monitoring system to evaluate the success of the interventions initiated (i.e. weekly weights, food/fluid intake studies, etc.).

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Significant Weight Loss

Policy:

The goal of medical nutrition therapy (MNT) for significant weight loss is to identify underlying causes or factors contributing to the significant unplanned weight loss, and intervene as appropriate to resolve the problem and stabilize the weight.

Procedure:

Appropriate members of the interdisciplinary team will:

1. Identify individuals with significant/severe weight losses.

Significant Weight Loss	Severe Weight Loss
5% weight loss in 1 month	>5% weight loss in 1 month
7.5% weight loss in 3 months	>7.5% weight loss in 3 months
10% weight loss in 6 months	>10% weight loss in 6 months

- Re-weigh the individual to assure accurate weight.
- Interview direct care givers for information on recent changes.
- Review the individual's food intake records to estimate the average percentage of food/fluid intake in the past two to four weeks.
- Assess whether or not the weight loss was desirable or expected (such as in resolution of severe edema), and document accordingly.
- Assess for stress factors (flu, fever, edema, infections, etc.) or cognitive changes (dementia, depression, etc.) that may have contributed to the weight loss.
- Assess ability to eat independently, chewing/swallowing ability, tolerance/acceptance of diet, etc.
- Assess the individual's laboratory values when available and if appropriate.
- Assess for potential food-medication interactions.
- Review the care plan for pertinent information.
- Document estimated nutritional needs (kcalories, protein, and fluid) versus estimated food/fluid intake (utilizing food intake records).
- Assess for risk of undernutrition or protein-energy malnutrition. Identify potential causes. Document findings in the medical record.
- Interview the individual to identify possible causes and to determine appropriate nutrition interventions.
- Individualize nutrition approach to accommodate the least restrictive diet appropriate to maximize meal intake.
- Request/implement nutrition interventions based on the individual case. Document the additional nutritional values (calories, protein, fluids) these interventions will add to the oral diet.
- Place the individual on weekly weights for one month and review these weights weekly.
- Monitor and evaluate to assess effectiveness of the intervention

©2013 Becky Dorner & Associates, Inc.

- Complete follow up documentation as needed.

2. Continued Weight Loss
   - Re-weigh to assure accurate weight.
   - Assess whether or not the weight loss was desirable (such as resolution of severe edema), and document accordingly.
   - Review meal and fluid intake documentation; a three day calorie count or plate waste study may also be considered.
   - Assess the individual's laboratory values when available and if appropriate.
   - Re-calculate estimated nutritional needs.
   - Compare nutritional needs to actual intake (calories, protein and fluids at minimum).
   - Note possible reasons why the initial nutrition intervention was not successful.
   - Interview the individual again for possible causes and appropriate interventions.
   - Provide individualized aggressive nutrition interventions. This may include, but is not limited to:
     - Assistance to eat as needed
     - Update and honor individual food preferences
     - Calorie boosters (i.e. Extra margarine, mayonnaise or gravy on foods)
     - Protein boosters (i.e. Whole milk, half and half or cream, pudding, ice cream, milk shakes)
     - Enhanced/Fortified foods (high calorie/high protein)
     - Brightly colored napkins on tray to signify that this individual needs extra attention
     - High calorie/high protein supplements
   - Confer with the individual about their wishes. Talk with appropriate family, the individual's representative, and/or care team regarding how aggressively to intervene. Check on living will, Advance Directives, and Durable Power of Attorney (DPOA) for healthcare.
   - Document findings, assessment of nutritional status, and nutritional intervention in medical record (including care plan). Documentation should reflect the goals of care for each individual.

3. Continued weight loss with poor intake
   - Re-weigh the individual to assure accurate weight.
   - Assess whether or not the weight loss was desirable, and document accordingly.
   - Assess the individual's laboratory values when available and if appropriate.
   - Review food intake records for 5 to 7 day meal intake
   - Observe meal intake on meal rounds.
   - Document information regarding intake. Request input from direct care givers and professional staff.
   - Interview the individual and/or family representative

   If the individual continues to have poor food/fluid intake and/or is refusing supplements or enhanced/fortified foods:

©2013 Becky Dorner & Associates, Inc.

Significant Weight Loss

- Review the medical record again for pertinent information and hydration status.
- Review Advance Directive regarding nutrition and hydration. Review prognosis, physician's notes, policy of facility for advanced directive for nutrition and hydration, and confer with social services and care plan team
- Continue to speak with the individual about their wishes (or family or representative). Share pertinent information with appropriate care staff.
- Document findings (in the care plan, assessment, or re-assessment) including the individual's/family's wishes if known, facility policy and best practice guidelines.
- If intake is not life sustaining, document nutritional needs versus current intake. Document that the physician may wish to consider an alternate route of feeding such as tube feeding or parenteral nutrition. Continue to encourage oral feeding.
- If the individual is to be provided comfort care only, cater to food preferences as much as possible to keep the individual as comfortable as possible. Document attempts to provide new interventions on a frequent basis.

Note: Avoidable weight loss means that the individual did not maintain acceptable parameters of nutritional status and that the facility did not do one or more of the following:

- Evaluate the individual's clinical condition and nutritional risk factors.
- Define and implement interventions that are consistent with the individual's needs, goals and recognized standards of practice.
- Monitor and evaluate the impact of the interventions.
- Revise the intervention as appropriate.

Unavoidable weight loss means that the individual did not maintain acceptable parameters of nutritional status even though the facility had evaluated the individual's clinical condition and nutritional risk factors:

- Defined and implemented interventions that are consistent with resident needs, goals and recognized standards of practice.
- Monitored and evaluated the impact of the interventions.
- Revised the approaches as appropriate.

Insidious weight loss refers to a gradual, unintended, progressive weight loss over time.

Usual body weight is the individual's usual weight through adult life or a stable weight over time.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Significant Weight Gain

Policy:

The goal of medical nutrition therapy (MNT) for significant weight gain is to stabilize the weight, identify underlying causes or factors contributing to the significant unplanned weight gain, and intervene as appropriate to resolve the problem.

Procedure:

Appropriate members of the interdisciplinary team will:

1. Reweigh individuals experiencing significant weight gain of 5% or more in one month, 7.5% in three months, and/or 10% in six months to assure accuracy of the weight. All individuals with actual significant weight gain will be reassessed by the care plan team.
   - Assess for recent weight loss and whether the individual is now regaining the weight previously lost.
   - Evaluate food intake other than meals; intake at activities, food kept in the individual's room, food brought into facility by family and friends.
   - Assess for possible depression: Are there any indications from nursing staff or physician? Have there been any recent losses, major changes in condition or family relationships?
   - Potential recommendations may include a change in diet, (such as low sodium or fluid restriction), decrease or change in supplements, decrease in the enteral feeding or fluids offered or change in medications.
   - Document all information and recommendations accordingly.

2. Review for positive or negative outcome of the weight gain: Was this a desirable/planned weight gain? If it was desirable, document it as such. Reassessment of estimated nutritional needs may still be needed to make adjustments in nutrition interventions and recommendations. If the weight was undesirable, proceed with the following.

3. Review the medical record for food and fluid intake, changes in medications (especially diuretics or steroids), renal status, laboratory values, weight history, recent changes in medical, physical or cognitive status, recent social events, etc.

4. Interview the individual, family and staff to determine desirability of weight gain, and possible underlying causes.

5. Assess food intake records, use of supplements, and changes in food/fluid intake or supplements.

6. Recalculate caloric needs, taking into consideration activity level or recent changes in activity level.

7. Assess behaviors such as hoarding, bingeing, or stealing food.

8. Investigate the weight scales. Has there been a recent change in the weight scales? Have they been calibrated recently? Have there been any changes in the staff who normally obtain weights?

9. Investigate weighing techniques: Was the individual weighed with a new prosthesis, brace, cast or other device? Was the individual weighed with a gel pad, wheel chair bag, or full catheter bag? Was the individual weighed at a different time of day? Was the individual weighed on a different scale or in a different wheelchair?

©2013 Becky Dorner & Associates, Inc.

10. Assess the possibility of overhydration, renal dialysis (dry weight versus predialysis weight), exacerbation of congestive heart failure (CHF), renal status, ascites, etc.

11. Assess for recent placement and administration of IV or TPN/PPN for hydration or nutritional intervention.

12. Refer to nursing or physician if fluid accumulations, overhydration or medications are suspected as potential causes of the weight gain.

13. The RD will make recommendations as appropriate based on the MNT assessment.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Nutrition Interventions

- ♦ Resident Wound, Weight Intervention and Nutrition Support (WINS) Committee 10-1
- ♦ Interventions for Unintended Weight Loss 10-2
- ♦ Resource: Interventions for Unintended Weight Loss 10-3
- ♦ Resource: Calorie Boosters/Fortified Foods 10-6
- ♦ Resource: Protein Boosters 10-7
- ♦ High Calorie/High Protein Supplements 10-8
- ♦ Supplement Formulary 10-9
- ♦ Dehydration 10-10
- ♦ Resource: Additional Recommendations for Promoting Adequate Hydration 10-12
- ♦ Fluids at the Bedside 10-13
- ♦ Encourage Fluids Order 10-14
- ♦ Fluid Restriction Order 10-15
- ♦ Distribution of Fluids for Fluid Restriction/Encourage Fluids Orders Sample 10-16
- ♦ Pressure Ulcers 10-17
- ♦ Resource: Risk Factors for Pressure Ulcers 10-19
- ♦ Resource: Recommended Nutritional Needs for Pressure Ulcers 10-20
- ♦ Individuals on Unsupplemented Clear Liquids or NPO 10-21
- ♦ Dysphagia 10-22
- ♦ Resource: Dysphagia Warning Signs 10-23
- ♦ EAT-10 Swallowing Screening Tool 10-24
- ♦ Resource: Positioning Tips to Increase Independence and Reduce Risk of Aspiration or Choking 10-25
- ♦ Thickened Liquids 10-26
- ♦ End of Life Decisions 10-28

©2013 Becky Dorner & Associates, Inc.

Nutrition Interventions

- ♦ **Guidelines for Enteral Feeding Eligibility 10-29**
- ♦ **Enteral Nutrition Care 10-30**
- ♦ **Basic Guidelines for Enteral Feeding 10-31**
- ♦ **Documentation for Enteral Feeding 10-32**
- ♦ **Enteral Feeding Assessment 10-33**
- ♦ **Transitioning to Oral Feedings from Enteral Feedings 10-34**
- ♦ **Enteral Formulas 10-35**
- ♦ **Total or Peripheral Parenteral Nutrition 10-36**
- ♦ **Food-Medication Interactions 10-38**
- ♦ **Education for Food-Medication Interactions 10-39**

©2013 Becky Dorner & Associates, Inc.

Nutrition at Risk Committee
(or Wound/Weight Intervention and Nutrition Support Committee)

Policy:

Residents/patients at high risk of nutrition problems or in need of nutrition intervention will be discussed by the interdisciplinary team in the Nutrition at Risk (or wound/weight intervention and nutritional support – WINS committee) meeting.

Procedure:

1. The Nutrition at Risk (or WINS) committee may consist of the following interdisciplinary team (IDT) members: food service manager, dietetic technician, registered (DTR), registered dietitian (RD), director of nursing (DON), charge nurses, and/or restorative nursing as appropriate for the facility. On an as needed basis, the following may attend: nursing assistants, speech-language pathologist (SLP), occupational therapist, registered (OTR), social services, MDS coordinator, physician, pastor, and/or activities director.

2. The committee will meet weekly or as needed to address the needs of these residents/patients.

3. The RD or designee will provide the list of residents/patients to be discussed at the meeting to the appropriate committee members. The following residents/patients may be included in the Nutrition at Risk (or WINS) list:
   - New admissions / readmissions (with 2% or more weekly weight loss)
   - Individuals with new tube feeding (first 4 weeks on tube feeding or new formula changes in the first 4 weeks)
   - Those with less than 50% PO intake for 9 consecutive meals, until intake is stable
   - Significant weight changes, or insidious weight loss, until stable
   - Pressure ulcers
   - Fluid imbalance (i.e. dehydration, overhydration)
   - Fecal Impaction diagnosis
   - Total parenteral nutrition
   - Dialysis
   - Hospice
   - Thickened liquids, or and fluid restrictions

4. Each committee member will review the resident's/patient's medical record and complete a reassessment as appropriate. Each committee member will come to the meeting prepared with information to share with the IDT. The individual's medical record will be brought to the meeting.

5. Clinical documentation in the medical record will be completed according to the results of the interdisciplinary team's decisions.

Source: Adapted with permission from Nutrition Alliance, LLC.

©2013 Becky Dorner & Associates, Inc.

Interventions for Unintended Weight Loss

Policy:

The facility has a weight-tracking program in place to identify any individuals with unintended weight loss so that assessment of the problem and appropriate intervention can be implemented.

Procedure:

1. Individuals will be weighed upon admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as insidious weight loss.

2. Individuals may also be weighed due to a significant change in condition, if food intake has declined and persisted (e.g., for more than a week), or there is other evidence of altered nutritional status or fluid and electrolyte imbalance. Note: In some cases, weight monitoring is not indicated (e.g., the individual is terminally ill and requests only comfort care). Other factors that may impact weight and the significance of apparent weight changes include:
   - The individual's usual weight through adult life
   - Current medical conditions
   - Calorie restricted diet
   - Recent changes in dietary intake
   - Edema

3. Staff will follow a consistent approach to weighing and use an appropriately calibrated and functioning scale (e.g., wheelchair scale or bed scale). Since weight varies throughout the day, a consistent process and technique (e.g., weighing the individual wearing a similar type of clothing, at approximately the same time of the day, using the same scale, either consistently wearing or not wearing orthotics or prostheses, and verifying scale accuracy) can help make weight comparisons more reliable. (See Policy and Resource on Obtaining Accurate Weights in the Anthropometrics section).

Note: The last weight obtained in the hospital may differ markedly from the initial weight upon admission to the facility, and is not to be used in lieu of actually weighing the individual.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

Refer to Policies and Procedures and Resources on Accurate Weights, How to Obtain Accurate Weights, Adjusting Weights for Amputees, Significant Weight Changes, Tracking Weight Changes, Significant Weight Loss and Significant Weight Gain, Sample Forms and Charts, etc. under Anthropometrics Section of this manual.

©2013 Becky Dorner & Associates, Inc.

Resource: Interventions for Unintended Weight Loss

Individualized Diets

Research suggests that an individualized nutrition approach can enhance the quality of life and nutritional status of older adults in healthcare communities (1). It is often beneficial to minimize restrictions (liberalize the diet), consistent with an individual's condition, prognosis, and choices before using supplementation. It may also be helpful to assure that individuals are provided with their food preferences, before using supplementation. This pertains to newly developed meal plans as well as to the review of existing diets.

Dietary restrictions, therapeutic diets (e.g., low fat or sodium restricted), and mechanically altered diets may help in select situations. At other times, they may impair adequate nutrition and lead to further decline in nutritional status, especially in already undernourished or at-risk individuals. When an individual is not eating well or is losing weight, the interdisciplinary team may temporarily remove dietary restrictions and individualize the diet to improve food intake to try to stabilize their weight.

Sometimes, an individual or their representative decides to decline medically relevant dietary restrictions. In such circumstances, the individual, facility and practitioner collaborate to identify pertinent alternatives.

Food Fortification and Supplementation

Examples of interventions to improve food/fluid intake include:

- Fortification of foods (e.g., adding protein, fat, and/or carbohydrate to foods such as hot cereal, mashed potatoes, casseroles, and desserts).
- Offering smaller, more frequent meals.
- Providing between-meal snacks or nourishments.
- Increasing the portion sizes of favorite foods and meals.
- Providing nutritional supplements.

Some research suggests that caloric intake may increase if nutritional supplements are consumed between meals, and may be less effective when given with meals; therefore, the use of nutritional supplements is generally recommended between meals instead of with meals (2).

Taking a nutritional supplement during medication administration may also increase caloric intake without reducing appetite at mealtime.

Use of Appetite Stimulants

To date, the evidence is limited about the benefits of appetite stimulants. While their use may be appropriate in specific circumstances, they are not a substitute for appropriate investigation and management of potentially modifiable risk factors and underlying causes of anorexia and weight loss (3).

Feeding Tubes

Feeding tubes have potential benefits and complications, depending on an individual's underlying medical conditions and prognosis, and the causes of anorexia or weight loss. Possible feeding tube use, especially for individuals with advanced dementia or at the end-of-life, should be considered carefully. The individual's values and choices regarding artificial nutrition should be identified and considered. The health care practitioner should be involved in reviewing whether potentially modifiable causes of anorexia, weight loss, and eating or swallowing abnormalities have been considered and addressed, to the extent possible. For individuals with dementia, studies have shown that tube feeding does not extend life, prevent aspiration pneumonia, improve function or limit suffering (4).

Refer to additional information in this section related to enteral feeding.

©2013 Becky Dorner & Associates, Inc.

Resource: Interventions for Unintended Weight Loss

End-of-Life
Individual choices and clinical indications affect decisions about the use of a feeding tube at the end-of-life. An individual at the end of life may have an advance directive addressing his or her treatment goals (or the individual's surrogate or representative, in accordance with state law, may have made a decision).

Decreased appetite and altered hydration are common at the end of life, and do not require interventions other than for comfort. Multiple organ system failure may impair the body's capacity to accept or digest food or to utilize nutrients. Thus, the inability to maintain acceptable parameters of nutrition status for someone who is at the end-of-life or in the terminal stages of an illness may be an expected outcome.

Care and services, including comfort measures, are provided based on the individual's choices and a pertinent medical nutrition therapy (MNT) assessment. The facility can help to support intake, to the extent desired and feasible, based on the information from the MNT assessment and on considering the individual's choices.

If individualized approaches for end-of-life care are provided in accordance with the care plan and the individual's choices, then the failure to maintain acceptable parameters of nutritional status may be an expected outcome for individuals with terminal conditions.

Refer to additional information in this section related to end of life care.

Maintaining Fluid and Electrolyte Balance
If an individual has poor intake or abnormal laboratory values related to fluid/electrolyte balance, the care plan addresses the potential for hydration deficits (5).

Examples of interventions include adjusting or discontinuing medications that affect fluid balance or appetite; offering a variety of fluids (water, fruit juice, milk, etc.) between meals, and encouraging and assisting individuals as appropriate. Serving additional beverages with meals will also help increase fluid intake (except to those with fluid restrictions).

Examples of ways to encourage fluid intake include maintaining filled water pitchers and drinking cups easily accessible to individuals (except those with fluid restrictions) and offering alternate fluid sources such as popsicles, gelatin, and ice cream.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

Note: There are many other Policies and Procedures and Resources in this manual that can help to address unintended weight loss.

References for this policy:

1. American Dietetic Association. Position Paper of the American Dietetic Association: Individualized Nutrition Approaches for Older Adults in Health Care Communities. J Am Diet Assoc 2010. 1549-1553.
2. Wilson M-M G, Purushothaman R, & Morley J E. (2002). Effect of liquid dietary supplements on energy intake in the elderly. The American Journal of Clinical Nutrition, 75(5), 944-947.

©2013 Becky Dorner & Associates, Inc.

Resource: Interventions for Unintended Weight Loss

3. Thomas D.R. (2006). Guidelines for the use of orexigenic drugs in long-term care. Nutrition in Clinical Practice, Vol. 21(1) 82-87.
4. Grant, M.D. & Rudberg, M.A., & Brody J.A. (1998). Gastrostomy placement and mortality among hospitalized Medicare beneficiaries. Journal of the American Medical Association, 279, 1973-1976.
5. Thomas D R, Cote T R, Lawhorne L, Levenson S A, Rubenstein L Z, Smith D.A, et al. (2008). Understanding clinical dehydration and its treatment. Journal of The American Medical Directors Association, 9(5), 292-301.

©2013 Becky Dorner & Associates, Inc.

Resource: Calorie Boosters/Fortified Foods

The following suggestions are intended for people who need to increase their calories in order to maintain or gain weight. These recommendations are not necessarily intended for people on low fat or carbohydrate controlled diets. Please use multiple suggestions to boost calories in the diet.

Margarine or Butter	Add to casseroles, hot cereals, vegetables, potatoes, rice and noodles, soups Spread on bread, sandwiches, toast, crackers, rolls, and muffins
Mayonnaise	Spread on bread, sandwiches, toast, crackers, rolls and muffins Use in egg, chicken, tuna or meat salad
Peanut Butter	Spread on bread, sandwiches, toast, crackers, rolls, muffins, apples, bananas
Sour Cream	Use on baked potatoes or as a dip
Half-and-half or Cream	Add to milk shakes, hot chocolate and other beverages; pour over cereals; use in cream soups and puddings
Other Calorie Dense Foods:	Casseroles with added cream Cheese *Corn Syrup Cream cheese Evaporated milk Fried foods Gravy *Hard Candy *Honey *Ice Cream floats and sundaes *Jam and jelly *Maple Syrup *Marshmallows Oils *Pudding Salad dressings Soups (made with whole milk or half-and-half) *Syrup Whipped cream
Commercially Prepared High Calorie/Protein Supplements	*Bars *Beverages Fortified or enhanced foods Juices *Milkshakes *Puddings
Meal Frequency	Offer three meals and two or more snacks each day

*These foods are high in simple sugars and must be counted into the day's total carbohydrate if on a carbohydrate controlled diet.

Note: There are products available that allow for easy creation of enhanced foods. These products may be in the form of powders or liquids that mix into certain foods or beverages, thus boosting calories.

Source: Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011.

©2013 Becky Dorner & Associates, Inc.

Resource: Protein Boosters

The following suggestions are intended for people who have difficulty eating high protein foods. Here are a few suggestions for boosting protein intake.

Skim Milk Powder (for cooking use only)	Mix one cup of skim milk powder into one quart of whole milk and use in recipes for creamed soups, hot cocoa, cooked cereals, cooked custard or pudding, casseroles and mashed potatoes Skim milk powder can also be added to scrambled eggs, soups, casseroles, meat loaf or meat balls, cookies and muffins. Start by adding 1 tablespoon of skim milk powder per serving.
Milk or Half-and-half	Use instead of water for soups, cereals and instant cocoa
Cheese or Cheese Sauce	Add grated or melted cheese to vegetables, casseroles, soups
Eggs (fully cooked only)	Plain or in mixed dishes
Peanut Butter	Use on bread, crackers, or celery, apples and bananas
Instant Breakfast Milk Shake	Combine and mix well; one packet instant breakfast mix, one-cup whole milk or half-and-half, ½ cup ice cream
Other High Protein Foods	Cottage cheese Yogurt Meat, fish, poultry

Caution: Do not use on dysphagia diets unless safely pureed into a pureed food item.

Note: There are products on the market that allow for easy creation of enhanced foods. These products may be in the form of powders or liquids that mix into certain foods or beverages, thus boosting protein.

Source: Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011.

©2013 Becky Dorner & Associates, Inc.

High Calorie/High Protein Supplements

Policy:

Individuals needing high calorie/high protein supplements, as determined through the nutrition care process, will be served a suitable high calorie/high protein supplement between meals or as part of a medication-pass supplement program.

Procedure:

1. Suitable high calorie/high protein supplements meet the following criteria:

   Per serving minimum of: 220 calories
8 grams protein
20% of USRDI for vitamins and minerals

2. Amount of high calorie/high protein supplement and/or oral nutritional supplement and frequency (for example: 10 AM, 2 PM and/or HS) will also be determined through the nutrition care process based on individual needs.

3. All oral nutritional supplements will be ordered or approved by a physician.

4. The food service department will prepare the supplements and deliver them to the nursing staff at the appropriate time.

5. The nursing staff will supervise the delivery and consumption of all supplements and record appropriately in the medical record and/or the medication administration record.

6. High calorie/high protein supplements given between meals or as part of the medication pass will be documented in the progress notes, care plans and/or assessments as appropriate.

7. Individual acceptance of supplements will be monitored and adjustments will be made as needed.

Note: For purpose of this policy, medical nutritional supplements are ordered through the pharmacy or medical supplier and include specialty supplements and modulars. High calorie/high protein supplements are ordered through a food vendor or prepared in the kitchen.

©2013 Becky Dorner & Associates, Inc.

Supplement Formulary

Insert your formulary here.

Manufacturers:

Hormel Health Labs, (800) 866-7757, www.hormelhealthlabs.com

- Lyons Magnus, 559-268-5966. www.lyonsmagnus.com (Sysco Brands)
- Nestle Clinical Nutrition, (800) 422-2752, www.nestleclinicalnutrition.com
- Abbott Nutrition, (800) 551-5838, www.abbottnutrition.com, www.ensure.com

©2013 Becky Dorner & Associates, Inc.

Dehydration

Policy:

Individuals at risk for dehydration will be identified, assessed, and provided with sufficient fluid intake to maintain proper hydration and health.

Procedure:

Assure that each individual receives sufficient amounts of fluids based on individual need to prevent dehydration and maintain health.

1. Risk factors for dehydration will be identified through continual nursing assessment.

   Risk factors for dehydration include:
   - Coma/decreased sensorium
   - Fluid loss and increased fluid needs (e.g. vomiting, diarrhea, fever, uncontrolled diabetes, medications, etc.)
   - Fluid restriction (physician's order required)
   - Functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs (e.g. aphagia, dysphagia)
   - Dementia in which the individual forgets to drink or forgets how to drink
   - Refusal of fluids

2. Clinical signs of possible insufficient fluid intake are assessed through continual nursing assessment:
   - Dry skin and mucous membranes
   - Cracked lips, dry/coated tongue
   - Decreased skin turgor
   - Thirst and dry mouth
   - Concentrated urine
   - Dizziness upon sitting or standing
   - Confusion or change in mental status
   - Lethargy
   - Newly present constipation or fecal impaction
   - Laboratory values (hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, BUN, or urine specific gravity)
   - Significant or severe weight loss
   - Elevated temperature (fever)
   - Headache
   - Flushed appearance
   - Functional decline (including increased risk for falls)

3. For individuals identified at risk of dehydration, assure that adequate fluids are provided. Fluid needs calculations are generally based on the following estimates:
   - Without renal or cardiac distress:
     30 mL/kg body weight (2.2 pounds = 1 kg) or 1 mL per calorie consumed.
   - Diagnosed with renal or cardiac distress:
     25 mL/kg body weight or as determined by physician (as in the case of fluid restriction).
   - Diagnosed with dehydration:
     35 mL/kg body weight
     When rehydrated, return to 30 mL/kg body weight.

©2013 Becky Dorner & Associates, Inc.

Dehydration

4. Fluids may include milk, juice, water, milkshakes, popsicles, ice cream, sherbet, gelatin, soups etc.
   - All individuals will have a water pitcher or container at the bedside (excluding those on fluid restrictions).
   - For those with dysphagia who need thickened liquids, fluids will be provided that are thickened to the consistency ordered (as recommended by the speech/language pathologist and/or ordered by the physician).
   - Foods contain fluids which may also be included as part of the total daily fluid needs.

5. If fluids by mouth are not tolerated, an IV or enteral feeding tube may be recommended, and if placed, appropriate fluids will be provided through the IV or feeding tube. The registered dietitian (RD) or designee should assess IV or enteral feeding /flush orders, and reevaluate per facility policy and as needed.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Resource: Additional Recommendations for Promoting Adequate Hydration

Solutions to Prevent/Treat Dehydration	
1. Monitor for risk factors and symptoms 2. If risk of dehydration is identified, monitor intake/output (I&Os) as per facility protocol 3. Educate individual residents/patients, families and staff on the need to encourage fluids: • Provide access to fluids at all times (excluding people on fluid restrictions). This can include a water pitcher and cup at the bedside, a water bottle on the wheelchair, a travel mug, or offering beverages every few hours. • Encourage nursing assistants to offer and encourage fluids each time they turn individuals on turning schedules. **TAPS** stands for: **T**urn, **A**lign, **P**osition, **S**ips (offer sips of fluid) • Offer additional fluids during medication pass (4-8 ounces)	4. Provide assistance to drink as needed: • Offer fluid with every contact • Provide assistance to drink fluids with and in between meals 5. Set up a hydration station: Self serve juice/beverage machine in common area 6. Be sure those on thickened liquids receive adequate fluids as they are at greater risk for dehydration (13) 7. Offer a variety of fluids: Any food that is fluid at room temperature, carbonated beverages, coffees, teas, gelatin, ice cream, fruit ices, juice, milk, milkshakes, sherbet, soup or broth, water

©2013 Becky Dorner & Associates, Inc.

Fluids at the Bedside

Policy:

All individuals will be provided with a fresh supply of water at the bedside unless otherwise medically contraindicated. Those who are unable to request or independently consume drinking water will be offered fluids by the nursing staff at every medication administration, individual contact for care, regularly scheduled snack passes and other times throughout the day.

Procedure:

1. All individuals will receive a water container and drinking container for their own use daily unless medically contraindicated as determined by the physician (i.e. fluid restrictions).

2. Staff will provide and fill the containers with fresh ice and water at least twice daily.

3. Staff will collect all containers that are not considered disposable for cleaning and sanitizing in the food service department on a daily basis. The food service staff will deliver the containers to the nursing department or notify the nursing department when the procedure has been completed.

4. Ideally, two complete sets of water and drinking containers of different colors will be available so that daily collection, cleaning and sanitizing can be verified. A procedure will be in place to ensure a regular cleaning schedule is followed.

5. Those who are unable to determine thirst, are unable to request fluids, or are unable to obtain fluids for themselves will be offered water or other fluids with every medication pass, every individual care contact, at regularly scheduled snack passes and other times of the day by nursing and other eligible facility staff unless medically contraindicated as determined by the physician.

©2013 Becky Dorner & Associates, Inc.

Encourage Fluids Order

Policy:

When the physician orders “encourage fluid”, this procedure below will be followed.

Procedure:

1. When the physician orders “encourage fluids”, this will refer to a minimum of 1500 to 2000 mL per 24 hours as determined by the individual’s medical nutrition therapy (MNT) assessment.

2. The individual is then placed on “Intake and Output” monitoring so an accurate record can be kept.

3. If the physician orders “encourage fluids” and the individual is not able to tolerate 1500 to 2,000 mL per 24 hours, the physician will be notified.

4. “Encourage fluids” can also be a nursing measure, and this policy should be followed.

5. The food service department will provide a minimum of 1440 mL fluid on meal trays daily (16 ounces per meal). Nursing will provide the remaining fluids.
   - Water will be provided at the bedside.
   - Nursing will provide additional fluids at medication pass, HS, and other times throughout the day as needed.

Note: See Distribution of Fluids for Fluid Restriction/Encourage Fluids Sample.

©2013 Becky Dorner & Associates, Inc.

Fluids Restriction Order

Policy:

When the physician orders “fluid restriction”, this procedure below will be followed:

Procedure:

1. When the physician orders a fluid restriction, the amount of fluid allowed per 24 hour period will be specified.

2. The food service department and the nursing department will determine how much fluid each will provide and at what times. See next page for Sample Distribution of Fluids for Fluid Restrictions.

3. The individual is then placed on “Intake and Output” monitoring so an accurate record can be kept.

4. No water will be provided at the bedside unless calculated into the daily total fluid restriction.

©2013 Becky Dorner & Associates, Inc.

Distribution of Fluids for Fluid Restriction/ Encourage Fluids Orders Sample

Fluid Restriction	Nursing Total	By Shift	Dietary Total	Breakfast	Lunch	Dinner
1000 ml	160 ml	80 ml 1st 80 ml 2nd 0 ml 3rd	840 ml	360 ml	240 ml	240 ml
1100 ml	260 ml	130 ml 1st 130 ml 2nd 0 ml 3rd	840 ml	360 ml	240 ml	240 ml
1200 ml	360 ml	120 ml 1st 120 ml 2nd 120 ml 3rd	840 ml	360 ml	240 ml	240 ml
1300 ml	460 ml	150 ml 1st 150 ml 2nd 160 ml 3rd	840 ml	360 ml	240 ml	240 ml
1400 ml	560 ml	190 ml 1st 190 ml 2nd 180 ml 3rd	840 ml	360 ml	240 ml	240 ml
1500 ml	660 ml	220 ml 1st 220 ml 2nd 220 ml 3rd	840 ml	360 ml	240 ml	240 ml
1600 ml	760 ml	260 ml 1st 260 ml 2nd 240 ml 3rd	840 ml	360 ml	240 ml	240 ml
1700 ml	860 ml	290 ml 1st 290 ml 2nd 280 ml 3rd	840 ml	360 ml	240 ml	240 ml
1800 ml	960 ml	320 ml 1st 320 ml 2nd 320 ml 3rd	840 ml	360 ml	240 ml	240 ml
1900 ml	1060 ml	360 ml 1st 360 ml 2nd 340 ml 3rd	840 ml	360 ml	240 ml	240 ml
2000 ml	1160 ml	390 ml 1st 390 ml 2nd 380 ml 3rd	840 ml	360 ml	240 ml	240 ml

Adapted with permission from Nutrition Alliance, LLC.

©2013 Becky Dorner & Associates, Inc.

Pressure Ulcers

Policy:

Medical nutrition therapy (MNT) will be provided for those who are at risk of, or have a diagnosed pressure ulcer. The goal will be to promote healing and restore the individual to optimal nutritional status if at all possible.

Procedure:

Nutrition Protocols for Individuals at High Risk of Pressure Ulcers or with Stage I, II, III, IV, Suspected Deep Tissue Injury or Unstageable Pressure Ulcers:

1. Upon admission or re-admission and as needed thereafter, the nursing staff will screen each individual for risk of skin breakdown using the tool assigned by the facility for predicting risk of pressure ulcers. The registered dietitian (RD) or designee will review the screening tool, the medical record and the pressure ulcer report to assess/reassess the individual's nutrition status.

2. The RD or designee is a member of the wound care team and will receive referrals and/or a copy of the pressure ulcer/impaired skin integrity report from nursing. All individuals with stage I, II, III, IV, suspected deep tissue injury or unstageable pressure ulcers will be referred to the RD or designee. The RD or designee will review all stage III, IV and unstageable pressure ulcers and provider medical nutrition therapy (MNT) services.

3. The MNT assessment on these high risk individuals will include a review of the following factors:
   - Pre-admission illness, medical history and diagnosis
   - Usual body weight and significant weight change
   - Current food/fluid intake and adequacy of total intake
   - Ability to eat independently
   - Pertinent nutrition related laboratory values if available
   - Current nutrient intake versus estimated needs
   - History of pressure ulcers
   - Other factors impacting nutritional status (chewing/swallowing ability, food-medication interactions, GI problems, depression, etc.)
   - Signs/symptoms of dehydration (poor skin turgor, flushed dry skin, coated tongue, oliguria, irritability, confusion)
   - Interview with the individual, family, caregiver, and/or staff for food preferences and tolerances

4. Based on the individual's food intake and on visitation with the individual, nutrient needs will be calculated. Nutrients (calories, protein, fluids, etc.) will be increased through additional food/fluid items on the tray, substitutions for foods not eaten and/or between meal supplements. Nutrition interventions may include:
   - Nutrient/intake study (if deemed appropriate).
   - Calories, protein, fluids to meet needs.*
   - Individualization/liberalization of diet restrictions. Encourage consumption of a well balanced diet.
   - Encouragement of food/fluid intake. Assistance at mealtime (encourage, prompt, assist or provide adaptive eating devices).
   - Enhanced foods and/or oral nutrition supplements if needed.
   - Adequate fluids for hydration.*
   - Multivitamin/mineral if intake is poor and nutritional deficiency is identified or suspected.

©2013 Becky Dorner & Associates, Inc.

- If intake does not support nutritional needs (calories, protein, fluids, and other nutrients), the interdisciplinary healthcare team may wish to recommend nutrition support.

*Refer to Recommended Nutritional Needs for Pressure Ulcer Chart in this section.

5. Nutrition interventions will be implemented (communicate to nursing, the food service department and/or physician as appropriate). The RD or designee will educate and counsel the individual as appropriate on nutritional needs related to the pressure ulcer.

6. A note will be written in the individual's chart indicating the plan of action and that the individual will be reviewed again within 1 to 4 weeks based on need.

7. The RD or designee will review effectiveness of nutrition interventions and adjust interventions as needed (if the individual is not accepting or not tolerating the intervention, or if condition is improved).

   For those at risk:
   - If the skin remains intact, additional nutrition intervention may not be necessary depending on the individual's status. Review the individual's condition and determine if the additional foods/supplements need to continue. Adjust the care plan to reflect the individual's needs. Review again in 1 to 4 weeks, based on individual need.
   - If the pressure ulcer has not changed or has worsened, re-evaluate needs and acceptance of nutrition interventions. Consult with the physician and/or nursing concerning the individual's continual problem.

   For those with pressure ulcers:
   - If the pressure ulcer has improved but is not completely healed, continue the care plan and review for additional interventions needed. Review again in 1 to 4 weeks, based on individual need.
   - If the pressure ulcer is healed, additional nutritional intervention may not be necessary depending on the individual's status. Review the individual's condition and determine if the additional foods/supplements need to continue. Adjust the care plan to reflect the individual's needs.

8. The RD or designee will continue to monitor high-risk individuals a minimum of every 1 to 3 months depending on status. (Monitoring will occur more often if significant weight loss develops or additional or worsening pressure ulcers occur.)

Reference: Dorner, Becky, Posthauer, Mary Ellen, Thomas, David and the National Pressure Ulcer Advisory Panel. The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White Paper, 2009. National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel (2009). Prevention and treatment of pressure ulcers: clinical practice guideline. Washington DC: NPUAP.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

See Calorie Boosters and Protein Boosters in this section for ideas on how to increase protein.

©2013 Becky Dorner & Associates, Inc.

Resource: Risk Factors for Pressure Ulcers

Risk Factors for Pressure Ulcer Development

As part of a comprehensive assessment, it is vital to identify risk factors for pressure ulcer development and assess pressure ulcer risk using a validated tool. *The Braden Scale: Predicting Pressure Ulcer Risk* includes a subscale for nutrition and can be helpful in determining not only pressure ulcer risk, but nutritional risk. The following risk factors should be evaluated during the screening and assessment process:

Risk Factors For Developing Pressure Ulcers	
• Impaired/decreased mobility and decreased functional ability • Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus; • Drugs such as steroids that may affect wound healing • Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency • Resident refusal of some aspects of care and treatment • Cognitive impairment	• Exposure of skin to urinary and fecal incontinence • Undernutrition, malnutrition, and hydration deficits • A healed ulcer (areas of healed Stage III or IV pressure ulcers are more likely to have recurrent breakdown) • Obesity (increases risk due to decreased mobility, increased incidence of diabetes, cardiovascular and pulmonary problems) • Other risk factors: diabetic neuropathy, frailty, cognitive impairment

Not all risk factors can be fully modified and some potentially modifiable risk factors (e.g., undernutrition) may not be corrected immediately, despite prompt intervention. It may be necessary to stabilize, when possible, the underlying causes (e.g., control blood sugars or ensure adequate food and fluid intake)

Note: Clinical signs and symptoms of undernutrition, protein energy malnutrition and dehydration may include:

- Pale skin
- Red, swollen lips
- Swollen and/or dry tongue with scarlet or magenta hue
- Poor skin turgor
- Cachexia
- Bilateral edema
- Muscle wasting
- Calf tenderness
- Reduced urinary output

Sources:

1. Department of Health & Human Services, Pub. 100-07 State Operations Provider Certification. CMS Transmittal 4, 11-12-04. Guidance to Surveyors for Long Term Care Facilities, Summary Of Changes: Appendix PP, Tag F314.
2. Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011.
3. Dorner, Becky, Posthauer, Mary Ellen, Thomas, David and the National Pressure Ulcer Advisory Panel. The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White Paper, 2009.

©2013 Becky Dorner & Associates, Inc.

Resource: Recommended Nutritional Needs for Pressure Ulcers

Nutrient Needs for Pressure Ulcers			
Based on individual assessment	**Prevention**	**Treatment**	**Goals**
Calories/kg body weight*	• 30-35	• 30-35 • Adjust calories as needed based on weight loss or gain, or level of obesity • Increased calories may be needed for individuals who have had significant unintended weight loss • 50-60% of calories from carbohydrate sources • Least restrictive diet when intake is poor • Enhanced foods or oral medical nutritional supplements if needed (between meals) • Nutrition support if needed and if consistent with the individual's goals of care	• Promote anabolism • Prevent or correct undernutrition, PEM, unintended weight loss or regain lost weight
Protein, grams/kg body weight	• 1.25-1.5	• 1.25-1.5 when compatible with goals of care • Reassess as condition changes • Monitor renal function	• Promote a positive nitrogen balance • Prevent or correct PEM
Fluids, mL/kg body weight**	• 1 mL of fluid intake per kcalorie per day	• Adequate fluid to promote hydration • Monitor for S&S of dehydration: changes in weight, skin turgor, urine output, elevated serum sodium or calculated serum osmolality • Additional fluids needed for insensible fluid losses: vomiting, diarrhea, profuse sweating, draining wounds, etc. • Methods to estimate fluid needs: 30 mL/kg body weight/day; Or 1 mL/kcalorie consumed	• Promote sufficient hydration • Correct known dehydration
Vitamins/Minerals		• Encourage a balanced diet with good sources of vitamins and minerals • If deficiencies are confirmed or suspected, provide multivitamin & mineral supplement (up to 100% USRDI) daily • If clinical signs of deficiency are present, provide <40 mg elemental zinc daily	• Provide adequate nutrients for prevention OR healing • Correct any known deficiencies

Reference: Dorner, Becky, Posthauer, Mary Ellen, Thomas, David and the National Pressure Ulcer Advisory Panel. The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White Paper, 2009. National Pressure Ulcer Advisory Panel and European Pressure Ulcer Advisory Panel (2009). Prevention and treatment of pressure ulcers: clinical practice guideline. Washington DC: NPUAP.

Note: For more information on nutrition care for pressure ulcers, refer to Becky Dorner & Associates, Inc. Diet Manual and Complete Guide to Nutrition Care for Pressure Ulcer Prevention and Treatment found at http://www.beckydorner.com/products/229.

©2013 Becky Dorner & Associates, Inc.

Individuals on Unsupplemented Clear Liquids or NPO

Policy:

All individuals who are NPO (nothing per oral or nothing by mouth) or on an unsupplemented clear liquid diet for longer than three (3) days will be evaluated for nutrition risk by the registered dietitian (RD) or designee.

Procedure:

1. Nursing will monitor individuals on NPO or on an unsupplemented clear liquid diet on a daily basis and refer to the RD or designee.

2. The RD or designee will review the medical record of each individual who is NPO or on an unsupplemented clear liquid diet for longer than three (3) days, and assess the individual's nutritional status.

3. The RD or designee will document assessment of nutrition status in the medical record. Document recommendations for addressing nutrition status, which may include:
   - An alternate feeding route (e.g. enteral or parenteral nutrition)
   - Progression of diet
   - Addition of nutrition supplements specifically for clear liquid diets
   - Referral to RD or designee

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), Nutrition Associates (four year degree in nutrition/dietetics), Certified Dietary Managers (CDM), Food Service Managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Dysphagia

Policy:

Individuals experiencing swallowing difficulties will be evaluated to determine the cause and possible interventions for dysphagia.

Procedure:

1. Individuals showing warning signs of dysphagia will be screened using a validated tool such as the EAT 10: A Swallowing Screening Tool.
2. Individuals with swallowing difficulties will be referred to the speech language pathologist (SLP) as appropriate to further screen for possible causes and solutions. The SLP will make recommendations for further evaluation to the physician. The SLP will make recommendations for diet consistency changes and or fluid consistency changes on an individual basis after the evaluation.
3. The food service manager (FSM) will:
   - Follow any written orders for diet and fluid consistency.
   - Provide adaptive feeding devices as requested.
   - Educate staff and supervise preparation of altered consistency diets.
   - Communicate any concerns regarding the individual's ability to tolerate or accept diet and/or liquid consistencies.
4. The nursing staff will:
   - Assure appropriate communication of referrals and recommendations to the physician.
   - Follow any written physician orders.
   - Supervise individuals at meal time to assure orders and feeding technique suggestions are followed.
   - Communicate any concerns to the registered dietitian (RD) or designee, SLP and/or FSM as appropriate.
5. The SLP and/or RD or designee will train staff to observe signs of dysphagia and will make appropriate referrals to other professionals as needed upon observation of the warning signs. (See Resource: Dysphagia Warning Signs in this section.)
6. Nursing will ensure that the appropriate diet order is obtained from the physician and delivered to the food service department.
7. The RD or designee will:
   - Follow any written orders for diet modification from the physician and/or the SLP.
   - Monitor the tolerance and diet acceptance of any individuals with swallowing difficulties as needed.
   - Notify the appropriate discipline (nursing, social service, SLP) of any swallowing problem that an individual may have upon identification of the problem.
   - Evaluate the need for alternate feeding method consideration through the care planning process and make appropriate recommendations and referrals.
   - Make appropriate recommendations for alternate feeding methods if needed. The diet (or alternate route of feeding) will be provided as ordered by the physician.
   - Work closely with the SLP and food service manager to ensure appropriate diet/alternate feeding.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Resource: Dysphagia Warning Signs

Warning signs of dysphagia include:

- Coughing frequently or a weak cough (before, during or after a swallow)
- Difficulty controlling liquids or solids in the mouth
- Extremely slow eater (more than 45 minutes per meal) which is not due to self-feeding difficulties
- Frequent throat clearing
- Complaining of fullness/tightness in the throat or chest
- Giving up or tiring out before the meal is eaten
- Needing to swallow 3 to 4 times with each bite of food
- Persistent low grade fever
- Pocketing food in the mouth
- Poor dentition, poor gum health, sores in the mouth or poor mouth care
- Prolonged oral preparatory phase (taking a long time to begin a swallow)
- Recurring or persistent pneumonia or repeated upper respiratory infections
- Refusing to eat and/or spitting food out
- Rocking the tongue back and forth (front to back)
- Sensation of food sticking in the throat or sternal area
- Unexplained loss of appetite, unintended weight loss or malnutrition
- Wet/gurgly voice

©2013 Becky Dorner & Associates, Inc.

EAT-10 Swallowing Screening Tool

EAT-10:
A Swallowing Screening Tool

LAST NAME	FIRST NAME	SEX	AGE	DATE

OBJECTIVE:

EAT-10 helps to measure swallowing difficulties.
It may be important for you to talk with your physician about treatment options for symptoms.

A. INSTRUCTIONS:

Answer each question by writing the number of points in the boxes.
To what extent do you experience the following problems?

1 My swallowing problem has caused me to lose weight.
0 = no problem
1
2
3
4 = severe problem

2 My swallowing problem interferes with my ability to go out for meals.
0 = no problem
1
2
3
4 = severe problem

3 Swallowing liquids takes extra effort.
0 = no problem
1
2
3
4 = severe problem

4 Swallowing solids takes extra effort.
0 = no problem
1
2
3
4 = severe problem

5 Swallowing pills takes extra effort.
0 = no problem
1
2
3
4 = severe problem

6 Swallowing is painful.
0 = no problem
1
2
3
4 = severe problem

7 The pleasure of eating is affected by my swallowing.
0 = no problem
1
2
3
4 = severe problem

8 When I swallow food sticks in my throat.
0 = no problem
1
2
3
4 = severe problem

9 I cough when I eat.
0 = no problem
1
2
3
4 = severe problem

10 Swallowing is stressful.
0 = no problem
1
2
3
4 = severe problem

B. SCORING:

Add up the number of points and write your total score in the boxes.
Total Score (max. 40 points)

C. WHAT TO DO NEXT:

If the EAT-10 score is 3 or higher, you may have problems swallowing efficiently and safely. We recommend discussing the EAT-10 results with a physician.

Reference: The validity and reliability of EAT-10 has been determined.
Belafsky PC, Mouadeb DA, Rees CJ, Pryor JC, Postma GN, Allen J, Leonard RJ. Validity and Reliability of the Eating Assessment Tool (EAT-10). Annals of Otology Rhinology & Laryngology 2008;117(12):919-924.

www.nestlenutrition-institute.org

Resource: Positioning Tips to Increase Independence and Reduce Risk of Aspiration or Choking

Positioning for Eating

Proper positioning is extremely important for a safe swallow. When positioning a person with dysphagia to eat or drink, it is best to seat them in a dining room chair with arms if possible and to seat them at "90 X 4" angles. (See explanation below.) Be sure the table height is at an appropriate level so the person can easily reach the food, and range of motion is comfortable for self-feeding.

Positioning for a Safe Swallow:

Remember *"90 X 4"*

Seat in a dining room chair with arms if possible

90° Angles:

1. Feet and lower legs
2. Lower legs and thighs
3. Lap and torso
4. Torso and base of the chin (most important)

- Feet on the floor
- Small of back against the back of the chair
- Head upright
- Chin *slightly* tucked
- Support as needed to maintain positioning
- Appropriate table height

Picture used with permission from Hunter New England Health Speech Pathology Adult Interest Group Fact Sheet, July, 2007.

For a person who is confined to bed, achieve as close to ***"90 X 4"*** position as possible. Prop the individual up with pillows if needed. Use pillows under the knees to achieve 90° hip flexion. It is most important to try to achieve a 90° angle with the head to torso. Avoid the incidence of the head tipping back at any time unless recommended by an SLP who has evaluated the patient. A nosey cup (cup with the side cut out for the nose, to keep the head from tipping back) may be helpful for drinking liquids. Straws may be unsafe as patients with poor mouth control may suck too hard on the straw and propel the liquid to the back of the throat too quickly, causing the possibility of choking and/or aspiration. The services of the SLP, PT and OT may be helpful to achieve the best positioning and for strategies for compensation.

Note: Please work very closely with the SLP on positioning that is appropriate for the individual patient. Be aware that the techniques noted in this manual are not appropriate for everyone, and should be individualized by the SLP to best meet the individual's needs.

After eating, provide good oral hygiene to remove any food debris from the mouth. It is best for the individual to remain upright for at least 30 minutes to reduce the incidence of aspiration of any food or fluid that is pocketed or pooled in the mouth. Keep the head of the bed elevated at least 6 inches or 30 degrees at all times to reduce the incidence of aspiration.

Sources:

- Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011.

©2013 Becky Dorner & Associates, Inc.

Thickened Liquids

Policy:

All individuals requiring thickened liquids as recommended by the speech and language pathologist (SLP) and ordered by the physician will be served liquids in a form to minimize the risk of choking and aspiration.

Procedure:

1. The food service department will receive a written order for individuals requiring thickened liquids.

2. The food service manager will write the ordered consistency on the individual's meal identification (ID) card.

3. The food service department should receive a written order for any individuals requiring liquids in a thickened form. The following consistencies may be ordered based on individual needs*:
   - **Thin** – thin liquids such as those listed below or anything that will liquefy in the mouth within a few seconds (1-50 cp).
   - **Nectar-like** – nectar thick liquids such as those listed below or beverages thickened to nectar consistency (51-350 cp).
   - **Honey-like** – liquids that have been thickened to honey consistency (351-1750 cp).
   - **Spoon Thick** – liquids that have been thickened to a pudding consistency (>1750 cp).

*As defined by the National Dysphagia Diet Task Force (NDDTF).
cp = centipoise, a measurement of the thickness of a liquid.

Thin	Nectar-like	Honey-like	Spoon Thick
Broth, Bouillon Carbonated beverages Coffee or Tea Gelatin Ice or ice chips Ice cream, frozen yogurt, Fruit ices, sherbet Frozen fruit bars Juice Malts Milk Milkshakes Nutritional supplements - Unless specified by manufacturer Popsicles™ Soda Soups, thin broth Tomato juice Water Watermelon	Apricot nectar Eggnog, thick Peach nectar Pear nectar Commercially prepared nectar-like thickened products Commercial thickeners may be used to achieve nectar-like consistency	Commercially prepared honey-like thick products Commercial product needed to achieve desired consistency	Commercial product needed to achieve desired consistency

©2013 Becky Dorner & Associates, Inc.

Thickened Liquids

4. The SLP may request other consistencies based on the individual's condition and/or need. The SLP will notify and instruct the food service department of any necessary deviations for thickened liquids.

5. The facility will determine whether nursing or food service will thicken the liquids or if already thickened products will be used.

6. Manufacturer's instructions will be followed when using thickening agents to provide the ordered consistency of liquids.

7. The registered dietitian (RD) and/or nursing supervisor will monitor staff competency for compliance as part of quality assurance.

***Sources:**

- National Dysphagia: Standardization for Optimal Care National Dysphagia Diet Task Force. American Dietetic Association, 2002.
- Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011.

©2013 Becky Dorner & Associates, Inc.

End of Life Decisions

Policy:

End of life decisions made by individuals will be respected and honored by the facility and staff.

Procedure:

1. The interdisciplinary team will initiate an accurate and complete assessment and review of each individual. The team will then develop the care plan and implement appropriate interventions. The care plan is re-evaluated as often as needed and interventions are revised to meet the desires and choices of the individual. End of life decisions will be initiated only after the interdisciplinary team is confident that all other approaches, interventions, and considerations have been examined, implemented and exhausted.

2. The individual's medical record will contain the living will, the durable power of attorney (DPOA) for healthcare, and any other advance directive documents regarding the individual's end of life decisions.

3. The facility staff will be made aware of these decisions by nursing or social services, or review of the medical record.

4. If no advance directives regarding hydration or alternate feeding have been made and it becomes necessary to initiate such interventions, a conference with the individual and/or family or DPOA will determine the desires and wishes before a decision is made. These discussions should ideally take place well in advance of need.

5. If the physician makes the determination for "comfort measures only". Facility staff will honor the written order and continue delivery of care as determined via the physician's orders.

6. The care plan will be updated to reflect the end of life decisions made by the individual or the individual's representative. All palliative interventions as described in the care plan will be implemented and revised as necessary to reflect the individual's needs and choices. The care plan will direct daily care to maintain the comfort and highest quality of life possible for the individual.

©2013 Becky Dorner & Associates, Inc.

Guidelines for Enteral Feeding Eligibility

Policy:

Care will be taken to evaluate each individual prior to placing an enteral feeding tube. All other methods of intervention will have been tried, and advance directive documents will be thoroughly reviewed as appropriate. In addition, a conference with the individual, the family or durable power of attorney (DPOA) for healthcare will take place before a decision is made.

Procedure:

1. The care plan team will contact the physician and the registered dietitian (RD) or designee when an individual's food and fluid intake is severely impaired.

2. The physician will complete an evaluation of the individual's condition.

3. The RD or designee will complete a thorough medical nutrition therapy (MNT) assessment and make recommendations as appropriate. If oral food/fluid intake cannot sustain healthy life, the recommendation should be made for consideration of enteral feeding.

4. The team will assess the individual's need for an enteral feeding. The individual and/or family or DPOA will be involved in the decision making process.

5. The care plan team and/or ethics team will discuss options with the individual, family and/or DPOA as appropriate and will provide information on the risks and benefits of enteral feeding. The care plan team will provide a thorough discussion on the process of tube insertion, feeding methods, quality of life, etc.

6. If it is determined that the individual/family/DPOA are in favor of this method of nutrition intervention, a meeting with the individual's physician will be suggested or the individual's physician will be contacted regarding a request for enteral feeding to be initiated.

7. Assessment criteria for enteral feeding includes:
   - Decreased food/fluid intake for 3 or more consecutive days.
   - Swallowing difficulty (dysphagia) - exhibits signs/symptoms of dysphagia. Dysphagia evaluation completed as needed. Individual is determined to be at risk of aspiration or choking (unsafe to consume food/fluid by mouth).
   - Significant unplanned weight loss.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

For additional information, refer to Becky Dorner & Associates, Inc. Enteral Nutrition for Older Adults found at http://www.beckydorner.com/products/242.

©2013 Becky Dorner & Associates, Inc.

Enteral Nutrition Care

Policy:

Enteral nutrition will be available for individuals who are unable to meet their nutrition and hydration needs via oral intake.

Procedure:

1. The registered dietitian (RD) or designee will perform an initial assessment that will include a calculation of the individual's energy, protein, and fluid requirements upon initiation of enteral feeding. A comparison will be made between the individual's requirements and the physician ordered enteral formula. Ideally, the RD or designee will assess and/or review the nutrition status of those receiving enteral nutrition support every month. If there are circumstances that make this impossible, no more than three months should elapse without a thorough assessment or review, and systems must be in place to assure referral to the RD or designee as needed.

2. The RD or designee will be informed by nursing of any changes that occur with the formula or route of administration.

3. The RD or designee will review how the formula is being administered, monitor weight, skin condition, labs, physical symptoms, tolerance to feeding, and oral food/fluid intakes when applicable. The RD or designee will visit the individual to check the enteral feeding flow rate, assess down times, check input and output records, and medicine administration records (MAR) for amount of feeding administered.

4. The nursing staff will communicate any concerns to the RD or designee regarding changes in condition such as weight loss, diarrhea, nausea, vomiting, bloating, gas, and high residual levels.

5. The enteral formula should be administered at room temperature. Hang times for formulas are manufacturer specific. Be sure to discard formula according to the manufacturer's recommended times.

Note: The decision regarding the type of feeding tube depends on the individual's medical status and the anticipated time that the enteral feeding will be required. Feeding tubes are classified as nasogastric (NG) (access to the gastrointestinal tract via the nose), gastro-enterostomy (G-tube or PEG tube) or Jejunoscopy (J-tube). In general, if the feeding tube is to be in place longer than 4 weeks, a G-tube is recommended.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

For additional information, refer to Becky Dorner & Associates, Inc. Enteral Nutrition for Older Adults found at http://www.beckydorner.com/products/242.

©2013 Becky Dorner & Associates, Inc.

Basic Guidelines for Enteral Feeding

Policy:

Basic guidelines for enteral feeding will be followed by all staff delivering care to enterally fed individuals.

Procedure:

1. Position the individual so that the head is elevated to 30 to 45 degrees at all times to reduce the risk of aspiration.

2. The nursing staff will check the tube placement regularly (every shift or more frequently as indicated).

3. The nursing staff will check for gastric residual (every shift or more frequently as indicated), and follow any specific facility protocols and/or physician orders related to residuals. The following provides guidance:
    a. Residuals greater than 250 mL after a second GRV test, may indicate the need to consider a promotility agent.
    b. If the GRV is greater than 500 mL, the patient should be assessed for tolerance of the tube feeding. Assessment should include: physical assessment, assessment of glycemic control, assurance that there is minimal sedation, assessment of glycemic control, and consideration of a promotility agent if not already prescribed and.
    c. If GRV is >500 mL, hold the enteral feeding and reassess tolerance by using an established protocol that includes physical assessment, GI assessment, evaluation of glycemic control use of medications that cause sedation, and consideration of promotility agent use.

4. The individual's response to enteral feeding will be monitored prior to the intiation of feeding. Any signs of excessive nausea, vomiting, diarrhea, abdominal distention, gas warrant a referral to the registered dietitian or designee.

5. Nursing will be responsible for providing the total amount of enteral feeding as ordered by the physician. (Bolus feeding or a short-term increase in mL per hour may be required to accommodate down times for bathing, therapies, or activities as needed to assure that the total ordered daily volume of enteral feeding is delivered).

References for this policy:

- Dorner, B, Posthauer ME, Friedrich EK, Robinson GE. Enteral Nutrition for Older Adults in Nursing Facilities. Nutr Clin Pract 2011 26: 261.
- Boullata J, Carney LN, Guenter P. ASPEN Enteral Nutrition Handbook. American Society for Parenteral and Enteral Nutrition. Silver Spring, MD. 2010. p256.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

For additional information, refer to Becky Dorner & Associates, Inc. Enteral Nutrition for Older Adults found at http://www.beckydorner.com/products/242.

©2013 Becky Dorner & Associates, Inc.

Documentation for Enteral Feeding

Policy:

Documentation for nutritional intervention of enteral feedings should include specific information on the nutritional assessment and progress notes.

Procedure:

The registered dietitian (RD) or designee will document:

1. The reason for the enteral feeding.

2. Problems/limitations as a result of the enteral feeding.

3. Changes in conditions (i.e., weight loss, abdominal distension, diarrhea).

4. Adequacy of feeding (calories, protein, total fluids, free fluids, type of feeding, frequency).

5. If applicable, attempts made to discontinue the enteral feedings (with oral feeding or TPN\PPN).

6. Nutritional needs as calculated for the individual receiving the enteral feeding (calories, protein, fluids).

7. Enteral feeding order from the physician including:
   - Feeding status (oral vs no oral feeding)
   - Formula type (generic name such as isotonic, or standard or commercial name)
   - Administration (pump, bolus, intermittent)
   - Rate of delivery (mL per hour or per feeding if bolus)
   - Number of mL for flush, including amount of flush with medications

Note: Enteral feeding formulas should be given at room temperature. Any remaining formula should be covered, dated and refrigerated after opening. Any enteral feeding formula more than 24 hours old should be discarded unless otherwise noted by manufacturer.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

For additional information, refer to Becky Dorner & Associates, Inc. Enteral Nutrition for Older Adults found at http://www.beckydorner.com/products/242.

©2013 Becky Dorner & Associates, Inc.

Enteral Feeding Assessment

Policy:

The initial medical nutrition therapy (MNT) assessment will include a calculation of the individual's energy, protein, and fluid requirements. A comparison will be made between the individual's requirements and the enteral formula provided. This procedure is also part of the monthly review of progress.

Procedure:

The registered dietitian (RD) or designee MNT assessment and/or reassessment should include:

1. A review of the nurse's notes on administration of the formula.

2. Visitation with the individual to note that the pump (if applicable) is functioning properly. (If the pump is not functioning properly, inform the nursing supervisor and/or director of nursing (DON).

3. A review of the medication/treatment record to note that the formula is being given as ordered. (If not, inform the nursing supervisor and/or DON).

4. Review how nursing staff is administering the formula. If there are discrepancies between what is ordered, what is documented, and what is actually being done, inform the nursing supervisor and/or DON.

5. A review of the medical record for changes in enteral feeding orders, changes in tolerance (as evidenced by nausea, vomiting, diarrhea, constipation, abdominal distention, flatulence, or other discomfort), weight status, skin condition, laboratory values, edema, food-medication interactions, oral food/fluid intake if applicable, etc.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

For additional information, refer to Becky Dorner & Associates, Inc. Enteral Nutrition for Older Adults found at http://www.beckydorner.com/products/242.

©2013 Becky Dorner & Associates, Inc.

Transitioning to Oral Feedings from Enteral Feedings

Policy:

When an individual has the potential for being transitioned off of an enteral feeding, the following guidelines will be followed as indicated by the registered dietitian (RD), speech language pathologist (SLP), nursing supervisor and physician.

Procedure:

1. The RD will work closely with the SLP to determine which individuals might be candidates for transition from an enteral feeding to a diet by mouth. The SLP will obtain orders for dysphagia/swallowing evaluation to determine rehabilitation potential for food/fluid by mouth.
2. The SLP will determine the individual's ability to tolerate a diet by mouth.
3. A physician's order will be obtained for the appropriate consistency of food and fluid as determined by the SLP. The SLP will work closely with the individual, and with the staff who is responsible for assisting the individual at meal time to assure proper positioning and eating/feeding techniques for safe swallowing.
4. As soon as the oral diet has begun, a 3 to 5 day nutrient intake assessment of food/fluid intake records will be conducted to assess the adequacy of the individual's oral intake.
5. The RD will continually reassess the individual's food and fluid intake by mouth, and make recommendations to balance the enteral feeding with the diet to assure adequacy of calories and nutrients. A night time enteral feeding will be considered if it will be of benefit to the individual.
6. The individual will be weighed weekly for a minimum of one month, and then as determined appropriate by the RD. Weights may be done more often if deemed necessary.
7. The RD and SLP will determine when the individual no longer requires the enteral feeding based on adequacy of oral diet, weight stabilization, and laboratory values, and request an order to discontinue enteral feeding.
8. The facility staff will intervene as appropriate for poor food/fluid intake, weight loss, or other negative reactions to the discontinuation of the enteral feeding, and refer to the RD, SLP and physician as needed.
9. The SLP will intervene as appropriate for negative reactions or intolerance to the diet and fluids by mouth. The RD and the SLP will work closely together to assure adequate consistency of diet texture and fluid thickness.
10. The nursing staff and physician will work closely with the RD and the SLP to assure the best quality of care for the individual involved.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

For additional information, refer to Becky Dorner & Associates, Inc. Enteral Nutrition for Older Adults found at http://www.beckydorner.com/products/242.

©2013 Becky Dorner & Associates, Inc.

Enteral Formulas

Insert your enteral formularies here.

Manufacturers:

- Abbott Nutrition, (800) 231-3330, www.ross.com, www.ensure.com
- Hormel Health Labs, (800) 866-7757, www.hormelhealthlabs.com
- Nestle Clinical Nutrition, (800) 422-2752, www.nestle-nutrition.com

©2013 Becky Dorner & Associates, Inc.

Total or Peripheral Parenteral Nutrition

Policy:

Total or peripheral parenteral nutrition (TPN or PPN) will be offered and/or provided upon physician order to individuals who are unable to meet their nutrient needs via an oral or enteral route of administration. Parenteral nutrition therapy is appropriate when the GI tract is non-functional or unsafe for enteral nutrition, or when the bowel needs rest.

Procedure:

1. The registered dietitian (RD) will be notified that total or peripheral parenteral nutrition (TPN or PPN) is being considered for the individual. The RD will fully assess the nutrition status of the individual within 24 hours of this notification. Conversely, the RD may recommend TPN/PPN in appropriate cases.

2. The medical nutrition therapy (MNT) assessment will include a review of the individual's medical condition and the reason for parenteral nutrition support. Generally, the individual will have a non-functioning GI tract. A review of the individual's current laboratory values, weight status, and physical activity will be completed.

3. The RD will calculate nutrition needs (calories, protein, fluids, nutrients) based on individual assessment using acceptable procedures.

4. The RD will review the physician ordered prescription for parenteral nutrition and contact the pharmacist if necessary. A review of the amino acids per liter, electrolytes and minerals, vitamins, and lipid solutions will be completed by the RD to assure adequacy. Recommendations for changes in the parenteral prescription will be made to the physician following the MNT assessment.

5. The RD will monitor individuals receiving TPN or PPN closely to assure the goals of nutrition support are met. Monitoring will be based on the individual's condition, and will be evaluated to determine if the goals of MNT are being met. Objective measures of nutrition status such as lab data, hydration status, and weight will be monitored. Subjective data such as wound healing, functional capacity, and the individual's own sense of well being and strength will also be monitored.

6. The RD will closely monitor the transitional phase of feeding from TPN/PPN to enteral or oral feeding for refeeding syndrome. TPN should not be stopped abruptly, gradual transitional feeding is preferred. Both clinical and biochemical indices will be monitored no less than weekly. Refeeding syndrome most often occurs in individuals who were severely malnourished prior to the initiation of parenteral support.

   Note: With refeeding, phosphate and magnesium move from the extracellular to the intracellular space often causing hypophosphatemia and hypomagnesemia. A rapid fall in serum potassium, glucose intolerance, thiamine depletion, edema, and cardiac arrythmias may also occur. Individuals at risk for refeeding syndrome include the chronically malnourished, alcoholic, morbidly obese, catabolically stressed, and those on prolonged hydration therapy. Refeeding must progress slowly; tolerance must be monitored closely to assure that the transition progresses with minimal complications.

Refer to your Diet/Nutrition Care Manual for more details.

©2013 Becky Dorner & Associates, Inc.

Total or Peripheral Parenteral Nutrition

Source:
Dorner, Becky, Diet Manual: A Comprehensive Nutrition Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011.

References for this policy:

1. American Society for Parenteral and Enteral Nutrition (ASPEN).
   - http://www.nutritioncare.org/Library.aspx
   - http://www.nutritioncare.org/wcontent.aspx?id=218
2. Whitney E, Debruyne LK, Pinna K, Rolfes SR, Nutrition for Health and Health Care. 2011; 15:450-457. Wadsworth Cengage Learning.

©2013 Becky Dorner & Associates, Inc.

Food-Medication Interactions

Policy:

Care will be taken to maintain nutrition status without altering the absorption, metabolism or excretion of medication used to improve or maintain health status.

Procedure:

1. The registered dietitian (RD) will review the prescribed drug regime of individuals as part of the assessment process to maintain best nutrition practice guidelines.
2. The RD or designee will notify the appropriate discipline (i.e. nursing, physician, care plan team, social service) if adverse food medication interaction potential is present.
3. The RD or designee will educate the individual on potential food-medication interactions as appropriate. (See Education for Food-Medication Interactions on the next page.)
4. The RD or designee will document the potential food-medication interaction information in the medical record as appropriate.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Education for Food-Medication Interactions

Policy:

Adequate discharge planning and education for individuals, and/or caregiver in the area of medications and potential nutrient interactions will be provided.

Procedure:

1. Pharmacy will be responsible for supplying all nursing units with medication lists and information cards on those medications with potential medication-nutrient interactions.

2. Individual guidelines on medication-nutrient interactions will be adhered to in administration of medications by the nursing staff. This information is supplied on the individual instructions provided by the pharmacy when dispensing the medications to the units.

3. The discharging nurse will be responsible for checking all home-going medications against those on the potential interactions list.

4. Upon discharge, each individual/caregiver will be supplied with written information pertaining to any medications. Verbal instruction will be given to the individual/caregiver responsible for administering the medications.

5. When further education on medication-nutrient interactions is required, the RN or physician will order a consultation by the registered dietitian (RD) or designee, or pharmacist.

6. The RD or designee will be responsible for consulting with the individual or caregiver prior to the individual's discharge and appropriate documentation pertaining to the consultation entered into the individual record. Titles of written information, pamphlets, etc. pertaining to the medication-nutrient interaction provided to the individual/caregiver will be documented in the medical record.

7. The appropriate documentation pertaining to education on medication-nutrient interaction will be entered on the home-going instructions sheet by the discharging nurse.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Quality Assurance/Performance Improvement

- Quality Assurance/Performance Improvement....11-1
- Facility Goals....11-3
- Monthly QA/PI Reports Sample Form....11-5
- Sanitation Audit....11-7
- Sanitation Audit Sample Form 1....11-8
- Sanitation Audit Sample Form 2....11-10
- Meal Preparation and Service Audit....11-15
- Meal Preparation and Service Audit Sample Form....11-16
- Steam Table and Tray Line Audit....11-18
- Steam Table and Tray Line Audit Sample Form....11-19
- Meal Round Audit....11-20
- Meal Round Audit Sample Form....11-21
- Food Satisfaction Audit....11-23
- Food Satisfaction Questionnaire Sample Form....11-24
- Test Meal/Tray Audit....11-25
- Test Meal/Tray Audit Sample Form....11-26
- Medical Record and Documentation Audit....11-27
- Chart Audit Sample Form....11-29
- Diet Order Audit Sample Form....11-30
- Supplements/Nourishments Audit Sample Form....11-31
- In-Depth Documentation Audit Sample Form....11-32
- Nourishment/Supplement Audit....11-33
- Nourishment/Supplement Audit Sample Form....11-34
- Meal Survey Sample Form 1....11-36
- Meal Survey Sample Form 2....11-37
- Resource: Audit to Assess Quality of Care Provided and to Prepare for Surveys....11-38

©2013 Becky Dorner & Associates, Inc.

Quality Assurance/Performance Improvement

Policy:

Each year, the food service and nutrition departments will define yearly goals. Steps will be taken to assure quality and safety of food served, and adequacy of nutrition services and documentation.

Procedure:

1. The food service manager and registered dietitian (RD) or designee will define department goals for the year. (See sample forms on the following pages.)

2. As deemed appropriate, the RD or designee will conduct quality assurance/performance improvement (QA/PI) surveys. This may be done monthly, quarterly, every six months or biannually depending on the facility's needs.)

3. Copies of the QA/PI reports will be given to the administrator, the food service manager, and the director of nursing, as appropriate.

4. The QA/PI surveys may include:
   - Sanitation audit
   - Meal preparation and service audit
   - Steam table and tray line audit
   - Meal round audit (dining services)
   - Food satisfaction questionnaire (for assessment of customer satisfaction)
   - Test tray audit
   - Medical record and documentation audit
   - Nourishment audit
   - Meal survey

5. The *Sanitation Audit Form* is intended to be open-ended. Use the guidelines in the Infection Control and Sanitation Section when evaluating the sanitation status of the food service department.

6. The *Meal Preparation and Service Audit* and Chart Audits are meant to be overview evaluations.

7. The *Steam Table/Tray Line Checklist*, the *Test Tray Evaluation, the Meal Round Audit, Documentation Audit and Nourishment Audit* are more in depth.

8. The *Meal Survey* is to be used for input from individuals. It is advisable to do the survey with as many alert individuals as possible, and to interview at least a percentage of family members who can speak on behalf of disoriented individuals.

9. The *Food Satisfaction Questionnaire* can be used during the meal round audit or in a group setting.

10. The *Medical Record/Documentation Audit* includes an audit of all charts and a more in-depth audit of a sampling of charts.

Note: The forms described above can be found on the following pages.

©2013 Becky Dorner & Associates, Inc.

Quality Assurance/Performance Improvement

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Facility Goals

The registered dietitian (RD) works with the facility administrator, director of nursing and food service manager to define the dietary goals for each year. The goal worksheet should include goals, methods of accomplishment (steps), estimated date of completion, and who will be responsible for each step.

The following are areas that you may wish to focus on:

• Sanitation	• Person Centered Dining
• Meal Preparation and Service	• Food Quality
• Steam Table and Tray Line Accuracy	• Food Costs
• Dining Service	• Unintended Weight Loss/Pressure Ulcers
• Customer Satisfaction	• Menus/Recipes
• Medical Records/Documentation	• Policies and Procedures
• Nourishments	• Nutrition Care Process
• Food Service staff Education	• Nursing Education

©2013 Becky Dorner & Associates, Inc.

Facility Goals

Facility ________________________________ Dietitian ____________________ Year _____

Goals	Action Steps	Assigned to	Due Date

©2013 Becky Dorner & Associates, Inc.

Monthly QA/PI Reports Sample Form

20__

Month											Facility Concerns:
January	☐	Chart Audit (Dates of NA, POC, PN's)	☐	Weight, Pressure Ulcer, and Tube Feeding Audit	☐	Sanitation	☐	Test Tray Regular	☐	Pressure Ulcer Audit	☐
February	☐	Meal Service Audit	☐	Weight, Pressure Ulcer, and Tube Feeding Audit	☐	Sanitation	☐	Test Tray Puree	☐	Pressure Ulcer Audit	☐
March	☐	Nourishments (Timely pass, Match Doc., Consumed)	☐	Weight, Pressure Ulcer, and Tube Feeding Audit	☐	Sanitation	☐	Test Tray Diabetic	☐	Pressure Ulcer Audit	☐

Month											Facility Concerns:
April	☐	Tray Line	☐	Weight, Pressure Ulcer, and Tube Feeding Audit	☐	Sanitation	☐	Test Tray Regular	☐	Pressure Ulcer Audit	☐
May	☐	Meal Service Audit	☐	Weight, Pressure Ulcer, and Tube Feeding Audit	☐	Sanitation	☐	Test Tray Puree	☐	Pressure Ulcer Audit	☐
June	☐	Tray Line Audit	☐	Weight, Pressure Ulcer, and Tube Feeding Audit	☐	Sanitation	☐	Test Tray Diabetic	☐	Pressure Ulcer Audit	☐

____________________ RD Signature/Date

____________________ Administrator Signature/Date

____________________ Food Service Manager Signature/Date

©2013 Becky Dorner & Associates, Inc.

Monthly QA/PI Reports Sample Form (Page 2)

20__

Month							Facility Concerns:
July	☐ Chart Audit (Dates of NA, POC, PN's)	☐ Weight, Pressure Ulcer, and Tube Feeding Audit	☐ Sanitation	☐ Test Tray Regular	☐ Pressure Ulcer Audit	☐	
August	☐ Meal Service Audit	☐ Weight, Pressure Ulcer, and Tube Feeding Audit	☐ Sanitation	☐ Test Tray Puree	☐ Pressure Ulcer Audit	☐	
September	☐ Nourishments (Timely pass, Match Doc., Consumed)	☐ Weight, Pressure Ulcer, and Tube Feeding Audit	☐ Sanitation	☐ Test Tray Diabetic	☐ Pressure Ulcer Audit	☐	

Month							Facility Concerns:
October	☐ Tray Line	☐ Weight, Pressure Ulcer, and Tube Feeding Audit	☐ Sanitation	☐ Test Tray Regular	☐ Pressure Ulcer Audit	☐	
November	☐ Meal Service Audit	☐ Weight, Pressure Ulcer, and Tube Feeding Audit	☐ Sanitation	☐ Test Tray Puree	☐ Pressure Ulcer Audit	☐	
December	☐ Tray Line Audit	☐ Weight, Pressure Ulcer, and Tube Feeding Audit	☐ Sanitation	☐ Test Tray Diabetic	☐ Pressure Ulcer Audit	☐	

______________________ RD Signature/Date

______________________ Administrator Signature/Date

______________________ Food Service Manager Signature/Date

Note: Include a copy of this form in the Quarterly Reports.

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit

Policy:

A sanitation audit will be conducted a minimum of once per month or more often if deemed necessary.

Procedure:

The registered dietitian (RD) or designee conducts the sanitation audit. The auditor will:

1. Perform the sanitation audit without giving prior notice to the staff.
2. Complete the form while touring the kitchen. Be as specific as possible with comments, and include positive comments where appropriate.
3. Review the report with the food service manager and/or staff.
4. The food service manager should initial and date each item as it is corrected.
5. Review findings with the staff and administrator as appropriate.
6. Develop a plan of correction for any problems.
7. Follow up to assure corrections are completed within 1 to 2 weeks.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Sample Form 1

Facility ____________________ Completed by ________________ Date __________

	Yes	No	Comments	Mgr Initials/Comments
Sanitation:				
Appearance of kitchen is acceptable				
Waste containers covered, clean				
Cleaning Schedule:				
Posted, and current				
Schedule followed				
Refrigerators:				
Clean				
Food dated, labeled, and covered				
Temperature acceptable				
Freezers:				
Clean				
Food dated, labeled, and covered				
Temperature acceptable				
Store Room:				
Clean / organized				
Food dated, labeled, and sealed; food off floor				
Stock rotated				
Cleaning supplies separated				

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Sample Form 1

	Yes	No	Comments	Mgr Initials/Comments
Equipment:				
Clean and in good repair				
Proper handling/storage of equipment				
Personnel:				
Hair acceptable/restrained				
Hands washed as needed				
Clean clothes, aprons, and appropriate shoes worn				
Dining Room:				
Appearance of dining room is acceptable				
Dish Room:				
Proper 3-sink method				
Proper clean dish handling and storage				
Food Safety:				
Leftovers promptly stored				
Gloves worn when needed				
Steps to prevent cross contamination posted and followed				

Other Comments:

____

____

____

____

____

____

____

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Sample Form 2

Date _____________ Time ___________

Items Reviewed	S	NI	U	Comments
Personnel				
1. Hair/beard restraint				
2. Uniforms/apron				
3. Hand washing				
4. Non-latex gloves used				
5. Jewelry per policy				
6. Personal hygiene appropriate				
7. Free of wounds				
8. Free of communicable disease				
9. Proper food handling				
10. Unauthorized traffic minimal				
11. Eating in designated area				
12. Proper beverage containers				
Food Production				
1. Hand washing sink				
2. Step can				
3. Prep sink				
4. Thermometer calibrated				
5. Cutting boards used properly				
6. Sanitizer buckets used properly				
7. Knife rack				
8. Utensils				
9. Spice rack				
10. Proper reheating				
11. Pasteurized eggs used				
Equipment				
1. Exhaust hood/fan				
2. Stove top				
3. Griddle				
4. Conventional oven				
5. Tilt skillet				
6. Convection oven				
7. Steamer				
8. Steam-jacketed kettle				
9. Steam table				
10. Pellet heater				
11. Tray dispenser				
12. Lid rack				
13. Toaster				

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Sample Form 2

Date ____________ Time __________

Items Reviewed	S	NI	U	Comments
Equipment continued				
14. Microwave				
15. Blender				
16. Food processor				
17. Slicer				
18. Mixer				
19. Can opener				
20. Food scale				
21. Ingredient bins				
22. Juice machine				
23. Coffee urn				
24. Milk dispenser				
25. Ice machine				
26. Other				
Dry Storage				
1. 18" from ceiling				
2. 6" from floor				
3. Covered/labeled/dated				
4. FIFO				
5. No dented cans				
6. No dusty cans				
7. Non-food separate				
8. Disaster water/food available				
Refrigerator and Freezer				
1. Temperatures appropriate				
2. Temperature log maintained				
3. Internal food temperatures appropriate				
4. Doors				
5. Gasket				
6. No spills				
7. 6" from floor				
8. Covered/labeled/dated/old food discarded				
9. Proper storage				
10. Proper thawing				
11. Proper cooling				
12. Leftovers used properly				
13. Fan clean				
14. Ice build up				

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Sample Form 2

Date ____________ Time __________

Items Reviewed	S	NI	U	Comments
Chemical Storage				
1. Chemicals labeled				
2. Off the floor				
3. MSDS available				
4. Mop buckets clean				
5. Proper storage of mop				
Pot and Pan Sink				
1. Sanitizer-PPM appropriate				
2. Sanitizer log maintained				
3. Proper procedure				
4. Items clean, no grease				
5. Items air dried				
Dishwashing Area				
1. Temperature appropriate				
2. PPM correct				
3. Temperature log				
4. Proper dishwashing				
5. Dish machine clean				
6. No lime deposit				
7. Chemicals off floor				
8. Hood clean				
9. Fan clean				
10. Garbage disposal				
11. Hose/faucet sprayer				
12. Garbage covered and area clean				
Dishwasher/Utensils				
1. Clean				
2. Air-dried				
3. Broken glass/dish policy				
4. Chip/stain/lime free				
5. Proper storage				
6. Proper handling				
7. Adequate supply				

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Sample Form 2

Items Reviewed	Food Prep			Dry Storage			Walk-ins			Dish-room			Chemical Closet			Comments
	S	NI	U	S	NI	U	S	NI	U	S	NI	U	S	NI	U	
General																
1. Floor																
2. Mats																
3. Baseboard																
4. Walls																
5. Ceiling																
6. Vents																
7. Sprinklers																
8. Lights																
9. Windows																
10. A/C																
11. Counter tops																
12. Drawers																
13. Cabinets																
14. Under shelves																
15. Table legs																
16. Carts & racks																
17. Shelves																
18. Safety																
19. Dumpsters																
20. Trash Cans																
21. Pest-free																
22. Sanitizer use																
23. Fire safety																
24. Drains clean																

Actual Points _____

Total Possible Points _____

Total Score _____

Code:
S = Satisfactory
NI = Needs Improvement
U = **Critical Violation** (Immediate Jeopardy)

Privileged and Confidential – This is a facility/QA worksheet only.
Adapted with permission from Nutrition Alliance, LLC.

©2013 Becky Dorner & Associates, Inc.

Sanitation Audit Form

Insert your detailed sanitation audit form here.

©2013 Becky Dorner & Associates, Inc.

Meal Preparation and Service Audit

Policy:

A meal preparation and service audit will be conducted a minimum of once per quarter or more often as deemed necessary.

Procedure:

The registered dietitian (RD) or designee will conduct the meal preparation and service audit. The auditor will:

1. Observe meal preparation and gather information as noted on the *Meal Preparation and Service Audit* sample form. This may include questions with the cooks, dietary aides and/or the food service manager in regard to meal preparation and service activities. Comments will be documented as appropriate.

2. Observe meal service and dining room activities, noting information on the *Meal Preparation and Service Audit* sample form. Comments will be documented as appropriate.

3. Review findings with the food service manager, director of nursing, and/or administrator as appropriate.

4. Develop a plan of correction for any problems.

5. Follow up on corrections within 1 to 2 weeks.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), Nutrition Associates (four year degree in nutrition/dietetics), Certified Dietary Managers (CDM), Food Service Managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Meal Preparation and Service Audit Sample Form

Date:	Yes	No	Comments
Menus:			
Current day's menu posted			
Extensions for all diets			
Followed for all diets			
Appropriate menu substitutions			
If applicable - substitution noted on the menu or substitution list			
Food Preparation:			
Recipes followed			
Sanitary procedures followed			
Appropriate temperatures			
Food taste tested prior to service			
Portion control			
Proper consistency			
Leftovers - amount is appropriate and is properly stored			
Comments:			
Meal:			
Appealing appearance			
Proper portions			
Acceptable taste			
Acceptable temperatures			
Comments:			

Completed by ____ Date __________________________

©2013 Becky Dorner & Associates, Inc.

Meal Preparation and Service Audit Sample Form

Date:	Yes	No	Comments
Meal Service (Meal times followed):			
Served in timely manner			
Served in sanitary manner			
Served at proper temperature			
Proper meal distribution			
Comments:			
Dining Room:			
Efficient service			
Diet tray card followed			
Food well accepted by residents			
Substitutions or replacements are offered, appropriate, and documented			
Adequate assistance provided to individuals who need it			
Employees are courteous			
Acceptable dining room atmosphere			
Special feeding devices are appropriate			
Individuals are spoken to and encouraged to eat			
Efficient dining room clean up			
Comments:			

Completed by ______________________________ Date ____________________

©2013 Becky Dorner & Associates, Inc.

Steam Table and Tray Line Audit

Policy:

A steam table and tray line audit will be conducted a minimum of once per quarter or more often as deemed necessary.

Procedure:

The registered dietitian (RD) or designee conducts the steam table and tray line audit. The auditor will:

1. Observe tray line and service at mealtime, documenting information as noted on *Steam Table/Tray Line Audit* sample form.

2. Discuss findings with appropriate personnel (food service manager, dietary staff, and/or administrator).

3. Develop a plan of correction for any problems.

4. Follow up on corrections within 1 to 2 weeks.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Steam Table and Tray Line Audit Sample Form

Breakfast ________ **Lunch** ________ **Dinner** ________

Supervisor ______________________________ **Date** __________

	Yes	No	Comments
Clothing appropriate and in accordance with policy			
Uniforms clean			
Clean aprons worn and in good condition			
Hands clean and gloves worn when necessary			
No excessive jewelry worn			
Proper shoes worn by all staff			
Hair nets worn covering all hair			
No gum chewing, smoking or eating in kitchen			
Dietary department free of personal items			
Tray line starts on time			
Temperatures of hot foods recorded			
Temperatures of milk, juice, and cold items checked			
Diets being followed			
Likes and dislikes followed			
Appropriate condiments provided			
All dishes covered properly (lids on cups, glasses, bowls)			
Speed of tray line efficient enough to retain temperatures of food			
Each tray set-up in correct manner-napkin, silverware (knife, fork, spoon)			

Comments:

____

____

____

©2013 Becky Dorner & Associates, Inc.

Meal Round Audit

Policy:

The registered dietitian (RD) or designee will conduct meal rounds a minimum of once per month (preferably weekly) or more often as deemed necessary.

Procedure:

1. Meal rounds will be conducted in the main dining area(s), smaller dining areas, and individual wings, rotating as needed to assure that all areas are being regularly monitored.

2. Conduct meal rounds and document information as noted on The *Meal Round Sample Form.* Discuss findings with the appropriate personnel (director of nursing, food service manager, and/or administrator).

3. Develop a plan of correction for any problems.

4. Follow up on corrections within 1 to 2 weeks.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Meal Round Audit Sample Form

Facility ______________________________________ **Date** _______________________

Completed by ____________________ **Reviewed with** __________________________

	Yes	No	Comments
1. Do trays arrive on time?			
2. Are individuals ready to receive trays?			
3. Is adequate staff available to pass trays?			
4. Do staff members pass trays efficiently?			
5. Are all individuals at a table given their trays at the same time?			
6. Do staff members present the trays pleasantly?			
7. Do staff members assist individuals to set up tray, (open, cut, and pour) only as needed?			
8. Are individuals positioned appropriately? (as close to a 90° angle as possible)			
9. Are table heights appropriate for all individuals?			
10. Do staff members give verbal cues to encourage eating when needed?			
11. Do staff members give physical prompts to encourage eating when needed?			
12. Are enough staff available to assist and feed those who need it?			
13. Do staff members treat individuals with respect and dignity?			
14. Do staff members wash hands between assisting/feeding each individual?			
15. Is dining room atmosphere generally pleasant?			
16. Is dining room well lighted?			
17. Is noise level acceptable?			

©2013 Becky Dorner & Associates, Inc.

Meal Round Audit Sample Form

	Yes	No	Comments
18. Are food alternates offered if an individual does not like or does not eat food served?			
19. Are replacements offered if less than 75% of food is eaten?			
20. Is the dining room set up to allow individuals to move in and out easily and safely?			
21. Are individual's hands/mouths wiped as needed?			
22. Are assistive feeding devices available and used when needed?			
23. Is food consistency appropriate for each individual?			
24. Is the menu posted?			
25. Is menu followed?			
26. Are special diets followed? (Are trays accurate?)			
27. Do staff members know what alternatives or replacement foods are available?			
28. Are individual food preferences honored?			
29. Are supplementation recommendations and/or orders followed as noted in the care plan or on the tray card?			
30. Are liquids thickened appropriately (per SLP recommendations or physician orders) and to correct consistency?			
31. Do staff members know what to do if an individual is choking?			
32. Are food temperatures acceptable to individuals?			
33. Are cold foods cold ($\leq$ 41° F) and hot foods hot ($\geq$ 135° F)?			
34. Do staff members avoid mixing foods when feeding?			
35. Do staff members converse with individuals?			

©2013 Becky Dorner & Associates, Inc.

Food Satisfaction Audit

Policy:

A customer service audit will be conducted a minimum of once a quarter or more often as deemed necessary by the food service manager or designee, or registered dietitian (RD) or designee to assure customers are satisfied with the quality of meals and dining services.

Procedure:

The food service manager or designee or registered dietitian (RD) or designee will conduct the audit using the *Food Satisfaction Questionnaire* Form.

1. This can be done individually or in a small group.

2. Interview a varied sample of individuals in the facility. Be sure to select objectively to get a fair range of people in your sample. A good sample should include at least 20 to 25% of the facility's population. For those who cannot speak for themselves, interview a family member or significant other.

3. Once all interviews have been completed, summarize the results and determine what action will be taken to improve on any concerns. Assign the action steps to specific staff, assign a due date and follow up to assure that all concerns are taken care of in a timely manner.

4. Document follow up in a final report to administration.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Food Satisfaction Questionnaire Sample Form

Name ______________________________ **Date** ___________________

Questions	Answers
Do you like the food here? If not, why not?	
Do you like the service here? If not, why not?	
Is the hot food HOT?	
Is the cold food COLD?	
Is there a choice available if you dislike the food?	
Are portion sizes adequate?	
Is the dining atmosphere pleasant?	
What items would you take off the menu if you were preparing the meals?	
Are there any other comments you'd like to share?	

List Your 5 Favorite Meats/Entrees:

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

List Your 5 Favorite Vegetables:

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

List Your 5 Favorite Salads:

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

List Your 5 Favorite Desserts:

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Comments:

____

____

____

____

©2013 Becky Dorner & Associates, Inc.

Test Meal/Tray Audit

Policy:

A test meal or tray audit will be conducted a minimum of once a quarter or more often as deemed necessary to ensure proper temperatures and acceptable quality of all foods served.

Procedure:

The food service manager or designee or the registered dietitian (RD) or designee will conduct the audit using the *Test Meal/Tray Audit* Form.

1. Request one or more test meals/trays from the kitchen for a regular, puree, diabetic, or other therapeutic diet. Test meal/trays will vary to represent different meals, with test being conducted on alternating days of the week and on different wings and/or dining areas.

2. Note the week and cycle of the menu and the meal being audited including the type of diet.

3. Each test meal/tray is assembled by the meal/tray line personnel in the usual manner. The test meal/tray is the last one placed on the cart or the last one delivered. Using the *Test Meal/Tray Audit Form:*
   - Check scoop sizes, etc. prior to leaving the kitchen or service area.
   - Note the time the meal/tray cart leaves the kitchen, the time the meal/tray arrives on the wing or dining room, and the time that all meals/trays are passed.
   - The meal/test tray should only be pulled after the last meal/tray has been passed and the last person has begun eating (or assisted to eat).

4. Once the test meal/tray arrives at its final destination and all customers have been served, remove the meal/tray from the cart and begin the evaluation process using the *Test Meal/Tray Audit Form.*

5. Test meal/tray reviews should include the following:
   - Note the food and beverage items served.
   - Record ratings for the appearance and color of each item.
   - Take temperatures of all foods and beverages and record them on the form.
   - Verify that all portion sizes match those noted on the menu.
   - Assess quality by appearance, texture and taste.
   - Taste each item and rate for flavor.
   - Note accuracy of the meal/tray. Foods should match the items noted on the menu.
   - Comments should be a summary of findings with a plan of correction for each problem noted.

6. Review the audit with food service manager, staff, and/or administrator as appropriate.

7. Follow up on corrections within 1 to 2 weeks.

8. The RD or designee will review the results regularly and develop a plan for correction for any identified problem areas.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Test Meal/Tray Audit Sample Form

Date: ________________________ **Diet Order:** ________________________________

Week of Menu Cycle: _______ Meal: ________________ Wing or Dining Area: ________________

Time Meal/Tray: Left Kitchen: ________ Arrived: ________ Served: ________

Tray Accuracy: Menu Followed for Diet Order: Y N Preferences Followed: Y N

Overall Tray Appearance/Neatness: Excellent Good Fair Poor

Ratings:
E = Excellent G = Good F = Fair P = Poor

Food Item	Appearance Color	Temperature	Portion Control	Quality	Flavor	Meal/Tray Accuracy

Comments: ________________________________

____
____
____
____
____
____
____

Plan of correction (if needed): ________________________________

____
____
____
____
____
____
____

Signature: ________________________________ Date: ________________________________

©2013 Becky Dorner & Associates, Inc.

Medical Record and Documentation Audit

Policy:

The registered dietitian (RD) or designee will conduct a documentation audit a minimum of once per quarter or more often as deemed necessary. Clinical documentation will be audited periodically for quality assurance/improvement purposes.

Procedure:

1. The auditor will pull all medical records and note:
   - Name
   - Room number
   - Date of nutrition assessment (NA)
   - Date of most recent plan of care (POC)
   - Date of most recent progress note (PN)

2. Medical records are audited for timeliness of documentation, nutrition needs assessment, and appropriate nutrition interventions and/or follow through.

   In addition, the *Chart Audit* may assess the dates of documentation for timeliness and check the following to assure a consistent and accurate delivery of care:
   - Check the diet order in the documentation against the physician's order for accuracy.
   - Check the diet order in the documentation against the meal identification (ID) card/ticket and cardex.
   - Check the documented supplements/nourishments against the physician's order.
   - Check the documented supplements/nourishments against the lists in the kitchen (cardex or computer record).
   - Check the documented enteral/parenteral feeding against the physician's order.

3. Comment on any problems found while doing the audit, including:
   - Incorrect diet orders.
   - New problems or significant changes which may have occurred since the last update (significant weight changes, pressure ulcer, new enteral feeding, etc.).
   - Documentation dates out of compliance.

4. Report findings to the appropriate people (food service manager, nutrition support staff, administrator, or others).

5. Decide on a plan of correction to include:
   - Update any charts that are untimely. Initial nutritional assessments must be completed within 14 days of admission, and annually thereafter. Initial plans of care must be completed within 7 days of completion of the initial nutritional assessment. Progress notes and care plans require updating every three months and more often if problems arise. Intermittent problems might include significant weight change, abnormal lab values, poor food intake, diet changes, etc.

6. Develop a running list of when yearly assessments and quarterly updates are due for each individual.

©2013 Becky Dorner & Associates, Inc.

Medical Record and Documentation Audit

For in depth documentation audit:

1. Medical records are chosen by the following criteria (this is not all inclusive):
   - Individuals with unintentional significant weight loss or gain
   - Pressure ulcers of stage II, III, IV
   - Dependency on alternate nutritional routes for nutrition and hydration (enteral/parenteral nutrition)
   - Renal Dialysis
   - Other

2. Report follow up actions to the appropriate staff.

3. Follow up to assure corrections are completed in a timely manner.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Chart Audit Sample Form

Date ___________________________ **Completed by** _____________________________________

Room	Name	NA Date	POC Date	PN Date	NCP Followed	Comments

NA = Nutritional Assessment
POC = Care plan
PN = Progress Notes
NCP = Nutrition Care Process

©2013 Becky Dorner & Associates, Inc.

Diet Order Audit Sample Form

Date ________________________ Completed by _________________________________

Room	Name	Diet Order or Enteral/Parenteral Feeding Order	Matches Physician Order	Matches Meal ID Card/Ticket	Matches Cardex/Computer Record

©2013 Becky Dorner & Associates, Inc.

Supplements/Nourishments Audit Sample Form

Date ________________________ **Completed by** ________________________________

Room	Name	Supplement/ Nourishment Order	Matches Physician Order	Matches Meal ID Card/Ticket	Matches Cardex/Computer Record

©2013 Becky Dorner & Associates, Inc.

In-Depth Documentation Audit Sample Form

Name: **Room:** **Date:**

	Yes	No	Comments
Nutrition Assessment: Original Assessment in Chart			
Yearly Assessment in Chart			
Signed			
Dated/Timely			
Complete			
Appropriate Information			
Care Plan: Signed			
Dated/Timely			
Current			
Consistent with Nutritional Assessment and Progress Notes			
Measurable Goals			
Progress Notes: Signed			
Dated/Timely			
Current			
Diet Order (Acceptable to Resident)			
Weight Status			
Eating Ability			
Food Intake			
Skin Condition			
Appropriate Interventions			
Appropriate Referrals to Registered Dietitian			
Diet Tray Card/Ticket: Name			
Food Preferences			
Special Needs			
Diet Order/Supplement Info Current			

©2013 Becky Dorner & Associates, Inc.

Nourishment/Supplement Audit

Policy:

The registered dietitian (RD) or designee will conduct a nourishment audit a minimum of once a quarter or more often as deemed necessary.

Procedure:

The auditor will:

1. Randomly select 25% of the facility's individuals. List individuals who receive nourishments according to the plan of care and/or physician's orders. List the nourishment/supplement ordered/planned and when it should be delivered. (Include extra ice cream, pudding, milkshakes, margarine, gravy, etc.).

2. Check the list against the kitchen's list and against the meal identification (ID) cards/tickets Note any discrepancies between the POC and the kitchen's documentation. Review the with food service manager and make adjustments as needed.

3. Observe a nourishment/supplement pass and note:
   - Time of nourishment/supplement arrival and amount of time taken to pass all nourishments.
   - Adequacy of assistance given.
   - Individuals who refuse nourishments/oral supplements.

4. Discuss with nursing those who refuse nourishments/supplements consistently and make adjustment accordingly

5. Develop a plan of correction for any problems.

6. Follow up on corrections within 1 to 2 weeks.

Note: Support staff work under the supervision of the registered dietitian (RD). Support staff include dietetic technicians registered (DTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food service managers, etc. The RD may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.

©2013 Becky Dorner & Associates, Inc.

Nourishment/Supplement Audit Sample Form

Facility ________________________ **Wing** __________ **Date** __________

Room	Name	Breakfast	10:00	Lunch	2:00	Dinner	HS	Matches Orders	Matches Cardex/ Computer	Matches Meal ID Card/ Ticket

©2013 Becky Dorner & Associates, Inc.

Nourishment/Supplement Pass Audit Sample Form 2

Facility ____________________ **Wing** __________ **Date** __________

Room	Name	% of Intake of Supplement					Comments
		100	75	50	25	0	

©2013 Becky Dorner & Associates, Inc.

Meal Survey Sample Form 1

	Excellent 5	Very Good 4	Good 3	Poor 2	Very Poor 1
Quality of meal today was:					
What is your overall impression of the food service?					
Is the hot food *HOT*?					
Is the cold food COLD?					
Is there a choice available if you dislike the meal?					
Portion sizes are Adequate.					
The food tastes good.					
The dining atmosphere is pleasant.					
What do you think of the variety and choice of foods offered?					

List 5 Favorite Foods that are Served

1.________________________________

2.________________________________

3.________________________________

4.________________________________

5.________________________________

List 5 Foods You Would Like on the Menu

1.________________________________

2.________________________________

3.________________________________

4.________________________________

5.________________________________

Comments:

____

____

____

____

©2013 Becky Dorner & Associates, Inc.

Meal Survey Sample Form 2

Name ______________________________ **Date** ____________________

Questions	Answers
If you were going to improve the quality of the food, what would you do?	
What is your overall impression of the "food service"?	
Is the hot food HOT?	
Is the cold food COLD?	
Is there a choice available if you dislike the meal?	
Are portion sizes adequate?	
Does the food taste good?	
Is the dining atmosphere pleasant?	
What items would you delete from the menu if you were preparing the meals?	

List Your 5 Favorite Meats/Entrees:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

List Your 5 Favorite Vegetables:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

List Your 5 Favorite Salads:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

List Your 5 Favorite Desserts:
1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________

Comments:

____

____

____

____

____

©2013 Becky Dorner & Associates, Inc.

Resource: Audit to Assess Quality of Care Provided and to Prepare For Surveys

Individual Interviews to Determine Customer Satisfaction and Person-Centered Care
Interview the individual, individual's representative or family:

1. Are staff responsive to the individual's eating abilities and supportive of needs, including the provision of adaptive equipment and personal assistance with meals as indicated?
2. Are the individual's food and dining preferences addressed (e.g., is the person is offered substitutions or choices at meal times as appropriate and in accordance with his/her preferences)?
3. Are pertinent nutritional interventions, such as snacks, frequent meals, and calorie-dense foods, provided?
4. If the individual refused needed therapeutic approaches, were treatment options, related risks and benefits, expected outcomes and possible consequences discussed with the individual or individual's representative, and were pertinent alternatives or other interventions offered?

Interviews with Health Care Practitioners
Interview interdisciplinary team members on various shifts (e.g. nursing assistant, registered dietitian, food service manager, charge nurse, social worker, occupational therapist, attending physician, medical director, etc.) to determine, how:

1. Food and fluid intake, and eating ability and weight (and changes to any of these) are monitored and reported.
2. Nutrition interventions, such as snacks, frequent meals, and calorie-dense foods are provided to prevent or address impaired nutritional status (e.g., unplanned weight changes).
3. Nutrition-related goals in the care plan are established, implemented, and monitored periodically.
4. Care plans are modified when indicated to stabilize or improve nutritional status (e.g., reduction in medications, additional assistance with eating, therapeutic diet orders).
5. A health care practitioner is involved in evaluating and addressing underlying causes of nutritional risks and impairment (e.g., review of medications or underlying medical causes).

If the interventions defined, or the care provided, appear to be inconsistent with current standards of practice, interview one or more physicians or other licensed health care practitioners who can provide information about the individual's nutritional risks and needs. Examples include, but are not limited to:

1. The rationale for chosen interventions.
2. How staff evaluated the effectiveness of current interventions.
3. How staff managed the interventions.
4. How the interdisciplinary team decided to maintain or change interventions.
5. Rationale for decisions not to intervene to address identified needs.

If the interventions defined, or the care provided, appear to be inconsistent with recognized standards of practice, interview one or more health care practitioners as necessary (e.g., physician, hospice nurse, dietitian, charge nurse, director of nursing or medical director). Depending on the issue, ask:

1. How it was determined that chosen interventions were appropriate.
2. Why identified needs had no interventions.
3. How changes in condition that may justify additional or different interventions were addressed.
4. How staff evaluated the effectiveness of current interventions.

©2013 Becky Dorner & Associates, Inc.

Resource: Audit to Assess Quality of Care Provided and to Prepare For Surveys

Record Review

Review the individual's medical record to determine how the facility:

1. Has evaluated and analyzed nutritional status.
2. Has identified individuals who are at nutritional risk.
3. Has investigated and identified causes of anorexia and impaired nutritional status.
4. Has identified and implemented relevant interventions to try to stabilize or improve nutritional status.
5. Has identified individuals' triggered Resident Assessment Instrument (RAI) for nutrition status.
6. Has evaluated the effectiveness of the interventions.
7. Has monitored and modified approaches as indicated.

Assessment and Monitoring

Review information including the RAI, diet and medication orders, activities of daily living worksheets, and nursing, dietitian, rehabilitation, and social service notes. Determine if the individual's weight and nutritional status were assessed in the context of his/her overall condition and prognosis, if nutritional requirements and risk factors were identified, and if causes of the individual's nutritional risks or impairment were sought.

1. Did the facility identify the individual's desirable weight range, and identify weight loss/gain?
2. Did the facility identify the significance of any weight changes, and what interventions were needed?

Where there have been significant changes in the individual's overall intake;

1. Were the reasons for the change identified and were appropriate interventions implemented?
2. Did the facility calculate nutritional needs (i.e., calories, protein and fluid requirements) and identify risk factors for malnutrition?
3. Did the facility meet those needs and if not, did they document why?
4. Did the individual's weight stabilize or improve as anticipated?
5. Was a need for a therapeutic diet identified and implemented, consistent with the current standards of practice?
6. Did the facility indicate the basis for dietary restrictions?
7. Were the reasons for dietary changes identified and appropriate interventions implemented?
8. Did the facility accommodate individual choice, individual food preferences, allergies, food intolerances, and fluid restrictions and was the individual encouraged to make choices?
9. Did the facility identify and address underlying medical and functional causes (e.g., oral cavity lesions, mouth pain, decayed teeth, poorly fitting dentures, refusal to wear dentures, gastroesophageal reflux, or dysphagia) of any chewing or swallowing difficulties to the extent possible?
10. Did the facility identify individuals requiring any type of assistance to eat and drink (e.g., assistive devices/utensils, cues, hand-over-hand, and extensive assistance), and provide such assistance?
11. Did the facility identify individuals receiving any medications that are known to cause clinically significant medication/nutrient interactions or that may affect appetite, and determine risk/benefit?
12. Did the facility identify and address to the extent possible medical illnesses and psychiatric disorders that may affect overall intake, nutrient utilization, and weight stability?
13. Did the facility review existing abnormal laboratory test results and either implement interventions, if appropriate, or provide a clinical justification for not intervening?
14. Was the individual's current nutritional status either at or improving towards goals established by the care team?

©2013 Becky Dorner & Associates, Inc.

15. Were alternate interventions identified when nutritional status was not improving or was clinical justification provided as to why current interventions continued to be appropriate?

Care Plan

Review the comprehensive care plan to determine if the plan is based on the comprehensive assessment and additional pertinent nutritional assessment information. Did the facility:

1. Develop measurable objectives, approximate time frames, and specific interventions to try to maintain acceptable parameters of nutritional status, based on the individual's overall goals, choices, preferences, prognosis, conditions, assessed risks, and needs?

If care plan concerns, related to nutritional status are noted, interview staff responsible for care planning about the rationale for the current plan of care.

Care Plan Revision

Determine if the staff has evaluated the effectiveness of the care plan related to nutritional status and made revisions if necessary based upon the following:

1. Evaluation of nutrition-related outcomes.
2. Identification of changes in the individual's condition that require revised goals and care approaches.
3. Involvement of the individual or the individual's representative in reviewing and updating the individual's care plan.

Source: Centers for Medicare & Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities, Appendix PP. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107_appendixtoc.pdf (scroll down to the Appendix PP link). Revision 70, 1/7/11. Accessed December 5, 2012.

©2013 Becky Dorner & Associates, Inc.

Disaster Planning

- ♦ Emergency/Disaster Planning 12-1
- ♦ Emergency Plan Employee Training 12-2
- ♦ Resource: Food Service Disaster Plan 12-4
- ♦ Coordination of Emergency and Disaster Plan 12-6
- ♦ Responsibilities and Assignments Sample Form 12-7
- ♦ Letter of Intent for Provision of Emergency Supplies Sample 12-8
- ♦ Emergency Contact Information 12-9
- ♦ Employee Contact Information Sample Form 12-10
- ♦ Water Requirements 12-11
- ♦ Sources of Water During an Emergency 12-12
- ♦ Water Purification 12-13
- ♦ Non-Perishable Foods List 12-14
- ♦ Emergency Menu and Supplies 12-15
- ♦ Resource: Emergency Plan Special Diets Conversion Table 12-17
- ♦ Sample Menu Shell 12-18
- ♦ Suggested Emergency Menu Pattern 12-19
- ♦ Suggested Serving Sizes for Starches 12-20
- ♦ Day 1 Emergency Meal Plan – Assumes No Utilities 12-21
- ♦ Day 2 Emergency Meal Plan – Assumes No Utilities 12-22
- ♦ Day 3 Emergency Meal Plan – Assumes No Utilities 12-23
- ♦ Sample 3 Day Emergency Meal Plan for Pureed Diets 12-24
- ♦ Hand Washing During a Disaster 12-25
- ♦ Sanitizing Dishes During a Disaster 12-26
- ♦ General Disaster Supplies 12-27
- ♦ Disaster Resources 12-29

©2013 Becky Dorner & Associates, Inc.

Disaster Planning

Note: For more information on Disaster Planning, refer to *Dietary Disaster Plan,* Becky Dorner & Associates, Inc. found at http://www.beckydorner.com/products/82.

Emergency/Disaster Planning

Policy:

Emergency and disaster plans will be available and used as needed. In the event of a disaster or emergency, the facility will have a written, acceptable disaster plan that includes emergency water and food needs. Refer to the facility's disaster plan for details on general procedures during an emergency.

The food service manager will coordinate the function of the food service department during an emergency. In the absence of the food service manager or designee, or senior cook will be responsible for the department. If neither is available, the administrator will assign a person to be responsible for the food service department.

Procedure:

The following will be available during an emergency or disaster:

1. Emergency food, water and supplies for the planned menu pattern for three to seven days. * Plan food and water to include the potential of staff and family members, rescue workers, and evacuees. Plan a menu that is palatable even if repetitious. Plan food that can be transported in the case of evacuation.

2. Emergency enteral supplies for tube fed individuals for at least three to seven days.*

3. Disposable dishes for three to seven (3 to 7) days. Include disposable wipes and hand sanitizer. Plan for extra as necessary to support nursing and other staff needs.

4. A list of organizations and vendors/suppliers that agree to provide assistance in case of an emergency.

5. A list of food service department employees' names and telephone numbers.

6. A preplanned disaster staffing schedule maintained with contact information for current employees. Schedule employees who agree to work during the disaster and those who agree to work following the disaster. Note: This schedule must remain flexible depending on circumstances and availability at the time of the disaster.

In the event of a reduction of food service department personnel and/or product deliveries:

a. The administrator will contact the food service manager and the registered dietitian (RD) or designee.
b. If the food service manager is unavailable, the administrator will assign a responsible person to direct the department.
c. Volunteers may be assigned to the food service department as necessary during the emergency.
d. Vendors will be notified of the emergency status of the facility.
e. The administrator may request that staff members pick up supplies for the food service department if vendors are unable to make deliveries.

*Check your state regulations and follow the more stringent recommendations. Joint commission requires a minimum of 4 days of food, water and supplies.

©2013 Becky Dorner & Associates, Inc.

Emergency Plan Employee Training

Policy:

Employees are prepared for unexpected events.

Procedure:

1. Staff will be inserviced on the following:
   - Contents of the Emergency and Disaster Plan
   - Contents of the Disaster Feeding Plan
   - Location of stored supplies including, food, drinking water, all purpose water, paper products, etc.
   - Water purification techniques
   - Responsibilities in case of emergency

2. Staff should be trained in emergency and disaster relief as part of their initial orientation and periodically thereafter. Mock disaster drills should be used to determine the training's impact.

Employee Training
To ensure that employees are prepared for the unexpected events that may occur, inservice staff on the following items:

- Contents of the Emergency and Disaster Plan
- Contents of the Disaster Feeding Plan
- Location of stored supplies to include, food, water, drinking water, all purpose water, enteral feeding supplies, paper products, etc.
- Location of emergency equipment and first aid supplies
- Water purification techniques
- Sanitation/ food safety
- Responsibilities in connection with other departments
- Coordinator of each department and contact information in case of unexpected events
- Contact person/ coordinator of each department in case of an emergency
- Emergency contact numbers
- How to locate and use the fire fighting equipment
- Evacuation routes and routines
- All alarm and signal systems
- Management of casualties, first aid training
- Use of generators

Staff should be trained as part of their initial orientation and periodically thereafter to reinforce the training. Mock disaster drills are a good way to determine the training's impact.

Staff Training:
Conduct emergency disaster drills at least twice per year. Time drills to prepare in advance of potential threats. For example, if your analysis indicates that your facility is in a geographic area that is prone to hurricanes, conduct a drill prior to hurricane season.

After each disaster drill, evaluate the staff's response and determine additional training needs. Then conduct the additional training and adjust disaster plans accordingly. (These evaluations and adjustments should also be made after each disaster).

©2013 Becky Dorner & Associates, Inc.

Emergency Plan Employee Training

Staff should be able to answer the following questions:

- If the fire alarm goes off, what do you do?
- What would you do if you discovered a fire in the kitchen? In a dining area? In a resident's room?
- Where are the fire alarms and fire extinguisher located in the kitchen? Dining area? Near residents'/patients' rooms?
- How do you use the fire extinguisher? (Please demonstrate.)
- Where is the emergency disaster plan kept?
- Where are the emergency food, water, and supplies stored? How do you access them?
- How can you purify contaminated water?
- What is the procedure in case of evacuation?

Also add questions related to geographically specific disasters (hurricanes, tornadoes, floods, earthquakes, winter storms, etc.).

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

Resources:

- Keeping Food Safe During an Emergency
  General Guidelines for Keeping Food Safe
  http://www.fsis.usda.gov/Fact_Sheets/keeping_food_Safe_during_an_emergency/index.asp
- Refrigerator Foods: When to Save and When to Throw Out
  Handy Chart to Guide Decisions http://www.foodsafety.gov/keep/charts/refridg_food.html
- Frozen Foods: When to Save and When to Throw Out
  Handy Chart to Guide Decisions http://www.foodsafety.gov/keep/charts/frozen_food.html

©2013 Becky Dorner & Associates, Inc.

Resource: Food Service Disaster Plan

General Instructions for Person in Charge

Check your state and local regulations for other information specific to your area.

1. Inventory the situation to make your plan of action.

2. Delegate work and details to others so that you are available for keeping the situation under control.

3. Plan to use foods in order of their keeping qualities:
   - Perishable fresh foods
   - Food in refrigerators – check temperatures to assure safety
   - Food in freezers - check temperatures to assure safety
   - Canned foods
   - Packaged nutritional supplements, and enteral formulas for those on tube feeding

4. Try to maintain well-balanced meals with as normal a menu as possible. Texture modifications, allergy and food intolerance concerns are most important. Have standing orders for “May have regular diet as needed for emergencies, holidays and special occasions and meal of the month”. Remember to have items for individuals with food allergies and/or intolerance (example: soy milk, Lactaid or Lactaid milk, gluten free products, etc.). Remember any special religious, social or cultural custom requirements.

5. Use extra precautions regarding sanitation.
   - Separate clean areas from dirty areas.
   - Keep waste and garbage in covered containers and remove from food areas as soon as possible.
   - If water quality is questionable, use bottled water, or follow boil requirements as directed by local authorities (see Water Purification in this section for instructions).
   - Do not use any food that might be spoiled.
   - Do not taste food that may be in question. Do not rely on the way it looks or smells.
   - Use disposable dishes and utensils when necessary. There should be a good supply in the storeroom.

Types of Disasters:

1. Gas Shut Off in the Kitchen:
   - If range and convection ovens in the kitchen use gas, utilize microwave ovens and electric stoves.
   - Use plain foods which need only minimal heating.
   - If nursing or activity areas have working electric stoves or microwaves available, take supplies for cooking and serving to these areas and serve directly from these areas.
   - Be cooperative with nurses and other staff/volunteers Ask for assistance with serving trays and offer assistance with individuals who need to be assisted.

2. No Water Supply or Water Supply is Shut Off:
   - The facility should have bottled water in the storeroom (0.5 gallons per person). Save this for cooking and drinking only.

     Note: Consider negotiating a water contract for additional water to be delivered by a vendor in a nearby area.

©2013 Becky Dorner & Associates, Inc.

- Other sources of fluids which should be on hand in kitchen, storeroom, and freezer include:
    - Fruit juices
    - Canned soups and broth
    - Ice cream
- Bottled water may be used to:
    - Mix nonfat dry milk - make up fresh for each meal (make only the amount that will be used for the meal)
    - Make instant coffee and tea
    - Dilute concentrated soups or condensed beverages
- Reduce the amount of salt used in cooking. Individuals on high protein foods or supplements should be monitored to insure adequate fluids.

3. Electricity Shut Off:
    - The facility has auxiliary power that should take over quickly. Staff must be trained on which equipment is connected to the emergency generator so they know which equipment is operable when the power goes off.
    - Should there be a delay, do not open refrigerator or freezer doors unless absolutely necessary until the power returns.

4. Unable to receive deliveries:
    - An emergency supply of foods, beverages and supplies must be available in the facility. A minimum of a three to seven (3 to 7) day supply is recommended.*
    - Have alternative supply sources lined up in advance. Alternate suppliers or a local restaurant, school or church may be appropriate alternate suppliers if delivery trucks cannot get through with supplies.

    See Sample Letter of Intent for Emergency Supplies from Provider to Facility and Sample Disaster Contingency Agreement from the Provider to the Facility.

5. Combination of Situations:
    - If a combination of these situations exists, combine instructions as needed.

*Check your state regulations and follow the more stringent recommendations. Joint commission requires a minimum of 4 days of food, water and supplies.

©2013 Becky Dorner & Associates, Inc.

Coordination of Emergency and Disaster Plan

Policy:

The food service manager or designee will coordinate the function of the food service department during an emergency.

Procedure:

The food service manager's responsibilities during an emergency include, but are not limited to the following:

1. Notify staff that an emergency plan is in effect.

2. Confirm a three to seven day emergency plan.

3. Assure a three to seven day (3 to 7) supply* of water, foods, beverages, enteral feedings/supplies, oral nutrition supplements, disposable dishes and supplies.

4. Provide a list of food service department employees' names and telephone numbers to be utilized if additional staff is needed. Notify vendors of the emergency status of the facility and any pressing needs. (See Emergency Contact information.)

5. Assign volunteers in each department as necessary to work during the emergency.

6. Request that staff members bring supplies if vendors are unable to make deliveries.

7. Determine how to use the perishable food items on hand in the coolers and freezers in the first and second day.

8. Use foods in order of their keeping qualities:
   - Food in refrigerators – check food temperatures to ensure food safety
   - Food in freezers – check food temperatures to ensure food safety
   - Canned and dry foods – use last
   - Packaged nutritional supplements and enteral formulas – see manufacturer's instructions

*Check your state regulations and follow the more stringent recommendations. Joint commission requires a minimum of 4 days of food, water and supplies.

©2013 Becky Dorner & Associates, Inc.

Responsibilities and Assignments Sample Form

Done	Duties	Responsible Person
X	**Prior to Disaster:**	
	Recruit experienced staff and/or volunteers (i.e. from restaurants, schools, Red Cross, churches) to serve during an emergency	
	Train staff and/or volunteers (including disaster drills)	
	Assign responsibilities of staff, volunteers	
	Food purchasing of emergency water, food and supplies (see Sample Letter of Intent for Emergency Supplies and Sample Disaster Contingency Agreement next pages)	
	Storage and rotation of emergency water, food and supplies (3 to 7 days of supplies including cleaning supplies)	
	Plan emergency menus	
	Contract with a generator supply company to provide electricity as needed	
	Plan for mobile feeding if kitchen/food/supplies are damaged beyond use	
	Meet with director of local Red Cross and develop written agreement to specify responsibilities/expectations	
	Maintain a list of emergency contact information for key personnel, county emergency manager, Red Cross, vendors (cell numbers whenever available)—verify list at least annually	
	Document location of keys to doors, coolers, freezers, storage areas	

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Letter of Intent for Provision of Emergency Supplies Sample

To: (Facility, address, phone, contact person)

From: (Food service vendor)

Letter of Intent

This letter of intent will document **(food service vendor's name)** commitment to your *facility*, to service your account during an emergency situation.

In case of emergency or natural disaster that disrupts the normal operation of the food service department of your facility, we will make every attempt to satisfy the needs of your facility by delivering food, water and supplies as soon as local authorities allow for safe travel to the affected area. (This may not be your normal delivery day).

Should we be unable to service your account, we will do our best to make arrangements with another food vendor to deliver food, water and supplies as soon as local authorities allow travel into the affected area and until we are capable of resuming normal operations. Your facility agrees to pay a normal and reasonable fee for all goods and services rendered.

As much advance notice as possible should be provided by the facility so the facility's needs can be met. This includes specific requests for amounts and types of food, water, paper products, and other products as designated by your facility. The facility should supply a list of potential emergency food supply needs in advance so we can prepare for a potential emergency.

This shipment will depend upon road conditions, availability of vehicles, products and supplies. (Food service vendor's name) supplies and product may be controlled by Civil Defense, Federal, State, County or City authorities. Hospitals, short and long term care nursing facilities, correctional facilities and/or public service utility entities may receive priority support at the direction of the authorities.

We will make terms and conditions of this statement and agreement known to all/any partners who might have to respond and make such information, as contact names and phone numbers, available to assure that the necessary goods and services will be reasonably available at any time.

This letter of intent will be valid as long as the prime vendor agreement between **(food service vendor's name)** and_________________________ continues. If the prime vendor relationship is terminated, this agreement automatically terminates as well.

Accepted by:	**Accepted by:**
________________________	___________________________
Food Service Vendor	Facility Representative
__________	_________
Date	Date

©2013 Becky Dorner & Associates, Inc.

Emergency Contact Information

Policy:

When the food service manager and/or the registered dietitian (RD) are not in the building, emergency services are provided to answer questions that need immediate attention.

Procedure:

1. In an emergency, staff will call 9-1-1 as needed for fire or police services.

2. The food service manager may be reached by phoning ____________________________. Calls are returned at the earliest possible time.

3. The RD may be reached by phoning ________________________. Calls are returned at the earliest possible time.

4. Additional emergency contacts (may include vendors/suppliers, local restaurants, professionals, or others who have agreed to assist in an emergency):

   American Red Cross – Local Chapter Number ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

   __________________________________ ______________________

©2013 Becky Dorner & Associates, Inc.

Employee Contact Information Sample Form

Name	Title	Shift	Cell Phone Number or Other Contact Info

©2013 Becky Dorner & Associates, Inc.

Water Requirements

Policy:

In the event of a loss of utilities, water may be unavailable, or if available, it may be contaminated and in need of purification. In either case, the food service department will need to have an adequate supply of water on hand. This water will be used for cooking, cleaning, drinking, and food preparation. Recognizing that suppliers may be unable to deliver immediately, a seven-day supply of water is recommended. Water should be stored in a cool, dry area away from heat sources.

Procedure:

1. A minimum seven (7) day supply of water should be available. The quantity of water that is needed can be determined by the following calculations:

Suggested Water Requirements:

Type of Water	Amount Needed	Formula	Example (7 day supply) for 100 People
Drinking water	2 quarts (0.5 gallon) per person per day**	# of people* X 0.5** gallons X 3 days (or 7 days) = gallons of drinking water needed	100 people X 0.5 gallon X 7 days = 350 gallons of drinking water
All-purpose water	1 gallon per person per day	# of people* X 1 gallon X 3 days (or 7 days) = gallons of all-purpose water needed	100 people X 1 gallon X 7 days = 700 gallons of all-purpose water

*Include residents/patients, staff, visitors, evacuees and rescue workers as appropriate in estimate of water needed. Include nursing needs as necessary (medication pass, etc.)
**Hot climates can double the amount of fluid needed. If you are located in a hot climate area, increase the amount of drinking water to 1 gallon per person per day. Adjust the amount of all-purpose water accordingly as well.

Note: Please check your state regulations for specific quantities of water required.

Use of Stored Water Supplies

1. Bottled or distilled water for emergency purposes should be stored and labeled "FOR EMERGENCY USE ONLY".

2. The nursing department may want to designate a specific amount for nursing procedures such as flushes, sterile dressing uses, or any other nursing procedure needing distilled or sterile water.

3. Staff should be instructed not to use the emergency water supply for any purpose other than an emergency situation. Provide staff with bottled or canned beverages for drinking.

Keeping Water Supplies Fresh

1. Rotate or discard water according to the manufacturer's expiration date on the container, then replace emergency water accordingly.

©2013 Becky Dorner & Associates, Inc.

Sources of Water During an Emergency

Policy:

In an emergency situation, additional water sources may be needed. Only safe water will be used. Water will not be rationed during an emergency. Each person needs to remain well hydrated, especially in warm climates. The Federal Emergency Management Agency (FEMA) recommends that each person be allowed to consume the needed requirements of water each day, and that individuals continue to search for more water supplies.

Procedure:

1. Locate and utilize safe sources of drinking water.

2. Bottled or distilled water for emergency purposes should be stored and labeled "FOR EMERGENCY USE ONLY". The nursing department may want to designate a specific amount of water for nursing procedures, such as enteral feeding flushes, or any other nursing procedure needing bottled or distilled water.

3. Staff should be instructed not to use the emergency water supply for any purpose other than an emergency situation.

4. Rotate supplies to use the water prior to the manufacturer's expiration date. Discard water according to the manufacturer's expiration date on the container.

5. Consider water barrels or water bladders which can be filled with water in advance of an emergency.

Emergency Water Sources*
Safe Sources

- Melted ice cubes
- Water drained from the water heater (if the water heater has not been damaged)
- Liquids from canned goods such as fruit or vegetable juices
- Water drained from pipes
- In an emergency, hot water tanks contain some emergency water. Remember, though, that this water is not purified and should be used as all-purpose water, not drinking water.

Unsafe Sources

- Radiators
- Hot water boilers (home heating system)
- Water beds (fungicides added to the water or chemicals in the vinyl may make water unsafe to use)
- Water from the toilet bowl or flush tank
- Swimming pools and spas (chemicals used to kill germs are too concentrated for safe drinking but can be used for personal hygiene, cleaning, and related uses)

*Reference: Emergency Water Storage & Purification Guidelines, Federal Emergency Management Agency, http://www.prepareandsurvive.info/documents/WaterPurificationandStorage.pdf. Accessed September 12, 2012.

See next page for information on water purification.

©2013 Becky Dorner & Associates, Inc.

Water Purification

Policy:

The water supply may need to be purified before using. Listen to local radio stations for instruction on when water purification is necessary.

Procedure:

Water Purification - Strain the water through a cheesecloth or coffee filter to remove dirt or other particles if needed. There are three (3) ways to purify water.

1. Boiling
   Boiling is one of the most common ways to purify water. The water should be poured into an appropriate container and brought to a rolling boil. The water should then be boiled vigorously for 1 to 3 minutes. To improve the taste of the water, the water can be poured from one container to another several times. It is important to remember that a loss of utilities may result in not having a heat source available to boil the water.

2. Purification Tablets
   Purification tablets are available from a number of different supplier sources or can be purchased locally at drug stores or camping supply stores. Follow the manufacturer's directions. It is important to order these in advance to insure that they are on hand when needed.

3. Bleach Purification
   The third purification method is the use of liquid household bleach (no fragrance added). The bleach that is used must be liquid and contain hypochlorite, preferably 5.25 to 6.0%. The following table details the bleach to water ratios. Add the bleach according to the table below and then mix well. Use this water within 24 hours of preparation.

Amount of Water	Amount of Bleach
1 quart (or 1 liter)	4 drops
2 quarts (or 1/2 gallon or 1 liter)	8 drops
1 gallon (or 4 liters)	16 drops (1/8 teaspoon)
5 gallons	1/2 teaspoon

Let the water stand for 30 minutes after adding the bleach. The water should have a slight bleach odor. If it doesn't, then repeat the dosage and let stand another 15 minutes. If it still does not smell of chlorine, discard it and find another source of water. (If the water is cloudy after 30 minutes at the highest amount of bleach given, do not drink the water.)

Resources:
Emergency Water Storage & Purification Guidelines, Federal Emergency Management Agency, http://www.prepareandsurvive.info/documents/WaterPurificationandStorage.pdf and http://www.fema.gov/plan/prepare/watermanage.shtm. Accessed September 12, 2012.

©2013 Becky Dorner & Associates, Inc.

Non-Perishable Foods List

Examples of Non-Perishable Foods

The following foods are easily inventoried and generally have a longer shelf life. These foods can be easily incorporated into your current menu or snack schedules. Be sure to follow inventory rotation and monitor expiration dates. Keep a manual can opener with the canned goods supply.

Canned Goods

Canned Meats, Poultry, Fish	**Canned Beans**	**Pureed Foods**	**Canned Nutritional Supplements**
Chicken Deviled ham Ham Peanut butter Salmon Tuna Vienna sausage	Baked Black Butter Cannelloni Chick Peas Kidney Navy	Chicken Fruits Meats Vegetables	Milkshakes Puddings
Canned Fruit Applesauce Apple slices Fruit cocktail Mandarin oranges Peaches Pears Pineapple	**Canned Pie Filling** Apple Blueberry Cherry Peach	**Canned Prepared Foods** Cheese sauce Chicken & dumplings Chili Ravioli Stew	**Soups** Chicken noodle Cream of celery Cream of chicken Cream of mushroom Cream of tomato Vegetable Vegetable beef
Canned Vegetables Corn German potato salad Green beans Peas Pickled vegetables Potatoes Spaghetti sauce Three bean salad Tomatoes Tomato sauce	**Canned Pudding** Chocolate Lemon Vanilla	**Broths** Beef Chicken Vegetable (Canned or aseptic packs)	**Fruit Juices** Apple Apricot nectar Cranberry Grape Orange Pear nectar Prune (Canned or aseptic packs)
Condiments Chocolate syrup Jam and jelly Maple syrup Mayonnaise Mustard Salad dressing	**Canned Milk** Evaporated milk Sweetened /condensed	**Beverages** Fruit punch Iced tea Other beverage drinks Soda pop	**Bottled Water** 16 or 20 ounces 1 Gallon 5 Gallon 50 Gallon Drums Larger Containers as needed

©2013 Becky Dorner & Associates, Inc.

Non-Perishable Foods List

Shelf Stable Items

Convenience Foods	**Supplements/ Proteins**	**Therapeutic Items**	***Condiments**
Instant mashed potatoes Instant mashed sweet potatoes Instant pudding Powdered cheese sauce mix Refried Beans Soy Protein	Egg whites, dried Instant breakfast mix Milkshake mix	Modified food starch or gel thickener Sweetener	Coffee creamer Honey Jelly Ketchup Mustard Salt and pepper Sugar
Crackers/Chips Butter crackers Cheese puffs Graham crackers Potato chips Saltine crackers	**Snacks** Cereal bars Cheese crackers Granola bars Peanut butter crackers Snack bars	**Soup** Bouillon Dried soup mix Soup base	**Coffee/Tea** Instant coffee Tea bags
Starches Pasta Noodles	**Cookies** Chocolate chip Filled cookies Shortbread cookies Sugar cookies Vanilla wafers	**Thickened Beverages** Thickened juice Thickened milk Thickened water	**Beverages** Large and small aseptic packs of juice Powdered beverage mixes (regular and sugar free): Fruit flavored iced tea Punch
Milk Pasteurized nonfat dry milk Canned evaporated milk Shelf stable milk	**Cereals** Dry (bulk or in single serve containers) Hot (cream of rice, cream of wheat, grits oatmeal)	**Nuts and Seeds** Almonds Mixed nuts Peanut butter Peanuts Walnuts	**Dried Fruit** Apples Apricots Bananas Cranberries Prunes Raisins

* Consider individual portion packs
**Shelf stable aseptic packages of milk may be available from food service vendors. These may be packed in individual portion sizes. They are shelf stable for approximately eight (8) months and include an expiration date.

Semi Perishable Foods:

Bread Items	Produce
Bread Buns/Rolls Pita bread Muffins/ English muffins Parmesan cheese	Potatoes Onions Apples

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Emergency Menu and Supplies

The following pages contain a special diet conversion table for use during emergencies, a sample three (3) day emergency meal plan, and a list of supplies needed for these menus.

The facility should have the required items in stock for a minimum of three (3) days, and preferably seven (7) days in case of an extended time that the facility is unable to receive deliveries.

Rotate emergency stock at least every 6 months to assure freshness.

Customize the following menus as needed for your clientele. If necessary, repeat the cycle for the duration of the disaster period. Diets should be liberalized according to the chart on the following page.

Note: During a disaster, foods that appear on the emergency menus may not be available in every situation. The menus provided are meant as guides, and will need to be adjusted during times of disaster. In some situations, the recommended nutritional guidelines of the USDA MyPlate or other recognized menu guides may not be met.

Sample Emergency Menus
For specific three (3) day emergency menus that assume there are no utilities available, and seven (7) day emergency menus that assume cooking ability, refer to Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Resource: Emergency Plan Special Diets Conversion Table

Textures, food allergies, food intolerance are the priority in following diets during a disaster.

Original Order	Diet During Disaster
Sodium Restricted 1 gram Na 2 gram Na 3 - 5 gram Na No added salt Any other sodium restrictions	**No Added Salt** **(No salt at table)**
Diabetic 1000 1200 1500 1800 2000 Any other calorie restricted ADA Carbohydrate Controlled Consistent Carbohydrate	**Low concentrated sweets** **(No sugar at table)** **Provide sugar substitute and sugar free foods if available**
Renal Diets 2 Gm Na, 2 Gm K, 60gPro Potassium Restricted Sodium Restricted Protein Restricted Any other Renal Diet	**No Added Salt; No Prunes, Prune Juice, Orange Juice, Oranges, Potatoes or Bananas; 1/2 c milk limit daily** **Limit Protein for Pre-Dialysis**
Consistency Alterations Mechanical soft Ground Chopped National Dysphagia Diet Level 3	**Mechanical Soft**
Puree National Dysphagia Diet Level 1 National Dysphagia Diet Level 2	**Puree**

Note: For diabetics, use sugar-free products whenever possible. For sodium restricted diets, remove salt packets. For mechanical soft diets, provide foods that can be chewed or spread easily. For pureed diets, provide pureed food. (An emergency supply of canned pureed foods should be kept on hand.)

*The use of canned evaporated milk or reconstituted powdered dry milk is allowed. For reconstituted canned evaporated or powdered milk, juices, soups or beverages, be sure to follow the water purification procedure in this section if the water supply is unsafe for drinking.

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Sample Menu Shell

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BREAKFAST							
LUNCH							
SNACK							
DINNER							
HS							

©2013 Becky Dorner & Associates, Inc.

Suggested Emergency Menu Pattern

Meal	Diets:				
	Regular	**Mechanical Soft**	**Puree**	**LCS**	**LCS Puree**
Breakfast	Juice, 6 oz Cereal, 1 serving Starch Bread or Other, 1 serving Milk or Nutrition Supplement, 8 oz Coffee/Tea	Juice, 6 oz Soft Cereal, 1 serving Soft Starch Bread or Other, 1 serving Milk or Nutrition Supplement, 8 oz Coffee/Tea	Juice, 6 oz Smooth Hot Cereal, 1 cup Pureed Starch Bread or Other, 1 serving Milk or Nutrition Supplement 8 oz Coffee/Tea	*Juice, 6 oz *Cereal, 1 serving *Starch Bread or Other 1 serving Milk or SF Nutrition Supplement 8 oz *Coffee/Tea	*Juice, 6 oz *Smooth Hot Cereal, 1cup *Pureed Starch Bread or Other, 1 serving Milk or SF Nutrition Supplement, 8 oz *Coffee/Tea
Lunch	Protein Source, 2-3 oz equivalent Starch, 2 servings Vegetable, 3/4 cup Fruit, 1 serving Water, 8 oz	Ground Protein Source, 2-3 oz equivalent Soft Starch, 2 servings Soft Veg, 3/4 cup Soft Fruit, 1 serving Water, 8 oz	Pu Protein Source, 2-3 oz equivalent Pu Starch, 2 servings Pu Veg, 3/4 cup Pu Fruit, 1 serving Water, 8 oz	Protein Source 2-3 oz equivalent *Starch, 2 servings *Vegetable 3/4 cup *Fruit, 1 serving Water, 8 oz	Pu Protein Source 2-3 oz equivalent *Pu Starch, 2 servings *Pu Veg, 3/4 cup *Pu Fruit, 1 serving Water, 8 oz
Dinner	Protein Source 2-3 oz equivalent Starch, 2 servings Vegetable, 3/4 cup Fruit, 1 serving Water, 8 oz Milk, 8 oz or Nutr Supplement, 6-8 oz	Ground Protein Source, 2-3 oz equivalent Soft Starch, 2 servings Soft Veg, 3/4 cup Soft Fruit, 1 serving Water, 8 oz Milk, 8 oz or Nutr Supplement, 6-8 oz	Pu Protein Source, 2-3 oz equivalent Pu Starch, 2 servings Pu Veg, 3/4 cup Pu Fruit, 1 serving Water, 8 oz Milk, 8 oz or Nutr Supplement, 6-8 oz	Protein Source 2-3 oz equivalent *Starch, 2 servings *Vegetable 3/4 cup *Fruit, 1 serving Water, 8 oz Milk, 8 oz or SF Nutr Supplement, 6-8 oz	Pu Protein Source 2-3 oz equivalent *Pu Starch, 2 servings *Pu Veg, 3/4 cup *Pu Fruit, 1 serving Water, 8 oz Milk, 8 oz or SF Nutr Supplement, 6-8 oz
Snack	Starch, 1 serving	Soft Starch, 1 serving	Pu Starch, 1 serving	*Starch, 1 serving	*Pu Starch, 1 serving
	Milk, 8 oz or Nutr Supplement, 6-8 oz	Milk, 8 oz or Nutr Supplement, 6-8 oz	Milk, 8 oz or Nutr Supplement, 6-8 oz	Milk, 8 oz or SF Nutr Supplement, 6-8 oz	Milk, 8 oz or SF Nutr Supplement, 6-8 oz

SF = Sugar Free LCS = Low Concentrated Sweets Pu = Pureed *Low in Simple Sugars

Note: All liquids offered must be thickened to the ordered consistency

©2013 Becky Dorner & Associates, Inc.

Suggested Serving Sizes for Starches

1 serving = approximately 15 gram carbohydrates)

Portions for Diabetic Diets (No Added Sugar)		Regular Portions	
Bread	1 slice	Bread	1 slice
Cold Cereal (no added sugar)	1 oz	Cold Cereal	1 oz
Hot Cereal (no added sugar)	6 oz	Hot Cereal	6 oz
Crackers	6	Crackers	6
Rice	1/3 cup	Rice	1/2 cup
Noodles	1/2 cup	Noodles	1/2 cup
Coffee Cake (no frosting or sugar topping)	2 x 2 "	Coffee Cake	2 x 2 "
Muffin	1 small	Muffin	1 medium
Plain Cookie	2 small	Cookies	2 medium
Graham Crackers	2-2" squares	Graham Crackers	4-2" squares
Roll	1 small	Roll	1 medium
Pudding, SF	1/2 cup	Pudding	1/2cup
Vegetable Soup	1 cup	Vegetable Soup	1 cup
Noodle Soup	1 cup	Noodle Soup	1 cup

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Day 1 Emergency Meal Plan – Assumes No Utilities

	Regular/NAS		Mech Soft		Puree		LCS		LCS Puree	
BREAKFAST	Assorted Juice	6 oz	Assorted Juice	6 oz	Assorted Juice	6 oz	*Assorted Juice	6 oz	*Assorted Juice	6 oz
	Muffin	1	Soft Muffin, No Nuts	1	Hot Cereal	1 c	*Muffin or Toast	1	Cream of Wheat	1 c
	Dry Cereal	¾ c	Dry Cereal (soft)	¾ c	None		Dry Cereal	¾ c		
	Cottage Cheese (if available)	½ c	Cottage Cheese (if available)	½ c	Yogurt (smooth) (if available)	½ c	Cottage Cheese (if available)	½ c	*Yogurt (smooth) (if available)	½ c
	Bananas (if available) or Canned Fruit	½	Bananas (if available) or Canned Fruit	½	Applesauce, Smooth	½ c	Bananas (if available) or SF Canned Fruit	½	SF Applesauce, (smooth)	½ c
	Instant Breakfast	8 oz	Instant Breakfast	8 oz	Instant Breakfast	8 oz	SF Instant Breakfast	8 oz	SF Instant Breakfast	8 oz
LUNCH	Canned Deviled Ham Spread	3 oz	Canned Deviled Ham Spread	3 oz	Pureed Canned Beef	#8s	Canned Deviled Ham Spread	3 oz	Pureed Canned Beef	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Canned 3 Bean Salad	¾ c	Canned 3 Bean Salad	¾ c	Pu Cnd Green Beans	#8s	Canned 3 Bean Salad	¾ c	Pu Cnd Green Beans	#8s
	Fresh or Canned Fruit	½ c	Fresh or Cnd Fruit	½ c	Pureed Canned Pears	#8s	SF Fresh or Cnd Fruit	½ c	SF Pu Canned Pears	#8s
	Water	8 oz	Water	8 oz	Water	8 oz	Water	8 oz	Water	8 oz
	Milk	8 oz	Milk	8 oz	Milk	8 oz	Milk	8 oz	Milk	8 oz
DINNER	Canned Chicken Salad	3 oz	Canned Chicken Salad, (soft)	3 oz	Pureed Canned Chicken	#8s	Canned Chicken Salad	3 oz	Pureed Canned Chicken	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Cheese Puffs	1oz	Cheese Puffs	1 oz	Pureed Canned Peaches	#8s	Cheese Puffs	1 oz	SF Pureed Canned Peaches	#8s
	Canned Pickled Beets	¾ c	Canned Pickled Beets	¾ c	Pureed Canned Beets	#8s	Canned Pickled Beets	¾ c	Pureed Canned Beets	#8s
	Assorted Beverages	8 oz	Assorted Beverages	8 oz	Assorted Beverages	8 oz	SF Asst Beverages	8 oz	SF Asst Beverages	8 oz
	Nutritional Supplement	6-8 oz	Nutritional Supplement	6-8 oz	Nutritional Supplement	6-8 oz	SF Nutr Supplement	6-8 oz	SF Nutr Supplement	6-8 oz
HS	Cereal Bar	1	Cereal Bar (soft)	1	Ready to Eat Pudding	½ c	Cereal Bar	1	SF Ready to Eat Pudding	6-8 oz
	Water	8 oz	Water	8 oz	Nutritional Supplement	8 oz	Water	8	SF Shelf Stable Supplement	½ c

SF = Sugar Free LCS = Low Concentrated Sweets Pu = Pureed *Low in Simple Sugars

Note: All liquids offered must be thickened to the ordered consistency

©2013 Becky Dorner & Associates, Inc.

Day 2 Emergency Meal Plan – Assumes No Utilities

	Regular/NAS		Mech Soft		Puree		LCS		LCS Puree	
BREAKFAST	Assorted Juice	6 oz	Assorted Juice	6 oz	Assorted Juice	6 oz	*Assorted Juice	6 oz	*Assorted Juice	6 oz
	Assorted Dry Cereals	¾ c	Dry Cereal (soft)	¾ c	Hot Cereal (if able)	1 c	*Assorted Dry Cereals	¾ c ¾ c	Hot Cereal (if able)	1 c
	Donuts	1	Donuts (soft, no nuts)	1						
	Canned Fruit	½ c	Canned Fruit (soft)	½ c	Puree Canned Pineapple	#8s	SF Canned Fruit	½ c	SF Pu Canned Pineapple	#8s
	Instant Breakfast	8 oz	Instant Breakfast	8 oz	Instant Breakfast	8 oz	SF Instant Breakfast	8 oz	SF Instant Breakfast	8 oz
LUNCH	Creamy Peanut Butter	1 Tbs	Creamy Peanut Butter	2 Tbs	Pureed Canned Beef Stew	#8s	Creamy Peanut Butter	2 Tbs	Pureed Canned Beef Stew	#8s
	Jelly	1 Tbs	Jelly	1 Tbs			SF Jelly	1 Tbs		
	Bread	2 sl	Bread	2 sl	Puree Bread Mix	#8s	Bread	2 sl		
	Cheese Puffs	1 oz	Cheese Puffs	1 oz	V-8 Juice	6 oz	Cheese Puffs	1 oz	V-8 Juice	6 oz
	Canned Fruit	½ c	Canned Fruit	½ c	Pureed Canned Peaches	#8s	SF Canned Fruit	½ c	SF Pu Canned Peaches	#8s
	Assorted Cookies	2	Assorted Cookies (no nuts or chips)	2			Graham Crackers	2		
	Water	8 oz	Water	8 oz	Water	8 oz	Water	8 oz	Water	8 oz
	Milk	4 oz	Milk	4 oz	Milk	8 oz	Milk	4 oz	Milk	8 oz
DINNER	Tuna Salad	3 oz	Tuna Salad (soft)	3 oz	Pureed Canned Chicken	#8s #8s	Tuna Salad	3 oz	Pureed Canned Chicken	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Canned Bean Salad	½ c	Canned Bean Salad	½ c	Pureed Canned Green Beans	#8s	Canned Bean Salad	½ c	SF Pureed Canned Green Beans	#8s
	Canned Fruit	½ c	Canned Fruit	½ c	Applesauce	½ c	SF Canned Fruit	½ c	SF Applesauce (smooth)	½ c
	Assorted Beverages	8 oz	Assorted Beverages	8 oz	V-8 Juice	8 oz	SF Asst Beverages	8 oz	SF Asst Beverages	8 oz
					Assorted Beverages	8 oz				
	Nutritional Supplement	6-8 oz	Nutritional Supplement	6-8 oz	Nutritional Supplement	6-8 oz	SF Nutr Supplement	6-8 oz	SF Nutr Supplement	6-8 oz
HS	Cookies	1	Cookies (soft)	2	Ready to Eat Pudding	½ c	*Plain Cookies	2	SF Ready to Eat Pudding	6-8 oz
	Water	8 oz	Water	8 oz	Nutr Supplement	8 oz	Water	8 oz	SF Nutr Supplement	½ c

SF = Sugar Free LCS = Low Concentrated Sweets Pu = Pureed *Low in Simple Sugars

Note: All liquids offered must be thickened to the ordered consistency

©2013 Becky Dorner & Associates, Inc.

Day 3 Emergency Meal Plan – Assumes No Utilities

	REGULAR/NAS		MECH SOFT		PUREE		LCS		LCS PUREE	
BREAKFAST	Assorted Juices	6 oz	Assorted Juices	6 oz	Assorted Juices	6 oz	*Assorted Juices	6 oz	*Assorted Juices	6 oz
	Cereal Bar	1	Cereal Bar (soft)	1	Hot Cereal	8 oz	*Cereal Bar	1	*Hot Cereal	8 oz
	Canned Fruit	½ c	Canned Fruit	½ c	Pu Canned Peaches	#8s	SF Canned Fruit	½ c	SF Pu Canned Peaches	#8s
	Assorted Dry Cereals	¾ c	Assorted Dry Cereals	¾ c	Pureed Bread	#8s	Assorted Dry Cereals Unsweetened	¾ c	SF Supplement	8 oz
	Instant Breakfast	8 oz	Instant Breakfast	8 oz	Instant Breakfast	8 oz	Instant Breakfast	8 oz	SF Instant Breakfast	8 oz
LUNCH	Peanut Butter	2 Tbs	Peanut Butter	2 Tbs	Pureed Canned Chicken	#8s	Peanut Butter	2 Tbs	Pureed Canned Chicken	#8s
	Jelly	1 Tbs	Jelly	1 Tbs			SF Jelly	1 Tbs		
					Pureed Canned Peas	#8s			Pureed Canned Peas	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Canned Fruit	½ c	Canned Fruit	½ c	Pureed Canned Pears	#8s	SF Canned Fruit	½ c	SF Pu Canned Pears	#8s
	Read to Eat Pudding	½ c	Ready to Eat Pudding	½ c	Ready to Eat Pudding	½ c	SF Ready to Eat Pudding	½ c	SF Ready to Eat Pudding	½ c
	Water	8 oz	Water	8 oz	Water	8 oz	Water	8 oz	Water	8 oz
	Milk	8 oz	Milk	8 oz	Milk	8 oz	Milk	8 oz	Milk	8 oz
DINNER	Deviled Ham Salad	3 oz	Deviled Ham Salad	3 oz	Pureed Canned Beef	#8s	Deviled Ham Salad	3 oz	Pureed Canned Beef	#8s
	Bread	2 sl	Bread	2 sl	Pureed Canned Corn	#8s	Bread	2 sl	Pureed Canned Corn	#8s
	Applesauce	½ c	Applesauce	½ c	Applesauce (smooth)	#8s	SF Applesauce	½ c	SF Applesauce (smooth)	#8s
	Cheese Puffs	1 oz	Cheese Puffs	1 oz	Pureed Bread Mix	#8s	Cheese Puffs	1 oz	SF Pureed Bread Mix	#8s
	Assorted Cookies	2	Cookies, soft, no nuts	2			Plain Cookies	2		
	Assorted Beverages	8 oz	Assorted Beverages	8 oz	Assorted Beverages	8 oz	SF Asstd Beverages	8 oz	SF Assorted Beverages	8 oz
	Nutr Supplement	6-8 oz	Nutr Supplement	6-8 oz	Nutr Supplement	6-8 oz	SF Nutr Supplement	6-8 oz	SF Nutr Supplement	6-8 oz
HS	Cookies	2	Cookies, soft, no nuts	2	Nutr Supplement	6-8 oz	Graham Crackers	4	SF Nutr Supplement	6-8 oz
	Juice	6 oz	Juice	6 oz	Juice	6 oz	*Juice	6 oz	*Juice	6 oz

SF = Sugar Free LCS = Low Concentrated Sweets Pu = Pureed *Low in Simple Sugars

Note: All liquids offered must be thickened to the ordered consistency

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Sample 3 Day Emergency Meal Plan for Pureed Diets

DAY 1	DAY 2	DAY 3
BREAKFAST	**BREAKFAST**	**BREAKFAST**
Hot cereal, double portion	Hot cereal, double portion	Hot cereal, double portion
Applesauce, smooth	Canned pureed pineapple	Canned pureed peaches
Cottage cheese, pureed if possible	Yogurt, smooth, if possible	Instant breakfast*
Assorted juices*	Assorted juices*	Assorted juices*
Milk*	Milk*	Milk*
LUNCH	**LUNCH**	**LUNCH**
Canned pureed beef	Canned pureed beef stew	Canned pureed chicken
Canned pureed green beans	V-8 Juice	Canned pureed pears
Canned pureed pears	Pureed canned peaches	Canned pureed peas
	Pureed bread mix	Read to eat pudding
Water*	Water*	Water*
Instant breakfast*	Instant breakfast *	Instant breakfast *
DINNER	**DINNER**	**DINNER**
Canned pureed chicken	Canned pureed chicken	Canned pureed beef
Canned pureed peaches	Canned pureed green beans	Canned pureed corn
Canned pureed peas	Ready to eat pudding	Applesauce, smooth
Assorted beverages*	Assorted beverages*	Assorted beverages*
Nutritional supplement	Nutritional supplement	Nutritional supplement
SNACKS	**SNACKS**	**SNACKS**
Nutritional supplement	Nutritional supplement	Nutritional supplement
Ready to eat pudding	Applesauce	Water*

Notes: Menu may not be adequate in nutrients for all residents. Menus average approximately 1800 to 2000 calories, 75 to 85 grams protein daily. Utilize nutritional supplements when needed.

For diabetics, use low sugar products when possible. For sodium restricted diets, remove salt packets. For pureed diets, provide pureed food. (An emergency supply of canned pureed foods should be kept on hand). For thickened liquids, follow manufacturer's instructions for appropriate level of thickness.

*Utilize safe water supplies for reconstituted canned evaporated or pasteurized non-fat powdered milk, juices, soups or beverages. (Follow the water purification procedure in this section if the water supply is unsafe for drinking.) The use of canned evaporated milk or reconstituted powdered dry milk is appropriate once fresh milk supplies have been used (use fresh milk within four hours of losing power, or move milk to freezer to maintain temperature of 41° F or lower to keep milk safe).

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Hand Washing During a Disaster

Policy:

Safe and effective hand washing and/or sanitizing techniques will be utilized during emergency situations.

Procedure:

1. The food service manager will determine the safety of the water supply. If water is contaminated, it will need to be purified prior to use for hand washing (see water purification), or stored water that is safe for general use will need to be used for hand washing.

2. A hand washing area will be set up for staff use. Clean water will be available in large containers.
   a. One staff person will pour water over the hands of the person washing his/her hands.
   b. Soap will be applied and thorough washing above wrists, between fingers, under nails, etc. will occur for a minimum of 20 seconds.
   c. Again, one staff person will pour water from the clean water container to rinse the other staff person's hands.
   d. A clean towel or paper towel will be used to dry hands.

3. Alternative to hand washing:
   An instant hand sanitizer (hand cleaner) that does not require rinsing will be utilized for hand sanitizing during a disaster. These products report high levels of success in killing most common disease causing germs. They also provide a fast and easy way to sanitize hands. However, they do not take the place of appropriate hand-washing techniques and are only for temporary use during emergency situations. Follow manufacturers' directions for use.

©2013 Becky Dorner & Associates, Inc.

Sanitizing Dishes During a Disaster

Policy:

If there is no electricity for dishwashing, hand dishwashing will be implemented.

Procedure:

1. Wash: A dish is first scraped and then washed in a solution of dish soap and hot water (if available).

2. Rinse: Once the dish has been washed, is it rinsed in a basin filled with clean water.

3. Sanitize: After the dish has been rinsed, it is run through the third basin, which contains a sanitizing solution. Keep enough sanitizing solution on hand for emergencies.

Note: Use disposable dishes and utensils when possible during emergency situations.

©2013 Becky Dorner & Associates, Inc.

General Disaster Supplies

The following items are necessary for emergency use and should be kept on hand at all times within the facility.

- Master contact list of employee and key community contacts
- Emergency cell phone, battery operated charger

Keep an adequate supply of the following items on hand. This supply should last at least 7 days at all times.

Amount	Items Needed – Food Safety/Sanitation
	Thermometers
	Alcohol swabs
	Hand sanitizer
	Hand soap
	Hand sanitizing wipes
	Bleach (recommended 5.25% concentration of hypochlorite without soap or additives)
	Water purification tablets
	Dish soap
	Sanitizing solution
	Food handling gloves
	Aluminum foil
	Plastic wrap
	Plastic food bags (sandwich, quart, gallon size)
	Paper towels
	Towels and dish rags (Handiwipes®)
	Rubber gloves
	Sanitizing solution
	Dish soap
	Large plastic bags for trash
	Clean up supplies – broom, shovel, buckets, rags, mops

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

General Disaster Supplies

Amount	Food Preparation/Service
	Styrofoam or plastic take out containers for food
	Foil pans for cooking and serving
	Straws
	Coolers
	Manual can opener
	Egg beater or whisk
	Potato masher
	Battery operated equipment (heating elements, whisks, etc.)
	Barbeque grill—portable, outdoor grill
	Charcoal
	Lighter fluid
	Sterno fuel and containers
Amount	**Emergency Supplies**
	Fire Extinguisher
	First aid kit and first aid book
	Weather radio, portable
	Portable flashlights
	Battery operated lanterns
	Extra batteries
	Blankets
	Adjustable wrench to turn off gas
	Tool box: hammer, screw drivers, crowbar, adjustable wrenches, etc.
	Heavy tape
	Matches in water proof container
	Battery operated clocks

Source: Dorner, B. Dietary Disaster Plan: Be Prepared for any Emergency, Becky Dorner & Associates, Inc., Akron, OH found at http://www.beckydorner.com/products/82.

©2013 Becky Dorner & Associates, Inc.

Disaster Resources

- Emergency Preparedness for Older Adults. Resource from the US Department of Health and Human Services and CDC. Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergencies: A Cross-Sector Guide for States and Communities. http://www.cdc.gov/aging/emergency/
- Survey & Certification: Emergency Preparedness for Every Emergency. http://www.bt.cdc.gov/
- Red Cross: Preparedness Tips. http://www.redcross.org/preparedness/cdc_english/foodwater-1.asp
- Building an Emergency Kit: FEMA. http://www.ready.gov/build-a-kit
- FNS Disaster Assistance. http://www.fns.usda.gov/disasters/disaster.htm
- National Food Service Management Institute. http://nfsmi-web01.nfsmi.olemiss.edu/ResourceOverview.aspx?ID=61
- Keeping food safe during an emergency. http://www.fsis.usda.gov/factsheets/keeping_food_safe_during_an_emergency/index.asp
- Keeping water and food safe during an emergency. http://www.bt.cdc.gov/disasters/foodwater/facts.asp
- Emergency Disinfection of Drinking Water (Environmental Protection Agency). http://water.epa.gov/drink/emerprep/emergencydisinfection.cfm
- Food Safety Information for Hurricanes, Power Outages & Floods (FDA). http://www.fda.gov/Food/FoodDefense/Emergencies/FloodsHurricanesPowerOutages/default.htm.
- Emergency Preparedness - What RDs & DTRs Should Know (Academy of Nutrition and Dietetics – members only). http://www.eatright.org/Members/content.aspx?id=2187.
- Indiana State Dept of Health Food Safety During Power Outages. http://www.in.gov/isdh/files/Power_Outages__2_.pdf.
- USDA Food Safety and Inspection Service. http://www.fsis.usda.gov/Fact_Sheets/keeping_food_Safe_during_an_emergency/index.asp

©2013 Becky Dorner & Associates, Inc.

Appendix

♦ Index to Federal Policies and Procedures and Nursing Home Federal Regulations 13-1

♦ References and Resources 13-14

©2013 Becky Dorner & Associates, Inc.

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F154 Resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition	• End of Life Decisions • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Total or Peripheral Parenteral Nutrition	• Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	10-28 10-29 10-30 10-36
F155 The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive	• End of Life Decisions • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Total or Peripheral Parenteral Nutrition	• Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	10-28 10-29 10-30 10-36
F241 Dignity (promoting resident's independence and dignity in dining, such as avoidance of day to day use of plastic cutlery and paper/plastic dishware, bibs instead of napkins, dining room conducive to pleasant dining)	• The Dining Experience • Dining and Meal Service • The Person Centered Dining Approach • Customer Service • Serving the Meal • Service Staff • Handling Customer Concerns • Table Setting • Timely Meal Service • Meal Preparation and Service Audit • Meal Round Audit	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • QA/Performance Improvement • QA/Performance Improvement	2-1 2-2 2-4 2-6 2-9 2-10 2-11 2-14 2-28 11-15 11-20
F252 Environment: must provide a safe, clean, comfortable, and homelike environment	• The Dining Experience • Dining and Meal Service • The Person Centered Dining Approach • Serving the Meal • Table Setting • Timely Meal Service	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service	2-1 2-2 2-4 2-9 2-14 2-28
F272 Resident Assessment: conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment (RAI, MDS)	• Documenting in the Medical Record • MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • Clinical Documentation • QA/Performance Improvement	8-3 8-24 11-27
F273 Must conduct a comprehensive assessment within 14 days of admission	• MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • QA/Performance Improvement	8-24 11-27
F274 Must conduct a comprehensive assessment within 14 days of significant change (major status decline or improvement in status)	• MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • QA/Performance Improvement	8-24 11-27

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F275 Must conduct a comprehensive assessment not less than every 12 months	• MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • QA/Performance Improvement	8-24 11-27
F276 Must conduct a quarterly review assessment not less than once every 3 months	• MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • QA/Performance Improvement	8-24 11-27
F279 Comprehensive Care Plans: develop a comprehensive care plan for each resident that includes measurable objectives and timetables	• Documenting in the Medical Record • MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • Clinical Documentation • QA/Performance Improvement	8-3 8-24 11-27
280 Care plan developed within 7 days after completion of comprehensive assessment; prepared by an interdisciplinary team; periodically reviewed and revised	• MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • QA/Performance Improvement	8-24 11-27
F281 Services must meet professional standards of quality (accepted standards of clinical practice)	• Diet/Nutrition Care Manual • Philosophy and Standards of Clinical Care • Nutrition Screening for Referrals to RD • MNT Documentation • MNT Recommendations • Communication of Nutritional Concerns • Body Mass Index • Tracking Weight Changes • Significant Weight Loss • Significant Weight Gail • High Calorie/High Protein Supplements • Individuals on Unsupplemented Clear Liquids or NPO • Dysphagia • Thickened Liquids • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Basic Guidelines for Enteral Feeding • Documentation for Enteral Feeding • Enteral Feeding Assessment • Transitioning to Oral Feedings from Enteral Feeding • Total or Peripheral Parenteral Nutrition	• Menus and Special Diets • Clinical Documentation • Clinical Documentation • Clinical Documentation • Clinical Documentation • Clinical Documentation • Anthropometrics • Anthropometrics • Anthropometrics • Anthropometrics • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	1-18 8-2 8-17 8-24 8-47 8-49 9-10 9-18 9-26 9-29 10-8 10-21 10-22 10-26 10-29 10-30 10-31 10-32 10-33 10-34 10-36

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F281 (continued)	Food-Medication Interactions • Medical Record and Documentation Audit	• Nutrition Interventions • QA/Performance Improvement	10-38 11-27
F282 Services must be provided by qualified persons in accordance with each resident's written plan of care	• Philosophy/Standards of Clinical Care • MNT Documentation • MNT Recommendations • Communication of Nutritional Concerns • Body Mass Index • Basic Guidelines for Enteral Feeding • Documentation for Enteral Feeding • Enteral Feeding Assessment • Transitioning to Oral Feedings from Enteral Feeding • Medical Record and Documentation Audit	• Clinical Documentation • Clinical Documentation • Clinical Documentation • Clinical Documentation • Anthropometrics • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • QA/Performance Improvement	8-2 8-24 8-47 8-49 9-10 10-31 10-32 10-33 10-34 11-27
F283 Discharge summary (summary of resident's stay and current status)	• Food-Medication Interactions	• Nutrition Interventions	10-38
F309 Quality of Care: each resident receives the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care	• Nutrition Screening for Referrals to RD • MNT Recommendations • Tracking Weight Changes • Significant Weight Loss • Significant Weight Gain • Dehydration • Pressure Ulcers • Individuals on Unsupplemented Clear Liquid or NPO	• Clinical Documentation • Clinical Documentation • Anthropometrics • Anthropometrics • Anthropometrics • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	8-17 8-47 9-18 9-26 9-29 10-10 10-17 10-21
F310 Activities of Daily Living do not diminish unless circumstances of the individual's clinical condition demonstrate it was unavoidable: Eating	• Dining and Meal Service • Service Staff • Adaptive Eating Devices	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service	2-2 2-10 2-40
F314 A resident does not develop pressure sores unless clinical condition demonstrates it was unavoidable; a resident who has a pressure sore receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing	• Pressure Ulcers	• Nutrition Interventions	10-17

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F322 Naso-gastric tubes: A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless clinical condition demonstrates it was unavoidable. A resident who is fed by a NG or G tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, Dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills	• Dehydration • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Basic Guidelines for Enteral Feeding • Documentation for Enteral Feeding	• Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	10-10 10-29 10-30 10-31 10-32
F325 Nutrition: Resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless clinical condition demonstrates that this is not possible. Receives a therapeutic diet when there is a nutritional problem	• Diet/Nutrition Care Manual • Nutrient Intake Study • MNT Documentation • MNT Recommendations • Obtaining Accurate Heights • Obtaining Accurate Weights • Adjusting Weights for Amputees • Obtaining Measurements for Unweighable Individuals • Body Mass Index • Tracking Weight Changes • Significant Weight Loss • Significant Weight Gain • Pressure Ulcers • Individuals on Unsupplemented Clear Liquid or NPO • Dysphagia • Thickened Liquids • End of Life Decisions • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Documentation for Enteral Feeding • Enteral Feeding Assessment • Transitioning to Oral Feedings from Enteral Feeding	• Menus and Special Diets • Clinical Documentation • Clinical Documentation • Clinical Documentation • Anthropometrics • Anthropometrics • Anthropometrics • Anthropometrics • Anthropometrics • Anthropometrics • Anthropometrics • Anthropometrics • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	1-18 8-14 8-24 8-47 9-1 9-3 9-6 9-7 9-10 9-18 9-26 9-29 10-17 10-21 10-22 10-26 10-28 10-29 10-30 10-32 10-33 10-34

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F325 (continued)	• Total or Peripheral Parenteral Nutrition • Food-Medication Interactions • Meal Preparation and Service Audit • Steam Table and Tray Line Audit • Meal Round Audit • Nourishment/Supplement Audit	• Nutrition Interventions • Nutrition Interventions • QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement	10-36 10-38 11-15 11-18 11-20 11-33
F327 Dehydration: Provide each resident with sufficient fluid intake to maintain proper hydration and health	• Dehydration • Fluids at the Bedside • Encourage Fluids Order • Individuals on Unsupplemented Clear Liquids or NPO • Dysphagia • Thickened Liquids • End of Life Decisions • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Documentation for Enteral Feeding • Enteral Feeding Assessment • Transitioning to Oral Feedings from Enteral Feeding • Total or Peripheral Parenteral Nutrition	• Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	10-10 10-13 10-14 10-21 10-22 10-26 10-28 10-29 10-30 10-32 10-33 10-34 10-36
F328 Special Needs: Parenteral and enteral fluids	• Dehydration • Guidelines for Enteral Feeding Eligibility • Enteral Nutrition Care • Basic Guidelines for Enteral Feeding • Documentation for Enteral Feeding • Transitioning to Oral Feedings from Enteral Feeding • Total or Peripheral Parenteral Nutrition	• Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions • Nutrition Interventions	10-10 10-29 10-30 10-31 10-32 10-34 10-36
F360 Facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident	• Diet/Nutrition Care Manual • Meal Time Observation • Dysphagia • Thickened Liquids • Test Meal/Tray Audit	• Menus and Special Diets • Dining/Meal Service • Nutrition Interventions • Nutrition Interventions • QA/Performance Improvement	1-18 2-41 10-22 10-26 11-25

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F361 Staffing: Facility must provide a qualified dietitian full time, part time, or on a consultant basis. Designate a person to act as food service director	• Food Service Manager's Responsibilities • Food Service Problems/Referral to FSM • Food Service Supervision • Line of Authority • Staffing the Food Service Department • Training/Orientation • Inservice Training • Evaluating Food Svc/Clinical Personnel • Documenting in the Medical Record • MNT Documentation	• Food Production/Food Safety • Food Production/Food Safety • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Clinical Documentation • Clinical Documentation	3-2 3-44 7-2 7-3 7-4 7-13 7-20 7-24 8-3 8-24
F362 Sufficient Staff: Must employ sufficient support personnel competent to carry out the functions of dietary service.	• Dining and Meal Service • Accuracy and Quality of Tray Line Service • Meal Time Observation • Food Service Manager's Responsibilities • Personnel-General • Food Service Supervision • Line of Authority • Staffing the Food Service Department • Training/Orientation • Inservice Training • Evaluating Food Service Personnel • Nutrition Screening for Referrals to RD	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Food Production/Food Safety • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Personnel/Training • Clinical Documentation	2-2 2-38 2-41 3-2 7-1 7-2 7-3 7-4 7-13 7-20 7-24 8-17
F363 Menus and nutritional adequacy. (1) Menus must meet the nutritional needs of residents in accordance with the recommendations of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. (2) Be prepared in advance (3) Be followed	• Menu Planning • Selective Menus • Diet/Nutrition Care Manual • Special Occasions/Holidays/Theme Meals • Displaying the Menu • Portion Control • Meal Preparation and Service Audit • Meal Round Audit • Test Meal/Tray Audit	• Menu and Special Diets • Menu and Special Diets • Menus and Special Diets • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement	1-1 1-5 1-18 2-25 2-37 2-39 11-15 11-20 11-25
F 364 Food (1) Food prepared by methods that conserve nutritive value, flavor, and appearance.	• Dining and Meal Service • Serving the Meal • Service Staff	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service	2-2 2-9 2-10

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F364 (continued) (2) Food that is palatable, attractive, and at proper temp	• Timely Meal Service • Nourishments and Supplements • Meat and Vegetable Preparation • HACCP/Food Safety • HACCP Principles • Food Temperatures • Handling Cold Foods for Trayline • Taste Testing • Use of Leftovers • Personal Food Storage • Meal Preparation and Service Audit • Meal Round Audit • Test Meal/Tray Audit	• Dining/Meal Service • Dining/Meal Service • Food Production/Food Safety • Food Production/Food Safety • Food Production/Food Safety • Food Production/Food Safety • Food Production/Food Safety • Food Production/Food Safety • Food Production/Food Safety • Food Production/Food Safety • QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement	2-28 2-48 3-23 3-3 3-8 3-24 3-32 3-33 3-34 3-38 11-15 11-20 11-25
F365 Food Prepared in a form designed to meet individual needs	• Diet/Nutrition Care Manual • Clear and /Full Liquid Diet Supplies • Special Occasions/Holidays/Theme Meals • Dining and Meal Service • Select Menus • Meal ID and Preference Cards/Tickets • Accuracy and Quality of Tray Line Service • Meal Time Observation • Diet History • Alternates for Food Dislikes • System for Recording Food Preferences • Meal Preparation and Service Audit • Meal Round Audit	• Menus and Special Diets • Menus and Special Diets • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Clinical Documentation • Clinical Documentation • Clinical Documentation • QA/Performance Improvement • QA/Performance Improvement	1-18 1-36 2-25 2-28 2-31 2-33 2-38 2-41 8-4 8-6 8-7 11-15 11-20
F366 Substitutes offered of similar nutritive value to residents who refuse food served	• Menu Substitutions • Offering Food Replacements at Meal Times • Meal Time Observation • Alternates for Food Dislikes • System for Recording Food Preferences • Individuals Who Do Not Drink Milk • Meal Preparation and Service Audit	• Menus and Special Diets • Dining/Meal Service • Dining/Meal Service • Clinical Documentation • Clinical Documentation • Clinical Documentation • QA/Performance Improvement	1-7 2-34 2-41 8-6 8-7 8-16 11-15

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F367 Therapeutic Diets must be prescribed by the attending physician	• Diet/Nutrition Care Manual • Transmission of Diet Orders • Diet Orders • Foods Not Allowed on the Physician Ordered Diet • Use of Salt Substitute • Renal Diets • Dysphagia Diets • Altered Portions • Festivity Foods/Diet Holiday • Clear/Full Liquid Diets • NPO Diet Orders • Select Menus • Meal ID and Preference Cards/Tickets • Accuracy and Quality of Tray Line Service • Meal Time Observation • Meal Preparation and Service Audit • Steam Table and Tray Line Audit • Nourishment/Supplement Audit	• Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Menus and Special Diets • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement	1-18 1-19 1-20 1-28 1-29 1-31 1-32 1-33 1-34 1-36 1-37 2-31 2-33 2-38 2-41 11-15 11-18 11-33
F368 Frequency of Meals (1) Three meals daily, at regular times comparable to normal mealtimes in the community (2) No more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below (3) Offer snacks at bedtime daily (4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day	• Timely Meal Service • Meal Times and Frequency • Early and Late Meals • Meal Round Audit • Hours of Operation • Nourishments and Supplements	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Food Production/Food Safety • QA/Performance Improvement	2-28 2-29 2-30 2-48 3-1 11-20
F369 Assistive devices	• Dining and Meal Service • Adaptive Eating Devices • Meal Preparation and Service Audit • Meal Round Audit	• Dining/Meal Service • Dining/Meal Service • QA/Performance Improvement • QA/Performance Improvement	2-2 2-40 11-15 11-20

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F371 Procure food from sources approved or considered satisfactory by federal, state or local authorities. Store, prepare, distribute, and serve food under sanitary conditions.	• Dining and Meal Service	• Dining/Meal Service	2-2
	• Dining Atmosphere	• Dining/Meal Service	2-8
	• Serving the Meal	• Dining/Meal Service	2-9
	• Restaurant Style Dining	• Dining/Meal Service	2-16
	• Family Style Dining	• Dining/Meal Service	2-17
	• Buffet Style Dining	• Dining/Meal Service	2-19
	• Open Style Dining	• Dining/Meal Service	2-21
	• In-Room Dining (Room Service)	• Dining/Meal Service	2-23
	• 24 Hour Dining	• Dining/Meal Service	2-24
	• Timely Meal Service	• Dining/Meal Service	2-28
	• Food Service Manager's Responsibility	• Food Production/Food Safety	3-2
	• HACCP and Food Safety	• Food Production/Food Safety	3-3
	• HACCP Principles	• Food Production/Food Safety	3-8
	• Food Procurement and Facility Gardens	• Food Production/Food Safety	3-15
	• Accepting Food Deliveries	• Food Production/Food Safety	3-16
	• Food Storage	• Food Production/Food Safety	3-17
	• General Food Preparation/Handling	• Food Production/Food Safety	3-21
	• Meat and Vegetable Preparation	• Food Production/Food Safety	3-23
	• Food Temperatures	• Food Production/Food Safety	3-24
	• Handling Cold Foods for Trayline	• Food Production/Food Safety	3-32
	• Use of Leftovers	• Food Production/Food Safety	3-34
	• Personal Food Storage	• Food Production/Food Safety	3-38
	• Employee Sanitary Practices	• Sanitation/Infection Control	4-4
	• General Sanitation of Kitchen	• Sanitation/Infection Control	4-6
	• Hand Washing	• Sanitation/Infection Control	4-7
	• Bare Hand Contact With Food and Use of Plastic Gloves	• Sanitation/Infection Control	4-9
	• Cleaning Dishes/Dish Machine	• Sanitation/Infection Control	4-10
	• Dish Machine Temperature Log	• Sanitation/Infection Control	4-12
	• Maintenance of Dish Machine	• Sanitation/Infection Control	4-15
	• Cleaning Dishes-Manual Dishwashing	• Sanitation/Infection Control	4-16
	• Handling Clean Equipment/Utensils	• Sanitation/Infection Control	4-18
	• Bedside Water Containers	• Sanitation/Infection Control	4-19
	• Dry Storage Areas	• Sanitation/Infection Control	4-20

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F371 (continued)	• Production, Storage and Dispensing of Ice	• Sanitation/Infection Control	4-21
	• Kitchen Cloths	• Sanitation/Infection Control	4-24
	• Pest Control	• Sanitation/Infection Control	4-26
	• Sanitation of Dining/Food Service Areas	• Cleaning Instructions	5-1
	• Material Safety Data Sheets	• Cleaning Instructions	5-7
	• Cleaning Broilers	• Cleaning Instructions	5-9
	• Cleaning Cabinets and Drawers	• Cleaning Instructions	5-10
	• Cleaning Can Opener	• Cleaning Instructions	5-11
	• Cleaning Cloths, Pads, Mops and Buckets	• Cleaning Instructions	5-12
	• Cleaning Coffee, Beverage, Juice, Frozen Yogurt/Ice Cream Machines	• Cleaning Instructions	5-13
	• Cleaning Counter Space	• Cleaning Instructions	5-14
	• Cleaning Cutting Boards	• Cleaning Instructions	5-15
	• Cleaning Floors, Tables and Chairs	• Cleaning Instructions	5-16
	• Cleaning Food Carts	• Cleaning Instructions.	5-17
	• Cleaning Food Preparation Appliances	• Cleaning Instructions.	5-18
	• Cleaning Freezers	• Cleaning Instructions	5-19
	• Cleaning Fryers	• Cleaning Instructions	5-20
	• Cleaning Garbage Disposal	• Cleaning Instructions	5-21
	• Cleaning Hoods and Filters	• Cleaning Instructions	5-22
	• Cleaning Ice Machine and Equipment	• Cleaning Instructions	5-23
	• Cleaning Microwave Oven	• Cleaning Instructions	5-24
	• Cleaning Ovens	• Cleaning Instructions.	5-25
	• Cleaning Ranges	• Cleaning Instructions	5-26
	• Cleaning Refrigerators	• Cleaning Instructions	5-27
	• Cleaning Slicers	• Cleaning Instructions	5-28
	• Cleaning Steam Tables	• Cleaning Instructions	5-29
	• Cleaning Toasters	• Cleaning Instructions	5-30
	• Sanitation Audit	• QA/Performance Improvement	11-7
	• Meal Preparation and Service Audit	• Q/A Performance Improvement	11-15
	• Steam Table and Tray Line Audit	• QA/Performance Improvement	11-18
	• Emergency/Disaster Planning	• Disaster Planning	12-1
	• Sanitizing Dishes During a Disaster	• Disaster Planning	12-26
F372 Dispose of garbage and refuse properly	• Waste Disposal	• Sanitation/Infection Control	4-25

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F373 A facility may use a paid feeding assistant who has successfully completed a State-approved training course and the use of feeding assistants is consistent with State law; the facility provides supervision by a registered nurse (RN) or licensed practical nurse (LPN); the feeding assistant calls a supervisory nurse for help in an emergency; and the facility ensures that feeding assistants feed only residents who have no complicated feeding problems.	• Paid Feeding Assistants (Nursing Facilities)	• Dining/Meal Service	2-26
F441 Infection Control: prevent development and transmission of disease and infection. Infection Control: preventing spread of infection Infection Control: prohibit employees with a communicable disease from direct contact with residents or their food if the contact will transmit the disease	• Family Style Dining • Buffet Style Dining • 24 Hour Dining • Food Safety-FSM Responsibility • Employee Sanitary Practices • Hand Washing • Bare Hand Contact With Food and Use of Plastic Gloves • Cleaning Dishes/Dish Machine • Dish Machine Temperature Log • Maintenance of Dish Machine • Cleaning Dishes-Manual Dishwashing • Handling Clean Equipment/Utensils • Bedside Water Containers • Production/Storage/Dispensing of Ice • Isolation Meals • Infection Control Cleaning Agents • Meal Preparation and Service Audit • Hand Washing During a Disaster • Sanitizing Dishes During a Disaster	• Dining/Meal Service • Dining/Meal Service • Dining/Meal Service • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Sanitation/Infection Control • Cleaning Instructions • QA/Performance Improvement • Disaster Planning • Disaster Planning	2-17 2-19 2-24 4-3 4-4 4-7 4-9 4-10 4-12 4-15 4-16 4-18 4-19 4-21 4-22 5-6 11-15 12-25 12-26
F444 Infection Control: require staff to wash hands after each direct resident contact	• Hand Washing • Bare Hand Contact With Food and Use of Plastic Gloves	• Sanitation/Infection Control • Sanitation/Infection Control	4-7 4-9

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F444 (continued)	• Infection Control Cleaning Agents • Meal Preparation and Service Audit	• Cleaning Instructions • QA/Performance Improvement	5-6 11-15
F454 Life safety from fire	• Fire Prevention • Fire Plan for Food Service Department • Fire Safety Rules	• Safety • Safety • Safety	6-11 6-12 11-15
F464 Dining and resident activities: Must provide one or more rooms designated for resident dining and activities.	• The Person Centered Dining Approach • Meal Preparation and Service Audit	• Dining/Meal Service • QA/Performance Improvement	2-4 11-15
F466 Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply	• Water Requirements	• Disaster Planning	12-11
F499 Staff qualifications: must employ on a full time, part time or consultant basis those professionals necessary. Professional staff must be licensed, certified or registered in accordance with applicable state laws.	• Philosophy and Standard of Clinical Care • Documenting in the Medical Record • Nutrition Screening for Referrals to RD • MNT Documentation	• Clinical Documentation • Clinical Documentation • Clinical Documentation • Clinical Documentation	8-2 8-3 8-17 8-24
F500 Use of outside resources: If facility does not employ qualified professionals, must obtain services that meet professional standards and principles that apply to professionals providing services	• Philosophy and Standard of Clinical Care • Nutrition Screening for Referrals to RD • MNT Documentation	• Clinical Documentation • Clinical Documentation • Clinical Documentation	8-2 8-17 8-24
F514 Clinical records: maintain clinical records on each resident in accordance with accepted professional standards and practices (complete, accurately documented, readily accessible, etc.))	• Philosophy and Standard of Clinical Care • Documenting in the Medical Record • MNT Documentation • Medical Record and Documentation Audit	• Clinical Documentation • Clinical Documentation • Clinical Documentation • QA/Performance Improvement	8-2 8-3 8-24 11-27
F517 Disaster and emergency preparedness: must have detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, missing residents	• Fire Prevention • Fire Plan for Food Service Department • Fire Safety Rules • Inservice Training • Emergency/Disaster Planning • Emergency Plan Employee Training • Water Requirements • Sources of Water During an Emergency • Water Purification • Hand Washing During a Disaster	• Safety • Safety • Safety • Personnel/Training • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning	6-11 6-12 6-13 7-20 12-1 12-2 12-11 12-12 12-13 12-25

©2013 Becky Dorner & Associates, Inc

Index to Policies and Procedures and Nursing Home Federal Regulations

Federal Nursing Home Regulation Tag Number & Description	Name of Related Policy & Procedure	Section of Manual	Page no.
F517 (continued)	• Sanitizing Dishes During a Disaster	• Disaster Planning	12-26
F518 Train all employees in emergency procedures when they begin to work in the facility and periodically review the procedures with existing staff, and carry out unannounced staff drills using those procedures	• Inservice Training • Emergency/Disaster Planning • Emergency Plan Employee Training • Water Requirements • Sources of Water During and Emergency • Water Purification • Hand Washing During a Disaster • Sanitizing Dishes During a Disaster	• Personnel/Training • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning • Disaster Planning	7-20 12-1 12-2 12-11 12-12 12-13 12-25 12-26
F520 Quality Assessment: must maintain a quality assessment and assurance committee	• Sanitation Audit • Meal Preparation and Service Audit • Medical Record and Documentation Audit	• QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement	11-7 11-15 11-27
F521 QA committee meets quarterly (create plans of correction for identified quality deficiencies)	• Sanitation Audit • Meal Preparation and Service Audit • Medical Record and Documentation Audit	• QA/Performance Improvement • QA/Performance Improvement • QA/Performance Improvement	11-4 11-15 11-27

©2013 Becky Dorner & Associates, Inc

References and Resources

General References:

- Guidance to Surveyors-Long Term Care Facilities, State Operations Manual, Medicare and Medicaid Requirements for Long Term Care Facilities, Health Care Financing Administration, US Dept. of Health and Human Services, Revised 2009.
- Dorner, Becky, Diet/Nutrition Care Manual: A Comprehensive Care Guide, Becky Dorner & Associates, Inc., Akron, OH, 2011. (Please refer to this publication for a complete list of references.).
- Dorner, Becky, Dietary Disaster Plan, Becky Dorner & Associates, Inc., Akron, OH, 2006.
- Dorner, Becky, Dietary Forms, Becky Dorner & Associates, Inc., Akron, OH, 2012.
- Dorner, Becky, Operations Manual: Guidelines for Food & Nutrition, Akron, OH, 2009.
- The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel (NPUAP) White Paper, 2009. (Please refer to the document for a complete list of references at www.npuap.org).
- Dorner, Becky, The Obesity Challenge: Weight Management in Older Adults, Becky Dorner & Associates, Inc., Akron, OH, 2012.
- Dorner, Becky, The Complete Guide to Nutrition Care for Pressure Ulcer Prevention and Treatment, Becky Dorner & Associates, Inc., Akron, OH, 2012.

Professional Organizations

- American Diabetes Association, www.diabetes.org.
- Academy of Nutrition and Dietetics, www.eatright.com and Dietetics in Health Care Communities, A Dietetic Practice Group of the Academy of Nutrition and Dietetics, www.dhccdpg.org and Dietitians in Nutrition Support, a dietetic practice group of the Academy of Nutrition and Dietetics, www.dnsdpg.org. .
- American Heart Association, www.americanheart.org.
- American Medical Association, www.ama-assn.org.
- American Public Health Association, www.apha.org.
- American Speech-Language Hearing Association, www.asha.org.
- American Society of Parenteral and Enteral Nutrition. (ASPEN). http://www.nutritioncare.org/.
- Association of Nutrition and Food Service Professionals, www.anfponline.org.

Food Safety and HACCP

- Center for Food Safety and Applied Nutrition, http://www.healthfinder.gov/orgs/HR2504.htm.
- Centers for Disease Control and Prevention, www.cdc.gov.
- “Fight Bac” website, www.fightbac.org.
- Food Code 2009. U.S. Public Health Service, FDA, Washington, DC 207-13, http://www.fda.gov/Food/FoodSafety/RetailFoodProtection/FoodCode/default.htm.
- Home Food Safety, http://homefoodsafety.org/.
- National Food Safety Information Network’s Gateway to Government Food Safety Information, www.FoodSafety.gov.
- United States Food & Drug Administration Hazard Analysis Critical Control Point. http://www.fda.gov/food/foodsafety/hazardanalysiscriticalcontrolpointshaccp/default.htm.

Nutrition

- Becky Dorner & Associates, www.beckydorner.com.
- Centers for Disease Control and Prevention. www.cdc.gov.
- Food and Drug Administration Food Safety Information Hotline, 1-888-SAFEFOOD (1-888-723-312-1) 24 hr.
- Food and Nutrition Information Center, http://www.choosemyplate.gov.
- Gateway to Government Food Safety Information, www.foodsafety.gov.
- International Association for Food Protection (IAFP), www.foodprotection.org.

©2013 Becky Dorner & Associates, Inc

References and Resources

- International Food Information Council Foundation, www.foodinsight.org.
- NHLBI, available from Internet, www.nhlbi.nih.gov.
- National Diabetes Education Initiative, www.ndei.org.
- National Institute of Diabetes and Digestive and Kidney Diseases, www.niddk.nih.gov.
- National Institute on Deafness and Other Communication Disorders (NIDCD) is part of the National Institute of Health (NIH), www.nidcd.nih.gov/health/hearing/noise.asp.
- National Institute of Health, www.nih.gov.
- National Kidney Foundation, www.kidney.org.
- The National Pressure Ulcer Advisory Panel (NPUAP), www.npuap.org.
- National Sanitation Foundation, www.nsf.org.
- Partnership for Food Safety Education, www.fightbac.org.
- Tufts University, Nutrition Information Center, www.nutrition.tufts.edu.
- U.S. Department of Health and Human Services, www.health.gov.
- U. S. Department of Agriculture Meat and Poultry Hotline, 1-800-535-4555.
- U.S. Food and Drug Administration, Center for Food Safety and Applied Nutrition, http://www.healthfinder.gov/orgs/HR2504.htm.

©2013 Becky Dorner & Associates, Inc

Becky Dorner, RD, LD

Becky Dorner, RD, LD is widely-known as one of the nation's leading experts on nutrition and long-term care issues, Becky Dorner is an enthusiastic, dynamic, innovative leader who motivates and inspires people into action.

Becky has almost 30 years' experience as a consultant, author and speaker. She is President of Becky Dorner & Associates, Inc., which publishes and presents CEU programs and information on nutrition care for older adults; and Nutrition Consulting Services, Inc. which employs RDs and DTRs to provide services to health care facilities in Ohio (since 1983).

Becky's mission to improve care for older adults has inspired her to present more than 500 programs for national, international and state professional meetings in 5 countries and 48 states; and to publish more than 260 manuals, CEU programs and practical articles for professional journals and newsletters. Her free email magazine keeps 35,000 health care professionals up to date on the latest news in the field.

Becky is a 25+ year volunteer to the Academy of Nutrition and Dietetics or A.N.D. (formerly American Dietetic Association or ADA). Becky currently serves on the A.N.D. Board of Directors and House Leadership Team as Speaker-elect/Speaker/Past Speaker of the House of Delegates (2011-2014). She has held many national positions including: Board of Directors of the National Pressure Ulcer Advisory Panel (2006-2012), chair of CD-HCF (now DHCC), and ADA Delegate. She has served on the ADA Research Committee, the ADA Evidence Analysis Library (Nutrition and Wound Care; Unintended Weight Loss in Older Adults), Nutrition Entrepreneurs Board of Directors, and the American Overseas Dietetic Association Leadership Team.

Honors include: ADA Award of Excellence in Business and Consultation, NE Outstanding Nutrition Entrepreneur, ADA Recognized Young Dietitian of the Year and CD-HCF Distinguished Member Award.

Curriculum vitae available at http://www.beckydorner.com/resume

Becky Dorner, RD, LD
President
Becky Dorner & Associates, Inc.
Becky@BeckyDorner.com
1-800-342-0285 X220