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

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Introduction

This policy and procedure manual can be used by hospitals, skilled nursing facilities, and other post-acute care facilities. Much of the language in the manual is based on Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities: A Rule by the Centers for Medicare & Medicaid Services (CMS) released on 10/04/2016. However, the policies, procedures, and resources can apply to a variety of acute and post-acute care facilities. When using the policies and procedures, also follow guidelines outlined by federal, state, and local authorities, including the Joint Commission and/or CMS.

The October 2016 rules issued by CMS add new language including language that:

- Designates dietary departments as “food and nutrition services” departments. This term will be used throughout this manual.
- Refers to nutrition care professionals as “qualified dietitians” (as defined below). For the purposes of this manual, the term Registered Dietitian Nutritionist (RDN) will be used most often with qualified dietitian used where appropriate.
- Allows a resident’s attending physician to delegate the task of writing dietary orders, to a qualified dietitian or other clinically qualified nutrition professional who is acting within the scope of practice as defined by State law; and is under the supervision of a physician (1). It is incumbent on each qualified dietitian that is employed in or consults in a CMS-certified facility to check with state licensure or certification laws and work within facility policies and procedures before implementing order-writing as designated by a physician. While many of the policies and procedures in this manual mention orders written by a physician or designee, it is recognized that each facility may have adopted order-writing by the qualified dietitian, as delegated by the physician and in accordance with state law.
- Refers to “residents/patients” to describe the patient population unless the information is specific to nursing homes, and then the term “resident” will be used. For purposes of this manual, the terms “individual”, “resident” and “patient” may be used interchangeably.

This manual will address policies and procedures for most aspects of the food and nutrition services department operation. Other policies and procedures (such as abuse and neglect policies, personnel policies, emergency policies, and others), are available in each facility’s general policy and procedure manual and may be inserted into this food and nutrition services policy and procedure manual as appropriate. Policies and procedures included in this manual include the following subject areas:

1. Menus and Therapeutic 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 and Performance Improvement
12. Disaster Planning
Purpose and Objectives of the Food and Nutrition Services Department

The purpose of the food and nutrition services department is to provide high quality, nutritious, palatable and attractive meals in a safe, sanitary manner. Food will be prepared in a form to accommodate resident/patient allergies, intolerances, and personal, religious, and cultural preferences, based on reasonable efforts. Therapeutic diets will be served as prescribed by the attending physicians or their designee.

The department will follow policies and procedures developed in accordance with local, state and federal regulations and will plan, organize, and evaluate all aspects of food and nutrition services.

Objectives of the food and nutrition services department are:
1. To provide food and drink that is nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs.

2. To promote optimal nutritional status of each individual through medical nutrition therapy (MNT), in accordance with written orders for nutrition care and consistent with each individual's physical, cultural, and religious needs and personal preferences.

3. To provide the highest quality food possible at a cost consistent with the facility’s budget guidelines.

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

5. To periodically evaluate the work of the department for the purpose of quality assurance and performance improvement.

6. To provide the services of a RDN or designee to participate in the interdisciplinary care planning team and assure that the nutritional needs of individuals living in the facility are met.

The Director of Food and Nutrition Services:
- Directs the food and nutrition services department.
- Is ultimately responsible for assuring safe, wholesome, high quality food and resident/patient satisfaction.
- Participates in resident care planning and assists with clinical documentation in the medical record.
- Works under the supervision of the qualified dietitian.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians registered (NDTR), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency level of each member of the nutrition team.
The Centers for Medicare and Medicaid Services (CMS) Requires the Following Guidelines for Staffing in the Department of Food and Nutrition Services in Skilled Nursing Facilities (1):

**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. This includes: 1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who:

(i) Holds a bachelor’s or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a “registered dietitian” by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.

(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who receives frequently scheduled consultation from a qualified dietitian.

The CMS State Operations Manual states:
The Food and Nutrition Services Director must meet educational requirements as follows: For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or (D) Has an associate’s or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. Source: Advanced Copy Revisions to State Operations Manual (1).

The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e) [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)].

Definitions

Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN): 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 registered dietitian nutritionist (RDN) as “individuals who have:

- completed the minimum of a Baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent;
- met current minimum academic requirements (Didactic Program in Dietetics) as approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- completed a supervised practice program accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- successfully completed the Registration Examination for Dietitians;
- remitted the annual registration fee;
- complied with the CDR Professional Development Portfolio (PDP) recertification requirements”

Source: Who is a Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) Commission on Dietetic Registration Web Site: https://www.cdrnet.org/about/who-is-a-registered-dietitian-rd. (2)

Note: The term Registered Dietitian (RD) may be used interchangeably with the term Registered Dietitian Nutritionist (RDN).

Licensed Dietitian (LD) or Licensed Dietitian Nutritionist (LDN): Licensed by the state if the state has dietetic licensure. Each state has different requirements for licensure however, most include minimum qualifications of the RDN as noted above.

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 RDN as noted above.

Nutrition Support Staff: May include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, or other support staff.

Nutrition and Dietetics Technician, Registered (NDTR): 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 (nutrition and dietetic technician, registered or NDTR – has completed a qualified internship and passed the CDR registration exam). Works under the supervision of the RDN and/or LD.

“Nutrition and Dietetics Technicians, Registered (NDTR)* or a Dietetic Technicians, Registered (DTR)* are individuals who have: completed a minimum of an Associate degree granted by a U.S. regionally accredited college or university, or foreign equivalent:

- completed a minimum of 450 supervised practice hours through a Dietetic Technician Program as accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- successfully completed the Registration Examination for Dietetic Technicians; and
- remitted the annual registration maintenance fee; and
- complied with the Professional Development Portfolio (PDP) recertification requirements

OR
Definitions

- completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent;
- met current academic requirements (Didactic Program in Dietetics) as accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- successfully completed the Registration Examination for Dietetic Technicians;
- remitted the annual registration maintenance fee; and complied with the Professional Development Portfolio (PDP) recertification requirements.”

Source: Who is a Nutrition and Dietetics Technician, Registered (NDTR), or a Dietetics Technician, Registered (DTR)? Commission on Dietetics Registration Website. https://www.cdrnet.org/about/who-is-a-dietetic-technician-registered-dtr. (3)

Note: The term Dietetic Technician, Registered (DTR) may be used interchangeable with the term Nutrition and Dietetic Technician, Registered (NDTR).

Medical Nutrition Therapy (MNT): The Academy defines MNT as “an evidence-based application of the Nutrition Care Process that 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”.


Nutrition Care Process: A systematic approach to providing high quality nutrition care. Use of a care process provides a framework for the RDN to individualize care, taking into account the patient/client's needs and values and using the best evidence available to make decisions. There are four steps in the process:
- Nutrition Assessment
- Nutrition Diagnosis
- Nutrition Intervention
- Nutrition Monitoring and Evaluation (4)

Therapeutic Diet: “A therapeutic diet is a diet intervention prescribed by a physician or other authorized non-physician practitioner that provides food or nutrients via oral, enteral and parenteral routes as part of treatment of disease or clinical conditions to modify, eliminate, decrease, or increase identified micro- and macro-nutrients in the diet”.


The term therapeutic diet is used by CMS in its Resident Assessment Instrument Minimum Data Set (MDS) 3.0 for Long Term Care/Nursing Homes. CMS includes 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
Definitions

- 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 (5).

Scope of Practice:
The Academy of Nutrition and Dietetics (Academy) has adopted the statutory scope of practice definition from The Center for the Health Professions, University of California, San Francisco as follows:

“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.”


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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. Based on a facility’s reasonable efforts, menus should reflect the religious, cultural, and ethnic needs of the patient/resident population, as well as input received from residents and resident groups.

Procedure:

1. Menu planning will be completed by the facility at least 2 weeks in advance of service and menus 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 will be 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 for patients/residents. (See Sample Menu Shells later in this chapter.)

2. Menus will be written using an accepted, standard meal planning guide, such as the USDA Choose MyPlate. Menus will 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 will be offered, one of which includes high quality protein. The meal will contain no less than 20% of the day’s total nutritional requirements. If there are more than 14 hours between the evening meal and breakfast the following day, a nourishing snack will be 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 of the snack, and verbalize satisfaction with the snack.

3. Regular and therapeutic menus will be written by the facility’s food and nutrition professional in accordance with the facility’s approved diet manual, or purchased from an approved vendor. The registered dietitian nutritionist (RDN) or designee will approve all menus.

4. Menus will be posted in areas, and at heights where all individuals can easily view them.

5. Temporary changes in the menu will be noted on the menu substitution sheets and posted for the staff’s benefit. (See Sample Menu Substitution Sheet later in this chapter.) The RDN or designee will approve all permanent menu changes.

6. Significant information and/or response to each individual’s diet will be recorded in the medical record and/or care plan. For example: “Mr. Jones refuses breakfast but will eat a sandwich and juice at 10 a.m.”

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
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## Sample Menu Shell for Diet Extensions

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Sample Production Sheet

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Freezer Pull | Pre-preparation

Menu Cycle _______________  Week Number _______________  Day _______________
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 his or her 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.

Procedure:

1. Selective menus will be 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 choices.
   a. Food and nutrition services staff will label menus with the individual’s name, room number and diet, and deliver the menus.

2. Nursing and/or other facility staff may assist in the delivery of menus and in menu selection as deemed necessary. Family members will be encouraged to assist when needed. Menus will be returned to the department of food and nutrition services when complete.

3. The director of food and nutrition services or designee will review menu selections for individuals on therapeutic diets, and refer to the registered dietitian nutritionist (RDN) or designee if there are concerns.
   a. The RDN 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. The RDN or designee will 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 RDN or designee will add the intervention to the individual’s selective menu.
   c. The RDN 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Standardized Recipes

Policy:

Standardized recipes will be used when preparing menu items.

Procedure:

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

2. The director of food and nutrition services or designee will be 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 director of food and nutrition services so that issues can be resolved.
Menu Substitutions

Policy:

Menu substitutions will be made after discussion with the director of food and nutrition services whenever possible. Substitutions may need to be made for uncontrollable situations (i.e. inventory emergency when a food item is temporarily unavailable).

Procedure:

1. Kitchen staff will consult with the director of food and nutrition services or designee on any needed menu substitutions.

2. If the director of food and nutrition services is unavailable, the designated staff (i.e. assistant supervisor, cook/chef) will refer to the Menu Substitution Lists later in this chapter.

3. All changes to the menu (including the date, menu item substitution, and reason for the substitution) will be recorded. See Sample Menu Substitution Sheet later in this chapter.

4. The registered dietitian nutritionist (RDN) or designee will periodically evaluate menu changes and if needed, an appropriate plan of action will be made to correct any concerns.

5. Records of menu substitutions should be retained for 12 months.

Note: To use the Menu Substitution Lists, staff may choose any food within the same list to substitute for the unavailable food. For example, if ½ cup corn is the scheduled item, then a starchy vegetable from the “Breads and Starches” list (where corn is listed) may be substituted, such as ½ cup peas, 1/3 cup yams, etc.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Menu Substitution Lists

**Note:** Refer to facility diet/nutrition care manual for more detailed food lists to assure that nutrient content is covered when substituting foods.

**Vegetables**
Provide carbohydrates, vitamin A, vitamin B6, potassium, copper, dietary fiber, calcium, iron, magnesium, vitamin C and folate.

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</tr>
<tr>
<td>• 1 cup raw vegetables (salad greens, tomatoes, carrots, broccoli, cauliflower, etc.)</td>
</tr>
<tr>
<td><strong>Canned, Cooked, Frozen or Juice</strong></td>
</tr>
<tr>
<td>• ½ cup (broccoli, carrots, greens, peas, spinach, sweet potatoes, etc.)</td>
</tr>
</tbody>
</table>

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

**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.

<table>
<thead>
<tr>
<th>Food and Amount Equivalent to ½ Cup</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fresh Fruit (1 piece)</strong></td>
</tr>
<tr>
<td>• Apple, banana, orange, peach, pear</td>
</tr>
<tr>
<td><strong>Fresh Fruit (1 cup)</strong></td>
</tr>
<tr>
<td>• Cubed Melon (cantaloupe, honeydew, watermelon), strawberries, fresh fruit cubed/small pieces, blueberries, etc.</td>
</tr>
<tr>
<td><strong>Canned or Frozen Fruit</strong></td>
</tr>
<tr>
<td>• ½ cup canned or frozen fruit</td>
</tr>
<tr>
<td><strong>Fruit Juice:</strong> ½ cup fruit juice (100% juice, vitamin C fortified juices)</td>
</tr>
<tr>
<td>• Apple juice, apricot nectar, cranberry juice, grape juice, grapefruit juice, orange juice, pear nectar, pineapple juice, prune juice</td>
</tr>
<tr>
<td><strong>Dried Fruit</strong></td>
</tr>
<tr>
<td>• ¼ cup dried fruit (apples, apricots, dates, prunes, raisins)</td>
</tr>
</tbody>
</table>

**Please Note:** The ChooseMyPlate serving size for juice is ½ cup. In order to provide 90 mg vitamin C a day, many health care facilities serve 6 oz of a high vitamin/fortified C juice. Some states also require a 6 oz serving. Please check your state regulations to assure that all requirements are met.

**Grains** (Whole Grain/enriched)
Provide B vitamins, carbohydrates, dietary fiber, iron. Choose at least half of the grains as whole.

<table>
<thead>
<tr>
<th>Food and Amount Equivalent to 1 Ounce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breads</strong></td>
</tr>
<tr>
<td>• 1 slice bread; ½ bun, bagel or English muffin, 1 small pancake, waffle, taco or tortilla shell, 6” across</td>
</tr>
<tr>
<td><strong>Cereals</strong></td>
</tr>
<tr>
<td>• 1 cup dry cereal or 1 ¼ cups puffed cereal</td>
</tr>
<tr>
<td>• ½ cup cooked cereal</td>
</tr>
<tr>
<td><strong>Crackers</strong></td>
</tr>
<tr>
<td>• 7 round or square crackers, 5 whole wheat crackers</td>
</tr>
<tr>
<td><strong>Grains</strong></td>
</tr>
<tr>
<td>• ½ cup pasta, rice, couscous, barley, bulgar, risotto, polenta</td>
</tr>
</tbody>
</table>
Menu Substitution Lists

**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.

<table>
<thead>
<tr>
<th>Food and Amount Equivalent to 1 Cup</th>
<th>Cheese</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Milk or Milk Substitutes</strong></td>
<td></td>
</tr>
<tr>
<td>• 1 cup milk or yogurt, fortified soy beverage or soy yogurt, ½ cup evaporated milk</td>
<td>• 1½ oz hard cheese (cheddar, mozzarella, parmesan, Swiss), 1/3 cup shredded cheese, 2 oz processed cheese</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td></td>
</tr>
<tr>
<td>• 1 cup pudding made with milk</td>
<td>• 2 cups cottage cheese (for calcium equivalent of 300 mg)</td>
</tr>
<tr>
<td>• 1 cup frozen yogurt</td>
<td></td>
</tr>
</tbody>
</table>

**Protein Foods** (Seafood, Poultry, Meat and Alternatives)
Provide protein, fat, B vitamins (niacin, thiamin, riboflavin, B6), iron, magnesium and omega-3 fatty acids.

<table>
<thead>
<tr>
<th>Food and Amount Equivalent to 1 Ounce</th>
<th>Lean Meat, Poultry, Alternates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fish and Seafood</strong></td>
<td></td>
</tr>
<tr>
<td>• 1 oz fish, shellfish (include 8 oz or more of seafood each week)</td>
<td>• 1 oz beef, pork, veal, chicken, turkey</td>
</tr>
<tr>
<td><strong>Dried Beans, Peas, Legumes</strong></td>
<td>• 1 egg, or 2 egg whites or ¼ cup egg substitute</td>
</tr>
<tr>
<td>• ¼ cup cooked peas/beans (baked, black, butter, garbanzo, kidney, lentils, etc.)</td>
<td>• 3 oz vegetarian soy or “meat” product</td>
</tr>
<tr>
<td><strong>Nuts and Seeds</strong> (unsalted)</td>
<td>• 1 oz cheese, preferably low fat</td>
</tr>
<tr>
<td>• ½ oz nuts (almonds, pistachios, walnuts, seeds, etc.)</td>
<td>• ¼ cup cottage cheese, preferably low fat</td>
</tr>
<tr>
<td>• 1 Tbs peanut butter or almond butter</td>
<td><strong>High Fat Meats</strong> (Use very sparingly)</td>
</tr>
<tr>
<td></td>
<td>• 1 oz chorizo, lunch meat, or sausage</td>
</tr>
</tbody>
</table>

**Healthy Fats**
Provides calories, essential fatty acids and vitamin E. Use in small amounts.

<table>
<thead>
<tr>
<th>Food and Amount Equal to 1 Serving (1 teaspoon each)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monounsaturated oils</strong></td>
</tr>
<tr>
<td>• Canola, olive, peanut, safflower</td>
</tr>
</tbody>
</table>

**Notes:** Nuts and seeds (unsalted), 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).

**Note:** ChooseMyPlate and the Dietary Guidelines for Americans use the terminology “ounce equivalents” and “cup equivalents” to describe the amount of each food group needed each day. For menu planning purposes, this menu substitution list uses standard portion sizes commonly used in food service. See Becky Dorner & Associates, Inc. Diet and Nutrition Care Manual for comprehensive food substitution lists and ounce and cup equivalents.
## Sample Menu Substitution Sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Scheduled Food Item</th>
<th>Substitute</th>
<th>Reason for Substitution</th>
<th>Employee Signature</th>
<th>Supervisor Initials</th>
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</thead>
<tbody>
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</tr>
</tbody>
</table>

Maintain this record on file for quality assurance.
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 nutritionist (RDN) will review available diet/nutrition care manuals, select and make recommendations for approval by the medical staff. The medical director or designee will approve the manual, along with the RDN, Administrator, and Director of Nursing (DON).

2. The selected diet/nutrition care manual will:
   a. Reflect current nutritional knowledge based on evidence based research and/or best practice standards.
   b. Meet the National Research Council nutritional standards.
   c. Have a revision/review date that is less than 5 years old (or according to your state regulations). Some professionals choose to revise their diet/nutrition care manuals every 3 years to stay up to date with changes in national nutrition guidelines.
   d. Be representative of the diets appropriate for and/or needed by the patients/residents served.
   e. Include information on the role of medical nutrition therapy (MNT) in treating various diseases and conditions.
   f. Provide clear guidelines for implementing diet prescriptions.

3. Diet/nutrition care manuals (hard copy and/or electronic versions) will be provided in the director of food and nutrition services office, the kitchen, and if requested, at each nursing station for staff reference.

4. The diet/nutrition care manual will be reviewed on a regular basis (preferably yearly):
   a. Revisions will be identified and dated.
   b. The revised manual will be approved in the same manner as described above for the original manual.
   c. Diet/nutrition care manuals will be replaced every 3 to 5 years to assure they are up to date with the most current standards of practice.

Transmission of Diet Orders

Policy:

The food and nutrition service department will receive written notification of a patient’s/resident’s diet order as soon as possible after admission, readmission, or following a diet order change.

Procedure:

1. Nursing staff will send the diet order to the food and nutrition services department as soon as possible after admission or diet change (preferably within 1 to 2 hours), using written communication or electronic communication if applicable. Refer to the Sample Diet Order Form found later in this chapter.

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

3. When the food and nutrition services 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 will be 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 and nutrition services department will be notified in writing using the Diet Order Form, other written communication, or electronic notification if applicable.

6. Following discharge of the patient/resident from the facility, diet orders will be kept on file in the food and nutrition services department for a minimum of 30 to 60 days.

7. Meal identification cards/tickets will be adjusted to reflect changes in diet and food preferences as needed.
Therapeutic Diets

Policy:

When necessary, the facility will provide a therapeutic diet that is individualized to meet the clinical needs and desires of a patient/resident to achieve outcomes/goals of care. These therapeutic diets should coincide with the therapeutic diets on the facility’s menu extensions.

Procedure:

1. The registered dietitian nutritionist (RDN) will approve all therapeutic diet menu extensions. The RDN 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 approved/standard diets will be available for the nursing staff, who will notify physicians of the diets available in the facility. These diets coincide with the therapeutic diets on the facility menu extensions.

3. Diets will be offered as ordered by the physician or designee. Designee may be the RDN, if the physician has granted order-writing privileges. (See policy on Order Writing later in this chapter.)

4. If the RDN or designee determines that the diet order is not appropriate for the individual, she/he will notify the physician with a recommendation for a more appropriate diet, or change the diet order, if RDN order-writing privileges have been adopted by the facility.

5. Individual response to therapeutic and texture-modified diets will be evaluated. Ineffective or inappropriate diets (including texture modifications) will be evaluated by the RDN and the diet order will be changed by the physician or RDN, if order-writing privileges are in place (see policy on Order Writing later in this chapter). This includes liberalization of the diet.

6. When appropriate, an individual will be educated by the RDN or designee about his/her therapeutic or texture-modified diet.

7. An individual has the right to refuse a therapeutic diet order. (See policy on Resident’s Right to Refuse a Diet later in this chapter).

8. The individual’s medical record and diet on file in the food and nutrition service office’s system must be reviewed on a regular basis to assure that they are in agreement. (See Sample Diet Order Audit Form later in this chapter.)

9. A diet and nutrition manual will be available in the food and nutrition services department for staff use. This manual will be updated as needed and will be considered current if the copyright date is within 3 to 5 years of the current date (depending on state regulations or RDN’s policy).

Note: Refer to the Definition of Therapeutic Diets and Nutritional Supplements in the Introduction.

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

Policy:

Diet orders will be written by the physician or his or her designee. A designee might be a nurse practitioner, physician’s assistant, a qualified dietitian or other clinically qualified nutrition professional. If the physician delegates order-writing to the qualified dietitian or other clinically qualified nutrition professional, that nutrition professional will operate within the scope of practice as outlined by state licensing or certification guidelines.

Procedure:

1. The physician will delegate order-writing, including diet order writing, to support staff, including nurse practitioners or physician’s assistants that practice in agreement or collaboration with a physician.

2. The physician will delegate order-writing to a qualified dietitian or other clinically qualified nutrition care professional who is acting within the scope of practice as defined by state law.

3. Order-writing by a qualified nutrition care professional or other clinically qualified nutrition care professional must meet state licensing and/or certification guidelines.

4. Facility staff, including members of the interdisciplinary team (IDT) and nursing staff will be notified about the health care professionals approved by the physician to write orders.
Resident’s Right to Refuse a Diet

Policy

A resident has the right to refuse and/or discontinue medical treatment, including therapeutic or texture-modified diets. Resident’s choices should be incorporated into treatment and care. If a resident cannot speak for themselves, their representative can make decisions on their behalf.

Procedure:

1. The facility will include residents in decisions regarding the ordering of therapeutic and/or consistency-modified diets or thickened liquids.

2. If the resident chooses to refuse a recommended intervention, the facility will discuss the risks and benefits of refusing the specific medical treatment with the resident and/or their surrogate.

3. The resident and/or their surrogate will make the ultimate choice about their diet order (therapeutic diets and/or consistency modifications or thickened liquids).

4. Conversations regarding the risks and benefits of refusing diets and the choices residents make will be documented in the medical record.

5. The care plan will be updated to reflect changes in the resident’s diet orders.

Resource:
http://www.ideasinstitute.org/PDFs/Process_for_Care_Planning_for_Residnet_Choice.pdf
Diets Available on the Menu

Policy:

Nursing staff and/or registered dietitian nutritionist (RDN) or designee will notify physicians of the diets that are offered on the facility 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 or his/her designee. If the RDN or designee finds through nutritional assessment that the diet order is not appropriate for the individual, she/he will recommend and/or, as designated by the physician, order a more appropriate diet.

   The therapeutic diet orders that will be offered are:
   a. Regular (or “General/House” diet)
   b. Regular/No Added Salt
   c. Mechanical Soft
   d. Puree
   e. Consistent Carbohydrate
   f. Consistent Carbohydrate Puree
   g. Other:

2. In an effort to individualize therapeutic diet orders, secondary diet orders will be offered and can be combined with the main diet order to achieve desired results. The following secondary diets are offered:
   a. No Salt Packet, No Salty Meats, Vegetables, Soups (i.e. ham, bacon, sausage, lunchmeat, sauerkraut, canned soup)
   b. No Sugar Packet, Unsweetened Beverages, Low Sugar Desserts
   c. Chopped Meat
   d. Puree Meat
   e. Other:
## Sample Diet Order Form

### Diet Order

<table>
<thead>
<tr>
<th>Name ____________________________</th>
<th>Room ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check main diet order:</td>
<td>Please check secondary diet order:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Regular/No Added Salt</td>
<td>_____ No Salt Pack/No Salt at Table</td>
</tr>
<tr>
<td>_____ Mechanical Soft</td>
<td>No Salt Pack, No Salty Meats, Vegetables, Soups</td>
</tr>
<tr>
<td>_____ Pureed</td>
<td>No Sugar Pack, Low Sugar</td>
</tr>
<tr>
<td>_____ Consistent Carbohydrate</td>
<td>No Sugar Pack, Low Sugar</td>
</tr>
<tr>
<td>_____ Consistent Carbohydrate Puree</td>
<td>Desserts</td>
</tr>
<tr>
<td>_____ Other:</td>
<td>Chopped Meat</td>
</tr>
<tr>
<td></td>
<td>Ground Meat</td>
</tr>
<tr>
<td></td>
<td>Puree Meat</td>
</tr>
<tr>
<td>_____ Discharged/Expired</td>
<td>LOA ______ Date __________ Meal</td>
</tr>
<tr>
<td></td>
<td>(Leave of Absence)</td>
</tr>
<tr>
<td>Signature: _______________________</td>
<td>Date: ____________</td>
</tr>
</tbody>
</table>

### Diet Order

<table>
<thead>
<tr>
<th>Name ____________________________</th>
<th>Room ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please check main diet order:</td>
<td>Please check secondary diet order:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>_____ Regular/No Added Salt</td>
<td>_____ No Salt Pack/No Salt at Table</td>
</tr>
<tr>
<td>_____ Mechanical Soft</td>
<td>No Salt Pack, No Salty Meats, Vegetables, Soups</td>
</tr>
<tr>
<td>_____ Pureed</td>
<td>No Sugar Pack, Low Sugar</td>
</tr>
<tr>
<td>_____ Consistent Carbohydrate</td>
<td>No Sugar Pack, Low Sugar</td>
</tr>
<tr>
<td>Consistent Carbohydrate Puree</td>
<td>Desserts</td>
</tr>
<tr>
<td>_____ Other:</td>
<td>Chopped Meat</td>
</tr>
<tr>
<td></td>
<td>Ground Meat</td>
</tr>
<tr>
<td></td>
<td>Puree Meat</td>
</tr>
<tr>
<td>_____ Discharged/Expired</td>
<td>LOA ______ Date __________ Meal</td>
</tr>
<tr>
<td></td>
<td>(Leave of Absence)</td>
</tr>
<tr>
<td>Signature: _______________________</td>
<td>Date: ____________</td>
</tr>
</tbody>
</table>
Diet Order Form

Insert facility diet order form or method of communicating diet orders here.
Diet Order Audit

Policy:

The individual’s medical record and/or the physician’s order must be reviewed on a regular basis to assure accuracy. All physician’s orders and information on meal identification (ID)/tray cards should be in agreement.

Procedure:

1. A report of all patients/residents’ diets will be provided for the food and nutrition services department at least once a month. (This report can be often be downloaded from the facility pharmacy and/or electronic medical record’s reporting system.)

2. The diet report will include the individual’s name, room number, and diet as stated in the written orders. Oral nutrition supplements, enteral feedings, or supplemental feedings should be included in the audit and may need to be generated separately from the diet order report, depending on facility systems.

3. The director of food and nutrition services or designee will compare the physician’s diet orders to the diet orders recorded on the meal identification (ID) card (and/or in the food and nutrition services filing system no less than monthly. Oral nutrition supplement orders should be audited in a similar fashion. (See Sample Audit Forms on the following pages.)

4. The registered dietitian nutritionist (RDN) or designee will be notified of any therapeutic diets not listed on the menu so that they can be developed as appropriate or changed to meet facility menu extensions.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Diet Order on Medical Record</th>
<th>Diet Report</th>
<th>Food and Nutrition Services Records</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
Sample Nutrition Supplement Audit Form

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Order for Nutrition Supplement</th>
<th>Nutrition Supplement List on File in Food and Nutrition Services</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Note:** This information may be computerized.
# Sample Weekly Diet Census Sheet

Week of: ______________________

<table>
<thead>
<tr>
<th>Diets</th>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular/No Added Salt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mechanical (Dental) Soft</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puree</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Chopped Meat</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Ground Meat</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pureed Meat</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Consistent Carbohydrate</td>
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<tr>
<td>Consistent Carbohydrate Puree</td>
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<td>Other:</td>
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</tbody>
</table>

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.
Making Choices that Do Not Meet Guidelines for Diet Order

Policy:

If an individual exhibits a pattern of requesting foods or a food texture or fluid consistency not allowed on the ordered diet the facility staff should refer the person to the registered dietitian nutritionist (RDN) or designee for re-evaluation and counseling. The speech/language pathologist (SLP) should be consulted if food texture or fluid consistency is an issue for the individual. The facility will respect each patient/resident’s right to make choices and change the diet order if necessary following counseling of the individual and documentation of counseling in the medical record.

Procedure:

Food and nutrition services staff should serve only the foods permitted on each diet as outlined on the menu extensions. If an individual requests or selects a food that is not allowed on the diet, staff should remind the individual that the food is not permitted on their diet. If the individual continues to request the food item staff should request input from the physician and/or speech/language pathologist. Staff should document consistent requests for foods not allowed on the diet and education should be provided on the risks and benefits of their requests.

1. If food and nutrition services or nursing staff are not sure about foods permitted on a diet, they should refer to the facility diet manual, or contact the RDN or SLP as needed.

2. If a pattern of requesting foods not permitted on a diet order continues repeatedly, the individual should be referred to the RDN or SLP for re-evaluation and counseling.

3. A new diet order communication 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 communication.
   - When on a full liquid diet, all foods served must follow the full liquid diet guidelines. A diet change 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.

4. The RDN or designee and the SLP should discuss the possibility of upward or downward progression of a consistency altered diet (i.e. pureed to mechanical soft diet or mechanical soft to puree.), and obtain physician’s orders in advance of serving foods not listed on the current diet.

5. A therapeutic diet and/or texture or consistency modified diet can be discontinued at the request of an individual after the risks and benefits have been outlined. A written order is required and the food and nutrition services department should be notified in writing.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Use of Salt Substitute

Policy:
Salt substitution should only be used as part of a written diet order.

Procedure:
1. Salt substitute can only be given with a written order from the physician and/or designee.
2. Once the order is obtained, “Salt Sub” is noted on the meal identification (ID) card/ticket, care plan, and progress notes as appropriate.
3. If a salt substitute is high in potassium, serum electrolytes should be monitored. If serum potassium level is elevated, the physician should be notified. Use of salt substitute high in potassium may need to be discontinued.
4. Individuals should be instructed to use salt substitutes sparingly. Staff should monitor individuals during meal service 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.
Food Replacement for Individuals with Diabetes

Policy:

If an individual with diabetes does not eat meals, nursing will be notified. If a pattern of refusal exists, nursing will refer to the registered dietitian nutritionist (RDN) 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 and nutrition services department 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 RDN or designee.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Renal Diets

Policy:

The registered dietitian nutritionist (RDN) or designee will supervise individuals requiring renal meal plans. The facility RDN or designee will contact the dialysis unit’s RDN for specific diet patterns if needed. The facility RDN or designee will plan menus in accordance with the diet that is ordered.

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 RDN’s role to educate and counsel, and determine the best approach in these cases. Refer to facility diet/nutrition care manual for more information.

Procedure:

1. The RDN or designee will review diet and assess for appropriateness in relation to the individual’s Medical Nutrition Therapy (MNT) assessment and their food and beverage preferences.

2. The RDN or designee will contact the dialysis center to discuss the individual’s needs.
   a. The RDN or designee will discuss the individual’s needs with the dialysis RDN, and request a copy of the dialysis daily meal plan/pattern, or refer to the facility’s diet/nutrition care manual as appropriate.
   b. The RDN will discuss the daily meal pattern/plan with the individual and incorporate food preferences as appropriate. Renal diets should be as liberal as appropriate to meet the individual’s needs and preferences.

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

3. The RDN or designee should provide specific instructions to food and nutrition services 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Texture and Consistency-Modified Diets

Policy:

Texture and consistency-modified diets will be individualized with modifications made by the speech/language pathologist (SLP) and physician in conjunction with the registered dietitian nutritionist (RDN) or designee and director of food and nutrition services. A written order is needed.

Note: There is little evidence 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 facility 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 testing to assess the individual’s condition. Once a diagnosis has been made, the SLP will work with the RDN or designee to make appropriate recommendations for proper food and fluid consistency.

4. Nursing staff will notify the director of food and nutrition services of consistency changes ordered by the physician or designee using the Diet Order Form or other facility communication.

5. The food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency as ordered. Care will be taken to serve the foods and fluids as ordered on the consistency-altered diet or fluids.

6. Individuals needing a change in diet consistency may be placed 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.

Note: It is advisable to state the reason for a pureed diet in the documentation. Food consistency changes should not be made without a written order. Upgrading or downgrading consistency may need to be evaluated by a SLP and requires a written order for a permanent change.
Altered Portions

Policy:

The director of food and nutrition services or designee will interview all individuals upon admission and periodically as needed for food and beverage preferences and meal satisfaction. Altered portion sizes will be served upon request and should be documented in the individual’s medical record and care plan.

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 should be interviewed for snack options between meals. This information should be documented in the individual’s medical record and care plan. The RDN or designee should monitor the individual’s weight and food intake for adequacy. A second portion is given if requested.

3. Large portions may be ordered if needed to increase protein, calorie, or fluids available, especially for individuals who are good eaters. Large portions are at 1 ½ - 2 times a regular portion.

4. A written order is required for altered portions, even if they are requested by a patient/resident. Once the order is received, the meal ID card/tray ticket should be changed accordingly.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Festivity Foods or Diet Holiday

Policy:

Individuals will be granted a diet holiday from their therapeutic diet for special holidays and events. This policy does not apply to those who received 100% of their nutrition and hydration via enteral or parenteral nutrition. See note below for exceptions.

Procedure:

Individuals on therapeutic diets will receive 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 Kippur
- Columbus Day
- Halloween
- Veterans Day
- Thanksgiving Day
- Christmas Eve
- Christmas Day
- Hanukkah (Chanukah)
- Kwanzaa

Other Pertinent Religious Holidays

Special Activities and Parties

Note: Individuals on carbohydrate-controlled diets will continue to receive lower carbohydrate alternatives to sweet desserts, snacks and beverages. Consistencies will be provided to meet individual needs (i.e. clear or full liquid diets, and dysphagia or modified consistency diets).

Food and Beverages for Activities

Policy:

Therapeutic and texture-modified diets will be provided as appropriate for individuals who consume food and beverages during activities.

Procedure:

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

2. Foods and beverages will be requisitioned from the food and nutrition services department per facility policy.

3. The director of food and nutrition services or designee will maintain a diet listing for all individuals. The list must include the most current therapeutic diets and texture modified food and/or consistency-modified liquid diet orders.

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

5. The food and nutrition services 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 therapeutic and 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. (Note: Activities personnel should also be trained in the Heimlich maneuver.)

8. The food and nutrition services department will only use leftovers if food safety can be confirmed, and only after following proper procedures for storage and reheating.
Clear Liquid and Full Liquid Diet

Policy:

Food and beverages for liquid diets will be available as needed. Patients/residents will be provided with a liquid diet when needed due to flu, cold, dental problems, or preparation for medical procedures. A written order is required.

Procedure:

1. Nursing will advise the food and nutrition service department in writing of the patient, 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 written order is obtained for any change in diet. Nursing will send a diet order to the food and nutrition services department for any changes in diet.

<table>
<thead>
<tr>
<th>Supplies</th>
<th>Clear Liquid</th>
<th>Full Liquid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Soft Drinks</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ginger ale or lemon lime soda</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Other carbonated beverages</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Juices</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apple, cranberry, grape and/or orange (no pulp)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Peach, pear, apricot nectars</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>Tomato juice, vegetable juice</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Broth/Bouillon</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken, beef and/or vegetable</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Gelatin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherry, lime, orange, raspberry, strawberry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Hot Cereal</strong></td>
<td></td>
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<tr>
<td>Cream of rice or cream of wheat</td>
<td>No</td>
<td>✓</td>
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<tr>
<td>Grits, fortified cereal</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Oral Nutritional Supplements/Shakes</strong></td>
<td>No</td>
<td>✓</td>
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<tr>
<td>Instant breakfast mix, commercial supplements, milkshakes, commercial egg nog</td>
<td>No</td>
<td>✓</td>
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<tr>
<td>High calorie/protein clear liquid supplements (variety of types and flavors)</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td><strong>Desserts</strong></td>
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<tr>
<td>Fudgesicles®</td>
<td>No</td>
<td>✓</td>
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<tr>
<td>Fruit ices</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Ice cream</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>Plain popsicles®</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Plain, smooth pudding (vanilla, chocolate, butterscotch)</td>
<td>No</td>
<td>✓</td>
</tr>
<tr>
<td>Sherbet, plain, smooth (no chunks of fruit)</td>
<td>No</td>
<td>✓</td>
</tr>
</tbody>
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Source:
NPO Diet Orders (Nothing by Mouth)

Policy:

The nutrition and food service department will not send food or beverages to any individual with an NPO (nothing by mouth) diet order.

Procedure:

1. Nursing will notify the food and nutrition services department of all NPO diet orders.

2. The food and nutrition services 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 RDN or designee, unless the individual is on enteral/parenteral feeding.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Resident’s Choice Meals

Policy:

Residents of post-acute care facilities will have input into menu planning and will select the menu for meals on a regular basis, once a month or more often if deemed appropriate.

Procedure:

1. The director of food and nutrition services will meet with residents via resident council meetings to get input on the menu and discuss their menu requests.

2. Minor changes to the cycle menus will be made based on resident input and plate waste studies.

3. At least once monthly, residents will select the menus, including alternatives and select menus as appropriate, for one meal.

4. Residents will be encouraged to develop menus that meet guidelines of ChooseMyPlate.gov, providing food from all 5 food groups, however exceptions are allowed for the patients’/residents’ choice menu.
Dining/Meal Service

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The Dining Experience: Staff Responsibilities

Policy:

The dining experience will enhance each individual’s quality of life through person centered dining: providing nourishing, palatable, and attractive meals that meet the individual’s daily nutritional needs and food and beverage preferences.

Procedure:

1. Staff will treat each individual with dignity and respect and strive to meet their personal needs. During meals staff will socialize with each individual, focus on the individual - listen, pay attention, and converse with each individual (rather than only with other staff). During dining service staff will:
   a. Respect the confidentiality of any special or pertinent individual directives (such as swallowing 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 music is played in the dining area, the type of music should be 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. This includes but is not limited to:
   a. Offering 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), if feasible, is best.
   b. Providing an attractive, functional, home-like or restaurant-like dining environment (depending on the facility) that is roomy, comfortable with nice décor, contrasting colors, and appropriate furniture.
   c. Providing comfortable sound levels, adequate lighting, furnishing, ventilation, space and absence of odors to accommodate dining.

3. The director of food and nutrition services will perform meal rounds routinely to determine if the meals are timely, attractive, nutritious, and meet the needs of each individual. The director of food and nutrition services will observe meals for preferences, portion sizes, temperature, flavor, variety and accuracy. Concerns will be reported to the administrator, nursing director, registered dietitian nutritionist (RDN) or designee, or other staff as appropriate.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
The Dining Experience

Policy:

The dining experience will be person centered with the purpose of enhancing each individual'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/or special dietary needs and food preferences and are served at a safe and appetizing temperature. Individuals will be provided restorative dining services as needed 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 left, knives and spoons on the right). 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 identify the original food.

3. Individuals will be provided with proper hand 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.
   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.
   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. 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 napkins will be encouraged, and dignified clothing protectors will be available as needed or requested.

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

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

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

9. Food will be at the proper texture and/or consistency to meet each individual's needs and desires. Mechanically altered diets, such as pureed diets, will be prepared and served as
The Dining Experience

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. Nursing staff will monitor individuals to determine the amount of food/fluids consumed.

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

13. The dining room will be cleaned and sanitized promptly after each meal and reset for the following meal.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
The Person Centered Dining Approach

Policy:

Person centered care and hospitality services, including dining, will be a vital part of everyday living. The person centered dining approach will focus on each individual’s needs related to food, nutrition, and dining.

Procedure:

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

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

3. Staff should have a professional appearance (neat, clean uniforms or clothing, hair, etc.), and a positive attitude towards serving patients/residents.

4. All individuals will be treated with the utmost courtesy, respect and dignity. Each person will be treated as a guest.
   a. Individuals will be greeted by their preferred name, recognizing their unique preferences and needs.
   b. Individuals will be greeted with a smile and a friendly “Hello! How can I serve you?”
   c. Staff should make every effort to satisfy individual requests, and always follow through on any promises made.

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

6. Seating preferences, food and beverage preferences, and special dietary needs should be met based on individual choice.
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.


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 that shows 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.
Customer Service

Policy:

All individuals will be treated with respect and prompt service. It is each department of food and nutrition services employee’s responsibility to find the best solution for any concerns of each individual being served. Employees should be empowered to “do whatever it takes” to provide great service.

Procedure:

1. Employees will support everyone on the team and strive to do the job correctly.

2. Employees will 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 achieves it).

3. Food and nutrition services management staff should encourage front line staff to make suggestions for improving individual service. Management staff should act as coaches to teach frontline employees how to deal with any issues that arise during dining service.

4. Management staff should be visible, involved and accessible, and provide training and support to frontline staff so they can provide excellent service.

5. Employees should be trained to treat each individual with the utmost dignity, respect and care.
Dining Room Service

Policy:

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

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

Procedure:

1. Meals will be served promptly to maintain adequate temperature and appearance.

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

3. 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 or texture or consistency modifications.

4. Adequate staff should be available in the dining areas to help individuals who need assistance and to handle any situation that may arise.

5. Staff will notify the food and nutrition services department of those who wish to receive room service.
Dining Atmosphere

Policy:

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

Procedure:

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

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

3. Appearance of the Table and Meal
   a. Dishware should be clean, eye appealing, matched, without chips, and of appropriate color to match the decor.
   b. Flatware should be clean, neatly placed, and in good condition. All meals served must include a fork and spoon (and knife as appropriate).
   c. Glasses should be clean and free of stains or spots.
   d. Placemats, tablecloths and napkins should be clean and wrinkle-free.
   e. Items should be placed so they are convenient for the individual to reach and neatly arranged.
   f. Food should be served carefully to avoid drips and spills.
   g. Dishes will be the proper size for various food items. For example:
      - Salads should be served on individual salad plates or bowls.
      - Bread and butter should be served on individual plates.
      - Saucers should be used for coffee or teacups. Mugs do not require a saucer.
   h. Hot food must be hot and cold food must be cold (as acceptable to the individual being served).
   i. Correct condiments and beverages should be available for the meal.
   j. Servers will offer assistance as needed.

4. Appearance of the Server
   a. The director of food and nutrition services will provide staff training on personal hygiene and proper attire for meal service.
   b. Aprons or other special uniforms will be made available to staff as appropriate (such as waiter/waitress uniforms, chef’s uniforms, etc.).
   c. The facility will address issues such as appropriateness of tattoos, body piercings, hair restraints, etc.
   d. All staff will abide by the facility dress code. Staff attire and appearance should be acceptable to the individuals being served.
Serving the Meal

Policy:

Food will be served with enthusiasm in a pleasant and tasteful manner to satisfy 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 chapter 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 cleaned, sanitized, and prepared for the next meal.
Service Staff

Policy:

Staff should create a person centered dining experience that focuses on each individual's needs and expectations.

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, eating independently, etc.)
6. Serve individuals beyond expectations: Do whatever is needed to assure a positive dining experience.
7. Resolve any 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. (Ex: chairs that need repair or food preferences that need to be changed.)
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 director of food and nutrition services will:
1. Provide staff with training on personal hygiene and proper attire.
2. Provide aprons or other special uniforms for staff, such as waiter/waitress uniforms and chef’s uniforms, etc. as appropriate.
3. Address issues such as appropriateness of tattoos, body piercings, hair restraints, etc.
Handling Customer Concerns

Policy:

All concerns should 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 solutions to be developed. Listen to the complaint and have a clear understanding of the problem. Repeat it back to be sure the concern has not been misinterpreted.
   b. Identify the cause of the problem and ask the individual how it can be resolved. Discuss possible solutions and resolve the problem. Ask if the individual is satisfied with the solution.
   c. Think about how to keep the problem from recurring with that individual or any other individual.
   d. Know when to listen. The most common complaints are often related to rudeness, lack of follow through, not listening to customer concerns, and 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 improvement ideas with fellow staff and management staff. Areas for improvement could be a Quality Assessment and Performance Improvement (QAPI) program.
   h. Be willing to constantly learn and improve.
   i. Embrace change for the betterment of service.

2. Management will conduct customer satisfaction surveys on a regular basis as part of ongoing quality assessment and assurance. (See Sample Dining Satisfaction Form and Sample Dining Satisfaction Meal Evaluation Form on the following pages.)

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

**Name** (Optional): ___________________________  **Date** ____________

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was your meal service timely?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the service courteous?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the hot food hot?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the cold food cold?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were your food preferences honored?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were your food substitutions available in a timely manner? (if applicable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was the dining atmosphere pleasant?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you enjoy your dining experience?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did the food taste good?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What foods would you like added to the menu?

What foods would you like taken off the menu?

Suggestions/Comments:

---

# Sample Dining Satisfaction Meal Evaluation Form

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Time</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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 is friendly and attentive to my needs.

The service is timely.

The dining room is clean and well organized.

The hours of service met my needs.

Suggestions/Comments:

---

*Policy & Procedure Manual 2-13
Table Setting

Policy:

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

Procedure:

1. Tables should allow for proper place setting and comfort of each individual. This includes adequate elbow room, space for wheelchairs, accommodations for those who need them, and adequate room for place settings.

2. Chairs with sturdy side arms and cushions should be provided.

3. Centerpieces should be low in height, so they do not interfere with the ability to socialize. Colors, shapes, and items used for centerpiece will depend on the season or occasion.

4. If linens are used, they should be easily cleaned or cleaned by 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 place setting:

8. Dishes, glasses, and silverware should be placed appropriately (see graphic above) with the dinner plate in the center, fork(s) on the left of the dinner plate, knife on the right of the dinner plate and teaspoon to the right of the knife. The water goblet and coffee mug should be placed at the top right of the plate with the bread plate to the top left of the dinner plate. The napkin can sit on the center of the plate.
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. Use of condiments placed on tables for meal service will be monitored for individuals on 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 in clean containers with appropriate lids or covers to maintain food safety.
   a. If using individual packages, assistance will be provided to open packages if necessary.

2. Designated facility staff will monitor use of condiments by individuals during the meal service.
   a. Adherence to 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 an individual chooses not to follow their therapeutic diet, the individual should be educated on the risk of not following the diet, but the facility should respect the right of each individual to make personal choices.
   c. If an individual is not able to make appropriate decisions about condiment choices, the durable power of attorney for medical care should be educated on the risks versus benefits and will determine what is best for the individual.

3. Diet education 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.
Restaurant Style Dining

Policy:

Restaurant style dining will enhance each individual's quality of life through provision of nourishing, palatable attractive meals that meet the individual's preferences, daily nutritional and special dietary needs, and food and beverage preferences.

Procedure:

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

2. Nursing staff will remind all residents/patients of the meal. Nursing will be 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 and nutrition services staff will offer food and beverage choices to the individual at the point of service.

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

5. Food and nutrition services 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 an individual chooses not to follow their therapeutic diet, they should be educated on the risk of not following the diet, but the facility should respect the right of each individual to make personal choices.

7. If an individual is not able to make appropriate decisions about condiment choices, the durable power of attorney for medical care should be educated on the risks versus benefits and will determine what is best for the individual.

8. Food and nutrition services and/or nursing staff members will serve food to the individual with nursing providing any eating/dining assistance as necessary.

9. Nursing staff will be responsible for recording food and beverage intakes per facility policy.

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

11. The director of food and nutrition services 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.
Family Style Dining

Policy:

Family style dining will support the customs 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 will be available to individuals during breakfast, lunch and dinner.

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

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

4. Foods may be served in separate courses as deemed necessary and/or appropriate.

5. Food will be placed in bowls or on platters and delivered to the dining tables just prior to service. The food will:
   a. Be at the appropriate and required temperature for service and be covered if necessary.
   b. Have the appropriate serving size or serving utensil according to the planned menu (example: 3 oz meat portion or ½ c serving utensil).

6. Food bowls and platters used should be appropriate for passing at the table. A lazy Susan turntable may be appropriate for passing items. Soup and dessert items may not lend themselves to family style dining and may be served similar to restaurant service.

7. A staff member will:
   a. Oversee the passing/serving of the food as needed and encourage appropriate portions. If an individual is unable to pass dishes, staff should assist or serve as necessary.
   b. 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 or coughing on or near the food to be passed).
   c. Remove any contaminated food from the table and obtain a replacement.

8. If the individual decides not to follow specific diet recommendations, they should be educated on the risk of not following their diet. The RDN or designee should assess the need for the diet restriction. If an individual is not able to make appropriate decisions, the durable power of attorney for medical care should be educated on the risks versus benefits and will determine what is best for the individual.

9. Nursing staff will be responsible for recording food and beverage intakes as per facility policy.

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

11. The director of food and nutrition services 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.
Buffet Style Dining

Policy:

Buffet style dining will offer infinite possibilities for food combinations and selections. Individuals will be provided personal choice dining and the ability to choose food portions that match their preferences and appetite. Appropriate assistance will be provided during meal service and dining. Infection control procedures will be followed.

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

Procedure:

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

2. Nursing will be responsible for assisting those needing help to the dining room. Individuals will be assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc.)

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

4. Residents should be encouraged to plate their own hot and cold food items. Nursing staff will be available to facilitate those who need assistance with their self-selection of hot and cold food items from the buffet line. Nutrition and/or food and nutrition services staff will plate the food items chosen. Most residents will require tray service for food/beverages selected and assistance to their dining table.

5. If the individual decides not to follow specific diet recommendations, they should be educated on the risk of not following their diet. The RDN or designee should assess the need for the diet restriction. If the individual cannot make this decision, then family and durable power of attorney for medical care will be educated on the risks and will determine what is best.

6. Nursing and/or food service staff will 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 patient/resident or staff member returning to the buffet line should obtain a clean plate.

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

9. Food and nutrition services staff must be attentive to food holding times and the possible need for batch cooking to assure a quality product. New food should never be added 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 will be responsible for recording food and beverage intake as per facility policy.
Buffet Style Dining

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

14. The director of food and nutrition services 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 and nutrition services staff will break down, clean, and sanitize the buffet equipment after each meal.
Open Style Dining

Policy:

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

Procedure:

1. Open dining will be available during breakfast, lunch and dinner.
   a. The dining room will be open for a minimum of two hours at each meal. Individuals should choose the time they prefer to eat their meals; that time may vary from day to day.
   b. Independent diners have the opportunity to start meals early or finish late.
   c. 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.

2. Nursing will be responsible for assisting those needing help to the dining room. Individuals will be assisted to prepare for the meal (glasses on, hearing aids in, hands washed, etc.)

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

4. Nursing and/or food and nutrition services staff will report an individual’s food and beverage choices to the staff members responsible for serving the food.

5. Food and nutrition services staff will serve food and beverage choices made with consideration given to any dietary restrictions and/or texture modifications.

6. If the individual decides not to follow specific diet recommendations, they should be educated on the risk of not following their diet. The RDN or designee should assess the need for the diet restriction. If the individual cannot make this decision, then family and durable power of attorney for medical care will be educated on the risks and will determine what is best.

7. Nursing staff will be responsible for recording food and beverage intake as per facility policy.

8. Individuals will be encouraged to linger and visit throughout meals.

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

10. Staff will clear, clean, sanitize, and reset tables between services.

11. The director of food and nutrition services 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 a substantial evening meal and breakfast the following day. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.
Open Style Dining

Reference:
In-Room Dining (Room Service)

Policy:

In-room dining (room service) will be served in a way to complement 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, or for any individual who prefers to dine in their room. 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
   a. The room must be clean, well lit, and free of unpleasant odors.
   b. Individuals will order from a rotating or fixed menu, the same menu that is being served in the dining room. Food preferences and choices will be honored as appropriate. A selective menu will be offered if that is the menu style offered in the facility.
   c. Use of colorful placemats, dishware or tray favors can enhance in-room dining.
   d. Insulated plate covers, coffee pots, or mugs and bowls will help maintain food temperatures during delivery. All foods should be covered and delivered as soon as possible after plating to maintain food quality and temperature.
   e. Assistance to set the tray up and uncover all food items will be provided as needed or requested.

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

3. Appearance of the Meal
   a. Dishware will be clean, eye appealing, matching, and without chips or stains.
   b. 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).
   c. Glasses will be clean and free of stains or spots.
   d. Tray covers and napkins will be clean and wrinkle free.
   e. Items will be placed so they are convenient for the individual and neatly arranged.
   f. Food will be served carefully to avoid drips and spills.
   g. Dishes will be the proper size for food items served. For example:
      - Salads will be served in individual bowls with dressing on the side.
      - Bread and margarine will be served on individual plates.
      - Coffee or teacups will be served with saucers (mugs do not require a saucer).
   h. Hot food must be hot and cold food must be cold (as acceptable to the individual being served).
   i. Correct condiments and beverages will be available for the meal.

4. Appearance of the Server
   a. The director of food and nutrition services will provide service training to the servers.
   b. All staff will abide by the facility dress code. Staff dress/appearance should be acceptable to the individuals residing at the facility.
   c. Each facility will address issues such as appropriateness of tattoos, body piercings, and hair restraints.
24 Hour Dining

Policy:

Twenty four hour dining will focus on the patient's/resident's needs, wants, and desires for greater choice and flexibility. Meals and snacks will be provided continuously around the clock to meet daily nutritional needs, and enhance individual's quality of life. Twenty four hour dining will provide a variety of food and beverage choices throughout the day and night.

Procedure:

1. Individuals will be 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. Staff will assist individuals as needed to request meal and snack items.

3. Each individual will determine 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 will be available from the main kitchen with many choices. If the individual doesn't like the meal option, they may select from a variety of available choices, including a soup and/or sandwich meal.

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

8. Staff will be available to help individuals make healthy choices but will honor their right to make choices.

9. If the individual decides not to follow specific diet recommendations, they should be educated on the risk of not following their diet. The RDN or designee should assess the need for the diet restriction. If the individual cannot make this decision, then family and durable power of attorney for medical care will be educated on the risks and will determine what is best.

10. 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.

11. Nursing staff will record food and fluid intake daily as per facility policy.

12. Food safety, sanitation, infection control, and patient/resident safety policies and procedures will be reviewed with staff routinely.
Special Occasions – Holiday and Theme Meals

Policy:

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

Procedure:

1. The director of food and nutrition services will meet with patients/residents to discuss and plan special events and celebrations. Input will be obtained from staff and families if possible.

2. A quarterly or yearly calendar will be used to help plan events.

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

4. Responsibilities for menu and activity planning will be defined.

5. A list of necessary equipment and supplies should be generated. Work schedules (including a timetable for set-up and break down) should be prepared.

6. After the event, a final report with suggestions for similar events should be prepared.

<table>
<thead>
<tr>
<th>Ideas for theme meals:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Movies (Gone with the Wind, Wizard of Oz, Casablanca, Singing in the Rain, True Grit)</td>
</tr>
<tr>
<td>- Las Vegas Night</td>
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<tr>
<td>- Western Day</td>
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<tr>
<td>- Holidays (Valentine’s Day, Halloween, Memorial Day, Veteran’s Day, etc.)</td>
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<tr>
<td>- Celebrations such as birthdays, weddings, or anniversaries</td>
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<tr>
<td>- Ethnic meals (French, German, Irish, Italian, Mexican, Oriental, Polish, Russian)</td>
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<tr>
<td>- Tailgating/football parties</td>
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<tr>
<td>- Barbeques or picnics</td>
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<td>- Special events for small groups</td>
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<tr>
<td>- Special small dining room for family meals</td>
</tr>
<tr>
<td>- Community involvement – boy scouts/girl scouts, churches</td>
</tr>
</tbody>
</table>
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. Paid feeding assistants will be: properly trained and adequately supervised. They will provide dining assistance only to 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:
   a. State-approved training course.
      - The feeding assistant has successfully completed a state-approved training course
        that meets the federal requirements before feeding residents; and
      - The use of feeding assistants is consistent with state law.
   b. Supervision.
      - 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.
      - The supervisory nurse should monitor the provision of the assistance provided by
        paid feeding assistants to evaluate on an ongoing basis:
        - Their use of appropriate feeding techniques;
        - Whether they are assisting assigned residents according to their identified eating
          and drinking needs;
        - Whether they are providing assistance in recognition of the rights and dignity of
          the resident; and
        - Whether they are adhering to safety and infection control practices.
        - In an emergency, a feeding assistant must call a supervisory nurse for help on
          the resident call system.
        - 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.
   c. Resident selection criteria.
      - A facility must ensure that paid feeding assistants provide dining assistance only to
        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.
      - 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.
      - Paid feeding assistants will not be permitted to assist residents who have
        complicated eating problems, such as (but not limited to) difficulty swallowing,
        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.
Paid Feeding Assistants (Nursing Facilities)

- 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.
- 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:
   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:
      • Feeding techniques
      • Assistance with feeding and hydration
      • Communication and interpersonal skills
      • Appropriate responses to resident behavior
      • Safety and emergency procedures, including the Heimlich maneuver
      • Infection control
      • Resident rights
      • 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 of 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.
      • These employees must successfully complete a minimum of 8 hours of training from a state-approved training course for paid feeding assistants.
      • 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.

Reference:
Timely Meal Service

Policy:

Food will be delivered promptly to assure safe, palatable, and high quality food served at the proper temperature.

Procedure:

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

2. Meals will be placed in the delivery 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 physician ordered diet.

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

4. Meals will be distributed promptly with supervision as needed by nursing staff. (Close supervision may be needed for those with feeding difficulties). Staff should check each 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.

6. Food will be served at preferable temperatures (hot food hot and cold foods cold) as discerned by patients/residents and customary practice. (Not to be confused with proper holding temperatures – as outlined later in the Food Production and Food Safety chapter for proper temperature monitoring and recording).
Meal Times and Frequency

Policy:

The facility will provide at least three meals daily at regular times comparable to standard meal times in the community or in accordance with patients'/residents' needs, preferences, requests, and plan of care. Meals will be served in a timely manner to maintain food quality and safe and palatable food temperatures.

Procedure:

1. There will be no more than 14 hours between a substantial evening meal (dinner) and breakfast the following day. All residents will be offered a bed-time snack. If a nourishing snack is served 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 and a nourishing snack must be served.

   Note: Check state regulations to assure compliance.

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

   Breakfast: __________
   Lunch: __________
   Dinner: __________
   HS Snack: __________

Notes: 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.

State regulations may also outline additional requirements for spacing of meals and snacks.

Reference:
Early and Late Meals

Policy:

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

Procedure:

Early Meals:
1. Nursing and/or the food and nutrition services 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 nursing unit, 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 and nutrition services personnel 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 director of food and nutrition services will notify the cook/chef at the start of the tray line how many late trays there are.

2. After the meal is served, the cook/chef will reserve enough food for the meals that will be served later. Food should be held safely at the proper temperatures.

3. When the nursing department phones that a certain individual is ready to eat, the cook/chef prepares the meal and one of the food and nutrition services staff delivers it to the proper nursing station, assuring that the meal is properly labeled with the name and room number of the individual.
Select Menus

Policy:

If select menus are offered, they will be provided to meet individual’s dietary modifications and preferences. 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 physician ordered diet).

Procedure:

Diet Clerk/Aide/Secretary:

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

2. Menus will be distributed 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 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 will also be encouraged to assist when needed. Menu choices will be returned to the food and nutrition services department once they are completed using the facility’s established procedures for menu collection.

3. Marked menus will be checked to be sure that there is a completed menu for each individual (except NPO) and menus are correct according to the diet order.
   a. There should be a select menu available at each meal for each person who uses the select menu system. Missing select menus will be retrieved and incomplete menus completed with assistance as needed.
   b. Select menus will be assembled in order according to service.
   c. Select menus will act as the individual’s meal identification (ID) card/ticket.

4. Select menus should be reviewed as follows:
   a. Complete the heading on the menu with name, diet order, dining area and date.
   b. Verify name, diet order and menu with the individual’s current records.
   c. Check menus for completeness and nutritional adequacy (example: if an individual selected cereal, check that milk is also selected; if an individual selects only one item, visit the individual and assist in completing the menu, if they want to add items). Refer to the RDN or designee for diet education if needed. Note: Nursing facility residents have the right to select only a few items.
   d. Check therapeutic menus for accuracy, and completeness using the individual’s records and the diet/nutrition care manual if needed.
   e. Do not add menu items without checking with the individual. It is their right to make their own selections.
   f. Check all menus within the parameters of the individual’s recorded likes/dislikes, food intolerances and allergies.
   g. Verify and honor per facility policy, requests that the individual may write on the menu.
   h. Verify that each food item on the menu is legible and neatly circled.
   i. Refer complicated therapeutic diets to the RDN or designee as needed to review and approve.
Select Menus

5. If an individual is unable to mark a menu, staff will 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. Each person should have a correct select menu each day (except those who are NPO).

3. Select menus (meal ID card/ticket) for the next meal should be placed at the starter station on tray line.

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

Diet Clerk/Supervisor:
1. Accuracy of meal according to the menu will be checked.

Nursing:
1. The meal (ID) card/ticket will be used while delivering meals to verify name and diet order to assure it is delivered to the correct individual.

For Dining Room Service:
1. The same basic guidelines as with tray-line service will be followed and adapted 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), director of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Meal Identification and Preference Cards/Tickets

Policy:

A meal identification (ID) and food preferences card (meal ID card/ticket) will be used to properly identify each individual’s needs including food and beverage preferences. The meal ID card/ticket may be a permanent card that is gathered, cleaned, and sanitized after each meal, or may be printed daily from a database and disposed of after meals.

Procedure:

1. The director of food and nutrition services or designee will visit 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 should include the name of the individual, diet order, beverage preferences, food dislikes and any other applicable 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 will be used during meal service to assure the correct diet is being served and food preferences are honored.

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

Meals delivered to the dining rooms, wings/neighborhoods:

6. The server will remove permanent meal ID cards/tickets after the meal is served and place them in a container to be sent to the kitchen.

7. Food and nutrition services staff will be responsible for keeping permanent meal ID cards/tickets clean and sanitized and in the correct serving order.

8. The director of food and nutrition services or designee will be responsible for keeping meal permanent ID cards/tickets up-to-date and for replacing worn cards when appropriate.

9. The director of food and nutrition services or designee will be responsible for keeping computerized meal ID cards/tickets up-to-date and for printing them prior to each meal.

10. Permanent meal ID cards will be cleaned and sanitized following each meal.

Note: Staff may use paper tray cards to note changes in preferences, food intake percentages and other pertinent information to return to the food service department.
Offering Food Replacements at Meal Time

Policy:

Each individual will receive appropriate nutrition when a food replacement is offered. Options should be appealing and of similar nutritive value as the food that is initially served.

Procedure:

1. If an individual is not eating a food (or foods) served, the nursing staff will be responsible for asking why and for verbally offering a suitable food replacement. (Please see Menu Substitution Lists earlier in this manual). The individual will be encouraged to verbalize his/her choice of substitution.

2. For individuals on therapeutic diets, the food replacements offered should be appropriate for the therapeutic diet order and appealing to the individual.

3. If an individual agrees to eat the food replacement, the nursing staff will notify food and nutrition services staff and explain the reason for the substitution. This may be done verbally, or in writing to avoid mistakes (see Resource: Sample Available Food Replacements on the following page).

4. The food server will be responsible for preparing the food replacement as soon as possible; making sure it is delivered to the individual in a timely manner.

5. If the individual dislikes the food that was offered, the director of food and nutrition services should be notified to help maintain an accurate list of food preferences.

6. If the individual refuses the offered food replacement, staff is not required to offer any further food replacements but should document that the substitute was refused. Individuals with diabetes who frequently refuse meals and alternates should be referred to the registered dietitian nutritionist (RDN) or designee and nursing should be notified in case medication adjustment are needed.

7. When food replacements are consistently refused, the staff will notify director of food and nutrition services or designee. Revisions to food preferences and documentation in the medical record and care plan may be necessary. The food and nutrition services manager will refer individuals to the RDN or designee as appropriate.

8. The director of food and nutrition services will maintain a list of meal alternates available, which will be provided to nursing staff. The following page lists the items that will be available for food replacement at all meals. 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Resource: Sample Available Food Replacements

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 an appealing option of similar nutritive value. The individual should be encouraged to give input for his/her choice of replacement.
- Food replacements should be provided within 15 minutes of determining an individual's wishes, if possible.
- The food and nutrition services 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 50% 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.

### Sample Food Replacements

<table>
<thead>
<tr>
<th>When an Individual Consumes &lt; 50% of:</th>
<th>Offer:</th>
</tr>
</thead>
</table>
| **Entrée/Meat 2 to 3 ounces*** | • Alternate meat or entrée item  
• Sandwich with 2 to 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, 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
Displaying the Menu

Policy:

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

Procedure:

1. The food and nutrition services staff will post planned written menus in a designated area that is easily viewed by all individuals.

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

3. The food and nutrition services staff is responsible for posting revisions to the planned menu in a timely manner.
Accuracy and Quality of Tray Line Service

Policy:

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

Procedure:

1. The menu extensions display food items and amounts for each regular or therapeutic diet.

2. The director of food and nutrition services or designee will be responsible for assuring 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 will be planned and determined:
   a. According to the menu
   b. To operate at maximum efficiency
   c. To obtain maximum accuracy

4. The meal will be 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 and Therapeutic Diets chapter of this manual.)

6. Each meal will be checked for:
   a. Correct name, room number, and diet order
   b. Accuracy of following the therapeutic diet extension
   c. Proper portion sizes
   d. Food and beverage preferences, allergies, intolerances and/or special food requests
   e. Neatness of tray and attractiveness of the food served

7. Problems with meal accuracy should be resolved immediately.

8. Ongoing problems should be brought to the attention of the director of food and nutrition services.
Portion Control

Policy:

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

Procedure:

1. Standardized recipes should be used 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. Food should be served 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.
   a. Portions that are too small result in the individual not receiving the nutrients needed.
   b. Portions that are too large increase food costs as well as providing the individual more food than needed.

4. Food and nutrition services staff will be inserviced at regular intervals by the director of food and nutrition service on proper portion sizes. The director of food and nutrition services, registered dietitian nutritionist (RDN) or designee will observe meals on a routine basis to ensure the quality control of portion sizes.

<table>
<thead>
<tr>
<th>Serving Utensils</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utensils</strong></td>
</tr>
<tr>
<td># 5 scoop</td>
</tr>
<tr>
<td># 6 scoop</td>
</tr>
<tr>
<td># 8 scoop</td>
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<tr>
<td># 10 scoop</td>
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<tr>
<td># 12 scoop</td>
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<td># 16 scoop</td>
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<td># 20 scoop</td>
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<tr>
<td># 24 scoop</td>
</tr>
<tr>
<td># 30 scoop</td>
</tr>
<tr>
<td># 40 scoop</td>
</tr>
<tr>
<td>6 ounce ladle</td>
</tr>
<tr>
<td>8 ounce ladle</td>
</tr>
</tbody>
</table>
Adaptive (Assistive) Eating Devices

Policy:

The facility will provide special eating equipment and utensils for residents who need them and appropriate assistance to assure that the resident can use the adaptive (assistive) device when consuming meals and snacks.

Procedure:

1. Individuals will be evaluated on admission, and periodically to assess the need for adaptive (assistive) devices. Referrals for needed equipment may come from speech therapy, occupational therapy, nursing, physician or designee or registered dietitian nutritionist (RDN) and/or designee.

2. Individuals will be referred to the therapy department as needed to evaluation for adaptive (assistive) devices.

3. A written order must be obtained for adaptive (assistive) devices.

4. Adaptive (assistive) devices should be noted on each individual's meal identification (ID) card/ticket and in the care plan and/or in the medical record.

5. The food and nutrition services department will be responsible for ensuring that each individual receives feeding devices as ordered for each meal.

6. Adaptive (assistive) devices will be cleansed and sanitized, then stored in the kitchen and provided for each meal and/or snack as appropriate.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Meal Time Observation

Policy:

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

Procedure:

1. The director of food and nutrition services or designee will complete meal rounds (see policy and sample forms in the *Quality Assurance and Performance Improvement* chapter) in the dining rooms and resident/patient rooms during meal times.

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

3. Staff will visit every table to be sure that all individuals have received the appropriate meal and service, with therapeutic or mechanically-altered diets delivered as ordered.

4. As necessary, referrals will be made to appropriate staff for difficulty chewing, swallowing, using utensils, self-feeding, or other problems.

5. Meal requests and/or alternates 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 will be the responsibility of the observer and should be completed within 48 hours.
Following the Meal Service

Policy:

Nursing staff will assist individuals to exit the dining areas, and food and nutrition staff and/or housekeeping staff will clean, sanitize, and prepare the dining areas for the next meal.

Procedure:

1. Patients/residents will be assisted to exit the dining area by nursing staff as needed.

2. Food and nutrition services and/or housekeeping staff will initiate cleaning of the dining area only 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 tables will be sanitized and re-set for the next meal.

4. The director of food and nutrition services or designee will inspect the dining area after every meal for cleanliness and preparation for the next meal.
Packed Meals

Policy:

Individuals requiring a meal while away from the facility will be provided with a packed or 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 and nutrition services department at least 24 hours in advance of an individual’s need for a packed or boxed meal, if possible.

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

3. Food and nutrition services personnel will prepare a packed or 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. Food and nutrition services personnel will store the meal under safe and sanitary conditions 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 and nutrition services department for the meal when needed.

6. The nursing department will notify the food and nutrition services department upon the individual’s return to the facility for normal resumption of meals and/or of any change in diet orders for the individual returning to the facility.
Pets

Policy:

Pets, including service animals, are not permitted in the food preparation areas, storage and receiving areas, or pantry areas at any time. Pets are not permitted in the dining areas during meal times. Service animals that are controlled by a handler are allowed in the dining area, as long as a health or safety hazard will not result. Other animals are permitted in the dining area at times other than meals as long as a health or safety hazard will not result.

Procedure:

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

2. Food employees may not care for or handle animals that may be present such as patrol dogs, service animals, or pets, with exception of shellfish or crustaceans in display tanks (to be prepared and served for a meal).

3. Non-food employees that handle pets during working hours must follow all facility policies and procedures for hand washing.

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

5. Pets will be kept out of the dining areas during meal service. At times other than meals, pets in the dining area must be properly restrained and/or be situated so as not to create a safety hazard (i.e. tripping over animals). Service animals may be allowed in the dining room during meal service as long as they are controlled by their handler and a hazard to health and safety is not present.

6. Condiments, equipment, and utensils must be stored in cabinets or removed from the dining area when pets are present.

7. Dining areas, including tables and countertops must be cleaned and sanitized after pets or service animals have been in the area and before the next meal service.

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

Source:
Federal Food Code.
Leave of Absence

Policy:

The food and nutrition services department will be notified in writing or via telephone call when a patient/resident will be away from the facility during a meal.

Procedure:

1. Nursing will send a diet change sheet or contact the food and nutrition services department via accepted facility communication (phone, text, or email, as per facility policy) when an individual will be away during meal service. They will specify the date, and meal(s) the individual will be away.

2. The food and nutrition services staff will remove the individual’s meal identification (ID) card/ticket for the designated meal(s).
Guest Meals

Policy:

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

Procedure:

1. Family and friends can purchase a meal at the business office in advance of the meal they plan to attend.

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

3. The business office should inform the kitchen of guest trays as soon as possible, preferably one day before the meal is served.

4. Food and nutrition services staff will serve the guest meal along with the patient’s/resident’s tray unless otherwise directed. Guests will receive the “regular” or “general” diet, unless special requests are prearranged and approved by the director of food and nutrition services or designee.

5. The director of food and nutrition services should keep an accurate record of all guest meals served, and reconcile this with the bookkeeper to assure that money from guest trays is credited to the food service department.

6. Facility policy regarding collecting and tracking payment for guest meals will be followed.
Food Availability

Policy:

Food and beverages will be available around the clock in the kitchenette, pantries, or nourishment rooms.

Procedure:

1. The director of food and nutrition services, with input from patients/residents, will determine foods and beverages and quantities to be maintained in the resident pantries.

2. The food and nutrition services staff will deliver items daily to the appropriate kitchenette or pantry, replenishing items as needed. They are also responsible for:
   a. Rotating stock and removing outdated items.
   b. Checking refrigerators and freezer temperature in kitchenettes or pantries weekly and maintaining documentation (See Sample Refrigerator and Freezer Temperatures Forms in Food Production and Food Safety chapter.)
   c. Checking internal food temperatures randomly to assure proper temperatures (< 41° F).
   d. Cleaning and sanitizing refrigerators on a regular cleaning schedule, and as needed.
Nourishments and Supplements

Policy:

The director of food and nutrition services will assure a supply of nourishments such as snacks between meals or supplements that have been ordered are available. Nursing staff will deliver the nourishments and/or supplements and assist individuals with set-up and/or consumption as needed.

Procedure:

1. Nourishment and/or supplement list
   a. The director of food and nutrition services or designee will maintain nourishment and/or supplement lists, using written orders and individual requests as a guide.
   b. Copies of supplement orders may be available from reports generated from the facility’s pharmacy and/or the electronic medical record.
   c. A list of supplements needed each shift should be given to appropriate food and nutrition services staff for preparation.
   d. Revisions will be given as needed to the director of food and nutrition services or designee.
   e. New lists will be prepared as needed.

2. Preparation of nourishments and supplements
   a. Assigned food and nutrition services staff will prepare nourishments and supplements according to the nourishment and/or supplement lists.
   b. All “high protein/high calorie supplements”, special nourishments, and other nourishments/supplements that have been ordered by a physician or designee will be individually wrapped, labeled and dated and include the patient’s/resident’s last name and room number for delivery.

3. Designated staff will deliver nourishments and/or supplements.

4. Designated staff will provide assistance with set-up or consumption to those who need it.

5. Soiled dishes and silverware are returned to the dish room by staff after nourishment passes are completed.

6. Nursing staff will document percent of supplements and/or nutrients consumed as per facility protocol and report intake problems to the nursing supervisor.

7. Nursing will notify the director of food and nutrition services, RDN or designee of needed changes in nourishments/supplements based on the individual’s acceptance (or lack of acceptance).

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Sample Nourishments and Supplements Form

Date: __________________________

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Diet Order</th>
<th>10 AM</th>
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This form may be computerized.
Food Production and Food Safety

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

Policy:

The kitchen will open promptly at__________AM and will close at__________PM.

Procedure:

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

2. The kitchen will be thoroughly cleaned and food preparation surfaces sanitized prior to closing each day.
Food and Nutrition Services Managers’ Responsibilities

Policy:

A well-trained food and nutrition services manager will assure that instructions for food and nutrition services department are properly carried out, and that all local, state and federal food, food safety and sanitation regulatory requirements are met.

Procedure:

1. The director of food and nutrition services will be familiar with all local, state and federal regulatory requirements related to food, food safety and sanitation; and assure that all requirements are met.

2. Employees will be trained, assisted and encouraged as needed.

3. Employees will be free from symptoms of contagious diseases.

4. Written work schedules will be posted in advance.

5. Food will be procured from sources approved or considered satisfactory by federal, state and/or local authorities.

6. Food will be prepared in a manner that prevents food borne illness. Staff will follow proper sanitation and food handling practices. Food will be served as soon as possible after it has been prepared, and at the proper temperature to assure safe and palatable food.

7. Food will be purchased, stored, prepared, and used in a way to maintain a budget within financial goals set by the facility administrator.

8. Standardized recipes will be followed and should include:
   a. Amount of ingredients, either by weight or volume
   b. Method of combining ingredients
   c. Cooking or baking temperatures and approximate time required
   d. Size, shape and type of pan to be used, and amount for each pan
   e. 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

9. Food waste will be prevented.

10. Food will be prepared according to procedures that minimize fatigue and save time for employees (i.e. work simplification methods).

11. Proper equipment and tools for safe and efficient food preparation will be available. Equipment and tools will be properly used, cleaned and sanitized, and kept in good repair.

12. Menus will provide a variety of foods acceptable to the individuals being served.

13. Food served will be attractive, palatable and meet the dietary needs of the individuals being served.
Inventory and Cost Control

Policy:

The director of food and nutrition services will be responsible for maintaining a department budget and cost per-patient-day that meets goals set by the administrator.

Procedure:

The director of food and nutrition services or designee will:

1. Meet routinely with administrator to determine budget and financial goals and evaluate success toward meeting those goals.

2. Complete monthly and annual inventory of raw food and supplies.

3. Maintain strict inventory control procedures to prevent theft or use of unnecessary food products and supplies.

4. Follow the “first in, first out” method to use all food before it expires.

5. Review menus prior to completing food orders.

6. Review invoices to assure that they accurately reflect deliveries of food and supplies.

7. Returns damaged products to vendors and assure refunds are granted as appropriate.

8. Reviews census and adjust production plans accordingly.

9. Monitor food production records for portion control and/or over-production.

10. Monitor for excessive plate waste, changing menus if appropriate.

11. Review food purchasing and production as needed to evaluate cost effectiveness.

12. Rotate emergency supplies into the menu to use prior to expiration.

13. Review inventory of and use of beverages, supplements, and snacks sent to nursing units, to assure use by expiration dates and assess for excessive use or theft.

14. Assure food purchased for other departments (activities, nursing, etc.) is billed accordingly.

15. Assure guest trays, staff trays, and other sales are applied to the appropriate budget line-item.

16. Adjust staffing as needed based on census and special events.
Policy:

Food and nutrition services 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 director of food and nutrition services 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.

Food 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 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 nutritionist (RDN) should determine the appropriate temperature ranges for the food service operation.

Procedure:

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

2. Staff will understand that some individuals are at a higher risk of FBI: older adults, children, pregnant women, and immune-compromised individuals, those who have had recent surgery or have chronic illness.

3. Staff will recognize potentially hazardous foods because of their protein content, moisture content and food source. They are referred to as time/temperature controlled for safety (TCS) foods. Staff will be careful when handling:
HACCP and Food Safety

- 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

4. Bacteria need certain things to reproduce: warmth, moisture, food, and time. It is helpful to remember the acronym, FAT TOM:
   a. Food - High protein food or foods that are already contaminated.
   b. Acidity 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).
   c. Time - 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.
   d. Temperature - Avoid TDZ of 41°F to 135°F.
   e. Oxygen - Most bacteria need oxygen, some do not (botulism).
   f. Moisture - 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. High temperatures do not destroy most toxins. A 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.

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:
   a. Cooking
   b. Cooling
   c. Holding
   d. Re-heating
8. The leading cause of FBI is **improperly cooled foods**, followed by:
   a. Food not thoroughly heated or cooked
   b. Infected employees/poor personal hygiene
   c. Food prepared a day or more in advance of serving
   d. Raw, contaminated ingredients added to food
   e. Food left too long at temperatures that favor bacterial growth
   f. Failure to reheat food to temperatures that kill bacteria
   g. Cross contamination - cooked food contaminated by raw food (ex. cooked vegetables contaminated by raw chicken), 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:
   a. Can the food become contaminated?
   b. Can the contaminants increase?
   c. Will the contaminants survive?
   d. Can hazards be prevented with corrective actions?
   e. Can hazards be prevented, eliminated or reduced in steps later in the handling process?
   f. Can CCP’s be monitored?
   g. How will CCP’s be measured?
   h. Can CCP’s be documented?

**Sources:**
Resource: Foodborne Illnesses – What You Need to Know

While the American food supply is among the safest in the world, the Federal government estimates that there are about **48 million cases of foodborne illness annually**—the equivalent of sickening 1 in 6 Americans each year. And each year these illnesses result in an estimated 128,000 hospitalizations and 3,000 deaths.

The chart below includes foodborne disease-causing organisms that frequently cause illness in the United States. As the chart shows, the threats are numerous and varied, with symptoms ranging from relatively mild discomfort to very serious, life-threatening illness. While the very young, the elderly, and persons with weakened immune systems are at greatest risk of serious consequences from most foodborne illnesses, some of the organisms shown below pose grave threats to all persons.

<table>
<thead>
<tr>
<th>Organism</th>
<th>Common Name of Illness</th>
<th>Onset Time After Ingesting</th>
<th>Signs &amp; Symptoms</th>
<th>Duration</th>
<th>Food Sources</th>
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</thead>
<tbody>
<tr>
<td>Bacillus cereus</td>
<td>B. cereus food poisoning</td>
<td>10-16 hours</td>
<td>Abdominal cramps, watery diarrhea, nausea</td>
<td>24-48 hours</td>
<td>Meats, stews, gravies, vanilla sauce</td>
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<tr>
<td>Campylobacter jejuni</td>
<td>Campylobacteriosis</td>
<td>2-5 days</td>
<td>Diarrhea, cramps, fever, and vomiting; diarrhea may be bloody</td>
<td>2-10 days</td>
<td>Raw and undercooked poultry, unpasteurized milk, contaminated water</td>
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<tr>
<td>Clostridium botulinum</td>
<td>Botulism</td>
<td>12-72 hours</td>
<td>Vomiting, diarrhea, blurred vision, double vision, difficulty in swallowing, muscle weakness. Can result in respiratory failure and death</td>
<td>Variable</td>
<td>Improperly canned foods, especially home-canned vegetables, fermented fish, baked potatoes in aluminum foil</td>
</tr>
<tr>
<td>Clostridium perfringens</td>
<td>Perfringens food poisoning</td>
<td>8–16 hours</td>
<td>Intense abdominal cramps, watery diarrhea</td>
<td>Usually 24 hours</td>
<td>Meats, poultry, gravy, dried or precooked foods, time and/or temperature-abused foods</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>Intestinal cryptosporidiosis</td>
<td>2-10 days</td>
<td>Diarrhea (usually watery), stomach cramps, upset stomach, slight fever</td>
<td>May be remitting and relapsing over weeks to months</td>
<td>Uncooked food or food contaminated by an ill food handler after cooking, contaminated drinking water</td>
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<tr>
<td>Cyclospora cayetanensis</td>
<td>Cyclosporiasis</td>
<td>1-14 days, usually at least 1 week</td>
<td>Diarrhea (usually watery), loss of appetite, substantial loss of weight, stomach cramps, nausea, vomiting, fatigue</td>
<td>May be remitting and relapsing over weeks to months</td>
<td>Various types of fresh produce (imported berries, lettuce, basil)</td>
</tr>
<tr>
<td>E. coli (Escherichia coli) producing toxin</td>
<td>E. coli infection (common cause of “travelers’ diarrhea”)</td>
<td>1-3 days</td>
<td>Watery diarrhea, abdominal cramps, some vomiting</td>
<td>3-7 or more days</td>
<td>Water or food contaminated with human feces</td>
</tr>
<tr>
<td>Organism</td>
<td>Common Name of Illness</td>
<td>Onset Time After Ingesting</td>
<td>Signs &amp; Symptoms</td>
<td>Duration</td>
<td>Food Sources</td>
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<tr>
<td><em>E. coli</em> O157:H7</td>
<td>Hemorrhagic colitis or <em>E. coli</em> O157:H7 infection</td>
<td>1-8 days</td>
<td>Severe (often bloody) diarrhea, abdominal pain and vomiting. Usually, little or no fever is present. More common in children 4 years or younger. Can lead to kidney failure.</td>
<td>5-10 days</td>
<td>Undercooked beef (especially hamburger), unpasteurized milk and juice, raw fruits and vegetables (e.g. sprouts), and contaminated water</td>
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<tr>
<td>Hepatitis A</td>
<td>Hepatitis</td>
<td>28 days average (15-50 days)</td>
<td>Diarrhea, dark urine, jaundice, and flu-like symptoms, i.e., fever, headache, nausea, and abdominal pain</td>
<td>Variable, 2 weeks - 3 months</td>
<td>Raw produce, contaminated drinking water, uncooked foods and cooked foods that are not reheated after contact with an infected food handler; shellfish from contaminated waters</td>
</tr>
<tr>
<td><em>Listeria monocytogenes</em></td>
<td>Listeriosis</td>
<td>9-48 hrs for gastrointestinal symptoms, 2-6 weeks for invasive disease</td>
<td>Fever, muscle aches, and nausea or diarrhea. Pregnant women may have mild flu-like illness, and infection can lead to premature delivery or stillbirth. The elderly or immuno-compromised patients may develop bacteremia or meningitis.</td>
<td>Variable</td>
<td>Unpasteurized milk, soft cheeses made with unpasteurized milk, ready-to-eat deli meats</td>
</tr>
<tr>
<td>Noroviruses</td>
<td>Variously called viral gastroenteritis, winter diarrhea, acute non-bacterial gastroenteritis, food poisoning, and food infection</td>
<td>12-48 hrs</td>
<td>Nausea, vomiting, abdominal cramping, diarrhea, fever, headache. Diarrhea is more prevalent in adults, vomiting more common in children.</td>
<td>12-60 hrs</td>
<td>Raw produce, contaminated drinking water, uncooked foods and cooked foods that are not reheated after contact with an infected food handler; shellfish from contaminated waters</td>
</tr>
<tr>
<td>Salmonella</td>
<td>Salmonellosis</td>
<td>6-48 hours</td>
<td>Diarrhea, fever, abdominal cramps, vomiting</td>
<td>4-7 days</td>
<td>Eggs, poultry, meat, unpasteurized milk or juice, cheese, contaminated raw fruits and vegetables</td>
</tr>
<tr>
<td>Organism</td>
<td>Common Name of Illness</td>
<td>Onset Time After Ingesting</td>
<td>Signs &amp; Symptoms</td>
<td>Duration</td>
<td>Food Sources</td>
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<tr>
<td>Shigella</td>
<td>Shigellosis or Bacillary dysentery</td>
<td>4-7 days</td>
<td>Abdominal cramps, fever, and diarrhea. Stools may contain blood and mucus.</td>
<td>24-48 hours</td>
<td>Raw produce, contaminated drinking water, uncooked foods and cooked foods that are not reheated after contact with an infected food handler</td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td>Staphylococcal food poisoning</td>
<td>1-6 hours</td>
<td>Sudden onset of severe nausea and vomiting. Abdominal cramps. Diarrhea and fever may be present.</td>
<td>24-48 hours</td>
<td>Unrefrigerated or improperly refrigerated meats, potato and egg salads, cream pastries</td>
</tr>
<tr>
<td>Vibrio parahaemolyticus</td>
<td>V. parahaemolyticus infection</td>
<td>4-96 hours</td>
<td>Watery (occasionally bloody) diarrhea, abdominal cramps, nausea, vomiting, fever</td>
<td>2-5 days</td>
<td>Undercooked or raw seafood, such as shellfish</td>
</tr>
<tr>
<td>Vibrio vulnificus</td>
<td>V. vulnificus infection</td>
<td>1-7 days</td>
<td>Vomiting, diarrhea, abdominal pain, blood borne infection. Fever, bleeding within the skin, ulcers requiring surgical removal. Can be fatal to persons with liver disease or weakened immune systems.</td>
<td>2-8 days</td>
<td>Undercooked or raw seafood, such as shellfish (especially oysters)</td>
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Note: Available in PDF format and in Spanish from the above website.
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.

<table>
<thead>
<tr>
<th>Source of Contamination</th>
<th>Primary Agents of Concern</th>
<th>Primary Control Strategies</th>
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<tbody>
<tr>
<td><strong>A. Hazards that are likely to occur/strategies that must be in place to prevent food borne illness</strong></td>
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</table>
| Eggs, raw or unpasteurized | • Salmonella | • Time/Temperature Control for Safety (TCS)  
• Cook to proper temperature  
• Prevention of cross-contamination to ready-to-eat (RTE) foods |
| Poultry, raw | • Campylobacter  
• Salmonella | • TCS  
• Cook to proper temperature  
• Prevention of cross-contamination to RTE foods |
| | • Clostridium perfringens | • TCS  
• Cook to proper temperature  
• Cool foods quickly to proper temperature |
| Meat, raw | • E. Coli 01507:H7  
• Salmonella  
• Campylobacter | • TCS  
• Cook to proper temperature  
• Prevention of cross-contamination to RTE foods |
| | • Clostridium perfringens | • 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 RTE foods |
| | • Staphylococcus aureus | • TCS  
• Proper hand-washing procedures  
• Avoid bare-hand contact with RTE 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  
• Salmonella | • Wash prior to use (unless pre-washed)  
• Keep cut and raw fruits and vegetables refrigerated |
| Ready-to-eat meat and poultry products | • Listeria monocytogenes  
• Hepatitis A virus  
• Shigella | • Proper refrigeration during storage  
• Discard expired food items |
| Pasteurized dairy products | • Listeria monocytogenes | • Proper refrigeration during storage |
| Ice | • Hepatitis A  
• Norovirus | • Clean/sanitize the internal components of ice machine per manufacturer’s guidelines  
• Proper handling of ice |

**Source:**
1. Do control measures exist for the identified hazard?  
   \begin{align*}
   \text{Yes} & \quad \rightarrow \quad \text{Modified step, process or product} \\
   \text{No} & \quad \rightarrow \quad \text{Is control at this step necessary for safety?}
   \end{align*}

2. Does this step eliminate or reduce the likely occurrence of a hazard to an acceptable level?  
   \begin{align*}
   \text{No} & \quad \rightarrow \quad \text{Could contamination with identified hazards occur in excess of acceptable levels or could these increase to unacceptable levels?} \\
   \text{Yes} & \quad \rightarrow \quad \text{Will a subsequent step eliminate identified hazards or reduce the likely occurrence to an acceptable level?}
   \end{align*}

3. Could contamination with identified hazards occur in excess of acceptable levels or could these increase to unacceptable levels?  
   \begin{align*}
   \text{Yes} & \quad \rightarrow \quad \text{Critical Control Point} \\
   \text{No} & \quad \rightarrow \quad \text{STOP Not a Critical Control Point}
   \end{align*}

4. Will a subsequent step eliminate identified hazards or reduce the likely occurrence to an acceptable level?  
   \begin{align*}
   \text{No} & \quad \rightarrow \quad \text{STOP Not a Critical Control Point} \\
   \text{Yes} & \quad \rightarrow \quad \text{Critical Control Point}
   \end{align*}

HACCP Principles

Policy:

The facility food and nutrition services department will utilize 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 time/temperature control for safety 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 2013 Food Code, Annex 4.

Procedure:

The facility staff will 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 time/temperature control for safety foods (TCS) foods, or complicated multiple step recipes that can be influenced by time or temperature.
   b. Review how staff handles non-time/temperature control for safety foods.
      - Is there a risk of cross contamination?
   c. Review suppliers, personnel and equipment.
      - Is staff trained in proper food handling?
      - Is staff clean and free of disease, cuts, and infections?
      - Does staff handle equipment properly?
      - Does staff handle food properly?
      - Is equipment up to date, clean and sanitary?
      - What can reasonably and safely be monitored to assure food safety?
   d. Some TCS with multiple food handling steps may be more safely purchased as a prepared item, which only requires heating and serving.
      - Determine which foods have the potential to cause severe hazards and determine the probability of occurrence.
      - 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:
      - Good personal hygiene.
      - Preventing cross contamination.
      - Proper cooking temperatures and times, and proper internal temperatures.
      - Rapid cooling.
      - Proper re-heating and holding temperatures.
      - Specific sanitation procedures.
      - Preparation ahead of time.
   b. Identify all steps of food preparation that need to be monitored.
      - Hand washing/contamination of hands.
HACCP Principles

- Recipes need to include all CCPs as appropriate (receiving, holding, serving, cooling, reheating).
- Sanitary equipment and surfaces.
- Time and temperature (avoiding the temperature danger zone).
- Cross contamination.
c. Develop guidelines to prevent hazards at each step (this can be done on a flow chart).
  - Wash hands before beginning preparation.
  - Utilize clean, sanitized equipment.
  - Utilize gloves if coming in direct contact with food, and change gloves as often as needed.
  - 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:
      - Specific cooking times and internal temperatures.
      - Specific holding and cooling instructions.
      - Directions for hand washing and sanitizing equipment where appropriate.
      - 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 on the following pages).

4. Monitor CCPs.
   a. Monitor 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.
      - Explain to staff why there is a problem or potential problem.
      - Determine corrections based on facts.
      - Develop measurable goals.
      - Teach staff how to decide if food should be discarded.
      - 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.
   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.

Policy & Procedure Manual  3-13
Recipe that has been converted to the HACCP system:

### Grilled Ham and Cheese Sandwich

<table>
<thead>
<tr>
<th>Ingredients</th>
<th>Measurement</th>
<th>4</th>
<th>8</th>
<th>12</th>
<th>16</th>
<th>20</th>
<th>Custom Serving</th>
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<td>8</td>
<td>16</td>
<td>24</td>
<td>32</td>
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<tr>
<td>Ham</td>
<td>Ounces</td>
<td>8</td>
<td>16</td>
<td>24</td>
<td>32</td>
<td>40</td>
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<tr>
<td>Cheese slices</td>
<td>1 ounce</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
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<td></td>
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<tr>
<td>Margarine, melted</td>
<td>Tablespoons</td>
<td>2 1/2</td>
<td>5</td>
<td>7 1/2</td>
<td>10</td>
<td>12 1/2</td>
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</tbody>
</table>

**Preparation:**
Wash, rinse and sanitize all equipment and utensils before and after use.
1. Place 2 ounces ham and 1 oz. 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*
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 (TDZ) 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:**
General HACCP Guidelines for Food Safety

Policy:

Food and nutrition services staff will 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 food and nutrition services 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 chapter.)

2. **The Time-Temperature Connection**
   
   a. Limiting the time that food is in the temperature danger zone (TDZ).
   
   b. The TDZ: Food must be held >135°F or <41°F.
      
      - 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 Minimum Cooking, Holding and Reheating Temperatures in this chapter.)

4. **Prevent Cross Contamination and Employee Contamination**
   
   a. Preparation: Avoid the TDZ, prevent cross contamination and employee contamination.
   
   b. Cooking: Final internal temperatures as noted earlier.
   
   c. Hot holding: >135°F, cover and stir often.
   
   d. 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).
   
   e. If food drops <135°F, reheat to 165°F for minimum of 15 seconds.

5. **Essentials of Cooling**
   
   a. 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.
   
   b. 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.
   
   c. 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.)
   
   d. 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.
   
   e. Allow air to circulate around the food.

6. **Safe Thawing Practices**
   
   a. 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).
   
   b. Completely submerge the item in clean running water (<70°F) that is running fast enough to agitate and float off loose ice particles.
General HACCP Guidelines for Food Safety

c. Thaw the item in a microwave oven using the defrost mode only if it is to be cooked immediately after thawing.
d. Thaw as part of the cooking process.

7. Food temperatures for Meal Service
   a. Check to be sure the staff takes food temperatures correctly and records temperatures.
   b. 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
   a. When temperatures are poor, take immediate action.
   b. 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
   a. Take the internal temperatures of each unit.
   b. Periodically, take internal temperatures of foods in the unit.
   c. Consistently schedule a plan to take the internal temperature of cooling foods to assure proper cooling.
   d. 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
    a. Be sure the wash and rinse temperatures are appropriate for the dish machine.
    b. Document temperatures regularly on a temperature log.
    c. Use one staff person to load dirty dishes and another to pull clean dishes.
    d. Air Dry. Use drying racks if needed; do not stack dishes immediately before or after washing.
    e. 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
    a. Take food temperatures upon receiving. Be sure the vendors have refrigerated trucks that are clean and in good repair.
    b. Label and date foods and put foods away promptly.
    c. 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):
    a. Obtain complete and reliable information.
    b. Evaluate the complaint and take immediate action to correct the problem.
    c. Deal with regulatory agencies in a positive manner.
    d. 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 unpasteurized eggs are not acceptable. Use pasteurized eggs for safe consumption of undercooked eggs (sunny side up fried eggs, soft cooked eggs, etc.)
General HACCP Guidelines for Food Safety

Resources on Food Safety:
Food Procurement and Facility Gardens

**Policy:**

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

**Procedure:**

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

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

3. After harvesting, safe food handling practices will be followed for delivery to the kitchen.

4. The food and nutrition services staff will be responsible for handling harvested foods properly once they reach the kitchen. This includes safe storage, thorough cleaning, and appropriate handling for preparation, service and storage of leftovers.

**Note:** Check local and state regulations for any additional requirements.

**Source:**

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. Food and nutrition services staff will spot check temperatures of refrigerated and frozen foods upon delivery to assure safe food temperatures.

2. The delivery person will be directed to the food storage area where the items are to be unloaded:
   a. Review the delivery slip and check off all items, as they are unloaded. Count the number of cases, boxes, cartons, etc. of each item.
   b. If items are missing, bring it to the attention of the delivery person and have him/her sign both copies of the delivery slip stating that those items were not delivered.
   c. 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.
   d. Do not allow delivery people to inventory and restock items without supervision.

3. Staff will refuse to accept delivery of 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.
Food Storage

Policy:
Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry and free from contaminants. Food will be stored, 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 mold.
2. Storage rooms must have only one access door to the outside delivery area. 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 director of food and nutrition services or designee will control the keys to the storage rooms.
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.
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. 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 if required by state regulation.
   d. Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food should be consumed, sold, or discarded will be visible on all high-risk food.
   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 will be purchased in quantities that can be stored properly.
10. Food will be arranged in food groups in the storage areas to make it easier to store, locate and inventory.
11. Food will be 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.).
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 will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2013 Federal Food Code. (Also see policy on Use of Leftovers later in this chapter.) Check state regulations as state regulations may allow shorter time frames for use of leftovers.

14. Refrigerated food storage:
   a. All refrigerator units will be kept clean and in good working condition at all times.
   b. TCS (temperature control for safety) 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 Sample Freezer and Refrigerator Temperature Forms on the following pages.) 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 will be 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 Sample Freezer and Refrigerator Temperature Forms on the following pages.) 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 will be free from rodent and insect infestation.
Sample Freezer and Refrigerator Temperatures 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).

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<th>3 AM</th>
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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.

Policy & Procedure Manual  3-23
Sample Freezer and Refrigerator Temperatures Form 2

Unit: ___________________________ Month/Year: ___________________________

Take AM Temperatures at ____AM  Take PM temperatures at ____PM

<table>
<thead>
<tr>
<th>Day</th>
<th>AM Temp.</th>
<th>Corrective Action</th>
<th>Initials</th>
<th>PM Temp.</th>
<th>Corrective Action</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
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</table>

Adapted from Nutrition Alliance, LLC. Used with permission.
General Food Preparation and Handling

Policy:

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

Procedure:

1. The kitchen will be kept neat and orderly.
   a. The kitchen surfaces and equipment will be cleaned and sanitized as appropriate.

2. Food Storage
   a. Foods will be received, checked and stored properly as soon as they are delivered.
   b. Time/temperature control for safety food will be refrigerated or frozen except when being handled.
      • Food will be covered for storage.
      • Food will be cooked as soon as possible after defrosting.
   c. Food in broken packages or swollen or dented cans, cans with a compromised seal, or food with an abnormal appearance or odor will not be served.

3. Food Preparation
   a. Meats, fish and poultry will be 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 will be cooked or heated to a safe minimum internal temperature. (Refer to the Resource: Minimum Cooking, Holding Times and Reheating Temperatures later in this chapter.) A meat thermometer will be used 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 time/temperature control for safety foods shall be prepared from chilled products and refrigerated below 41° F IMMEDIATELY after preparation.
   d. No raw eggs will be served; eggs must be cooked completely. 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 will be 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 dish washer safe.
      • Cutting boards will be cleaned and sanitized after each use, following the dish machine or 3 compartment sink method, and will be air dried before storing.
   f. Raw, unprocessed fruits and vegetables should be thoroughly washed under clean, potable, running water before use.
   g. Bare hands should never touch ready to eat raw food directly.
   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. 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.
   j. Any food that is dropped on the floor must be discarded.
General Food Preparation and Handling

k. Tops of canned foods should be washed before opening.
l. The can opener will be cleaned and sanitized daily and/or as needed.

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: Minimum Cooking, Holding and Reheating Temperatures in this chapter.) Leftovers are not to be used as pureed food. Use leftovers within 7 days per 2013 Food Code or discard. Check state regulations for more detail.

5. Equipment
   a. All food service equipment should be cleaned, sanitized, air-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. Flatware will be stored in such a manner to encourage contact with handles only.
   e. Staff will 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. Tongs or other serving utensils will be used to serve breads or other items to avoid bare hand contact with food.

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.
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 foodborne illness.

Procedure:

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

2. Vegetables
   a. All raw vegetables will be 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. Overcooking and long holding times should be avoided.

3. Meats
   a. Meat will be 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: Minimum Cooking, Holding and Reheating Temperatures in this chapter 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 time/temperature control for safety 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 later in this chapter.)
Food Temperatures

Policy:

The temperatures of all food items will be taken and properly recorded prior to service of 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.
   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 to avoid the risk of burns.

2. All cold food items must be stored 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 holding and plating process and until food leaves the service area. (See Resources: Taking Accurate Temperatures and Minimum Cooking, Holding and Reheating Temperatures later in this chapter)

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. Food preparation and service areas will avoid the following methods:
   a. Holding foods in the temperature danger zone (41°F to 135°F).
   b. Using the steam table to heat foods.
   c. 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 unit storage areas 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.
(1) Microwave cooking and reheating:
   - When cooking temperature control for safety (TCS) 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.
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 easy to calibrate.
- 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.
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 $212^\circ F$ ($100^\circ C$) 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 $2^\circ F$ 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 $165^\circ$ to $180^\circ F$ or higher when removed from the cooking heat source. Assure a high enough holding temperature to maintain a temperature at or above $135^\circ F$ 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 $135^\circ F$ and cold foods stay below $41^\circ F$ during the serving process.
   - Maintain a cold enough holding temperature to assure foods are maintained at or below $41^\circ F$ until they leave the service area.
   - 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/wps/portal/fsis/topics/food-safety-education/teach-others/isodes-educational-campaigns/thermy/types-of-food-thermometers/CT_Index, May 18, 2017.
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 microorganisms can no longer survive and food is safe for consumption. Foods should reach the following internal temperatures.

Summary Chart for Minimum Cooking Food Temperatures and Holding Times

<table>
<thead>
<tr>
<th>Food</th>
<th>Minimum Temperature</th>
<th>Minimum Holding Time at the Specified Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw Eggs prepared for immediate service</td>
<td>145° F (63° C)</td>
<td>15 seconds</td>
</tr>
<tr>
<td>Commercially Raised Game Animals and Exotic Species of Game Animals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish, Pork, and Meat not otherwise specified in this chart or in 3-401.11 (B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Raw Eggs not prepared for immediate service</td>
<td>158° F (63° C)</td>
<td>&lt;1 second</td>
</tr>
<tr>
<td>Comminuted Commercially Raised Game Animals and Exotic Species of Game Animals</td>
<td>155° F (68° C)</td>
<td>15 seconds</td>
</tr>
<tr>
<td>Comminuted Fish and Meats</td>
<td>150° F (66° C)</td>
<td>1 minute</td>
</tr>
<tr>
<td>Injected meats</td>
<td>145° F (63° C)</td>
<td>3 minutes</td>
</tr>
<tr>
<td>Meats</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poultry</td>
<td>165° F (74° C)</td>
<td>15 seconds</td>
</tr>
<tr>
<td>Baluts</td>
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</tr>
<tr>
<td>Stuffed Fish; Stuffed meat; Stuffed Pasta; Stuffed Poultry: Stuffed Ratites</td>
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<tr>
<td>Stuffing Containing fish, Meat, Poultry, or Ratites Wild Game Animals</td>
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</tr>
<tr>
<td>Food Cooked in a Microwave Oven</td>
<td>165° F (74° C)</td>
<td>And hold for 2 minutes after removing from microwave oven</td>
</tr>
</tbody>
</table>

Source:
### Summary Chart for Minimum Food Temperatures and Holding Times for Reheating Foods for Hot Holding

<table>
<thead>
<tr>
<th>Food</th>
<th>Minimum Temperature</th>
<th>Minimum Holding Time at the Specified Temperature</th>
<th>Maximum Time to Reach Minimum Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-403.11(A) and (D) Food that is cooked, cooled, and reheated</td>
<td>165° F (74° C)</td>
<td>15 seconds</td>
<td>2 hours</td>
</tr>
<tr>
<td>3-403.11(B) and (D) Food that is reheated in a microwave oven</td>
<td>165° F (74° C)</td>
<td>and hold for 2 minutes after reheating</td>
<td>2 hours</td>
</tr>
<tr>
<td>3-403.11(C) and (D) Food that is taken from a commercially processed, hermetically sealed container or intact package</td>
<td>135° F (57° C)</td>
<td>No time specified</td>
<td>2 hours</td>
</tr>
</tbody>
</table>

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

**Source:**
Sample Food Temperatures Form

**Week of:**
Record food temperature PRIOR to service, and AGAIN after half of the meal has been served.

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eggs</td>
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<td>Pureed Hot Item</td>
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<table>
<thead>
<tr>
<th>Lunch</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
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Hot foods should be ≥ 165°F prior to tray line and ≥ 135°F through end of tray line. 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.
### Sample Critical Control Point Documentation 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.

<table>
<thead>
<tr>
<th>Critical Control Point (CCP)</th>
<th>1 Temperature/Time</th>
<th>2 Temp. °F</th>
<th>Actions to Resolve Problem Temperatures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Meal</td>
<td>Food Item</td>
<td>A</td>
</tr>
</tbody>
</table>

**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.
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, juice, milk, and other cold food items for meal service will be placed in the refrigerator at least 3 to 4 hours before serving. Food should be chilled to $\leq 41^\circ F$.
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 or system for icing cold foods down on the serving line 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 $\leq 41^\circ F$. 
Taste Testing

Policy:

All food will be taste-tested prior to serving.

Procedure:

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

2. Proper tasting procedure should be used: One spoon will be used 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 will not be served until the problem has been corrected.
Use of Leftovers

Policy:

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

Procedure:

1. Recipe will be calibrated to census 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 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. Food that is leftover will be handled as noted above and may be used as follows:
   a. Leftovers may be given as nourishments as allowed by diet order.
   b. Leftovers can be used if used within 7 days (day of preparation being day 1) according to the 2013 Federal Food Code and if reheated to 165°F for a minimum of 15 seconds for hot foods*.
   c. Leftovers are not to be used as pureed food.
   d. See state regulations for more guidelines.

Note: A leftover is any food that was prepared for service but was not served.
*Some state regulations may be more stringent. Check state regulations.
Food Allergies

Policy:

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

Procedure:

1. Food allergies will be identified during the resident 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 or allergies, allergies should be identified and documented in the medical record. Any food can cause an allergic reaction, so details are important. Questions should include whether the individual is allergic to any of the following eight foods which are known to be the cause of 90% of all food allergies:
   a. Eggs
   b. Fish (bass, flounder, cod, etc.): fish and shellfish cause the most allergic reactions
   c. Shellfish (shrimp, crab, lobster, etc.): shellfish and fish cause the most allergic reactions
   d. Milk
   e. Soy
   f. Peanuts cause the most severe allergic reactions. The individual allergic to peanuts is also advised to avoid tree nuts.
   g. 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.
   h. 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 resident identification for food allergy. For example, if state regulations allow, 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 food and nutrition services department will be notified of food allergies using standard facility diet communication upon admission to the facility. The diet order must include the primary diet order as well as a listing of all known food allergies.

6. When the nutrition and food service department receives the diet order, the allergies listed trigger the director of food and nutrition services or designee, or registered dietitian nutritionist (RDN) or designee to interview the individual and clearly identify and confirm all food allergies.

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

8. The director of food and nutrition services is responsible for training food and nutrition services 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 director of food and nutrition services 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 director of food and nutrition services 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.

Resource:
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 contamination. (See Cleaning Instructions: Ice Machines and Equipment in the Cleaning Instructions chapter of this manual.)

3. Ice that is used to keep foods cold or to cool foods will not be used for consumption.

4. Staff will wash hands prior to handling ice.

5. Ice will not be handled with bare hands, but rather with a sanitized scoop and container for transport and distribution.

6. Ice machines and containers will be cleaned and sanitized on a regular basis.
Personal Food Storage

Policy:

Food brought to the facility by family members or friends will be handled according to safe food handling guidelines. Designated staff will monitor foods and beverages brought in from outside sources for storage in facility pantries, refrigeration units, or personal room refrigeration units.

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. Foods and beverages brought in from outside sources that require refrigeration or freezing will be labeled with the patient/resident’s name and date and stored in the refrigerator/freezer on the nursing unit.

3. Food that can be stored at room temperature can be kept in a resident’s/patient’s room.

4. 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.)

5. 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).

6. 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 Sample Refrigerator and Freezer Temperatures Forms in this chapter of the manual).

7. Food can be reheated in a microwave. It should be stirred during the reheating process and reheated to at least 165° F for 15 seconds.

8. Reheated food should be cooled to a palatable temperature prior to eating to prevent burns.
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 passed the manufacturer’s expiration date will be discarded.
- Food or beverage items without a manufacturer’s expiration date should be dated upon arrival in the facility and thrown away 7* days after the date marked.
- Foods in unmarked or unlabeled containers should be marked with the current date the food item was stored and the resident’s /patient’s name.
- 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 director of food and nutrition services.

*Per 2013 Food Code. Please check state regulations as some state regulations may differ.

<table>
<thead>
<tr>
<th>Foods should be cooked to safe internal temperatures:</th>
<th>Foods should be stored at the appropriate temperature to maintain safety:</th>
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</thead>
<tbody>
<tr>
<td>• Ground meats: 155° F for a minimum of 15 seconds.</td>
<td>• Cold foods: Less than 41° F.</td>
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<tr>
<td>• Fish, pork and other meats: 145° F for a minimum of 15 seconds.</td>
<td>• Hot foods: Hold at 135° F or higher.</td>
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<tr>
<td>• Stuffed meat, poultry, fish or pasta: 165° F for a minimum of 15 seconds.</td>
<td>• Foods that are leftover should be stored promptly and cooled to 41° F or less within 4 hours.</td>
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<tr>
<td>• Eggs: 145° F if cooked for immediate service, 155° F if held for service.</td>
<td>• Foods that are leftover should be reheated to an internal temperature of 165° F for a minimum of 15 seconds.</td>
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<tr>
<td>• Food cooked in microwave: 165° F (and let stand for 2 minutes).</td>
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<tr>
<td>• Cooked food that is cooled and reheated: 165° F for a minimum of 15 seconds.</td>
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Providing Food and Supplies for Other Departments

Policy:

The food and nutrition services department will provide other departments with food, snacks, beverages, and/or supplies for activities and special occasions.

Procedure:

1. The department head will request food and supplies at least two weeks in advance of an occasion (see Sample Special Events Food/Meal Form on the next page).

2. The administrator will decide which department budget incurs the costs for events.

3. Foods for special meals and picnics that replace the usual meal are charged to the food and nutrition services department.

4. The food and nutrition services department can usually purchase food and supplies more economically from their purveyors. The food and nutrition service director will place orders and maintain records that indicate which department the purchase order is charged to.

5. The food and nutrition services staff will prepare food items for special meals and events.

6. Department heads and/or designated staff will assist nursing in bringing individuals to and from the special event site and then with serving food and beverages.

7. Clean up will be assigned or all staff will help with the cleanup.
Sample Special Events Food/Meal Form

Please submit all requests at least two weeks in advance of the scheduled event.

Request from (Name/Department) ____________________________________________

Date of Special Event ___________________________ Time ________________________

Special Event Description:

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<thead>
<tr>
<th>Meal</th>
<th>Buffet</th>
<th>Snack</th>
<th>Coffee/Tea</th>
<th>Other</th>
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<tr>
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<td>Salad:</td>
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<td>Starch/Bread:</td>
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<td>Dessert/Fruit:</td>
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Supplies Requested | Cost

| Dinnerware: | |
| Table Set up: | |
| Linens: | |
| Other: | |

Event Location:  Group Attending Event/Estimated Number Attending:  

Comments:  

Total cost for food/labor/supplies:  

Signature (Name/Title) ____________________________ Date: ________________
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 director of food and nutrition services will:
   a. Determine floor stock items and par levels to be delivered to each area.

2. The food and nutrition services staff will:
   a. Deliver floor stock items daily to the appropriate area, replenishing items according to predetermined levels.
   b. Record all stock items issued on the floor stock supply sheets (see Sample Floor Stock Supply Form on the next page).
   c. Rotate stock and remove outdated items.
   d. Check the temperatures of the refrigerators/freezers in the units daily, document temperatures, and actions taken for any inappropriate temperatures. (See Sample Refrigerator/Freezer Temperatures Form in this chapter.)
## Sample Floor Stock Supply Form

**Nursing Station** ____________ **Date** ____________ **Personnel** ____________

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<tr>
<th>Food Item</th>
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Preparer's Initials

**OH** = On Hand  
**D** = Delivered

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*Policy & Procedure Manual 3-47*

Food and Nutrition Services Problems/
Referral to the Director of Food and Nutrition Services

Policy:

Food and nutrition services issues and/or unusual incidents will be brought to the attention of the food and nutrition services manager in a timely manner.

Procedure:

1. Staff will notify the food and nutrition services manager of problems or unusual incidents via verbal and/or written communication.

2. Referrals may include, but are not limited to, problems with:
   a. Food quality
   b. Recipes
   c. Equipment
   d. Food preparation
   e. Sanitation
   f. Resident/patient food preferences, allergies, or intolerances
   g. Dining areas
   h. Meal delivery and/or service
   i. Food safety
   j. Food brought in by families or visitors
Reporting a Foodborne Illness (FBI)

Policy:

Facility staff will follow the proper procedure to report, investigate, document, and follow up on suspected or confirmed food borne illness outbreaks.

Procedure:

1. Staff will report any possible foodborne illness (FBI) incidents or outbreaks to the director of food and nutrition services. Potential concerns may come from a variety of sources including nursing staff, resident/patient, or a family member reporting symptoms.

2. The director of food and nutrition services or designee should document the following information:
   a. Date/time of complaint.
   b. Detailed report of possible FBI.
      • Person experiencing symptoms.
      • Details of symptoms, concerns or complaint related to possible FBI.
   c. Specific food suspected and any helpful details including:
      • Source of the food.
      • Condition in which food was received and stored.
      • Food handling procedures including timing (how quickly food was stored after receiving) and temperature logs of storage units.
      • Preparation and cooking processes, internal cooking temperature procedures, temperature logs for holding and service.
      • Procedures for cooling, handling leftovers, reheating for service, etc.
   d. Details on any other individuals reporting similar symptoms.
   e. Details on whether the incident was reported to the individual’s physician, whether the individual was hospitalized, and treatment provided.

If two or more people report FBI symptoms, it is considered an outbreak and the incident must be reported to the local health department. Contact information of the health department and facility staff, date reported, and detailed information of the report will be included in the report.

3. Any suspected food should be saved for testing by the health department and clearly labeled as potentially unsafe with a “do not use” label.

4. The director of food and nutrition services 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 (from 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.
   h. Assessing employee health concerns to assess presence of illness, cuts, infections, or sores that may be of issue related to FBI.

Policy & Procedure Manual 3-49
Reporting a Foodborne Illness (FBI)

i. Assuring proper use of sanitizer and sanitizing cloths.

j. Assuring access to clean water supplies, proper disposal systems, and proper wastewater 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 local health department (this may be the responsibility of the administrator, director of nursing, director of food and nutrition services, 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:
Food Safety: Preventing Burns

Policy:

Hot food and beverages will be served at a safe temperature that prevents burns.

Procedure:

1. Staff will monitor hot beverages and hot food temperatures on a regular basis at the point they are served.

2. Food will be cooked to safe food temperatures to prevent food borne illness.

3. Food will be held and plated at a minimum of 135°F, as per accepted food safety guidelines.

4. Food reheated in a microwave oven will be heated to 165° F, stirred at least once during the heating process to evenly distribute the heat, and then allowed to sit for 2 minutes prior to service to meet food safety guidelines. Care should be taken when serving microwave heated food to assure that it has been cooled enough to avoid burns (including burning the mouth) upon serving.

5. Hot beverages will be served at 160° F to 185° F, the optimum temperature for patient satisfaction.

6. Hot beverages will be handled carefully during food delivery and meal set-up in an attempt to avoid spills that could cause burns.

7. Appropriate supervision to obtain hot beverages and/or reheat foods in a microwave will be provided to any individual demonstrating decreased safety awareness and/or anyone who is at risk for burns or scalds based on clinical assessments.

8. Lap trays, slip guards, or cup holders on wheelchairs may be used to help hot liquids remain upright.

9. Residents/patients concerns about food and beverage temperatures will be addressed as needed.

The chart below shows the estimated time for persons to receive second and third degree burns at various temperatures.

<table>
<thead>
<tr>
<th>Water Temperature</th>
<th>Time to Receive Second Degree Burn</th>
<th>Time to Receive Third Degree Burn</th>
</tr>
</thead>
<tbody>
<tr>
<td>120° F</td>
<td>8 minutes</td>
<td>10 minutes</td>
</tr>
<tr>
<td>124° F</td>
<td>2 minutes</td>
<td>4.2 minutes</td>
</tr>
<tr>
<td>131° F</td>
<td>17 seconds</td>
<td>30 seconds</td>
</tr>
<tr>
<td>140° F</td>
<td>3 seconds</td>
<td>5 seconds</td>
</tr>
<tr>
<td>150° F</td>
<td>&lt; 1 second</td>
<td>1 second</td>
</tr>
</tbody>
</table>

Source:
Food Safety: Preventing Burns

Additional Sources:
Sanitation and Infection Control

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Policy:

All local, state and federal standards and regulations will be followed in order to assure a safe and sanitary department of food and nutrition services.

Procedure:

1. Food and Nutrition Services Department
   a. The department will be routinely inspected by the environmental health services of the local public health department, following their accepted standards and regulations. The director of food and nutrition services will have a copy of the applicable regulations on file, and should be familiar enough with this information to implement policies and procedures to meet those regulations.
   b. The food and nutrition services department will follow regulations as outlined by other official health agencies and organizations with jurisdiction over the facility.

2. Employees
   a. All staff will be in good health, will have clean personal habits and will use safe food handling practices.
   b. All staff should have physical exams (refer to facility’s policy manual) and a Mantoux test (tuberculin sensitivity test) prior to beginning employment. Thereafter, follow the facility policy for how often a physical exam and Mantoux test are required.
   c. Employees 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.
      • Refer to the facility’s personnel manual for facility dress code.
   d. Employees will wash their hands just before they start to work in the kitchen and after smoking, sneezing, using the restroom, handling poisonous compounds or dirty dishes, and touching face, hair, other people or surfaces or items with potential for contamination.
   e. Employees with symptoms of communicable diseases or open, infected wounds are not permitted to work in the kitchen.
      • Any employee that has a contagious illness (coughing, sneezing, diarrhea, vomiting or open wounds) will report to the supervisor immediately.
      • Any employee who has one of the following should report this illness to their supervisor immediately: Hepatitis A, E Coli, Norovirus, Salmonella, Nontyphoidal Salmonella, or Shigella.
      • Any employee 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. Employees are not permitted to use tobacco in any area of the kitchen at any time. The use of tobacco may result in contamination of food, equipment, utensils, or other items needing protection.

3. Food Purchasing
   a. All food will be purchased from sources that have been approved or are considered satisfactory by the local health department. Food must be clean, and free from spoilage when received after purchase.
      • Milk must be pasteurized.
Food Safety and Sanitation

- Eggs must be clean with shells intact. Pasteurized fresh, 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, with the exception of facility-grown produce that is properly handled (see Food Procurement and Facility Gardens in the Food Production and Food Safety chapter of this manual).
- Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used.

4. Food Storage (see Food Storage in the Food Production and Food Safety Chapter)
   a. Stored food is handled to prevent contamination and growth of pathogenic organisms.
      - Refrigerated food is stored at or below 41°F.
      - Frozen food is stored at a temperature that keeps them frozen solid.
      - Food is protected from contamination (dust, flies, rodents, and other vermin).
      - Food stored in dry storage is placed on clean racks at least 6 inches above the floor, 18” from the ceiling, and 2 inches from the wall (check state and local regulations for additional information).
      - The room should be clean, dry and cool, and between 50°F and 70°F.
      - Perishable ingredients should be refrigerated when they are not being used.
      - Poisonous and toxic materials including cleaning agents should be stored (and secured) outside the food storage area.
      - All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored.
      - When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food.
      - Leftovers are used within 72 hours (or discarded). Note: 2013 Federal food code 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 local and state regulations and determine which regulation should be followed.
      - Perishable food with expiration dates is used prior to the use by date on the package.
      - Canned and dry food without expiration dates are used within six months of delivery or according to the manufacturer’s guidelines.

Note: In order to assure that the nutritional 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 and Performance Improvement chapter of this manual for Sample Audit Forms.
Food Safety – Director of Food and Nutrition Services Responsibility

Policy:

The director of food and nutrition services will be responsible for providing safe foods to all individuals.

Procedure:

The director of food and nutrition services assures all of the following:

1. Sanitary conditions will be maintained in the storage, preparation and serving areas.

2. Dishwashing guidelines and techniques will be understood by staff and carried out in compliance with the state and local health codes.

3. Proper waste disposal methods will be used.

4. All refrigerated and frozen foods will be stored and handled properly. All dry and staple food items will be stored properly.

5. Employees will follow sanitary practices and good personal hygiene at all times.

6. Cleaning schedules will be posted and followed.

7. Employees will follow proper cleaning and sanitizing instructions for all kitchen equipment.

8. Employees, when hired will have a medical report from their physician, including a yearly Mantoux test. Personnel having or suspected of having infections will not be permitted to work.

9. The director of food and nutrition services or designee will conduct regular inspections to assure proper food handling.

10. All HACCP procedures will be followed.
Employee Sanitary Practices

Policy:

All nutrition and food service employees will practice good personal hygiene and safe food handling procedures.

Procedure:

All employees will:

1. Wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food. Note: This does not apply to 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, using posted hand-washing procedures.

3. Keep finger nails clean and neat. Acrylic or painted nails must be covered when handling or serving food. (Note: Some facilities do not allow acrylic or painted nails.) Gloves must be worn if raw food is handled.

4. Keep jewelry to a minimum. Only a plain band ring such as a wedding band can be worn. Facial piercings should be removed or covered. Medical alert bracelets may not be worn per the 2013 Federal Food Code.

5. Use utensils to handle food, avoiding bare hand contact with food.

6. Avoid touching mouth or face while preparing food (and wash hands if contaminated).

7. Use clean cloths when handling hot utensils.

8. Use clean spoons when tasting food.

9. Clean and sanitize equipment and work areas after use.

10. Use these guidelines in handling clean dishware, glasses and flatware:
   a. Have clean hands.
   b. Pick flatware and cups up by their handles.
   c. Pick dishes up by their rims.
   d. Pick glasses up by their base.
   e. Store clean dishes inverted, in enclosed cabinets or storage units.
   f. Store glasses and cups on a clean, sanitary surface - bottoms up.

Note: Follow all federal, state and local requirements.
Authorized Personnel in Food Service Department

Policy:

The food and nutrition services department is restricted to department employees.

Procedure:

1. Only food and nutrition services personnel are allowed in the kitchen, including food preparation and food service areas and dish room.

2. Signs indicating “Food and Nutrition Services 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 director of food and nutrition services or designee will be responsible for enforcing this requirement.

5. Note: The registered dietitian nutritionist (RDN) and nutrition dietetics technician, registered (NDTR), maintenance, and delivery personnel are exceptions to this policy.
General Sanitation of Kitchen

Policy:

Food and nutrition services staff will 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 outlined in a written cleaning schedule.

2. Tasks will be assigned to be the responsibility of specific positions.

3. Frequency of cleaning for each task will be defined.

4. Method and materials/cleaning compounds to be used for cleaning/sanitizing will be written for each task.

5. Employees will be trained on how to perform cleaning tasks.

6. On the cleaning schedule employees will initial and date tasks when completed. (Refer to the Sample Cleaning Schedule and Sample Cleaning Forms in the Cleaning Instructions chapter of this manual.)

7. Employees will wear rubber gloves and an apron to protect hands and clothing while cleaning the kitchen. Protective eyeglasses will be worn as appropriate.

8. The Safety Data Sheets (SDS) will be available for all chemicals used by the food and nutrition services staff. Employees will be inserviced on the proper use of chemicals and SDS Sheets.

Resource:
Hand Washing

Policy:

Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures (and surrogate prosthetic device washing procedures as appropriate). Hand washing facilities will be readily accessible and equipped with hot and cold running water, paper towels, soap, trash cans and signage outlining hand washing procedures. If chemical sanitizing gels are used, staff must first wash hands as outlined below.

Procedure:

Clean hands and exposed portions of arms (or surrogate prosthetic devices) immediately before engaging in food preparation.

1. When to wash hands:
   a. When entering the kitchen at the start of a shift.
   b. After touching bare human body parts other than clean hands and clean, exposed portions of arms.
   c. After using the restroom.
   d. After caring for or handling service animals or aquatic animals.
   e. After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking.
   f. After handling soiled equipment or utensils.
   g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks.
   h. When switching between working with raw food and working with ready to eat food.
   i. Before donning gloves for working with food.
   j. After engaging in other activities that contaminate the hands.

2. How to wash hands:
   a. Turn on the faucet using a paper towel to avoid contaminating the faucet.
   b. Wet hands and forearms with warm water (minimum 110°F) and apply an antibacterial soap.
   c. 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.
   d. Rinse thoroughly.
   e. Dry hands with paper towel. Turn the faucet off with the paper towel, use a hand blow dryer.
   f. Use the towel to open the door if needed, and then discard the towel.

3. Staff will be educated on the importance of hand washing and retrained and reminded as necessary on the above philosophy/guidelines.

4. Hand washing procedures will be posted by each hand washing sink.

5. Food preparation and/or pot sinks will be not used for handwashing.

Resource:
Poster on How to Wash Hands from the World Health Organization:
Hand Antiseptic

Policy:

Hand antiseptic or antimicrobial gel 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. Hand antiseptic cannot be used in place of proper hand washing technique in a food service setting.

Procedure

1. Hand antiseptic must comply with 2-301.16 (A) of the 2013 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 may be used after hand washing, and between hand washing as long as hands are not soiled.

3. Hand antiseptic use should be limited to situations where direct contact of food with bare hands does not occur.

4. To use hand antiseptic: 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:

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 will 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 or antiseptic gel is not used in place of proper hand washing techniques.

2. Staff will use clean barriers such as single-use gloves, tongs, deli paper and spatulas when handling food.

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 (before beginning work with food).

5. Clean barriers such as single-use gloves are to be used when:
   b. Handling raw meat, poultry, raw eggs, fish and shellfish.
   c. Preparing foods such as meatloaf or meat salads.
   d. Hand tossing salad, mixing coleslaw, potato or macaroni salad.
   e. Bagginc bread or cookies.
   f. Removing frozen foods from boxes.
   g. 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 changed.
   a. After coughing or sneezing into hands, using a handkerchief or tissue, using tobacco or touching hair or face.
   b. After handling garbage or garbage cans.
   c. After handling soiled trays or dishes.
   d. After handling anything soiled.
   e. After handling boxes, crates or packages.
   f. After picking up any item from the floor.
   g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks.
   h. When switching between working with raw food and working with ready-to-eat food.
   i. After engaging in other activities that may possibly contaminate the hands with bodily fluids.
   j. After using the rest room.
   k. After caring for or handling service animals or aquatic animals.
   l. Anytime a contaminated surface is touched.

7. Wash hands after removing the gloves.
Cleaning Dishes/Dish Machine

Policy:

All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing.

Procedure:

Staff will follow the following procedures for washing dishes:

1. Prior to use, verify proper temperatures and machine function. Confirm that soap and rinse dispensers are filled and have enough cleaning product for the shift.

2. The person loading dirty dishes will not handle the clean dishes unless they change into a clean apron and wash hands thoroughly before moving from dirty to clean dishes.

3. Dishes should be scraped into a wastebasket and/or garbage disposal. Refer to garbage disposal manufacturer’s instructions to determine what foods can be placed in the garbage disposal.

4. Dishes should be rinsed in the sink, using hot, soapy water if needed. Pots and pans should be scrubbed with a non-metallic scouring pad when necessary, and rinsed in sink.

5. Dishwasher safe items should be loaded into the dishwasher racks, avoiding overloading and nesting.

6. Flatware should be pre-soaked prior to washing, and loaded into cylinders with mouthpiece exposed. Flatware should be washed twice, with the mouthpiece down during the second washing. Flatware should not be nested prior to washing in cylinders.

7. Dish racks should be loaded into dishwasher. Detergent should be added according to manufacturer’s directions. Controls should be set for operation of the dish machine. Press the start button and allow the dishwasher to run full cycle, following 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. Dishes should be air dried on the dish racks. Do not dry with towels.

10. Inspect for cleanliness and dryness, and put dishes away if clean (be sure clean hands or gloves are used).

11. Dishes should not be nested unless they are completely dry.

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).
## Resource: Sanitation of Dishes/Dish Machine

<table>
<thead>
<tr>
<th>Type of Dish Machine</th>
<th>Wash Temperature</th>
<th>Final Rinse Temperature or Sanitization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Temperature Dishwasher</strong></td>
<td>150 to 165° F</td>
<td>180° F</td>
</tr>
<tr>
<td><strong>Spray Type Dish Machines Using Hot Water to Sanitize</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stationary rack, single temperature machine</td>
<td></td>
<td>165° F</td>
</tr>
<tr>
<td>• Stationary rack, dual temperature machine</td>
<td></td>
<td>150° F</td>
</tr>
<tr>
<td>• Single tank, conveyor, dual-temperature machine</td>
<td></td>
<td>160° F</td>
</tr>
<tr>
<td>• Multi-tank, conveyor, multi-temperature machine</td>
<td></td>
<td>150° F</td>
</tr>
<tr>
<td><strong>Low Temperature Dishwasher</strong></td>
<td>120° F</td>
<td>50 PPM Hypochlorite</td>
</tr>
<tr>
<td><strong>Spray Type Dish Machines Using Chemicals to Sanitize</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mechanical Dish Machine Using Hot Water to Sanitize</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hot water sanitizing rinse as it enters the manifold may not be more than or less than</td>
<td>194° F</td>
<td></td>
</tr>
<tr>
<td>• For a stationary rack, single temperature machine</td>
<td>165° F</td>
<td></td>
</tr>
<tr>
<td>• For all other machines</td>
<td>180° F</td>
<td></td>
</tr>
</tbody>
</table>

**Sources:**
Dish Machine Temperature Log

Policy:

Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes.

Procedure:

The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures. (See Sample Dish Machine Temperature and Sanitizer Log Form on the next page.)

1. Staff will monitor dish machine temperatures throughout the dishwashing process.

2. Staff will record dish machine temperatures for the wash and rinse cycles at each meal.
   a. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures.

3. Staff will be trained to report any problem with the dish machine to the director of food and nutrition services as soon as they occur.

4. The director of food and nutrition services will promptly assess any dish machine problems and take action immediately to assure proper sanitation of dishes.
Sample Dish Machine Temperature and Sanitizer Log Form

Facility: ___________________________  Month: ___________  Year: ___________

<table>
<thead>
<tr>
<th>Date</th>
<th>Meal</th>
<th>Wash</th>
<th>Final Rinse</th>
<th>Sanitizer Concentration (PPM)</th>
<th>Thermal Strip</th>
<th>Corrective Action If needed</th>
<th>Initials</th>
</tr>
</thead>
</table>

Directions:
Insert dish machine instructions here:

Temperature Standards for 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 inappropriate temperatures or sanitizing issues to the supervisor immediately for corrective action.
## Resource: Dish Machine Problems and Solutions

<table>
<thead>
<tr>
<th>Problems</th>
<th>Reasons</th>
<th>Possible Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale in machine</td>
<td>Water hardness</td>
<td>Soften water</td>
</tr>
<tr>
<td></td>
<td>Wrong kind or amount of detergent</td>
<td>Select detergent better for your situation (consult supplier) De-lime the machine</td>
</tr>
<tr>
<td>Greasy film</td>
<td>Poor cleaning guidelines; Water not hot enough</td>
<td>Improve job of cleaning Check that wash and rinse cycle temperature is appropriate</td>
</tr>
<tr>
<td></td>
<td>Not enough detergent</td>
<td>Use additional detergent</td>
</tr>
<tr>
<td>Cloudy film on glasses; dirty soap film on dishes</td>
<td>Final rinse jets clogged</td>
<td>Be sure jets are clean and that the spray reaches all dishes Be sure scrap traps are emptied and cleaned often</td>
</tr>
<tr>
<td>Water spots and film on glasses and dishes</td>
<td>Too short a rinse time</td>
<td>Lengthen time: If time is too short, soil is not removed</td>
</tr>
<tr>
<td></td>
<td>Pressure of rinse</td>
<td>Adjust pressure: If pressure is too low, the rinse is poor If pressure is too high, dishes tend to fog</td>
</tr>
<tr>
<td></td>
<td>Water hardness</td>
<td>Soften water</td>
</tr>
<tr>
<td></td>
<td>Drying time</td>
<td>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</td>
</tr>
</tbody>
</table>

**Sources:**
Maintenance of Dish Machine

Policy:

The dish machine will be maintained to assure proper functioning.

Procedure:

1. The dish machine will be regularly cleaned and de-limed according to manufacturer’s instructions.

2. The dish machine should be cleaned at least once per week, following manufacturer’s instructions. General guidelines are as follows:
   a. Turn the heat off on the wash and rinse tanks, and drain the water from the tanks.
   b. Remove any removable parts, and any loose food particles from the scrap traps.
   c. Check and clean the final rinse sprays if needed.
   d. Close the tank drain, refill the tank, flush out the pump and lines, running machine at least one minute, and then drain.
   e. Replace the scrap traps, wash and rinse the removable parts.
   f. Leave all the doors open.
   g. Clean and refill the detergent dispenser.
   h. Check the filler opening, final rinse, and pump for leaks.
   i. 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.
Cleaning Dishes - Manual Dishwashing

Policy:

Dishes and cookware will be cleaned and sanitized after each meal.

Procedure:

1. Scrape dishes into a clean wastebasket and/or garbage disposal.

2. Rinse dishes off and stack them carefully. Pre-soak as needed.

3. Clean and sanitize sinks prior to beginning. Prepare sinks according to the chart below. Place a few dishes at a time into the sink. Clean 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.

4. After dishes are done, clean and sanitize sinks and faucets.

5. Check sanitation sink often using a test strip to assure the level of sanitizing solution is appropriate. Follow chemical manufacturer’s guidelines to prepare sanitizing solution.

<table>
<thead>
<tr>
<th>Sink 1: Wash</th>
<th>Sink 2: Rinse</th>
<th>Sink 3: Sanitize</th>
</tr>
</thead>
</table>
| 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 at 110°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.  
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). Water should be 75 to 100°F.  
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:

<table>
<thead>
<tr>
<th>Disinfectant</th>
<th>Strength</th>
<th>Minimum Temperature</th>
<th>Contact Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot Water</td>
<td>N/A</td>
<td>171°F</td>
<td>30 seconds</td>
</tr>
<tr>
<td>Chlorine</td>
<td>50 to 100 PPM</td>
<td>75°F</td>
<td>10 seconds</td>
</tr>
<tr>
<td>Quaternary Ammonium</td>
<td>150 to 200 PPM</td>
<td>75°F</td>
<td>Per manufacturer</td>
</tr>
<tr>
<td>Iodine</td>
<td>12.5 PPM</td>
<td>75°F</td>
<td>30 seconds</td>
</tr>
</tbody>
</table>


Policy & Procedure Manual 4-16
Chlorine Solutions
Chlorine solutions must have a minimum temperature based on concentration and pH of the solution.

<table>
<thead>
<tr>
<th>Minimum Concentration Mg/L</th>
<th>pH 10 or Less</th>
<th>pH 8 or Less</th>
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</thead>
<tbody>
<tr>
<td>25</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>50</td>
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<td>75</td>
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<tr>
<td>100</td>
<td>55</td>
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</tbody>
</table>

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

Handling Clean Equipment and Utensils

Policy:

Clean equipment and utensils will be handled properly to prevent contamination.

Procedure:

1. When handling cleaned and sanitized equipment, staff will avoid touching the parts that will come in contact with the food.

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 and utensils will be handled by the hand piece only.
Bedside Water Containers

Policy:

The facility will provide patients/residents with fresh drinking water at their bedside daily.

Procedure:

1. Each patient/resident should have two complete water container sets for water at the bedside.

2. Night shift staff will be responsible for collecting used water containers and replacing clean water containers, filled with fresh water and ice on a daily basis.

3. Soiled water containers will be taken to the food and nutrition services department dish room to be cleaned and sanitized the next day.

4. Clean water containers will be returned to the unit the following day.

5. Clean water containers will be stored inverted in a designated location 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 needs of each patient/resident. If this method is used, bottles are recycled. If styrofoam containers are used, they are replaced daily.
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. Floors, walls, shelves and other storage areas will be kept clean.

3. 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. Smoking will not be allowed in storage rooms.

6. Storerooms must be well lighted.

7. Storerooms will be treated for pests and vermin on a regular schedule.

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 will be present in the storeroom, and will be monitored on a regular basis.

10. Grain products, dried vegetables and broken lots of bulk food will be stored in labeled containers with tight-fitting covers.

11. Poisonous and toxic material will be stored outside the food storage and preparation area or in cabinets 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. Staff will maintain care of the storeroom according to the following directions.
   a. All food will be arranged in the storeroom logically, with similar foods stored together.
   b. Canned and dry foods should be labeled with date of receipt so that they will be used within six months of delivery (or according to manufacturer’s guidelines). New stock will be placed behind previously-delivered items so that older stock will be issued first.
   c. Refrigerated and frozen foods will be dated upon delivery. Foods with expiration dates are used prior to the date on the package. New stock will be placed behind previously delivered items so that older stock will be used first.
   d. The storeroom will be cleaned on a regular basis. Floors will be swept and mopped at least weekly and more often as needed. Refer to the Sample Cleaning Schedule in the Cleaning Instructions chapter of this manual for details.
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 will be cleaned and sanitized at least monthly, and/or as needed. Inside and outside of machine and the area around the machine will be cleaned.

2. Ice scoops will be stored outside of the ice dispenser in a closed, clean container. Ice scoops will be cleaned and sanitized daily.

3. Ice will be dispensed into properly cleaned and sanitized receptacles.

4. Ice scoops will be used to dispense ice. Ice will be 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 refer to Cleaning Ice Machines and Equipment in the Cleaning Instructions chapter of this manual.
Isolation Meals

Policy:

Meals, dishes and utensils will be handled properly to prevent contamination. Universal precautions will be followed.

Procedure:

1. Nursing staff will inform the director of food and nutrition services 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 patient/resident.

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.
Isolation Meals

Insert facility’s isolation meal policy here.
Clean-up Procedures for Vomit/Fecal Accidents

Policy:

The 2016 Ohio Uniform Food Safety Code requires that all food service operations and retail food establishments have written procedures for employees to follow when responding to vomiting and diarrheal events.

Note: Effective cleaning of vomitus and fecal matter in a food service operation or retail food establishment should be handled differently from routine cleaning procedures.

Procedure:

Vomiting and diarrheal accidents should be cleaned up using the following recommended steps:

1. Segregate the area.

2. Wear disposable gloves during cleaning. To help prevent the spread of disease, it is recommended that a disposable mask and/or cover gown (apron) be worn when cleaning liquid matter.

3. Wipe up the matter with towels and dispose into a plastic garbage bag.

4. Use the recommended U.S. Environmental Protection Agency (EPA) registered disinfectants effective against Norovirus (Norwalk-like virus) following label directions or mix a chlorine bleach solution that is stronger than the chlorine solution used for general cleaning [the Centers for Disease Control and Prevention recommends 1000 to 5000 ppm or 5 to 25 tablespoons of household bleach (5.25%) per gallon of water]. Note: quaternary ammonia is not an effective sanitizer for Norovirus.

5. Apply the bleach solution and allow it to remain wet in the affected area for at least 10 minutes. Allow to air dry. Dispose of any remaining sanitizer solution once the accident has been cleaned up.

6. Discard gloves, mask, and cover gown (or apron) in a plastic bag.

7. Take measures to dispose of and/or clean and disinfect the tools and equipment used to clean up vomit and fecal matter.

8. Properly wash hands.

9. Discard any food that may have been exposed.

10. Food contact surfaces that have been disinfected must be washed, rinsed, and sanitized prior to use.

11. Minimize the risk of disease transmission through the prompt removal of ill employees, customers and others from areas of food preparation, service, and storage.

Additional references:
Clean-up Procedures for Vomit/Fecal Accidents

Kitchen Cloths

Policy:

Kitchen cloths will be clean and available as needed.

Procedure:

1. An adequate supply of clean kitchen cloths will be available, allowing a clean cloth for each task.

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 will not be used to dry dishes, cups, glasses, flatware, utensils or cooking equipment. These items must be cleaned, sanitized, rinsed, and air dried.

6. Cloths that are used for cleaning countertops and other surfaces should be stored in sanitizing solution between uses. (See Cleaning Cloths, Pads, Mops and Buckets in the Cleaning Instructions chapter of this manual.)
Waste Disposal

Policy:

Garbage will be disposed of and as needed throughout the day and at the end of each day.

Procedure:

1. Prior to disposal, all waste shall be kept in leak-proof, non-absorbent, fireproof containers that are kept covered when not in use.

2. Containers will be emptied as often as necessary throughout the day and at the end of each 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:
   a. Rinse the can and lid with cold water.
   b. Wash/scrub the can and lid, inside and out with hot soapy water.
   c. Rinse the can and the lid with water.
   d. Sanitize the can and lid with prepared sanitizing solution.
   e. Invert to drain and air dry.
   f. Fit the can with clean plastic liners and return to the kitchen.
   g. Report any leaks, cracks or dents in the can or lid to the director of food and nutrition services or designee.
Pest Control

Policy:

Routine pest control procedures will be in place. If pests are seen in the kitchen, the director of food and nutrition services or designee 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. A pest control contractor will complete preventative treatments at prescheduled appointed times.

2. If a pest situation is reported, the contractor will be notified and may be requested to make an unscheduled visit to address concerns.

3. The contractor will document all visits along with actions taken.

4. During pest control treatment, 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 will chemically treat the kitchen only after receiving consent from the food service manager.

6. Pest traps will be monitored every shift and disposed of according to the contractor's specifications.
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- Sample Cleaning Schedule .................................................................................. 5-2
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Cleaning and Sanitation of Dining and Food Service Areas

Policy:

The nutrition and food services 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 director of food and nutrition services will determine 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. Staff will be trained on the frequency of cleaning as 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 Schedule 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.
# 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
<table>
<thead>
<tr>
<th>Item</th>
<th>Responsible Party</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
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<th>Sat</th>
<th>Sun</th>
<th>DFNS</th>
</tr>
</thead>
</table>

DFNS = Director of food and nutrition services or designee (initial here after checking to assure work was done satisfactorily)
### Sample Weekly Cleaning Schedule Form

<table>
<thead>
<tr>
<th>Item</th>
<th>Responsible Party</th>
<th>Week 1</th>
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DFNS = Director of food and nutrition services or designee (initial here after checking to assure work was done satisfactorily)
Sample Monthly Cleaning Schedule Form

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Director of food and nutrition services or designee: Check to assure work was done satisfactorily.
## Resource: Infection Control Cleaning Agents

Agents used are:

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:

Safety Data Sheets (SDS) 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.
Safety Data Sheets

Policy:

Staff will be trained on the safe use of chemicals. Safety Data Sheets (SDS) will be readily available for staff use.

Procedure:

1. The director of food and nutrition services will arrange for staff to be inserviced on any chemicals in use in the department at orientation, at least yearly and more frequently if changes are made.

2. The SDS will be readily available to staff for reference in an easily accessible location in the kitchen/dish room area.

3. Staff will be trained on what to do in an emergency when the chemicals injure someone in the department.

4. SDS sheets will be updated any time the manufacturer makes revisions. The director of food and nutrition services should check for changes in SDS sheets routinely for quality assurance and safety purposes.

5. Staff will be informed of changes in the SDS sheets as they occur.
Cleaning Instructions: Broilers

Policy:

Broilers will be cleaned on a regular basis and cared for in a way to maintain optimum production.

Procedure:

1. Cool broiler 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).

4. Sanitize the broiler and grills. Air dry.

5. Reassemble the broiler to prepare it for the next use.

Note: Follow manufacturer’s cleaning and sanitizing instructions if available.
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 and as needed when spills occur.

Procedure:

1. Remove food, utensils, equipment, and other articles from cabinets and drawers.
2. Remove drawers, if possible.
3. Clean with a clean cloth soaked in mild detergent and water.
4. Sanitize.
5. Air dry.
6. Clean and sanitize, or wipe off articles if needed before replacing.
7. Replace drawers, food, utensils, and other articles.

Note: Shelf liner should not be used in drawers, cabinets or on storage shelves.
Cleaning Instructions: Can Opener

Policy:

The can opener will be cleaned after each use.

Procedure:

1. Use the following procedure for cleaning hand held can openers:
   a. Remove the can opener shaft from the base.
      • Clean in the sink filled with soapy water. Pay special attention to the blade and moving parts.
      • Rinse
      • Sanitize
      • Air dry
   b. Clean the base thoroughly with hot detergent water. Be sure to remove all food particles from the blade and base.
      • Sanitize
      • Air dry
      • Reassemble

2. Use the following procedure for cleaning electric can openers:
   a. Unplug the appliance.
   b. 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, clean and sanitize thoroughly.
   c. Air dry
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.
   a. Cleaning cloths should be kept in a container of clean sanitizing solution between uses.
   b. The sanitizing solution will be tested periodically 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. Fresh mop heads will be used each day.

3. Mop buckets and wringers will be washed out after each use, and stored inverted to allow for proper drainage. Mops, wringers and buckets will be stored in an appropriate area away from food and food preparation.

4. Mops should be hung inverted between uses, and stored separately from food areas.
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.

Procedure:

Coffee Machines:
1. Rinse the coffee maker with clear hot water.
2. Use baking soda or urn cleaner to clean the liner, gauges, faucets, and glass pots.
3. Rinse 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. Clean gauges 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.

Note: Follow manufacturer’s cleaning and sanitizing instructions if available.

Beverage, juice, frozen yogurt and ice cream machines:
1. Follow the manufacturer’s cleaning and sanitizing instructions.
Cleaning Instructions: Counter Space

Policy:

Counter space will be cleaned and sanitized prior to and following food preparation and meal service, and as needed.

Procedure:

1. Clean spills as needed using a clean cloth and warm water.

2. To sanitize:
   a. Remove small appliances and other items from the counter.
   b. Wipe off debris.
   c. Spray the counter with sanitizing solution and wipe with a clean cloth.
   d. Wipe the outer surfaces of small appliances.
   e. Allow countertops and small appliances to air dry.
   f. Store cleaning cloths in sanitizing solution between uses.
Cleaning Instructions: Cutting Boards

Policy:

Cutting boards will be cleaned and sanitized after each use. Acrylic cutting boards, not wooden boards, will be used for cutting foods. Separate cutting boards will be 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.
Cleaning Instructions: Floors, Tables and Chairs

Policy:

Kitchen and dining room floors, tables and chairs will be cleaned and sanitized regularly.

Procedure:

1. Sweep and clean kitchen floors after each meal. Sanitize at least once daily. Move major appliances at least once a month (as appropriate) in order to facilitate cleaning behind and underneath them.

2. Vacuum carpeted areas after each meal. Clean carpets as needed to maintain a healthy and clean atmosphere.

3. Clean and sanitize dining room tables after each meal.

4. Wipe dining room chairs (as needed) after each meal using a clean cloth and clean, hot soapy water. Brush off or vacuum cloth covered chairs.

5. Clean dining room chairs (wooden or metal legs, arms, etc.) at least once a week (or more often as needed) and sanitize daily using a sanitizing solution.
Cleaning Instructions: Food Carts

**Policy:**

Food carts will be cleaned and sanitized immediately after each use.

**Procedure:**

1. Clean and sanitize the inside and outside of each food cart daily.
2. Clean the wheels on the food carts as needed.
3. Polish the outside of the food carts with stainless steel polish on occasion if applicable.
4. Clean food carts at least weekly (preferably daily) in a designated area using a power washer as available.
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. Clean, sanitize, 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 and sanitizing.
Cleaning Instructions: Freezers

Policy:

Freezers will be defrosted as needed (when frost is greater than or equal to ¼ inch thick, the freezer should be defrosted), or per the manufacturer’s instructions.

Procedure:

1. Remove all food from the freezer. Store 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. Clean 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 for cleaning and sanitizing, or if unavailable, follow steps 4 thru 7.
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 free from clogs and running freely.
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.
5. Check with the maintenance department on the proper disposal of used oil. Do not pour oil down the sink drains.

Note: Follow manufacturer’s instructions for cleaning and sanitizing if available.
Cleaning Instructions: Garbage Disposals

**Policy:**

Garbage disposals will be cleaned at least once per week, and more often if needed with 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. Clean the disposal and surrounding area with detergent solution.
5. Rinse with sanitizing solution.

**Note:** Follow manufacturer’s instructions for cleaning and sanitizing if available.
Cleaning Instructions: Hoods and Filters

Policy:

Stove hoods and filters will be cleaned according to a 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. Air dry screens after cleaning.

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 and sanitizing if available.
Cleaning Instructions: Ice Machine and Equipment

Policy:

Ice machine and equipment (scoops and receptacles that are used to hold or transport ice) will be cleaned and sanitized on a regular basis.

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 daily. Rinse and allow to air dry. Clean the area underneath and around the machine.

7. Clean and sanitize the ice scoop and other ice receptacles daily or as needed in the dishwasher and allowed to air dry.

8. Store 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.
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. Clean, rinse, sanitize trays or shelves 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.
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.

Note: Follow manufacturer’s cleaning and sanitizing instructions if available.
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 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 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, follow the manufacturer's cleaning and sanitizing instructions if available.

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.
Cleaning Instructions: Ranges

Policy:

The cook/chef 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 surfaces 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.
Cleaning Instructions: Refrigerators

Policy:

The refrigerators will be cleaned 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 occur.

Procedure:

1. Remove all food from the refrigerator. Store food in another refrigerator or cooler until the refrigerator is cleaned.

2. Remove shelves, drawers and other removable parts. Wash the parts in the sink using the hand dishwashing method.

3. Clean 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 facility 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.
Cleaning Instructions: Slicers

Policy:

The slicer will be cleaned and sanitized after each use.

Procedure:

1. Turn off the machine and disconnect 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. Clean all removable parts in the pot and pan sink.
6. Sanitize all removable parts in a chemical sanitizer, immersing for the appropriate amount of time to sanitize.
7. Wear safety gloves when cleaning the slicer blade.
8. Carefully clean the remaining parts with hot detergent water, rinse and dry. Pay special attention to any moveable parts, being very careful when cleaning blade.
9. Reassemble and cover the machine.
10. Clean 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. Follow manufacturer’s cleaning and sanitizing instructions if they are available.
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 clean according to the guidelines for pots and pans. Send the serving pans through the dish machine for final cleaning, rinsing, and sanitizing 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. Sanitize surfaces that might come in contact with food or utensils.

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.
Cleaning Instructions: Toasters

Policy:

Toasters 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 clean in warm soapy water. Rinse, and sanitize. Allow to air dry.
4. Move the toaster and clean and sanitize the counter surface underneath.
5. Clean the outside with appropriate cleaner and sanitize. Air dry.
6. Replace the crumb tray.

Note: Follow manufacturer’s cleaning and sanitizing instructions if available.
Safety

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Safety Guidelines

Policy:

Safety is an important aspect of food service. The food and nutrition services department will be supplied with safety equipment, including appropriate signage and protective work gear. Staff will be trained on safety precautions to maintain a safe working environment. Safe procedures will be followed in daily work routines and equipment operations to help prevent accidents.

Procedure:

1. Staff will be well-trained on general safety guidelines and precautions.

2. The director of food and nutrition services will stress safe techniques during the orientation of new employees, and on a daily basis with all employees. For example:
   a. Instructions for safe equipment operation should be readily available. Staff should be trained to ask for help if they are not sure how to use a piece of equipment. Equipment should meet standards set by the National Sanitation Foundation.
   b. Hot equipment should be handled carefully to guard against burns. Pot holders should be used to handle hot pots and pans. Handles of pans should be turned away from the edge of the stove to prevent accidental spilling. Appliances should be turned off immediately after using.
   c. Chipped or cracked glassware and dishes should be discarded.
   d. Spills on the floor should be wiped up immediately to help prevent falls. All personnel should observe warning signs, such as “wet floor” signs.
   e. Heavy boxes should be lifted properly to prevent injury but squatting rather than bending over. Two or more employees should lift heavy articles when necessary, or lifting equipment used as needed.
   f. Gloves will be required when using bleach, oven cleaner, abrasive cleaner, or other harsh chemicals. Safety glasses will be required as recommended by chemical SDS or equipment manufacturer's instructions.
   g. Steady, sturdy stepladders, not boxes or chairs should be used to reach for items. Swinging doors should be approached with caution.
   h. Appropriate cleaners should be used to avoid slippery areas on the floors. Use “wet floor” signs in appropriate areas to avoid falls.
   i. Employees should walk, not run, in the kitchen, dining, and storage areas. Flat shoes with skid guard (rubber) soles and closed toes are required.
   j. Traffic areas will be free from debris and clutter.

3. Equipment should be kept in proper working order. Malfunctions should be reported to the director of food and nutrition services immediately.
   a. Employees should be familiar with work procedures and safe practices to be followed.
   b. Employees should immediately report any unsafe conditions to the director of food and nutrition services.
      • 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 director of food and nutrition services.
      • Accidents, injuries, burns, cuts, sores, respiratory or gastrointestinal infections should be reported to the director of food and nutrition services and an incident form completed. Injured employees or visitors will receive immediate medical attention.

4. Staff should be trained on the safety data sheets (SDS) for the chemical products in use in the facility.

5. Fire safety procedures will be followed if a kitchen or facility fire occurs.
Safe Water Temperatures

Policy:

Food service water temperatures will be safe for employees, patients/residents, and guests.

Procedure:

1. Water temperatures will be monitored and logged in all food and dining areas accessible to employees, patients/residents as part of routine facility maintenance.

2. Hot beverages and food temperatures will be monitored on a regular basis to assure appropriate temperatures at the point of service.

3. Supervision will 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.

<table>
<thead>
<tr>
<th>Water Temperature</th>
<th>Time to Receive Second Degree Burn</th>
<th>Time to Receive Third Degree Burn</th>
</tr>
</thead>
<tbody>
<tr>
<td>120° F</td>
<td>8 minutes</td>
<td>10 minutes</td>
</tr>
<tr>
<td>124° F</td>
<td>2 minutes</td>
<td>4.2 minutes</td>
</tr>
<tr>
<td>131° F</td>
<td>17 seconds</td>
<td>30 seconds</td>
</tr>
<tr>
<td>140° F</td>
<td>3 seconds</td>
<td>5 seconds</td>
</tr>
<tr>
<td>150° F</td>
<td>&lt; 1 second</td>
<td>1 second</td>
</tr>
</tbody>
</table>


*Check state regulations. Some states have a maximum allowable water temperature.
Policy:

Food will 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. Food should be cooked in appropriate size containers to avoid boiling over. When the food reaches the boiling point, heat should be reduced to prevent boil over.

3. Pot and pan covers should be removed slowly and by lifting sideways and away from face and body to assure that steam escapes without scalding hands or face.

4. Handles of cooking utensils should be turned away from the edge of the stove so utensils will not be accidentally bumped off. Handles should not be positioned over an open flame.

5. Adequate assistance should be available prior to removing heavy containers from the stove. The work area should be clear prior to moving hot containers.

6. All pots, pans and any cooking equipment can potentially be hot and should be handled properly to avoid burns and other accidents.

7. Grease should be considered a fire hazard. Avoid splashing grease on top of the range. Do not allow grease to build up on equipment (including the hoods). Avoid overheating fat.

8. Food containers should not be over-filled. Ladle foods into other containers to transfer instead of pouring to prevent spills and burns.

9. Breakable dishes and glassware should not be stored on or above shelves or tables where food is prepared.

10. Poisonous and toxic materials should be labeled and used only under conditions that will not contaminate food. They should 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.

12. Cut-resistant gloves should be used to protect hands when using knives.
Equipment Safety

Policy:
Safety precautions will be followed when using electrical equipment.

Procedure:
Employees will be trained in the use of the equipment they will use on the job, as follows:

1. Hands should be dry prior to touching any electrical appliance, plug or electrical outlet.
2. Safety devices (guards, attachments, etc.) should be firmly attached and in place prior to using the equipment.
3. Fingers, hands, spoons, knives, etc. should be kept away from moving parts. Food should not be removed until moving parts have stopped.
4. Equipment should be in the “off” position prior to plugging the machine into the electrical outlet.
5. Electrical equipment should be turned off and unplugged prior to cleaning or adjusting.
6. All equipment should be cleaned properly, following the instructions in the equipment manual.
7. Mixers should not be started until the bowl is properly placed and the “beater” is securely fastened.
8. A spatula or other appropriate tool should be used to push food into a mixer, grinder, blender, or food processor.
9. Equipment should not be left on when unattended.
10. Extension cords should not be used.
11. All electrical plugs manufactured with 3 prongs must be maintained as such.
12. The safety guard and food holder on the slicer, rather than hands, should always be used to push the food down to the blade. The slicer should be turned off and the slicer blade returned to zero (0) when finished slicing or walking away from the machine.
13. Cut-resistant gloves should be used to protect hands when using slicers.
Knife Safety

Policy:

Knives will be handled in a safe manner to prevent employee injury.

Procedure:

Employees will be trained to pay special attention to their work when using knives, as follows:

1. Knives will be utilized only for the operation for which they are intended.
2. Knives should be pointed away from the body and away from other staff during use and when wiping clean, sanitizing, or drying.
3. Knives should be stored safely and neatly with handles easily accessible to prevent cuts.
4. Steel particles should be wiped from knives after they are sharpened.
5. Knives should not be placed in a sink full of soapy water, or other locations where they are not obviously visible.
6. Employees should not attempt to catch a falling knife.
7. Knives should be picked up by the handle, not the blade.
8. Knives will be kept sharpened for ease of use. Knife sharpening should only be done by trained personnel in the facility or by an outside source.
9. Cut-resistant gloves should be worn when using knives.
Dishware and Glassware Safety

Policy:

Dishware and glassware will be handled safely.

Procedure:

Employees will be trained to pay special attention to their work when handling dishware and glassware, as follows:

1. Chipped or cracked drinking glasses or china will be discarded immediately.
2. Dishes and glassware should not be stacked too high or too tightly.
3. Caution should be used when transporting glass and china, maintaining complete control of the load at all times.
4. China and glassware should not be placed on the top of food carts.
5. Meal carts should be pushed slowly, along a wall and away from potential obstructions.
6. Glass and china should not be placed in a soapy sink where they may be difficult to see.
7. Broken glass should be swept up with a broom and dust pan. A dampened towel can be used for cleaning slivers of glass.
8. Employees should never reach blindly into a wastebasket or can, especially if they could contain broken glass or china.
9. When clearing broken glassware or dishes from soapy water, the water should be drained and then the glass pieces removed carefully. Employees should not reach into a filled sink with bare hands to retrieve broken glass.
10. Glassware should not be used to form or prepare food (such as cutting biscuits or ladling liquids).
Dish Clearing and Cleaning Safety

Policy:
Dishes will be transported, 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 should be pushed, never pulled.
3. Cart wheels will be inspected regularly and replaced as needed.
4. Meal carts that are in poor repair should be removed from service.
5. Any broken or chipped dishes or glassware will be carefully removed from service and discarded.
6. Staff will be trained to prevent breakage while clearing and transporting dishware.
7. When clearing tables, dishes and trays should not be stacked.
Receiving and Storage Safety

Policy:

Safety precautions should be followed when delivery containers, crates, or boxes are opened, and when food and supplies are stored.

Procedure:

1. When opening boxes, cartons, barrels, crates, etc., nails or staples should be removed carefully.

2. When storing materials on shelves, heavier and bulkier materials should be located on lower shelves. Avoid storage of heavy items 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. Odd shaped or sharp-edged objects will be placed where they are readily visible, never on top shelves.

6. Safe and sturdy step stools will be available and used for reaching high shelves.
Lifting Techniques

Policy:

Correct procedures will be followed when lifting objects. Staff will be well trained on proper lifting techniques.

Procedure:

Staff will be able to demonstrate proper lifting at the end of the training, as follows.

1. Determine the load size and details
   a. If the item is large, bulky, awkward or heavy, assistance will be requested or a hand truck will be used.
   b. Employee should check for any exposed hazardous surfaces such as nails, wood splinters, etc. and use gloves if needed to lift the object.
   c. Employee should be sure there is a clear path to where the object is to be moved.

2. Lift the object
   a. If lifting by hand, the object should be held as close to the body as possible before lifting.
   b. Employee should squat or bend at the knees, keeping back straight.
   c. A firm grip is required and the weight should be divided between both hands.
   d. A firm footing is required before lifting the object.
   e. Leg and thigh muscles should be used for lifting rather than the back.
   f. Keep the back straight when lifting and keep the object close to the body.

3. Moving the object
   a. The object should be held close to the body with the weight evenly distributed between both hands.
   b. A clear vision of the path for moving the object should be determined.
   c. When turning, feet should be shifted rather than turning at the waist.

4. Lowering the object
   a. A clear spot for the object to be set down should be determined.
   b. The object should be lowered by bending at the knees and keeping the back straight.
   c. Fingers and toes should be clear before putting the object down.

Note: Heavy articles should not be lifted overhead. Employees should request help lifting heavy objects.
Floor Safety

Policy:

Floors will be maintained to maximize safety.

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. “Wet floor” signs will be used to caution others to be careful. Mops and cleaning equipment will be kept out of the line of traffic. Cleaning agents should 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, floors should be dry.

6. Spills should be cleaned immediately.

7. The floor around all dishwashing areas should have a surface to prevent slipping. Rubber mats beside the dishwasher are acceptable, but must be removed each day (or as needed) in order to mop and clean the floor in that area.
Fire Prevention

Policy:

The facility should be constructed, equipped, and maintained to promote fire safety and protect the health and safety of patients/residents, employees and the public. Food and nutrition services employees 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. Fire extinguishers will be checked monthly. (This is usually done by the maintenance department).

3. Employees should be familiar with the location and use of fire extinguishers and the fire reporting system.

4. 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.

5. Employees will be made aware of procedures to follow in case of fire.

6. Hoods, fans, vents, grills and other equipment will be kept free of grease and dust accumulation.

7. A routine cleaning schedule should be posted and enforced for all equipment where grease or dust accumulates.

8. Smoking, if allowed at all, should only be allowed in designated areas. It will not be permitted in the kitchen, storeroom, restrooms, or patient’s/resident’s rooms.

9. All employees will participate in routine fire drills.

10. All fire doors, exits, and stairways will be maintained to be clean of material and equipment.

Note: Check state fire authority, or local or county health department regulations for area-specific regulations.

Resource:
Fire Plan for Food and Nutrition Services Department

Policy:

All food and nutrition services employees will follow the fire plan for the department. Staff will be well trained on fire safety, procedures to follow in the event of a fire, and will be aware of rules to follow in a fire emergency.

Procedure:

1. Staff will be trained on behavior in the event of a fire:
   a. Stay calm (do not panic). Never yell “Fire!”

2. In the event of a small fire, proper procedures will be followed for the type of fire:
   a. If the fire is small and confined to a burner or a pan skillet fire, a pan lid or baking soda should be used to smother the fire.
   b. Water should not be used to extinguish any fire that involves grease.

3. If needed, the nearest hand fire extinguisher should be located and used to extinguish the fire. Do not fight the fire if it becomes dangerous to personal safety.

4. If a fire is large and uncontrolled:
   a. Use overhead fire extinguishers.
   b. Turn off vents/exhaust systems if in close proximity to the fire.
   b. Notify a supervisor, who will oversee the following:
      • Notify the person in charge (facility administrator or designee) to alert other employees of the fire as needed.
      • Pull the fire alarm box.
      • Call 9-1-1 and report the following information:
        – Name, address and telephone number of the facility
        – Location of fire (in the building)
        – Name of employee making the phone call and their department

5. If there is extensive smoke or flames:
   a. The cook/chef on duty will turn off all electrical and gas cooking equipment, and exhaust fans.
   b. The director of food and nutrition services (or person in charge) will oversee the following:
      • Evacuate the kitchen.
      • Turn off lights and close doors in storage areas and offices.
      • Turn off the air conditioning.
      • After employees are in a safe area:
        – Turn off main light switch
        – Close all outside doors
        – Take the posted staffing schedule when leaving (to serve as a reference for head count).

6. Food and nutrition services employees on duty during a fire shall assist in evacuating patients/residents from the dining room and other areas as directed.

7. Attend to emergency needs of employees as needed.

Note: Food and nutrition services procedures should be discussed with maintenance, safety officer and/or fire department and adjust this policy and procedure to reflect their input and the facility’s procedures.
Resource: How to Contain Food and Nutrition Services 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: Food and nutrition services procedures should be discussed with maintenance, safety officer and/or fire department and adjusted to reflect their input and the facility’s procedures.
Helpful Fire Safety Information: R.A.C.E. and P.A.S.S.

Routine fire safety training and practice drills using different scenarios will help staff prepare for fire emergencies. All staff members should know the primary and secondary safe areas and route of evacuation according to the facility’s fire plan, which should be on display. The plan should include a chain of command for clear and frequent communication so all staff understands what has been done and what needs to happen next. Fire plans should be tailored to the facility and shared with the community fire department. Audits should be performed routinely to ensure good lighting and a clear path for all exit doors - exits must never be blocked.

To help staff remember the information, the following acronym is often used: R.A.C.E., which stands for the four steps that should be used when responding to a fire emergency:

1. **(R) Remove** – Remove individuals in danger of immediate harm by evacuating them from the room and closing the room door. This is always the first step to keeping people safe and avoiding injury or death. Smoke inhalation is the primary killer in a fire, and older adults and children are especially susceptible.

2. **(A) Alarm** – Call 911 and activate the fire call box/pull station. Use the intercom system to call out a “Code Red.” When calling 911 provide: name, phone number you are calling from, location (address, facility name, area of the building – kitchen, floor and/or room number), and what you are reporting (sight or smell of smoke or fire). Note: Alarms will trigger locked doors to unlock including exits and lock down areas, so exits should be quickly monitored.

3. **(C) Contain** – Contain the fire, smoke, and/or toxic combustion products to the area where the fire started. Close doors and windows to prevent smoke from spreading and cut off the flow of oxygen to the fire.

4. **(E) Extinguish/Evacuate** – Know the location of the fire extinguishers and be able to find them even if the lights are out or there is a lot of smoke. Use the fire extinguisher label to determine the type of fire it will extinguish, and the operating instructions. All fire extinguishers operate in the same way, which can be remembered using the P.A.S.S. acronym:

   P – Pull the pin in the nozzle of the extinguisher  
   A – Aim the nozzle at the base of the fire  
   S – Squeeze the handle  
   S – Sweep from side to side, covering the fire

Only attempt to extinguish small, contained fires (no larger than the size of a waste basket) - and only if safety is assured, there is an escape route behind you, and other staff members are there to assist. Other staff should be rescuing people in immediate danger, activating the alarm, and confining fire and smoke at the same time. If the fire is not easily extinguished, leave the area immediately, close it off, and wait for the fire department.
Evacuation Methods
When there is danger from smoke or fire in the immediate area, evacuate by moving people down the hall, through at least one set of fire doors to a safe area.
1. Never open a door if it is hot to the touch.
2. Never use elevators to evacuate a fire area.
3. Evacuate people closest to danger first, then those who are ambulatory then non-ambulatory, and last, critically ill people on life support (they will need more time and care).
4. If possible, take the medical record with the patient/ resident. If electronic records are used there should be a back-up for the files available.

If there is continued danger from smoke or fire, move people down the stairs to a lower level of safety and eventually out of the building.

If there is enough staff available form a line and pass frail or injured people along from one staff member to another, until they reach a safe, smoke-free area. If there is insufficient staff, frail or injured people can be moved by placing the person in a blanket and pulling them down the hall to safety. As rooms are evacuated, mark the area to let others know that the room has been evacuated.

Additional Notes:
1. Do NOT go through closed fire doors unless you are part of the ‘Fire Response Team’.
2. Unless you must pass another area for the safety of a resident/patient or yourself, stay in the area you are in until the ‘All Clear’ is given.
3. If you arrive to work during a fire or a fire drill, remain outside. Congested entrances could slow the fire department response time.
Facility Specific Policy and Procedure for Fires

Insert facility fire policy and procedure here.
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 safety data sheets (SDS).  
   b. Know where and how to use eye wash station if chemicals are in eyes and washing is appropriate according to SDS sheets.
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 will be inserviced at least during initial employee orientation and yearly thereafter on the following:
   a. Location of the eye wash station.
   b. Operation of the eye wash station.
   c. Appropriate use of the eye wash.

Note: Follow manufacturer’s instructions for use of eye wash/eye wash station.
Emergency Eye Wash

Insert a copy of facility eye wash/station instructions here.
Accident/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 director of food and nutrition services.

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. The accident or incident should be thoroughly documented on the appropriate facility form.

5. Any accident or incident should be reported whether an injury occurred or not and the appropriate person should be informed according to facility policy.
Accident/Incident Report

Insert a copy of facility’s accident/incident report here.
Malfunctions and Repairs

Policy:

All malfunctions and repairs will be reported to the director of food and nutrition services and/or maintenance department.

Procedure:

1. When a piece of equipment malfunctions, the director of food and nutrition services will be notified.

2. The director of food and nutrition services will notify the maintenance department by phone or in writing if needed, informing them how quickly that piece of equipment is needed.

3. Outside repair services or purchase of parts must be approved by the administrator as per facility policy.
Malfunctions and Repairs

Insert a copy of facility’s maintenance work order here.
Malfunctions and Repairs

Insert facility’s policy and procedure for repairs that involve use of companies outside of facility here.
Personnel/Training

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Policy:

The food and nutrition services department will be staffed to assure that sufficient, competent, supportive personnel carry out the functions of the department.

Procedure:

1. The food and nutrition services department will have an adequate number of staff.

2. Food and nutrition services staff will be on duty for a period of no less than 12 hours. A department employee shall be present in the kitchen during hours of operation. (See Hours of Operation in the Food Production and Food Safety chapter of this manual.)

3. A clearly written job description for each position will be on file in this policy and procedure manual.

4. Food and nutrition services staff will be trained to perform assigned duties and will be expected to participate in inservice programs. These programs will be conducted by the director of food and nutrition services and/or designee.

5. Work schedules will be posted two weeks in advance. Weekly work schedules shall include all department personnel including management and/or professional staff.

6. Work schedules will be maintained on file for a minimum of one year.

7. Meal and break times will be clearly stated on the work schedule. All exceptions need to be approved by the director of food and nutrition services or designee.

8. Overtime hours must be preapproved by the director of food and nutrition services or designee.

9. A food and nutrition services 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.
Policy:

The director of food and nutrition services will be responsible for the safe, sanitary, economical, and nutritional operation of the food and nutrition services department.

Procedure:

1. The director of food and nutrition services will be hired by the administrator, or by the immediate supervisor of the position.

2. The director of food and nutrition services will be qualified according to the position’s job description and guidelines put forth by the agency that regulates the facility.

3. The director of food and nutrition services will carry out his or her duties according to the job description, work schedule, and list of duties.

4. The director of food and nutrition services or designee will be considered the immediate supervisor of the cooks/chefs and other food and nutrition services staff.

5. The director of food and nutrition services will cooperate with other department heads and other professionals for the health and welfare of the patients/residents.

6. The director of food and nutrition services will participate in:
   a. Regular meetings with the administrator and/or the immediate supervisor.
   b. Regular meetings with the food and nutrition services staff.
   c. Department head meetings.
   d. Care plan meetings.
   e. Infection control and/or safety committee meetings and activities.
   f. Quality assessment and quality assurance, and quality assessment performance improvement (QAPI) meetings as appropriate.
   g. Weight committee and/or nutrition risk committee meetings.
   h. Regular meetings with the registered dietitian nutritionist (RDN) or designee.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Line of Authority

Policy:

When the director of food and nutrition services is not available, temporary management of the food and nutrition services department will be assigned in the following order:
1. Assistant director of food and nutrition services
2. Head cook/chef

Procedure:

1. In the absence of the director of food and nutrition services, the next available staff member will be in charge of the kitchen per shift assigned.

2. When another person acts as director, he or she will be responsible for performing his or her usual duties as well as:
   a. Inserting new or temporary meal identification (ID) cards/tickets for new or readmitted residents/patients.
   b. Completing diet changes to assure that all residents/patients receive diets as ordered.
   c. Supervising meal preparation and service.
   d. Placing orders for food supplies.
   e. Rescheduling staff as needed.
   f. Assuring safe and sanitary food service and clean up.
   g. Assuring accuracy of therapeutic diets.
   h. Assuring timeliness of meal service.
   i. Managing disciplinary problems.
   j. Contacting the administrator or assigned representative in their absence in cases of emergency that the cook is not authorized to handle.

3. The director of food and nutrition services will be responsible for being prepared and up-to-date prior to his or her planned absence (i.e., scheduling of staff, planning food/beverage orders, reviewing menus and preparation with the staff, as well as other routinely scheduled supervisory duties).

4. In the director of food and nutrition service’s absence, the temporary manager will not hire, discipline, or fire employees. Temporary managers will not chart in the permanent medical record or participate in care plan meetings unless trained to do so.

5. In the director of food and nutrition service’s absence, the temporary managers will confer with the administrator and registered dietitian nutritionist (RDN) or designee, plan and prepare food orders, record food preferences, and make note of other pertinent information for the director of food and nutrition services to follow-up on upon his or her return.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Staffing the Food and Nutrition Services Department

Policy:

The director of food and nutrition services is responsible for hiring and scheduling food and nutrition services staff, with recommendation, consultation and direction from the administrator and/or director of human relations.

Procedure:

1. Open position advertisements will be placed with the assistance of the human relations manager or administrator.

2. Applications will be reviewed and candidates eliminated as appropriate.

3. Interviews for top candidates will be scheduled by the director of food and nutrition services. (See Sample Interview Questions later in this chapter)

4. All proper hiring procedures and forms as outlined by facility policy will be followed. This may include, but is not limited to:
   a. Background check
   b. Reference check
   c. Physical exam
   d. Mantoux test
   e. Employee information
   f. Residents or patient’s rights information

5. The most qualified applicants will be hired by the director of food and nutrition services, with input from administration as appropriate.

6. Employee orientation and work schedules will be completed by the director of food and nutrition services.
Facility Personnel Forms/Policies

Insert facility personnel forms or policies here.
Sample Interview 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.)
Policy:

Food and nutrition services staff will be adequately trained to perform assigned duties and are required to participate in regularly scheduled inservice training sessions. Upon completion of initial mandatory facility training, each employee will be trained in all food service areas that are related to the job. The director of food and nutrition services will be responsible for department orientation and training of new staff.

Procedure:

Staff will be trained on the following:

1. **Overview of Food Service**
   **Goal:** To introduce work and the general responsibilities of the employee.
   a. Organizational charts
   b. Job descriptions
   c. Reference materials (menus, recipes, diet/nutrition care manual, policy manual, etc.)
   d. Record keeping
   e. Communication with other departments
   f. Customer service training, including waiter/waitress/hostess training if applicable
   g. Meal service/tray line training
   h. 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.
   a. Purchasing
   b. Receiving
   c. Storing
   d. Equipment
   e. Cleaning

3. **Sanitation**
   **Goal:** To understand the importance of maintaining a clean and sanitary environment. To give specific information on food protection and cleaning of dishes and equipment.
   a. Personal hygiene
   b. Equipment
   c. Pest control
   d. Dishwashing – machine pot and pan washing
   e. Cleaning schedules and procedures
   f. Infection control
   g. Facility pets (not allowed in food service/storage areas or dining areas during meal times)

4. **Safety**
   **Goal:** To provide instructions and guidelines for safety.
   a. General safety guidelines
   b. Safety data sheets (SDS) for chemical products in use in the department
   c. Knife skills and safety
   d. Equipment safety
   e. Fire safety
   f. Emergency/disaster plans
5. **Food Preparation and Food Safety**  
   **Goal:** To explain methods of safe food preparation.  
   a. Hot foods and cold foods  
   b. Methods of cooking  
   c. Food safety/preventing foodborne illness  
   d. Temperature protection (internal cooking temperatures, holding, storage, reheating and cooling temperatures)  
   e. Proper storage of left-over food

6. **Standard Measurements**  
   **Goal:** To provide standards of food preparation and service.  
   a. Standardized recipes  
   b. Weights and measures  
   c. Tools and utensils  
   d. Portion control  
   e. Tasting  
   f. Temperature testing and documentation

7. **Nutrition**  
   **Goal:** To provide basic information about the importance of nutrition, the function of food, and the results of nutrient deficiencies.  
   a. Basic nutrition including role of vitamins, minerals, protein, carbohydrate, fat, and water  
   b. Food allergies, intolerances, and preferences  
   c. Culture and religious food preferences

8. **Menus/Therapeutic Diets**  
   **Goal:** To give information on the types of menus and therapeutic diets offered.  
   a. Diet/nutrition care manual  
   b. Review of basic therapeutic diets offered  
   c. Review menus and recipes  
   d. Menu extensions for therapeutic diets  
   e. Meal identification (ID) cards/tickets  
   f. Consistency modifications  
   g. Bed time snacks and supplements  
   h. Patient’s/Resident’s rights to make care choices

   **Goal:** To provide a basic overview of the department’s policies and procedures.  
   a. Documentation requirements for the food and nutrition services department  
   b. Methods for receiving diet orders and/or food preferences from other departments  
   c. Menus and therapeutic diets  
   d. Dining/meal service  
   e. Sanitation and infection control  
   f. Cleaning instructions  
   g. Food production  
   h. Food safety  
   i. Personnel/training  
   j. Quality assurance

(See *Sample Training/Orientation Form* later in this chapter of the manual for recording each new employee’s training.)
Nursing Homes: Resident’s Rights Training

Policy:

All staff working in skilled nursing facilities will be made aware of a resident’s right to make choices and be involved in their plan of care.

Procedure:

1. Director of food and nutrition services will coordinate training on resident’s rights with facility staff development department.

Resources:


Insert a copy of facility’s Nursing Home Resident’s Rights Document here.
Facility-Wide Inservice Training

Policy:

The facility will follow OSHA, Centers for Medicare and Medicaid Services, and/or the Joint Commission requirements of facility-wide staff training that includes the department of food and nutrition services. Training may include but is not limited to Health Insurance Portability and Accountability Act (HIPPA), abuse and neglect, resident’s rights, infection control, emergency preparedness, use of restraints, and workplace safety.

Procedure:

1. Facility-wide required inservice training will be developed and delivered at scheduled staff meetings by the staff development department.

2. The director of food and nutrition services will coordinate with the facility staff development coordinator on scheduling employees and consultants (as appropriate) to attend required facility-wide training.
Hospitals: Patient’s Rights Training

Policy:

All staff working in the Hospital System will be made aware of Patient’s Rights.


Insert a copy of the facility’s Hospital’s Patient’s Rights Information here.
Sample Training/Orientation Form

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<th>Subject</th>
<th>Date</th>
<th>Instructor Initials</th>
<th>Employee Initials</th>
<th>Review Date</th>
<th>Instructor Initials</th>
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</tbody>
</table>

I have been oriented to the department, and the subjects listed above have been explained to me.

Employee Signature ______________ Date __________ Director of Food and Nutrition Service’s Signature
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Policy:

The food and nutrition services department will abide by policies and procedures to maintain HIPAA compliance. Department staff will keep all health information collected confidential, and deliver care and services to maintain acceptable parameters of nutritional health.

Procedure:

1. All new food and nutrition services staff will obtain training or pertinent HIPAA information during their orientation.

2. All food and nutrition services staff will be in-serviced on HIPAA compliance upon hiring and no less than yearly.

3. The food and nutrition services 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, food allergies and/or intolerances, 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 such as diet orders will be held and updated by the department and destroyed as needed per HIPAA policy.

6. No food and nutrition services 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 services staff will follow all procedures for HIPAA compliance.

Insert Facility-Wide HIPPA Compliance Policy here.
Sample Personal Hygiene Training Policy

Policy

All food and nutrition services employees will be trained on appropriate personal hygiene.

Procedure

1. Employees will follow the facility dress code.

2. Employees will wear clean clothing and a clean apron daily.

3. Jeans, street clothes, shorts, tank tops and other sleeveless apparel will not be permitted. Facility policy for "casual days" attire must be followed.

4. Clothing should be comfortable, and shoes should be closed-toe with non-slick soles at all times while on duty.

5. Hair should be neat and clean. Hair restraints must be worn around exposed foods, in the kitchen or food service areas and dining areas.

6. Beards and mustaches should be closely cropped and neatly trimmed. When around exposed foods, beards must be restrained using beard covers.

7. Fingernails should be clean and trimmed. No nail polish or false nails are allowed, unless gloves are worn. Follow facility policy on nail polish and false nails.

8. Jewelry shall be kept to a minimum, such as small earrings, wedding band and watch.

9. Street clothing, coats, purses, packages, and other personal effects will be stored in employee lockers and not in the kitchen.

10. Hands should be washed in the designated hand washing sinks. Refer to the Hand Washing Policy in the Sanitation and Infection Control chapter of this manual.

11. Employees will not report to work if ill but are expected to call in and explain the nature of 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)
   - Fever and sore throat
   - Diarrhea lasting over 24 hours
   - Vomiting lasting over 24 hours
   - Salmonellosis

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.
Inservice Training

Policy:

Inservice training will be offered on a regular basis to update employees’ knowledge.

Procedure:

1. A yearly inservice schedule will be developed so that employees receive training on a regular basis.

2. Employees will be notified of each in-service at least one week in advance.

3. Inservice topics will cover a range of topics, including, but not limited to:
   a. Documentation in the food and nutrition services department
   b. Menus and therapeutic diets
   c. Meal service
   d. Sanitation and infection control
   e. Cleaning instructions
   f. Emergency meal plans
   g. Food production (including maintenance of equipment)
   h. 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)
   i. Personnel/training
   j. Work place safety
   k. Quality assurance and performance improvement projects
   l. Survey readiness
   m. Survey follow up and corrective action plans

(Also see Resource: Inservice Training on the following page.)

4. Mandatory facility inservices will also be scheduled to cover the following topics:
   a. Fire/Disaster Preparedness (including natural emergencies, such as flooding, hurricanes, tornadoes)
   b. Patients'/Residents' Rights
   c. Infection Control
   d. Safety Data Sheets (SDS)
   e. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
   f. Abuse and neglect

5. All employees attending the inservice must sign the attendance sheet, which is completed by the person conducting the inservice. (See Sample Inservice Sign in Form later in this chapter)

6. Records of each inservice will be kept on file for a period of 3 years.

7. Records of inservice attendance for each employee should be kept in their employee file. (See Sample Inservice Training Report Form later in this chapter)
## 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 its role in health
- Implication of diseases/conditions
- Food allergies, intolerances
- Older adults food habits/preferences

## Therapeutic Diets
- Diet manual
- Review of therapeutic 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/soups
- Beverages
- Desserts/fruits
- Snacks/supplements
- Methods of cooking
- Temperature protection

## Survey Readiness
- Survey process*
- Survey questions and responses*
- Common food service deficiencies*
Sample Inservice Training Report Form

Department: _________________________________________________________________

Date: _________________________________ Time: _______________________________

Employee Group(s) Present: _____________________________________________________

Total Number of Employees in Group: ___________________________________________

Number Present: _________________ Number Not Present: _______________________

Method of Presentation: _______________________________________________________

Pre-Post Test Attached:

Subject(s) Covered:
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________

Recommendations/Follow-Up:
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________
________________________________________________

Conducted by ___________________________________________

Title
Sample Inservice Sign in Form

Date: ______________ Time: ________  Inservice Title: ______________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Shift</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Policy:

The director of food and nutrition services will complete periodic written evaluations for department staff. Clinical staff should be evaluated using a competency-based assessment. The registered dietitian nutritionist (RDN) should evaluate nutrition support staff, and an appropriate supervisor or peer should evaluate the RDN.

Procedure for Food and Nutrition Services Personnel:

1. The first evaluation should be completed 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 completed 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 director of food and nutrition services should review evaluations with the administrator and/or designated staff member such as human relations manager.
5. The director of food and nutrition services will review the evaluation with the employee.
6. A signed copy of the evaluation should be given to the employee and the original should be placed in the employee’s file.

Procedure for Clinical Staff:

1. The registered dietitian nutritionist (RDN) 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 RDN will use guidance from the Academy of Nutrition and Dietetics Scope of Practice and Standards of Professional Performance to assess competency of the nutrition support staff, including the nutrition and dietetics technician, registered (NDTR).
4. The RDN will use guidance from the Association of Nutrition and Food Service Professionals Scope of Practice to assess the competency of the certified dietary manager (CDM) and/or director of food and nutrition services.
5. Competency based evaluations should be used. All evaluations should include a list of suggestions for improvement, education resources for action, and recommended completion dates.
6. The RDN should share evaluation with administration as appropriate and/or per facility policy. A copy of the evaluation should be given to the employee and the original should be placed in the employee’s file.

Note: Consultant dietitians do not evaluate clinical staff or the CDM or director of food and nutrition services unless it is designated in the contract or requested by the administrator.
Insert facility employee evaluation forms and employee coaching or discipline forms here.
Sample Vacation/Leave Request 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.
Sample Employee Request for Leave Form

Name __________________________________________ Date _____________________

I request the following time off:

<table>
<thead>
<tr>
<th>Type</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Vacation</td>
<td>________________________________</td>
</tr>
<tr>
<td>☐ Other</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

Approved __________________________________________ Date _____________________

Name __________________________________________ Date _____________________

I request the following time off:

<table>
<thead>
<tr>
<th>Type</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Vacation</td>
<td>________________________________</td>
</tr>
<tr>
<td>☐ Other</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

Approved __________________________________________ Date _____________________
Employee Request for Leave Form

Insert facility vacation and leave request forms here.
Adult learners are often juggling many responsibilities, including jobs and families. Everyone learns differently; some people prefer visual learning (such as slides or handouts). Others prefer auditory learning (learning by listening), while some prefer hands on activities to help them learn.

Five Basic Principles of Adult Learning:

1. **Personal Benefit.** Adult learners must be able to see the personal benefit of what they are learning and how it satisfies a need. They are motivated to learn if:
   a. It solves or avoids a problem.
   b. It provides an opportunity or increases status, or leads to professional or personal growth.

2. **Experience.** Adult learners bring a unique background of knowledge and experience. They are motivated to learn if:
   a. They are involved in the learning and sharing what they know.
   b. The learning builds on what they know.
   c. The learning validates an experience they have had.

3. **Self-Direction.** Adult learners must have some control over what they are learning. They are motivated to learn if they can:
   a. Make decisions about the content and process.
   b. Contribute to the learning of their coworkers.
   c. Have some independence in the learning process.

4. **Application and Action.** Adult learners are practical and learn by doing. They learn best when:
   a. There is an immediate application for the learning.
   b. They can be an active participant in the learning process.
   c. They can practice new skills or test new knowledge.

5. **Learning Styles.** Adult learners learn best when:
   a. The learning taps into a mix of styles.
   b. The material is taught using multiple styles.

Providing active, relevant, learning experiences, letting them discuss the topic and interact through games, humor, and examples in their workplace can facilitate learning.

**Source:**
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
- Sample Food Preferences Form ...................................................................... 8-5
- Alternates for Food Dislikes ........................................................................... 8-6
- System for Recording Food Preferences .......................................................... 8-7
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Clinical Documentation

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Note: Also see sample job descriptions and competency evaluations available from Becky Dorner & Associates, Inc. at www.beckydorner.com.
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 nutritionist (RDN) 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.

“The Centers for Medicare and Medicaid services rules allow a patient’s/resident’s attending physician to delegate the task of writing diet orders to a qualified dietitian (or other clinically qualified nutrition professional). The qualified dietitian must act within their scope of practice as identified by state law. It is imperative that RDNs be aware of state laws and practice accordingly. If state law allows order-writing privileges, the physician must sign off on the order”.

**Note:** Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
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) will be provided based on current standards of practice, evidence based research and clinical outcome studies. The registered dietitian nutritionist (RDN) 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 RDN or designee will:
   a. Assess the nutrition status of all referrals, including individuals who are identified “at risk”.
   b. Communicate to the health care team any information that impacts care.
   c. Participate in quality assurance and performance improvement efforts related to nutrition care.
   d. Participate in the patient/resident care planning process.
   e. Provide patient/resident education/guidance per physician order and/or as deemed appropriate by the RDN or designee including those being discharged.
   f. Function as a nutrition educator and resource to individuals and their families, the medical and nursing staff, nutrition and food service staff, other facility staff, students and community organizations as appropriate.
   g. Provide input to assure compliance to standards in nutrition care.
   h. 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 RDN will:
   a. Participate in the nutrition care process: nutrition assessment, nutrition diagnosis, nutrition intervention, nutrition monitoring and evaluation.
   b. Identify and assess each individual’s nutrition status and risk factors.
   c. Evaluate and analyze the assessment information for nutrition diagnosis as appropriate.
   d. Develop and consistently implement pertinent food and nutrition interventions.
   e. Monitor and evaluate the effectiveness of nutrition interventions and revise them as necessary.
   f. Provide nutrition education as appropriate.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
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 paper 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.
7. In an electronic medical record, changes can be made as desired before "locking" or "signing" a nutrition assessment or progress note. Most systems allow a completed progress note to be deleted by showing a single line through the note after locking or signing, with the user's name attached to indicate they approved the deletion. However, most systems will not allow individual sentences, phrases, or data to be deleted once an assessment or progress note has been locked or signed. Some programs allow addendums to be written, which can be used to clarify or correct a progress note. Follow facility policies and electronic health record's procedures for correcting errors in electronic medical records.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Diet History

Policy:

Information will be gathered upon admission to inform the nutrition and food and nutrition services department of the individual’s food preferences, allergies, intolerances, cultural preferences, and diet history. Food preferences will be updated periodically as needed or upon reassessment.

Procedure:

1. Upon admission and periodically as needed, the director of food and nutrition services or designee will interview the individual for the following information using the Food Preferences Form (sample form on the following page):
   a. Understanding and acceptance of the diet as ordered
   b. Food preferences, intolerances, allergies
   c. Cultural and/or religious preferences
   d. Location where meals are to be served
   e. Preferred portion sizes for each meal
   f. Select menu preference (if applicable)
   g. Beverage preferences

2. When interviewing an individual for food and beverage preferences, the director of food and nutrition services or designee will offer the names of foods as needed (some individuals may have a difficult time with open ended questions). The Sample Food Preferences 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 if the individual is unable to provide the information themselves.

4. Each individual will be visited by the director of food and nutrition services 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 and nutrition services department and used to assure that each individual’s needs and desires for food are met.

6. If the facility offers a select menu, buffet, or other programs that provide food choices at each meal, individual choices at each meal or snack, they take precedence over food preferences on file.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
**Sample Food Preferences 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)**

<table>
<thead>
<tr>
<th></th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Dinner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juice</td>
<td>Milk</td>
<td>Coffee</td>
<td>Reg/Decaf</td>
</tr>
<tr>
<td>Milk</td>
<td>Coffee</td>
<td>Reg/Decaf</td>
<td>Hot Tea</td>
</tr>
</tbody>
</table>
| Reg/Decaf | Hot Tea | Reg/Decaf | Water
| Water | Soda Pop  | Iced Tea |

**Food Dislikes (Circle)**

<table>
<thead>
<tr>
<th>Meat/Substitutes</th>
<th>Vegetables</th>
<th>Fruits</th>
<th>Starches</th>
<th>Cereal</th>
<th>Milk/Dairy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacon</td>
<td>Beets</td>
<td>Apples</td>
<td>Baked Beans</td>
<td>Cream of Wheat</td>
<td></td>
</tr>
<tr>
<td>Beef Liver</td>
<td>Broccoli</td>
<td>Applesauce</td>
<td>Black-eyed Peas</td>
<td>Grits</td>
<td></td>
</tr>
<tr>
<td>Beef Patty</td>
<td>Brussels Sprouts</td>
<td>Apricots</td>
<td>French Fries</td>
<td>Malt-O-Meal</td>
<td></td>
</tr>
<tr>
<td>Cheese</td>
<td>Cabbage</td>
<td>Bananas</td>
<td>Lima Beans</td>
<td>Oatmeal</td>
<td></td>
</tr>
<tr>
<td>Chicken</td>
<td>Carrots</td>
<td>Cantaloupe</td>
<td>Macaroni</td>
<td>Dry Cereal</td>
<td></td>
</tr>
<tr>
<td>Chicken Liver</td>
<td>Corn</td>
<td>Grapefruit</td>
<td>Mashed Potatoes</td>
<td></td>
<td></td>
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<tr>
<td>Chili</td>
<td>Coleslaw</td>
<td>Mango</td>
<td>Navy Beans</td>
<td></td>
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<tr>
<td>Cottage Cheese</td>
<td>Green Beans</td>
<td>Oranges</td>
<td>Noodles</td>
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<tr>
<td>Eggs</td>
<td>Green Peas</td>
<td>Papaya</td>
<td>Pancakes</td>
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<tr>
<td>Enchiladas</td>
<td>Greens</td>
<td>Peaches</td>
<td>Pinto Beans</td>
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<tr>
<td>Fish</td>
<td>Lettuce</td>
<td>Pears</td>
<td>Potatoes</td>
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<tr>
<td>Ground Beef</td>
<td>Lima Beans</td>
<td>Pineapple</td>
<td>Rice</td>
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<tr>
<td>Ham</td>
<td>Okra</td>
<td>Plums</td>
<td>Sweet Potatoes</td>
<td></td>
<td></td>
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<tr>
<td>Lamb</td>
<td>Onions</td>
<td>Prunes</td>
<td>Tator Tots</td>
<td></td>
<td></td>
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<tr>
<td>Luncheon Meat</td>
<td>Peas</td>
<td>Tangerines</td>
<td>Waffles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuts</td>
<td>Sauerkraut</td>
<td>Watermelon</td>
<td></td>
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<tr>
<td>Pork Loin</td>
<td>Tomatoes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pork Chop</td>
<td>Yellow Squash</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roast</td>
<td>Wax Beans</td>
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<td>Sausage Link</td>
<td>Zucchini</td>
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<td>Sausage Patty</td>
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<td>Shellfish</td>
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<td>Shrimp</td>
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<td>Soy Burgers</td>
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<td>Tuna</td>
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<td>Turkey</td>
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<td><strong>Soups</strong></td>
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<td>Bean</td>
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<td>Beef Noodle/Veg.</td>
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<td>Broth</td>
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<td>Lentil</td>
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<td>Potato</td>
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<td>Split Pea</td>
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<td>Tomato</td>
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<tr>
<td>Vegetable</td>
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<tr>
<td>Cream Soups</td>
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<td><strong>Spicy Foods</strong></td>
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<td>Chili</td>
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<td>Sauce</td>
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<tr>
<td>Tacos</td>
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<tr>
<td>Tomato Sauce</td>
<td></td>
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</tbody>
</table>

Special meal preferences or pattern if different from menu (including cultural/religious preferences):

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*Policy & Procedure Manual  8-5*

Alternates for Food Dislikes

Policy:

Appropriate alternate foods will be prepared and offered at each meal for food preferences, allergies and/or intolerances.

Procedure:

1. Individual food preferences, allergies and/or intolerances are obtained upon admission, and updated as needed.

2. The director of food and nutrition services or designee is responsible for planning, ordering and scheduling the preparation of appropriate alternate foods to replace food dislikes, allergies or intolerances.

3. The director of food and nutrition services 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 and nutrition services staff is responsible for preparing and serving the alternates, and recording them as appropriate.

6. The food and nutrition services staff will use the menu Substitution Lists (in the Menus and Therapeutic Diets chapter of this manual) as a guideline for appropriate, nutritionally balanced alternates. Examples of appropriate alternates include:
   a. Substituting another meat or protein food for disliked meat or protein food
   b. 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. Even if a select menu or buffet service is provided, other alternates may be necessary to accommodate allergies or those with multiple food dislikes.
Policy:

Food and beverage preference notes must be kept on file, recorded on the meal identification (ID) card/ticket, or may be kept in a computerized tray card system.

Procedure:

For meal identification cards:
1. Note the food and beverage 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. Update computer files 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 and beverage preferences should be maintained on file for at least one year (paper or electronic as appropriate).

Note: If the facility offers a select menu, buffet, or other programs that provide food choices at each meal, individual choices at each meal or snack, these programs take precedence over food preferences on file.
Food Preference Form and/or Meal Identification Card

Insert a sample of facility food and beverage preference form and/or meal identification (ID) card here if applicable.
Recording Percent of Meal Consumed

**Policy:**

Staff will document the percentage of each meal consumed for each individual on a daily basis. Information should be recorded using facility-approved electronic or paper records. The registered dietitian nutritionist (RDN) or designee will provide the form or format to be used for paper records. If electronic meal intake reporting is used, recording should be completed using electronic forms on file. The RDN should specify how the data is to be recorded (See Sample Food Intake Record Form and Sample Total Meal Percentage Form located later in this chapter of the manual.)

**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 than 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, including those that are pre-programmed into electronic medical records. This is just one example. An alternate system is provided on the following page.

**Note:** Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Alternate Meal Recording System

Policy:

Staff will utilize the food intake percentage system as designated by the registered dietitian nutritionist (RDN). The point system for recording meal intake percentages may be used as an alternative to the total meal intake percentage system previously described.

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 = 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 Sample Food Intake Record/Total Meal Percentage Form and Sample Food Intake Record/Point System Form located later in this chapter of the manual.)

**Note:** Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
# Sample Food Intake Record/Total Meal Percentage Form

<table>
<thead>
<tr>
<th>Rm</th>
<th>Name</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>PM Snack</th>
<th>Dinner</th>
<th>H.S. Snack</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fluid mLs</td>
<td>Fluid mLs</td>
<td>Fluid mLs</td>
<td>Fluid mLs</td>
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<td></td>
<td></td>
<td>0% 25% 50% 75% 100%</td>
<td>0% 25% 50% 75% 100%</td>
<td>0% 25% 50% 75% 100%</td>
<td>0% 25% 50% 75% 100%</td>
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<td>0% 25% 50% 75% 100%</td>
<td>0% 25% 50% 75% 100%</td>
<td>0% 25% 50% 75% 100%</td>
</tr>
</tbody>
</table>

0% - Refused
25% - Poor
50% - Fair
75%-100% - Good

Comments can include meal replacement, preferences, etc.

A = Accepted
R = Refused
## Sample Food Intake Record/Point System Form

Date _______________________

<table>
<thead>
<tr>
<th>Rm</th>
<th>Name</th>
<th>Points</th>
<th>mLs</th>
<th>Points</th>
<th>mLs</th>
<th>Points</th>
<th>mLs</th>
<th>Points</th>
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<th>mLs</th>
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</tbody>
</table>
Food Intake Record

Insert a sample of facility food intake record form here if applicable.
Nutrient Intake Study

Policy:

Staff will conduct individual nutrient intake studies as deemed necessary by the registered dietitian nutritionist (RDN) or designee, the interdisciplinary team, or as ordered by the physician. Individuals identified to have a poor food/fluid intake or those at risk for development of unintended weight loss, undernutrition, dehydration, or pressure injuries may be candidates for a nutrient intake study.

Procedure:

1. The RDN or designee will provide the appropriate number of forms for the number of days the nutrient study is to be conducted (typically 3 to 7 days). The RDN or designee will write in the food items and amounts served in the appropriate column and provides the forms to the staff who will record the individual's intake.

2. Staff will observe the individual's food/fluid intake at each meal, and check the percentage of each food/fluid item consumed at each meal and snack, and record on the form provided. (See Sample Food Intake Study Form on the following page.)

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 will submit the completed form to the RDN or designee for evaluation.

5. The RDN or designee will estimate the number of calories and amount of 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
# Sample Food Intake Study Form

<table>
<thead>
<tr>
<th>Name __________________________</th>
<th>Date __________________________</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Food Item and Amount Served</th>
<th>Amount Eaten</th>
<th>For Dietitian</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>25%</td>
</tr>
<tr>
<td>Breakfast:</td>
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<td>10:00 AM Snack or Supplement:</td>
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<td>2:00 PM Snack or Supplement:</td>
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<td>Dinner:</td>
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<td>HS Snack or Supplement:</td>
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<td>Totals</td>
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**Instructions:**

1. Food and Nutrition Services: 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 and nutrition services.
3. Food and Nutrition Services: Provide the completed form to registered dietitian nutritionist (RDN) or designee for estimation of calorie and protein intake.
Individuals Who Do Not Drink Milk

Policy:

Substitutions will be made for individuals who do not drink milk (i.e. dislikes, allergies or intolerances) to assure provision of adequate calcium and vitamin D.

Procedure:

1. The facility staff and director of food and nutrition services or designee are responsible for identifying individuals who do not like milk, are allergic to or intolerant to milk and/or milk products based on information provided by the individual, family, or the medical record.

2. The facility staff is responsible for advising the director of food and nutrition services or designee when an individual does not drink milk or consume milk products.

3. The director of food and nutrition services or designee is responsible for making the appropriate suggestions to the patient/resident for substitutions. The resident has the right to choose substitutions, or refusal of substitutions.

4. The director of food and nutrition services 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 nutritionist (RDN) and/or the facility diet manual along with the individual’s preferences. (Also see number 7 below.)

5. The director of food and nutrition services or designee is responsible for informing the RDN so that this can be included on the individual’s care plan.

6. This information should be communicated to nursing to share with the physician, 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.
   a. 1 cup yogurt
   b. 1 1/2 ounces of cheese
   c. 1 cup pudding
   d. 1 3/4 cup ice cream
   e. 2 cups cottage cheese
   f. 8 to 9 ounces calcium-fortified juice
   g. 8 ounces lactose free milk (lactose intolerance only, not appropriate for milk allergy or milk intolerance)
   h. 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. Refer individuals to the RDN or designee to assess the need for additional diet alterations, including recommendations for protein, calcium and/or vitamin D supplementation as needed.
Nutrition Screening for Referrals to the Registered Dietitian Nutritionist

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 [http://www.mna-elderly.com/](http://www.mna-elderly.com/).

2. The facility will designate responsibility for completing the nutrition screening form. The nursing staff may complete the nutrition screening during initial assessment or the nutrition support staff may complete it during the initial visit when they 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 RDN or designee. Staff will notify the registered dietitian nutritionist (RDN) or designee and provide information for individuals with:
   a. Malnutrition as indicated by the screening tool (MNA® scores 7 or less)
   b. Risk for malnutrition or (as indicated by MNA® screening score of 8-11)
   c. Other criteria as determined by a facility’s screening tools or protocols (see policy on referral to RDN)

   The facility RDN, nutrition support staff and/or nurse manager will initiate appropriate interventions, as necessary, for the individual resident/patient. The RDN or designee will complete a comprehensive nutrition assessment and determine appropriate nutrition interventions.

5. The facility may choose to have the RDN or designee 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.

   As an alternate option, the facility may choose to use the MNA® as an internal document which is reviewed by the RDN during the next scheduled visit. The RDN will document in the medical record interventions or changes to the care plan as appropriate.

Note: The MNA® is a validated tool to identify malnutrition, or undernutrition, in adults age 65 and older. The MNA® and the 2012 A.S.P.E.N./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 psychosocial issues that increase malnutrition risk for older adults; it does not address inflammation.
Nutrition Screening for Referrals to the Registered Dietitian Nutritionist

Refer to the MNA® and MNA®-Self Assessment Forms, Sample Letter to the Physician and Sample Physician Communication Mini Nutritional Assessment® Report for Malnutrition later in this chapter. These tools are helpful when implementing this system.

**Note:** Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Referrals to the Registered Dietitian Nutritionist

Policy:

Facility staff will refer high-risk individuals to the RDN for assessment and interventions as needed.

Procedure:

1. The nutrition support staff, director of nursing, or designee will provide the RDN or designee with a list of the individuals no less than monthly including:
   a. New or re-admissions to the facility
   b. Physician-ordered nutrition consults
   c. Malnutrition risk score on MNA® of 11 or less, or as determined by the specific nutrition screening tool
   d. Others as determined by the facility may include but are not limited to:
      - Enteral/parenteral feedings
      - Significant weight changes (loss or gain)
      - Insidious weight loss (unplanned gradual weight loss)
      - Pressure injuries and other wounds
      - Dehydration risk
      - Dialysis or renal diets
      - Fluid restriction
      - 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
      - Desire to refuse diet as ordered

2. Facility staff will use the referral form provided to notify the RDN or designee of any problems as they arise. If the problem is urgent, facility staff will notify the RDN or designee of the problem by phone or secure email or fax and provide supporting information as requested by the RDN. (See Sample Referrals for Registered Dietitian Nutritionist Forms on the following pages.)

3. 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 RDN or designee.

Note: The Mini Nutrition Assessment® (MNA®) is a validated tool to identify malnutrition, or undernutrition, in adults age 65 and older. The MNA® and the 2012 A.S.P.E.N./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®-Self-Assessment Form (MNA®-SF) also addresses psycho-social issues that increase malnutrition risk for older adults; it does not address inflammation.

Refer to the MNA® and MNA®-Self Assessment Forms, Sample Letter to the Physician and Sample Physician Communication Mini Nutritional Assessment® Report for Malnutrition later in this chapter. These tools are helpful when implementing this system.
Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>Desire to Refuse Physician-Ordered Diet</td>
</tr>
<tr>
<td>Fluid Restriction</td>
</tr>
<tr>
<td>Needs Nutrition Education</td>
</tr>
<tr>
<td>Annual Assessments</td>
</tr>
<tr>
<td>Terminal Condition</td>
</tr>
<tr>
<td>Dialysis or Renal Diet</td>
</tr>
<tr>
<td>Dehydration risk</td>
</tr>
<tr>
<td>Pressure Injury or Wound</td>
</tr>
<tr>
<td>Significant Weight Loss or Gain (or insidious loss)</td>
</tr>
<tr>
<td>Enteral / Parenteral Feeding</td>
</tr>
<tr>
<td>Physician Ordered Consult</td>
</tr>
<tr>
<td>Screened for Referral (MNA® Score of 11 or less)</td>
</tr>
<tr>
<td>New/ Re-admit</td>
</tr>
</tbody>
</table>

| Facility: __________________________ |
| Date: ___________________ |
| Referral Date | Completed | Room Number | Name |
Sample Referrals for Registered Dietitian Nutritionist Form (2)

<table>
<thead>
<tr>
<th>Facility: __________________________</th>
<th>Date: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room/Name</td>
<td>New/ Re-admit</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Mini Nutritional Assessment MNA®

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 neurological 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

For more information: www.mna-elderly.com
Self-MNA® Mini Nutritional Assessment

For Adults 65 years of Age and Older

Last name:  
First name:  
Date:  
Age:  

Complete the screen by filling in the boxes with the appropriate numbers. Total the numbers for the final screening score.

<table>
<thead>
<tr>
<th>Screening</th>
<th>0 = severe decrease in food intake</th>
<th>1 = moderate decrease in food intake</th>
<th>2 = no decrease in food intake</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Has your food intake declined over the past 3 months? [ENTER ONE NUMBER] Please enter the most appropriate number (0, 1, or 2) in the box to the right.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>How much weight have you lost in the past 3 months? [ENTER ONE NUMBER] Please enter the most appropriate number (0, 1, 2 or 3) in the box to the right.</td>
<td>0 = weight loss greater than 7 pounds</td>
<td>1 = do not know the amount of weight lost</td>
</tr>
<tr>
<td>C</td>
<td>How would you describe your current mobility? [ENTER ONE NUMBER] Please enter the most appropriate number (0, 1, or 2) in the box to the right.</td>
<td>0 = unable to get out of a bed, a chair, or a wheelchair without the assistance of another person</td>
<td>1 = able to get out of bed or a chair, but unable to go out of my home</td>
</tr>
<tr>
<td>D</td>
<td>Have you been stressed or severely ill in the past 3 months? [ENTER ONE NUMBER] Please enter the most appropriate number (0 or 2) in the box to the right.</td>
<td>0 = yes</td>
<td>2 = no</td>
</tr>
<tr>
<td>E</td>
<td>Are you currently experiencing dementia and/or prolonged severe sadness? [ENTER ONE NUMBER] Please enter the most appropriate number (0, 1, or 2) in the box to the right.</td>
<td>0 = yes, severe dementia and/or prolonged severe sadness</td>
<td>1 = yes, mild dementia, but no prolonged severe sadness</td>
</tr>
</tbody>
</table>

Please total all of the numbers you entered in the boxes for questions A-E and write the numbers here:  

---

Policy & Procedure Manual  8-24  
Self-MNA® Mini Nutritional Assessment

Now, please CHOOSE ONE of the following two questions – F1 or F2 – to answer.

**Question F1**

<table>
<thead>
<tr>
<th>Height (feet &amp; inches)</th>
<th>Body Weight (pounds)</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>4'10&quot; Less than 91</td>
<td>91 – 99</td>
<td>0</td>
</tr>
<tr>
<td>4'11&quot; Less than 94</td>
<td>94 – 103</td>
<td>1</td>
</tr>
<tr>
<td>5'0&quot; Less than 97</td>
<td>97 – 106</td>
<td>2</td>
</tr>
<tr>
<td>5'1&quot; Less than 100</td>
<td>100 – 109</td>
<td>3</td>
</tr>
<tr>
<td>5'2&quot; Less than 104</td>
<td>104 – 113</td>
<td></td>
</tr>
<tr>
<td>5'3&quot; Less than 107</td>
<td>107 – 117</td>
<td></td>
</tr>
<tr>
<td>5'4&quot; Less than 110</td>
<td>110 – 121</td>
<td></td>
</tr>
<tr>
<td>5'5&quot; Less than 114</td>
<td>114 – 126</td>
<td></td>
</tr>
<tr>
<td>5'6&quot; Less than 118</td>
<td>118 – 129</td>
<td></td>
</tr>
<tr>
<td>5'7&quot; Less than 121</td>
<td>121 – 133</td>
<td></td>
</tr>
<tr>
<td>5'8&quot; Less than 125</td>
<td>125 – 137</td>
<td></td>
</tr>
<tr>
<td>5'9&quot; Less than 128</td>
<td>128 – 141</td>
<td></td>
</tr>
<tr>
<td>5'10&quot; Less than 132</td>
<td>132 – 145</td>
<td></td>
</tr>
<tr>
<td>5'11&quot; Less than 136</td>
<td>136 – 149</td>
<td></td>
</tr>
<tr>
<td>6'0&quot; Less than 140</td>
<td>140 – 153</td>
<td></td>
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<tr>
<td>6'1&quot; Less than 144</td>
<td>144 – 158</td>
<td></td>
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<tr>
<td>6'2&quot; Less than 148</td>
<td>148 – 162</td>
<td></td>
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<tr>
<td>6'3&quot; Less than 152</td>
<td>152 – 167</td>
<td></td>
</tr>
<tr>
<td>6'4&quot; Less than 156</td>
<td>156 – 171</td>
<td></td>
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</tbody>
</table>

Please refer to the chart on the left and follow these instructions:
1. Find your height on the left-hand column of the chart.
2. Go across that row and circle the range that your weight falls into.
3. Look to the bottom of the chart to find out what group number (0, 1, 2, or 3) your circled weight range falls into.

Write the Group Number (0, 1, 2, or 3) here: 

Write sum of questions A-E (from page 1) 

Lastly, calculate the sum of these 2 numbers. This is your SCREENING SCORE:

**Question F2** DO NOT ANSWER QUESTION F2 IF QUESTION F1 IS ALREADY COMPLETED.

Measure the circumference of your LEFT calf by following the instructions below:
1. Loop a tape measure all the way around your calf to measure its size.
2. Record the measurement in cm: 
   - If less than 31cm, enter "0" in the box to the right.
   - If 31cm or greater, enter "3" in the box to the right.

Write the sum of questions A-E (from page 1) here: 

Lastly, calculate the sum of these 2 numbers. This is your SCREENING SCORE:

Screening Score (14 points maximum)

<table>
<thead>
<tr>
<th>Points</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-14</td>
<td>Normal nutritional status</td>
</tr>
<tr>
<td>8-11</td>
<td>At risk of malnutrition</td>
</tr>
<tr>
<td>0-7</td>
<td>Malnourished</td>
</tr>
</tbody>
</table>

Copy your SCREENING SCORE:

If you score between 0-11, please take this form to a healthcare professional for consultation.

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Sample Letter to Physician

(Letterhead)

Date

Dear Doctor _______________________,

__________________________ (facility name) has adopted the Mini Nutritional Assessment - (MNA®) to screen for malnutrition in the elderly. The MNA® is a 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 malnutrition. 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 is one way to diagnose malnutrition. 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 Nutritionist
Insert Title and Contact Information

Note: Attach a copy of MNA® Form and MNA® Physician Communication Form.
Sample Physician Communication Mini Nutritional Assessment® Report for Malnutrition

<table>
<thead>
<tr>
<th>Room #</th>
<th>Patient Name</th>
<th>Review Date</th>
<th>*MNA Score</th>
<th>Intervention(s)</th>
<th>Physician Initials</th>
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</thead>
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*Score of 0-7 indicates patient has triggered 'Malnourished'
Medical Nutrition Therapy Documentation

Policy:

Documentation of medical nutrition therapy (MNT) for each individual is the responsibility of the registered dietitian nutritionist (RDN) with assistance as assigned to the nutrition support staff (i.e. nutrition associate, qualified dietitian, nutrition and dietetic technician, registered, and/or certified dietary manager, or director of food and nutrition services), as appropriate within each professional’s scope of practice and competency level. The facility will:

1. Provide nutrition care and services to each individual, consistent with the individual’s comprehensive assessment and individual preferences.

2. 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, using facility-approved electronic health records and/or forms.

Note: MNT documentation should use the Academy of Nutrition and Dietetics (The Academy) Nutrition Care Process of: 1) Nutrition Assessment, 2) Nutrition Diagnosis, 3) Nutrition Intervention, and 4) Nutrition Monitoring and Evaluation. Many facilities and RDNs have implemented the Academy’s Nutrition Care Process (NCP). The Academy encourages all RDNs and health care communities to use the NCP. For more information on the Academy Nutrition Care Process, visit http://www.eatrightpro.org/resources/practice/nutrition-care-process.

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 injuries 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 Policy: Comprehensive Medical Nutrition Therapy Assessment and Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment found later in this chapter of the manual.)

   Information for the MNT assessment will be gathered through interviews with individuals, family and staff, observations, and review of the medical record and other tools such as meal intake reporting, wound assessment, speech-language pathologist documentation, and bowel and bladder reporting. The form will be completed and reviewed by the RDN and/or designee. The assessment form will be filed in the medical record or completed in the electronic medical record. A new or re-assessment will be 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 RDN or designee.
Medical Nutrition Therapy Documentation

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.

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, as well as individual preferences. 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 RDN 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 should be 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 Skilled Nursing Facilities:
• The initiation of the nutrition assessment should be completed within 5 days of admission for Medicare patients/residents and within 14 days of admission for all residents.
• The initial care plan should be completed within 7 days after completion of the assessment.
• Progress notes and care plan updates should be 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 should be completed each time an individual is re-admitted, quarterly, upon significant change in condition and as deemed necessary by the facility or the RDN.
Role delineation is dictated by the current Standards of Practice (SOP) and Standards 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) and/or trained Director of Food and Nutrition Services** 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 and beverage preferences, pertinent data such as food allergies or intolerances, chewing and swallowing abilities and other relevant information. The CDM or food director of food and nutrition services 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 director of food and nutrition services manager’s role is to collect the factual data for documentation, communicate pertinent information to the RDN or designee and the interdisciplinary team, and implement the physician’s diet and supplement orders as applicable. The CDM or director of food and nutrition services also can communicate and implement the RDN or designee recommendations as appropriate.

- **The Nutrition and Dietetic Technician Registered (NDTR), Dietetic Technician Registered (DTR), Nutrition Associate, Licensed Dietitian (LD) and/or Registered Dietitian Nutritionist (RDN)** 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 RDN guides nutritional care of each resident/patient and provides information and guidance for facility wide systems for nutrition care. As support staff, the NDTR and Nutrition Associate work under the supervision of the RDN. The Academy SOP/SOPP for RDNs 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 or director of food and nutrition services). Review 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 RDN is ultimately responsible for the direction of nutrition care and should delegate tasks based on state and federal guidelines and the competency of the NDTR, DTR, Nutrition Associate or CDM.

**Summary:**
- The CDM or director of food and nutrition services gathers information to initiate assessments and progress notes.
- The RDN or designee assesses the nutritional status and completes the nutrition care process.

**For more information on Role Delineation:**
- Individual State Dietetic Licensure or Certification Board.
Resource: Role Delineation (Division of Responsibility for Documentation)

- Association of Food and Nutrition Professionals:
Comprehensive Medical Nutrition Therapy Assessment

Policy:

The RDN will complete a comprehensive medical nutrition therapy (MNT) assessment for each individual that is referred or identified for assessment. The purpose of nutrition assessment is to obtain, verify, and interpret data needed to identify nutrition-related problems, their causes, and significance. It is an ongoing, nonlinear and dynamic process that involves data collection and continual analysis of the individual’s status compared to specified criteria (1).

Note: Skilled nursing facilities use the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) for basic assessment (section K covers nutrition). The standard of care in skilled nursing facilities is to complete a comprehensive nutrition assessment in addition to the MDS. This policy refers to that comprehensive assessment.

Procedure:

1. An in-depth medical nutrition therapy (MNT) assessment will help identify the nature and causes of impaired nutrition and nutrition-related risks. The in-depth MNT assessment may use existing information from sources such as assessments from other disciplines, laboratory tests, patient/resident observations, and individual and family interviews. (See Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment later in this chapter of the manual.)

2. The RDN gathers information for the comprehensive MNT assessment from information available in the facility, individual observations, and nutrition-focused physical assessment. A variety of health care professionals contribute information, including:
   a. Nursing staff provides details about the individual’s nutrition intake, daily routines, and food preferences, and vital signs.
   b. Health care practitioners (e.g., physicians and nurse practitioners) determine medical diagnosis, identify causes of nutrition problems (i.e. anorexia and weight loss), and tailor interventions specific to each individual.
   c. Therapy staff provides information about swallowing ability, ability to self-feed, and need for adaptive feeding equipment or positioning during meals.
   d. Consultant pharmacists can help the staff identify medications that affect nutrition by altering taste or causing dry mouth, lethargy, nausea, or confusion.

3. The registered dietitian nutritionist (RDN) and/or designee will identify nutritional risk factors and nutrition diagnosis and recommend nutrition interventions based on each individual’s medical condition, needs, desires, and goals. (See Referrals to the Registered Dietitian Nutritionist located earlier in this chapter of the manual).

4. Interventions and goals will be developed based on individual’s preferences (e.g., desire to participate in weight management interventions or desire for nutritional support at end-of-life), the anticipated course of an 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 desire and capacity to permit additional diagnostic testing, monitoring and treatment.

5. The facility may use 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 can confirm the
likelihood of nutrition issues through additional clinical evaluation and evidence such as food intake, underlying medical condition, etc.

e. 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 an 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 (2,3). Serum albumin and pre-albumin appear to better reflect severity of the inflammatory response rather than poor nutritional status (4). They do not specifically indicate malnutrition and do not typically respond to feeding interventions when an acute inflammatory response is present (4).

f. 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. If lab tests are ordered, they should be consistent with the individual’s preferences, right to refuse treatment, and goals of care.

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 will conduct 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 will develop the specification of the nutrition concern (Nutrition Diagnosis determined by the RDN) 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% unintended weight loss the past 30 days
   b. Increased energy needs
      • Related to energy needs greater than calculated needs
      • As evidenced by 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 RDNs to adopt the Nutrition Care Process of Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention and Nutrition Monitoring and Evaluation.
References for Comprehensive Medical Nutrition Therapy Assessment:


Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment

The in-depth medical nutrition therapy (MNT) assessment should include the following information (1):

1. **Food and Nutrition-Related History:**
   a. Estimate of calorie, nutrient and fluid needs, and whether intake is adequate to meet those needs.
   b. The route (oral, enteral or parenteral) of food and/or fluid intake.
      - Meal and snack patterns and preferred portions sizes
   c. Food and beverage preferences (including ethnic foods and form of foods such as finger foods)
   d. Food allergies or intolerances.
   e. Food and fluid intake at meals and between meals
   f. Participation in select menus, buffet-style dining, or open dining.
   g. Ability to make food choices.
   h. Use of fortified foods, oral nutrition supplements, or other supplements that might affect nutritional status such as high calorie medication passes or protein supplements

2. **Nutrition-Focused Physical Findings:** Refer to Resource: Nutrition-Focused Physical Assessment in this chapter).
   Findings that may affect or reflect nutritional status:
   a. Robust, thin, obese, or cachectic
   b. Level of consciousness, responsiveness, affect
   c. Oral health and dentition
   d. Ability to use hands and arms
   e. Condition of hair, nails, and skin

3. **Anthropometric Measurements Including Height:**
   Refer to Policy and Procedure: Obtaining Accurate Heights and Resource: How to Obtain Accurate Heights in the Anthropometrics chapter of this manual.

   **Weight:**
   Significant unintended changes in weight (loss or gain) or insidious weight loss. Refer to the following Policies and Procedures and Resources: Obtaining Accurate Weights, How to Obtain Accurate Weights on Adjusting Weights for Amputees, Significant Weight Changes, Tracking Weight Changes, Significant Weight Loss, Significant Weight Gain all located in the Anthropometrics chapter of this manual.

   **Biochemical Data, Medical Tests, and Procedures**
   a. Lab data, such as electrolytes and glucose
   b. Medical tests and procedures, such as gastric emptying time, resting metabolic rate, swallowing tests, etc.

   **Client History**
   a. 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.
Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment

Additional information that might be useful to assessment of nutritional status includes:

1. **Fluid Intake and Fluid Balance:**
   a. Clinical manifestations of fluid and electrolyte imbalance, including abrupt weight changes, changes in food and fluid intake, or altered level of consciousness.
   b. Laboratory tests (e.g., electrolytes, BUN, creatinine and serum osmolality) that can identify, manage, and monitor fluid and electrolyte status.

2. **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:
   a. 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).
   b. Insufficient availability of food and fluid (e.g., inadequate amount of food or fluid or inadequate tube feedings).
   c. Environmental factors affecting food intake or appetite (e.g., comfort and level of disruption in the dining environment).
   d. Adverse consequences related to medications.
   e. 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).

3. **Medications (2,3)**
   a. **Medications that affect fluid balance:**
      • 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.
   b. **Medications that affect nutrient utilization:**
      • Examples include liquid phenytoin taken with tube feedings or grapefruit juice taken with some antihyperlipidemics).
   c. **Medications that affect nutrition status**
      • Almost every pharmaceutical class has medications that can affect nutritional status, directly or indirectly 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.

4. **Gastrointestinal (GI) Disorders:**
   a. 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.
   b. **Prolonged diarrhea or vomiting may increase nutritional requirements due to nutrient and fluid losses.**
   c. **Constipation or fecal impaction may affect appetite and excretion.**

5. **Hypermetabolic State related to Wounds or Medical Conditions:**
   Pressure injuries and some other wounds and other medical conditions can affect nutritional requirements.

Policy & Procedure Manual  8-36
a. 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 a facility choose appropriate interventions to minimize any subsequent complications.
b. Several medical problems that result in hypermetabolism can co-exist.

6. **Chewing Problems:**
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.

7. **Swallowing Problems**
a. A variety of conditions, including but not limited to stroke, pain, lethargy, confusion, dry mouth, and diseases of the oropharynx and esophagus can affect swallowing.
b. Swallowing ability may fluctuate from day to day or over time. In some individuals, aspiration pneumonia can complicate swallowing abnormalities.

8. **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.
a. 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).
b. Cognitive impairment may also affect an individual's ability to use a fork, or to eat, chew, and swallow effectively.

**References for Components of a Comprehensive Medical Nutrition Therapy Assessment:**
Resource: Nutrition-Focused Physical Assessment

Nutrition-focused physical assessment (NFPA) is an emerging area of nutrition and dietetics practice for RDNs and nutrition and dietetic technicians registered (NDTRs). Although it is only one component of the nutrition assessment process, it can help identify causes of nutritional deficiency and characteristics of malnutrition. NFPA goes beyond the traditional measurement of height, weight, body fat, arm and calf circumference and is considered an adjunct to traditional nutrition assessment. The NFPA combines a physical examination, vital signs, and anthropometrics with patient/resident interviews and data from the medical record (1). It is an important tool in the identification of malnutrition using the guidelines proposed by the Academy of Nutrition and Dietetics and the American Society for Enteral and Parenteral Nutrition.


Performing a Nutrition-Focused Physical Assessment
Nutrition-focused physical assessment is a hands-on assessment that uses four steps (1).

**Inspection:** A general observation that progresses to a more focused observation using the senses of sight, smell, and hearing. Most RDNs and NDTRs already perform a general observation of an individual’s condition and this should include things like noticing an order that might indicate ketosis or alcohol use and observing visually for signs of undernutrition or wasting.

1. **Palpitation:** Touching the individual to feel the skin’s temperature, and presence of edema, and touching the abdomen to assess for tenderness, and superficial masses.
2. **Percussion:** Assessment of body sounds to detect gas in the abdomen, fluid in the lungs, or other issues.
3. **Auscultation:** Use of the ear or a stethoscope to listen to heart and lung sounds, bowel sounds, and blood vessels.

The assessment uses a systems approach by evaluating the factors in the table on the next page (1,3). Traditionally physicians, nurse practitioners, physician’s assistants, and nurses perform these assessments. However, RDNs can embrace a hands-on approach and incorporate physical assessment into their practices (4) and/or review findings of another health care professional (1). Clinical judgment must be used to select indicators and determine the appropriate measurement techniques and reference standards (5). To successfully use the results of a NFPA, the practitioner must be able to interpret vital signs and physical findings and be familiar with how findings correlate with compromised nutritional status. Understanding these correlations is key to identifying and categorizing malnutrition.

Nutrition-Focused Physical Assessment and Scope of Practice
In 2013 the Academy of Nutrition and Dietetics published a *Scope of Practice for the Registered Dietitian*. Registered dietitians must practice under the state statutes (practice acts) that may (but not always) outline the types of activities they can perform. Each individual is responsible for understanding the legal requirements they operate under in the state in which they practice. The Academy’s *Scope of Practice* indicates that individual RDNs “can only practice in areas in which they are qualified and have demonstrated competence to achieve ethical, safe, and quality outcomes in the delivery of food and nutrition services” (6). This applies to all areas of nutrition and dietetics practice including the NFPA.

It is imperative for RDNs who plan to conduct NFPA develop their assessment skills and demonstrate competence using a framework outlined by an employer or qualified agency.
Reference standards that are outlined in facility policies and procedures should be used (2). For example, a hospital or nursing facility may have competency guidelines for nurses and nursing assistants for taking vital signs, listening to bowel sounds, etc. An RDN could easily undergo facility training and demonstrate competency to perform these evaluations and interpret their results. RDNs that are learning the NFPA process should, with the agreement of their employer, shadow other professionals who perform assessments and participate in hands-on assessments as part of the training process.

Systems Approach to Evaluating Physical Factors for Nutrition-Focused Physical Assessment

<table>
<thead>
<tr>
<th>Physical Appearance</th>
<th>Nerves and Cognition</th>
<th>Extremities, Muscles, and Bones</th>
<th>HEENT (Head, Eyes, Ears, Nose, and Throat)</th>
<th>The Cardiopulmonary System</th>
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</thead>
<tbody>
<tr>
<td>• Body size</td>
<td>• Ability to communicate</td>
<td>• Hand grip strength</td>
<td>• Ability to smell and taste</td>
<td>• Ability to breathe</td>
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<tr>
<td>• Body type</td>
<td>• Cognitive status</td>
<td>• Range of motion</td>
<td>• Loss of orbital (around the eye), buccal (around the cheeks), facial fat</td>
<td>• Breath sounds</td>
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<tr>
<td>• Appearance of wasting or obesity</td>
<td>• Reflexes</td>
<td>• Subcutaneous fat</td>
<td>• Vision and hearing</td>
<td>• Regular heart rhythm</td>
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<tr>
<td>• Level of consciousness</td>
<td>• Ability to feel pain in extremities</td>
<td>• Muscle mass</td>
<td>• Chewing or swallowing problems</td>
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<tr>
<td>• Paralysis or involuntary movement</td>
<td>• Gross and fine motor skills</td>
<td>• Edema</td>
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<tr>
<td>• Amputations or contractures</td>
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<td>• Ability to stand and walk</td>
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<td>• Affect</td>
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<tr>
<td>• Condition of hair and nails</td>
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<th>Vital Signs</th>
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<td>• Blood pressure</td>
<td>• Oxygen saturation/respiratory rate</td>
<td>• Temperature</td>
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<td>• Heart rate</td>
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<td>• Presence of surgical wounds, pressure injuries, stasis ulcers, or diabetic foot ulcers</td>
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<tr>
<td>• Poor or delayed wound healing</td>
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<td>• Skin turgor</td>
<td>• Skin color</td>
<td>• Presence of surgical wounds, pressure injuries, stasis ulcers, or diabetic foot ulcers</td>
<td>• Condition of teeth, presence of dentures and/or partials</td>
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<td>• Condition of oral cavity and tongue</td>
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<td>• Bowel sounds</td>
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<td>• Abdominal pain</td>
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References for Nutrition-Focused Physical Assessment


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. The care plan should be based on patient/resident strengths and preferences, be oriented toward avoiding preventable declines in functioning, and reflect current standards of care in professional practice (1). The director of food and nutrition services, qualified dietitian, and/or designee will be part of the care planning team.

Procedure:

1. Based on information generated by the comprehensive assessment and any pertinent additional MNT assessment, the interdisciplinary team will develop an individualized care plan with input from the resident/patient and/or representative.
   a. Care plan format should reflect facility protocols and should be resident-centered and/or resident directed (“I” care plans). Resident centered care plans involve the resident and multiple disciplines. “I” care plans are totally focused on the wants, needs, and desires of the resident and written from their perspective (2).
   b. The care plan should include an assessment of the patient’s/resident’s strengths and needs and incorporate personal and cultural preferences in developing goals of care. (1)

2. The care plan should address, to the extent possible, identified causes of impaired nutrition status. The care plan should reflect the individual’s goals and choices, and identify individual-specific interventions. It should include a time frame in which goals might be achieved and parameters for monitoring progress.

3. The care plan should be updated as needed: i.e., 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.
   a. If nutrition goals are not achieved, new or additional pertinent approaches are identified and implemented as indicated.
   b. 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. Each individual or their representative should make informed choices about accepting or declining care and treatment.
   a. The facility can help the individual exercise the right of choice effectively by discussing condition, treatment options (including related risks and benefits, and expected outcomes), personal preferences, and 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.
   b. 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
Comprehensive Care Plan

should take into account relevant considerations such as the individual's condition, prognosis, and known values and choices. See Resource: End of Life Nutrition and Hydration in the Nutrition Interventions chapter of this manual).

5. A variety of interventions should be used to meet the individuals’ nutritional needs based on many factors including, but not limited to food and beverage preferences, 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.
   a. 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. Outcomes should be monitored interventions evaluated after care plan implementation. Review the individual’s-specific factors identified as part of the latest comprehensive individual assessment and any supplemental MNT assessment.
   a. 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).
   b. 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:
      • Observing for and recognize emergence of new risk factors (e.g., acute medical illness, pressure injuries, or fever).
      • Evaluating consumption of between-meal snacks and oral nutritional supplements.
      • Reviewing the continued relevance of any current nutritional interventions (e.g., therapeutic diets, tube feeding orders or oral nutritional supplements).

7. The care plan should be evaluated 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.
   a. Subsequent adjustment of interventions will depend on progress, underlying causes and overall condition.
   b. Nutrition-related goals should be modified 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).

References for Comprehensive Care Plan:

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, RDN 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.
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; and providing personal hygiene before and after meals (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/individualized diet, and the individual’s preferences to accept risks in favor of a more liberalized food intake (6,7).

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.

References for Weight Related Nutrition Interventions:
Medical Nutrition Therapy Documentation Forms

Insert a blank copy of your medical nutrition therapy (MNT) documentation forms here. Include any instructions, policies on nutrition screening, assessment, progress notes and care plans, as applicable to your specific forms.

Medical Nutrition Therapy Recommendations

Policy:

Medical nutrition therapy (MNT) recommendations from the registered dietitian nutritionist (RDN) or designee will be implemented, or the reason for non-implementation will be documented.

Procedure:

1. Any of the RDN’s or designee’s recommendations related to food and beverage preferences will be given to the director of food and nutrition services, who will follow through and implement them in the facility. (Informing staff, making necessary changes on the meal identification (ID) card/ticket, etc.). The director of food and nutrition services will follow through on these recommendations in a timely manner.

2. Any recommendations that need nursing’s attention or a physician’s order will be forwarded in writing to the nursing staff (see Sample Nutrition Recommendations Form on the following page) When nursing addresses the recommendations, comments regarding follow through will be added to the form and orders written in the medical record as appropriate. Completed forms will be returned to the RDN or designee for documentation of actions taken, new orders and follow through. Referrals will be made back to the RDN or designee as needed.

3. Routine recommendations will be implemented in a timely manner. Recommendations that are urgent will be handled and physician’s orders written in 72 hours or less.

4. The RDN or designee will follow up on routine recommendation in a timely manner (within one to two weeks for nursing facilities). Urgent recommendation may require more timely follow up. Urgent recommendations or concerns may be handled via phone, secure fax or secure email.

5. If the physician is not in agreement with recommendation from the RDN or designee, documentation will be written in the physician’s progress notes, nurse’s notes, and/or nutrition progress notes.

6. If the physician has delegated order-writing privileges to the RDN, the RDN will write the diet order, alert nursing staff, and leave the order in the appropriate place for the MD to sign in a timely manner as per facility protocols.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/diетetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
### Sample Nutrition Recommendations Form

**Facility:**

**Wing:**

Please complete and return to RDN or designee. Thank You!

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<th>Room__________</th>
<th>New____</th>
<th>Re-admit____</th>
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Communication of Nutrition Concerns

Policy:

The registered dietitian nutritionist (RDN) or designee will communicate concerns about individual patients/residents, nutrition care delivery and/or food service systems to the appropriate facility staff.

Procedure:

1. The RDN or designee is an active member of the appropriate interdisciplinary (IDT) committees (i.e. care plan team, nutrition at risk committee, wounds/pressure injury team, weight team, dining team etc.).

2. Under the direction of the RDN or designee, nutrition support staff may communicate issues of concern to key personnel (RDN, physician, nursing staff, therapists, etc.) and help resolve problems with input from the RDN.
   a. Nutrition support staff will follow through on duties as delegated by the RDN as appropriate.
   b. Nutrition support staff will follow up on communications as needed and serve as a liaison between the RDN and the interdisciplinary team as needed when the RDN is not readily available.

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

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Obtaining Accurate Heights

Policy:

Each individual's height will be determined and documented upon admission to the facility. Height will be re-measured 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 re-measure 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.
To obtain an accurate height, the following methods may be used:

**Standing 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, without shoes.
  - 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.
Obtaining Accurate Weights

Policy:

Each individual’s weight will be obtained 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 nutritionist (RDN) 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.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Follow these best practices:
- Balance the scale back to 0 before and after weighing each time.
- If possible, scale should remain stationary and not be moved.
- Weigh each individual at the same time each month.
- Record the weight immediately after weighing 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 presence of casts, 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.
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 re-measured for accuracy.
- The registered dietitian nutritionist (RDN) or designee should review these measurements monthly and assess the need for changes in medical nutrition therapy.
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 later in this chapter.)

<table>
<thead>
<tr>
<th>Average Weight Percentage of Body Segments</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Arm and Hand</td>
<td>2.3%</td>
</tr>
<tr>
<td>Entire Arm and Hand</td>
<td>5.0%</td>
</tr>
<tr>
<td>Lower Leg and Foot</td>
<td>5.9%</td>
</tr>
<tr>
<td>Entire Leg</td>
<td>16%</td>
</tr>
</tbody>
</table>

Procedure:

1. Using the Height/Weight Tables for Determining Body Weight Ranges to determine the individual’s normal IBW for height

2. Locate the percentage weight of the amputated limb and calculate the number of estimated pounds for that limb.

3. 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) – 148#
- 148# x .059 (5.9%) = 8.73 pounds
- Adjusted Ideal Body Weight = 148# - 8.55# = 139.27#

Reference:
Measurements For Those Who Can’t Be Weighed

Policy:

For individuals who are unable or unwilling to be weighed, measurements can be taken on a regular basis and tracked for changes.


Procedure for Mid-Arm Circumference

- Using a tape measure find mid-point of arm which is half the distance between the tip of the shoulder and the tip of the elbow. Mark the mid-point with a pen or marker.
- Use the marked location on the arm measured to measure the mid-arm circumference; the individual being measured should be in a supine position with the arm extended along the side of the body and the palm facing upward.
- Raise the individual’s arm slightly off the surface of the bed by placing a folded towel under the elbow.
- Slip the tape measure around the arm and into position over the mid-point mark.
- Read and record the measurement and repeat twice for accuracy.

Procedure for Mid-Thigh Circumference

- Legs should be slightly apart. Measure midway between the proximal border of the patella (upper knee) and the intersection of the inguinal crease and the mid-line of the thigh.
- Pull tape snug, but do not compress the tissue.
- Read and record the measurement and repeat twice for accuracy.

Procedure for Mid-Calf Circumference

- Individual should lie in a supine position with the knee bent at a 90 degree angle.
- Slip the tape over the bent leg and slide it up to the calf, until the largest diameter is located.
- Pull the tape snug but do not compress the tissue.
- Read and record the measurement and repeat twice for accuracy.

Procedure for Abdomen Circumference

- Place measuring tape around the waist, just above the bony crease of the hip.
- The tape should run parallel to the floor and is snug but does not compress the tissue.
- The measurement should be taken at the end of normal expiration of breath.
- Read and record the measurement and repeat twice for accuracy.

To Assure Accurate Measurements

- Tape measure should be taut, but not tight. Measurement variations of >1/4” difference from the previous measurement should be re-measured for accuracy.
- For accuracy and reliability each measurement should be taken three times, yielding similar readings, measurements should be taken by two separate professionals repeated measurements should agree within 0.5 cm.
- Measurements should be done monthly and are recorded in inches, recorded per facility policy and monitored for change.
- The registered dietitian nutritionist (RDN) or designee will review these measurements monthly and assess the need for changes in medical nutrition therapy (MNT).
Measurements For Those Who Can’t Be Weighed

Reference

See *Sample Measurement Tracking for Individuals Who Cannot Be Weighed Form* for measurement record keeping later in this chapter.

**Note:** Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
**Sample Measurements Tracking for Individuals Who Cannot be Weighed Form**

**Body Measurements**

<table>
<thead>
<tr>
<th>Date</th>
<th>Abdomen*</th>
<th>Arm (Mid-Point) R</th>
<th>Arm (Mid-Point) LT</th>
<th>Mid-Thigh (Mid-Point) R</th>
<th>Mid-Thigh (Mid-Point) LT</th>
<th>Mid-Calf (Widest Point) R</th>
<th>Mid-Calf (Widest Point) LT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Measure abdominal girth just above the bony crease of the hip. Measure upper arm, calf and thigh at the midpoint.
### Adult Ideal Weight Ranges 51 + Years

<table>
<thead>
<tr>
<th>Females:</th>
<th>Males:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Height</td>
</tr>
<tr>
<td></td>
<td>Height</td>
</tr>
<tr>
<td></td>
<td>Height</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>4'8&quot;</td>
<td>81-99</td>
</tr>
<tr>
<td>4'9&quot;</td>
<td>83.5-102</td>
</tr>
<tr>
<td>4'10&quot;</td>
<td>85-105</td>
</tr>
<tr>
<td>4'11&quot;</td>
<td>87.5-107</td>
</tr>
<tr>
<td>5'0&quot;</td>
<td>90-110</td>
</tr>
<tr>
<td>5'1&quot;</td>
<td>94-116</td>
</tr>
<tr>
<td>5'2&quot;</td>
<td>99-121</td>
</tr>
<tr>
<td>5'3&quot;</td>
<td>104-127</td>
</tr>
<tr>
<td>5'4&quot;</td>
<td>108-132</td>
</tr>
<tr>
<td>5'5&quot;</td>
<td>112-138</td>
</tr>
<tr>
<td>5'6&quot;</td>
<td>117-143</td>
</tr>
<tr>
<td>5'7&quot;</td>
<td>121-149</td>
</tr>
<tr>
<td>5'8&quot;</td>
<td>126-154</td>
</tr>
<tr>
<td>5'9&quot;</td>
<td>130-160</td>
</tr>
<tr>
<td>5'10&quot;</td>
<td>135-165</td>
</tr>
</tbody>
</table>

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.

Determining 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.

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
<th>Principal cut-off points</th>
<th>Additional cut-off points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>U ≤ 18.50</td>
<td>&lt;18.50</td>
<td>&lt;18.50</td>
</tr>
<tr>
<td>Severe thinness</td>
<td>S ≤ 16.00</td>
<td>&lt;16.00</td>
<td>&lt;16.00</td>
</tr>
<tr>
<td>Moderate thinness</td>
<td>M 16.00 - 16.99</td>
<td>16.00 - 16.99</td>
<td>16.00 - 16.99</td>
</tr>
<tr>
<td>Mild thinness</td>
<td>M ≤ 17.00</td>
<td>17.00 - 18.49</td>
<td>17.00 - 18.49</td>
</tr>
<tr>
<td>Overweight</td>
<td>O ≥ 25.00</td>
<td>≥25.00</td>
<td>≥25.00</td>
</tr>
<tr>
<td>Pre-obese</td>
<td>P 25.00 - 29.99</td>
<td>25.00 - 27.49</td>
<td>27.50 - 29.99</td>
</tr>
<tr>
<td>Obese</td>
<td>O ≥ 30.00</td>
<td>≥30.00</td>
<td>≥30.00</td>
</tr>
<tr>
<td>Obese class I</td>
<td>O 30.00 - 34.99</td>
<td>30.00 - 32.49</td>
<td>32.50 - 34.99</td>
</tr>
<tr>
<td>Obese class II</td>
<td>O 35.00 - 39.99</td>
<td>35.00 - 37.49</td>
<td>37.50 - 39.99</td>
</tr>
<tr>
<td>Obese class III</td>
<td>O ≥ 40.00</td>
<td>≥40.00</td>
<td>≥40.00</td>
</tr>
</tbody>
</table>


2. The registered dietitian nutritionist (RDN) or designee will determine the BMI for individuals utilizing the following formula (or by utilizing the online BMI calculator that can be found at [https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html](https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html)). In some instances, computer programs utilized by the RDN or designee will calculate the BMI automatically when weights and heights are recorded.

\[
\text{BMI} = \frac{\text{weight (kg)}}{\text{height (meters squared)}}
\]

Current weight in kilograms divided by the square of the height in meters

OR

\[
\text{BMI} = \frac{\text{weight (lbs.)}}{\text{height (inches squared))} \times 705}
\]

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Determining Body Mass Index

3. The RDN or designee will provide appropriate nutritional interventions for individuals with low or declining BMI or individuals with BMI over 30 as appropriate and consistent with goals of care.

4. BMI is interpreted based on age, health history, usual body weight, and weight history.

Reference:
Resource: Significant Weight Change

Significant and severe weight change is defined as follows:

<table>
<thead>
<tr>
<th>Time Interval</th>
<th>Significant Change</th>
<th>Severe Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Week</td>
<td>1-2%</td>
<td>Greater than 1-2%</td>
</tr>
<tr>
<td>1 Month</td>
<td>5%</td>
<td>Greater than 5%</td>
</tr>
<tr>
<td>3 Months</td>
<td>7.5%</td>
<td>Greater than 7.5%</td>
</tr>
<tr>
<td>6 Months</td>
<td>10%</td>
<td>Greater than 10%</td>
</tr>
</tbody>
</table>

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 Policy and Procedure: Significant Weight Loss found later in this chapter.
- For weight gain, follow the Policy and Procedure: Significant Weight Gain on found later in this chapter.

To calculate significant weight change, use the following formula:

\[
\text{Recent body weight} - \text{current body weight} \times 100 = \text{percent weight change} \\
\text{Recent body weight}
\]

**Example:**
Weight January 1: 152 pounds
Weight February 1: 142.5 pounds

\[
152 - 142.5 = 9.5 \text{ pounds}
\]

\[
9.5 \div 152 = 0.0625
\]

\[
0.0625 \times 100 = 6.25\%
\]

Most electronic weight tracking systems or electronic medical records generate reports that can automatically calculate weight loss over a period of time. Refer to users guide for information.

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 will be 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 nutritionist (RDN) or designee, nursing supervisor, etc. The RDN or designee will review monthly weights and calculate significant change over one, three, and six months. Many electronic weight tracking programs or electronic medical record reports will calculate weight changes over time and flag those that are significant, however they should be confirmed by a review by the RDN. 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. The care plan team should address weight loss that does not trigger as significant 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 RDN or designee. The RDN or designee will review all significant weight losses, and assess for insidious weight loss. The RDN or designee will make referrals and take action as necessary (including follow up documentation).

6. The individual, family (or representative), physician and RDN or designee will be notified of any individual with an unintended significant weight change of 5% in one month, 7.5% in three months, or 10% in six months. This includes significant weight gain, which could be an indicator of heart or kidney failure.

7. Individuals with significant unintended weight changes will be added to weekly weights for a minimum of 4 weeks or until weight stabilizes.

8. Individuals with insidious weight loss may be added to weekly weights at the discretion of the physician, RDN, or interdisciplinary team, particularly if medical condition has changed or meal intake has declined.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
# Sample Monthly Weight Record Form

## Monthly Weight Record for _________ Year

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Ht</th>
<th>UBW</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
</table>

Ht = Height  
UBW = Usual body weight
# Sample Individual Weight Chart Form

Name ___________________________ Ht __________ UBW _______ Year ________

<table>
<thead>
<tr>
<th>Time Interval</th>
<th>Significant Change</th>
<th>Severe Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>5%</td>
<td>Greater than 5%</td>
</tr>
<tr>
<td>3 months</td>
<td>7.5%</td>
<td>Greater than 7.5%</td>
</tr>
<tr>
<td>6 months</td>
<td>10%</td>
<td>Greater than 10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month/Date</th>
<th>Wt</th>
<th>% Wt. Change Past Month</th>
<th>% Wt. Change Past 3 Months</th>
<th>% Wt. Change Past 6 Months</th>
<th>Date Resident, Family, RD &amp; Physician Notified</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
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UBW = Usual body weight

Formula to determine weight loss:

Percentage Weight Change:

\[
\text{Previous Weight} - \text{Current Weight} \div \text{Previous Weight} \times 100
\]

Circle % weight change if significant or severe.

Comments should reflect identified causes and/or interventions implemented for significant weight loss.
<table>
<thead>
<tr>
<th>Name</th>
<th>Room</th>
<th>Previous Weight/Date</th>
<th>Date</th>
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Sample Significant Weight Changes Form

<table>
<thead>
<tr>
<th>Room No.</th>
<th>Name</th>
<th>Previous Month Weight</th>
<th>Present Month Weight</th>
<th>↑ ↓ % Gain or Loss</th>
<th>Re-weigh Required</th>
<th>Re-weigh Weight/Date</th>
<th>Notified</th>
<th>Comments</th>
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+ For significant weight gain of ≥ 5%
- For significant weight loss of ≤ 5%
Sample Weight Change Notification and Recommendations Form*

Patient/Resident Name _________________________________ Date ________________

Physician ____________________________________________ Room ID_____________

<table>
<thead>
<tr>
<th>Significant Weight Change</th>
<th>Recommendations</th>
</tr>
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<tbody>
<tr>
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</table>

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 _________________________________________________________

☐ RDN Notified  Yes  No  Date ________________

Notes _________________________________________________________

Additional Comments
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

*Note: This form is only used when RDN order-writing privileges have not been granted by physician.
Sample Significant Weight Loss Form

Name ____________________________________________

Weight loss _____% loss in _____ months                  Clinically Unavoidable Yes  No

Interventions attempted to address weight loss
____________________________________________________
____________________________________________________
____________________________________________________

Identified Concerns
_____ Refusal to eat and/or inadequate intake
_____ End-stage disease state: __________________________
_____ Increased nutritional needs associated with pressure ulcers, burns, fractures or surgery:
________________________________________________________________________________

_____ Prolonged nausea, vomiting or diarrhea not relieved by treatment provided
_____ Radiation or Chemotherapy
_____ Medications with weight loss implications
_____ Other: __________________________________________

<table>
<thead>
<tr>
<th>Dietary Notes</th>
<th>Nursing Notes</th>
<th>Social Service Notes</th>
<th>Physician Notes</th>
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<tbody>
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</table>

RDN Signature ___________________________   Date ________________
RN Signature ___________________________   Date ________________
SS Signature ___________________________   Date ________________
Physician Signature ______________________ Date ________________
Immediate Temporary Interventions for Unintended Significant Weight Loss

Policy:

Individuals with unintended 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. Facility staff 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:
   a. Oral nutritional supplement one to three times a day, between meals or with medication passes.
   b. Other interventions such as extra milk, pudding, yogurt, milkshakes, fortified foods, or extra portions as appropriate.

3. The food and nutrition services will be notified using facility procedures (dietary communication slip or electronic communication as appropriate) to request this temporary intervention.

4. The food and nutrition service staff will change the temporary intervention if it is not appropriate for the individual. For example, if the individual is lactose intolerant or has milk allergy but a milk-based supplement has been ordered. The director of food and nutrition services has the authority to change this to an appropriate intervention based on information on retarding allergies, intolerances, and food and beverage preferences.

5. The registered dietitian nutritionist (RDN) or designee will review all significant/severe weight losses monthly or more often as needed and assess nutritional status. At that time, the temporary intervention may be changed as needed. The RDN or designee will document the interventions and their nutritive value (portion, number of times per day ordered, and calories and protein they provide).

6. The RDN 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Significant Weight Loss

Policy:

The goal of medical nutrition therapy (MNT) for significant unintended weight loss is to identify underlying causes or factors contributing to the significant unintended weight loss, and intervene as appropriate to resolve the problem and stabilize weight.

Procedure:

Appropriate members of the interdisciplinary team will:

1. Identify individuals with significant/severe weight losses.

<table>
<thead>
<tr>
<th>Significant Weight Loss</th>
<th>Severe Weight Loss</th>
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<tbody>
<tr>
<td>5% weight loss in 1 month</td>
<td>&gt;5% weight loss in 1 month</td>
</tr>
<tr>
<td>7.5% weight loss in 3 months</td>
<td>&gt;7.5% weight loss in 3 months</td>
</tr>
<tr>
<td>10% weight loss in 6 months</td>
<td>&gt;10% weight loss in 6 months</td>
</tr>
</tbody>
</table>

a. Re-weigh the individual to assure accurate weight.
b. Interview direct care givers for information on recent changes.
c. Review the individual’s food intake records to estimate the average percentage of food/fluid intake in the past two to four weeks.
d. Assess whether or not the weight loss was desired by the individual or expected (such as in resolution of severe edema), and document accordingly.
e. Assess for stress factors (flu, fever, edema, infections, etc.) or cognitive changes (dementia, depression, etc.) that may have contributed to the weight loss.
f. Assess ability to eat independently, chewing/swallowing ability, tolerance/acceptance of diet, etc.
g. Assess the individual’s laboratory values when available and if appropriate.
h. Assess for potential food-medication interactions.
i. Review the care plan for pertinent information.
j. Document estimated nutritional needs (calories, protein, and fluid) versus estimated food/fluid intake (utilizing food intake records).
k. Assess for risk of undernutrition or protein-energy malnutrition. Identify potential causes. Document findings in the medical record.
l. Interview the individual to identify possible causes and to determine appropriate nutrition interventions.
m. Individualize nutrition approaches to accommodate the least restrictive diet appropriate to maximize meal intake.
n. Request/implement nutrition interventions based on the individual’s food and beverage preferences. Document the additional nutritional value (calories, protein, fluids) these interventions will provide.
o. Place the individual on weekly weights for one month and review these weights weekly.
p. Monitor and evaluate to assess effectiveness of the intervention.
q. Complete follow up documentation as needed.

2. Continued Weight Loss

a. Re-weigh to assure accurate weight.
b. Assess whether or not the weight loss was desired by the individual or expected (such as resolution of severe edema), and document accordingly.
c. Review food and fluid intake documentation over the past 7 to 14 days. Observe intake directly if possible. A three day calorie count or plate waste study may also be considered.
d. Assess the individual’s laboratory values when available and if appropriate.
e. Re-calculate estimated nutritional needs.
f. Compare nutritional needs to actual intake (calories, protein and fluids at minimum).
g. Note potential reasons why the initial nutrition intervention was not successful.
h. Interview the individual again for possible causes and appropriate interventions.
i. Provide individualized aggressive nutrition interventions, including but not limited to:
   - Assistance with eating as needed
   - Update and honor individual food and beverage preferences
   - Liberalize /individualize diet
   - Offer six small meals
   - Offer nutritional snacks between meals
   - 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
   - Consider appetite stimulants, if appropriate
   - High calorie/high protein supplements
j. 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 as needed.
k. Speak with the individual (or family representative) about their wishes for aggressive nutrition care. Share pertinent information with appropriate care staff.
l. 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.
m. 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.
n. 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.
Significant Weight Loss

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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Significant Weight Gain

Policy:

The goal of medical nutrition therapy (MNT) for significant weight gain is to stabilize the weight if possible, 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. Identify individuals with significant/severe weight gain.

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<thead>
<tr>
<th>Significant Weight Gain</th>
<th>Severe Weight Gain</th>
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<tbody>
<tr>
<td>5% weight gain in 1 month</td>
<td>&gt;5% weight gain in 1 month</td>
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<tr>
<td>7.5% weight gain in 3 months</td>
<td>&gt;7.5% weight gain in 3 months</td>
</tr>
<tr>
<td>10% weight gain in 6 months</td>
<td>&gt;10% weight gain in 6 months</td>
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</table>

   a. Reweigh to assure accurate weight.
   b. Assess for recent weight loss and whether the individual is now regaining back to baseline weight.
   c. Consider food intake at activities, food kept in the individual’s room, food brought into facility by family and friends, or food consumed when out of the facility.
   d. Assess for possible fluid imbalance.

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; Are there negative outcomes associated with the weight gain? Does the resident enjoy food and get pleasure from eating? Is the resident aware of the weight gain and comfortable with it? Are there negative outcomes associated with interventions to address weight gain (such as loss of muscle mass)? If the weight gain is not desired, proceed with the following:
   a. Review the medical record for food and fluid intake, changes in medications (especially steroids), renal status, laboratory values, weight history, recent changes in medical, physical or cognitive status, recent social events, etc.
   b. Interview the individual, family and staff for information on habits and weight history.
   c. Assess food intake records, use of supplements, and changes in food/fluid intake or supplements.
   d. Estimate calorie needs, taking into consideration activity level or recent changes in activity level.
   e. Assess for behaviors such as hoarding, bingeing, or stealing food.
   f. Consider scale accuracy and weighing technique. Has the scale been calibrated recently? Is there a pattern of weight gain in the facility that might indicate problems with the scale? Have there been any changes in the staff that normally obtain weights?
   g. Investigate weighing techniques: Was the individual weighed with a new prosthesis, brace, cast or other device, or a gel pad, wheel chair bag, or full catheter bag? Was the individual weighed at a different time of day, on a different scale, or in a different wheelchair?
   h. Assess for conditions such as over-hydration, dialysis (dry weight versus predialysis weight), exacerbation of heart failure (HF), impaired renal status, edema, or ascites.
   i. Assess for recent administration of IV for rehydration or TPN/PPN for hydration or nutritional intervention.
j. Provide individualized nutrition interventions as indicated:
   • Change in diet, (such as reduced sodium or fluid restriction if needed)
   • Decrease in supplements
   • Decrease in enteral feeding or fluids
   • Changes in medications
k. Document all information and recommendations accordingly.

The RDN will make recommendations as appropriate based on the MNT assessment.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
<table>
<thead>
<tr>
<th>Nutrition Interventions</th>
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<td>Nutrition at Risk Committee (or Weight Intervention and Nutrition Support Committee)</td>
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<tr>
<td>Interventions for Unintended Weight Loss</td>
<td>10-2</td>
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<tr>
<td>Resource: Potential Interventions for Unintended Weight Loss</td>
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<tr>
<td>Resource: Calorie Boosters/Fortified Foods</td>
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<td>Resource: Protein Boosters</td>
<td>10-6</td>
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<td>High Calorie/High Protein Supplements</td>
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<td>Supplement Formulary</td>
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<td>Dehydration</td>
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<td>Resource: Additional Recommendations for Promoting Adequate Hydration</td>
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<td>Fluids at the Bedside</td>
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<td>Encourage Fluids Order</td>
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<tr>
<td>Fluid Restrictions and Sample Distribution of Fluids</td>
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<td>Pressure Injuries</td>
<td>10-15</td>
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<tr>
<td>Resource: Risk Factors for Pressure Injury Development</td>
<td>10-18</td>
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<tr>
<td>Resource: Nutritional Needs for Prevention and Treatment of Pressure Injuries</td>
<td>10-19</td>
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<tr>
<td>Individuals on Unsupplemented Clear Liquids or NPO</td>
<td>10-21</td>
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<tr>
<td>Dysphagia</td>
<td>10-22</td>
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<tr>
<td>Resource: Dysphagia Warning Signs</td>
<td>10-23</td>
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<tr>
<td>EAT-10 Swallowing Screening Tool</td>
<td>10-24</td>
</tr>
<tr>
<td>Resource: Positioning Tips to Increase Independence and Reduce Risk of Aspiration or Choking</td>
<td>10-25</td>
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<tr>
<td>Thickened Liquids</td>
<td>10-26</td>
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</table>
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- Sample Decline of Life-Prolonging Procedures and Treatments Form .... 10-29
- Guidelines for Enteral Feeding Eligibility .................................. 10-30
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Nutrition at Risk Committee  
(or Weight/Wound Intervention and Nutrition Support Committee)

Policy:

The interdisciplinary team in the nutrition at risk (or weight/wound intervention and nutritional support – WINS committee) meeting will discuss individuals assessed to be at nutritional risk.

Procedure:

1. The nutrition at risk (or WINS) committee may consist of the following interdisciplinary team (IDT) members: director of food and nutrition services, nutrition and dietetic technician registered NDTR), registered dietitian nutritionist (RDN), director of nursing (DON), charge nurses, and/or restorative nursing or other direct care staff 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, pastor, and/or activities director.

2. The committee will meet weekly or as needed to address the needs of high-risk residents/patients.

3. The RDN or designee will provide the list of individuals 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:
   a. New admissions/readmissions for 4 weeks or until the committee discontinues weekly weights
   b. Individuals with new tube feeding (first 4 weeks on tube feeding or new formula changes in the first 4 weeks)
   c. Individuals transitioning from tube feeding to oral feeding with recent decreases in tube feeding orders to promote increased oral intake
   d. Those with less than 50% food intake for 3 days (9 consecutive meals), until intake is stable
   e. Those identified as being at risk or having malnutrition or undernutrition
   f. Significant unintended weight changes, or insidious weight loss, until stable
   g. Pressure injuries
   h. Fluid imbalance (i.e. dehydration, over-hydration)
   i. Diagnosis of fecal impaction
   j. Total parenteral nutrition
   k. Dialysis
   l. Those receiving thickened liquids, or 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 and/or electronic record will be accessed.

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.
Interventions for Unintended Weight Loss

Policy:

Individuals with unintended weight loss or insidious weight loss will be identified and monitored so that appropriate intervention can be implemented.

Procedure:

1. Individuals will be weighed upon admission or readmission, weekly for the first 4 weeks after admission, and at least monthly thereafter to help identify and document weight trends. Individuals may also be weighed weekly 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. Factors that may impact weight and the significance of apparent weight changes include:
   a. The individual's usual weight through adult life
   b. Current medical condition
   c. Therapeutic diet
   d. Calorie restricted diet or calorie-enhanced diet
   e. Recent changes in food or fluid intake
   f. Edema
   g. Dehydration

In some cases, weight monitoring is not indicated (e.g., the individual is terminally ill and requests only comfort care). 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 chapter of this manual.)

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:
Resource: Potential 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, and assure food and beverage preferences are met before using oral nutrition supplements. Unless a medical condition warrants a restrictive diet, consider beginning with a regular diet and monitor how the person does eating it (2).

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.

An individual or their representative may choose 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 nutrient 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 oral 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 (3), if consistent with individual preferences.

Providing a nutritional supplement during medication administration may 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 (4).

**Feeding Tubes**
Tube feeding as an intervention for unintended weight loss present both risks and benefits, depending on an individual’s underlying medical conditions and prognosis, and causes of weight loss. The decision to place a tube should be made carefully and should include a review of a patient’s advance directives regarding tube feeding. The health care practitioner should be involved in reviewing whether all other interventions to address anorexia, weight loss, and eating or swallowing abnormalities have been attempted. Studies have shown that tube feeding does not extend life, prevent aspiration pneumonia, improve function or limit suffering in individuals with dementia (5).

Refer to additional information in this chapter related to enteral feeding.
Resource: Potential Interventions for Unintended Weight Loss

Note: There are many other Policies and Procedures and Resources in this manual that can help to address unintended weight loss.

References:
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.

<table>
<thead>
<tr>
<th>Resource: Calorie Boosters/Fortified Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Margarine or Butter</strong></td>
</tr>
<tr>
<td>Add to casseroles, hot cereals, vegetables, potatoes, rice and noodles, soups</td>
</tr>
<tr>
<td>Spread on bread, sandwiches, toast, crackers, rolls, and muffins</td>
</tr>
<tr>
<td><strong>Mayonnaise</strong></td>
</tr>
<tr>
<td>Spread on bread, sandwiches, toast, crackers, rolls and muffins</td>
</tr>
<tr>
<td>Use in egg, chicken, tuna or meat salad</td>
</tr>
<tr>
<td><strong>Peanut Butter</strong></td>
</tr>
<tr>
<td>Spread on bread, sandwiches, toast, crackers, rolls, muffins, apples, bananas</td>
</tr>
<tr>
<td><strong>Sour Cream</strong></td>
</tr>
<tr>
<td>Use on baked potatoes or as a dip</td>
</tr>
<tr>
<td><strong>Half-and-half or Cream</strong></td>
</tr>
<tr>
<td>Add to milk shakes, hot chocolate and other beverages; pour over cereals; use in cream soups and puddings</td>
</tr>
<tr>
<td><strong>Other Calorie Dense Foods:</strong></td>
</tr>
<tr>
<td>Casseroles with added cream</td>
</tr>
<tr>
<td>Cheese</td>
</tr>
<tr>
<td>*Corn Syrup</td>
</tr>
<tr>
<td>Cream cheese</td>
</tr>
<tr>
<td>Evaporated milk</td>
</tr>
<tr>
<td>Fried foods</td>
</tr>
<tr>
<td>Gravy</td>
</tr>
<tr>
<td>*Hard Candy</td>
</tr>
<tr>
<td>*Honey</td>
</tr>
<tr>
<td>*Ice Cream floats and sundaes</td>
</tr>
<tr>
<td>*Jam and jelly</td>
</tr>
<tr>
<td>*Maple Syrup</td>
</tr>
<tr>
<td>*Marshmallows</td>
</tr>
<tr>
<td>Oils</td>
</tr>
<tr>
<td>*Pudding</td>
</tr>
<tr>
<td>Salad dressings</td>
</tr>
<tr>
<td>Soups (made with whole milk or half-and-half)</td>
</tr>
<tr>
<td>*Syrup</td>
</tr>
<tr>
<td>Whipped cream</td>
</tr>
<tr>
<td><strong>Commerically Prepared High Calorie/Protein Supplements</strong></td>
</tr>
<tr>
<td>*Bars</td>
</tr>
<tr>
<td>*Beverages</td>
</tr>
<tr>
<td>Fortified or enhanced foods</td>
</tr>
<tr>
<td>Juices</td>
</tr>
<tr>
<td>*Milkshakes</td>
</tr>
<tr>
<td>*Puddings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Meal Frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer three meals and two or more snacks each day</td>
</tr>
</tbody>
</table>

*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 commercial 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:**
The following suggestions are intended for people who have difficulty eating high protein foods. Here are a few suggestions for boosting protein intake.

<table>
<thead>
<tr>
<th>Resource: Protein Boosters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skim Milk Powder</strong></td>
</tr>
<tr>
<td>(for cooking use only)</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Milk or Half-and-Half</strong></td>
</tr>
<tr>
<td>Use instead of water for soups, cereals and instant cocoa</td>
</tr>
<tr>
<td><strong>Cheese or Cheese Sauce</strong></td>
</tr>
<tr>
<td>Add grated or melted cheese to vegetables, casseroles, soups</td>
</tr>
<tr>
<td><strong>Eggs (fully cooked only)</strong></td>
</tr>
<tr>
<td>Plain or in mixed dishes</td>
</tr>
<tr>
<td><strong>Peanut Butter</strong></td>
</tr>
<tr>
<td>Use on bread, crackers, or celery, apples and bananas</td>
</tr>
<tr>
<td><strong>Instant Breakfast Milk Shake</strong></td>
</tr>
<tr>
<td>Combine and mix well; one packet instant breakfast mix, one-cup whole milk or half-and-half, ½ cup ice cream</td>
</tr>
<tr>
<td><strong>Other High Protein Foods</strong></td>
</tr>
<tr>
<td>Cottage cheese</td>
</tr>
<tr>
<td>Yogurt, Greek yogurt</td>
</tr>
<tr>
<td>Meat, fish, poultry</td>
</tr>
</tbody>
</table>

Caution: Do not use on dysphagia diets unless safely pureed into a pureed food item.

**Note:** There are commercial products 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:
High Calorie/High Protein Supplements

Policy:

Individuals needing supplemental nutrition, as determined through nutrition assessment, will be served a suitable high calorie/high protein supplement between meals or as part of a medication-pass supplement program. Commercial oral nutritional supplements (medical foods*) or supplements prepared in-house by the facility may be used.

Procedure:

1. Amount of supplement and frequency (for example: 10 AM, 2 PM and/or HS) will be determined through nutrition assessment based on individual needs.

2. All commercial medical food supplements will be ordered or approved by a physician or designee.

3. The food and nutrition services department will prepare supplements and deliver them to nursing staff at the appropriate time.

4. Nursing staff will supervise the delivery and consumption of all supplements and record appropriately in the medical record, meal intake reporting records, and/or the medication administration record.

5. Supplement acceptance will be documented in progress notes, care plans and/or assessments as appropriate.

6. Individual acceptance of supplements will be monitored and adjustments will be made as needed.

* Medical foods are labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirement. Medical foods are for oral or enteral feeding and are intended to be used under medical supervision.

Source:
Medical Foods Guidance and Regulatory Information. U.S. Food and Drug Administration Web site.
Supplement Formulary

Insert facility formulary here.

Sources for oral nutritional supplements:

- Hormel Health Labs, (800) 523-4635, [www.hormelhealthlabs.com](http://www.hormelhealthlabs.com)
- Lyons Magnus, (800) 634-2345 (east), (800) 344-7130 (west), [www.lyonsmagnus.com](http://www.lyonsmagnus.com)
- Nestle Clinical Nutrition, (800) 422-2752, [www.nestleclinicalnutrition.com](http://www.nestleclinicalnutrition.com)
- Abbott Nutrition, (800) 227-5767, [www.abbottnutrition.com](http://www.abbottnutrition.com)
Dehydration

Policy:

Individuals at risk for dehydration will be identified, assessed, and provided with sufficient fluid intake to maintain proper hydration and health.

Procedure:

Each individual will receive sufficient amounts of fluid based on individual need and personal preference to prevent dehydration and maintain health.

1. Risk factors for dehydration will be identified through routine nursing assessment.
   Risk factors include:
   a. Coma/decreased sensorium
   b. Fluid loss and increased fluid needs (e.g. vomiting, diarrhea, fever, uncontrolled diabetes, medications, etc.)
   c. Fluid restriction as ordered by a physician
   d. Functional impairments that make it difficult to drink, reach fluids, or communicate fluid needs (e.g. aphagia, dysphagia)
   e. Dementia that causes an individual to forget to drink
   f. Refusal of fluids

2. Clinical signs of possible insufficient fluid intake include:
   a. Dry skin and mucous membranes
   b. Cracked lips, dry/coated tongue
   c. Decreased skin turgor
   d. Thirst and dry mouth
   e. Concentrated urine
   f. Dizziness upon sitting or standing
   g. Confusion or change in mental status
   h. Lethargy
   i. Newly present constipation or fecal impaction
   j. Abnormal laboratory values (hemoglobin and hematocrit, potassium, chloride, sodium, albumin, transferrin, BUN, or urine specific gravity)
   k. Significant or severe weight loss
   l. Elevated temperature (fever)
   m. Headache
   n. Flushed appearance
   o. Functional decline (including increased risk for falls)

3. Adequate fluids should be provided.
   Fluid needs calculations are generally based on the following estimates:
   a. Without renal or cardiac distress:
      • 30 mL/kg body weight (2.2 pounds = 1 kg) or 1 mL per calorie consumed.
   b. Diagnosed with renal or cardiac distress:
      • 25 mL/kg body weight or as determined by physician (such as a fluid restriction)
   c. Diagnosed with dehydration:
      • 35 mL/kg body weight
   d. When rehydrated, return to 30-mL/kg-body weight

4. Fluids include milk, juice, coffee, tea, water, milkshakes, popsicles, ice cream, sherbet, gelatin, and soups.
Dehydration

a. All individuals will have a water pitcher or container at bedside (excluding those on fluid restrictions).
b. If thickened liquids have been ordered, fluids will be provided that are thickened to the consistency ordered.
c. Foods contain fluids which may also be included as part of the total daily fluid intake.

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 nutritionist (RDN) 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
<table>
<thead>
<tr>
<th>Solutions to Prevent/Treat Dehydration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Monitor for risk factors and symptoms</td>
</tr>
<tr>
<td>2. If risk of dehydration is identified, monitor intake/output (I&amp;Os) as per facility protocol</td>
</tr>
<tr>
<td>3. Educate individual residents/patients, families and staff on the need to encourage fluids:</td>
</tr>
<tr>
<td>• Provide access to fluids at all times (excluding those 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.</td>
</tr>
<tr>
<td>• Encourage nursing assistants to offer and encourage fluids each time they turn individuals on turning schedules. <strong>TAPS</strong> stands for: Turn, Align, Position, Sips (offer sips of fluid).</td>
</tr>
<tr>
<td>• Offer additional fluids during medication pass (4-8 ounces).</td>
</tr>
<tr>
<td>4. Provide assistance to drink as needed:</td>
</tr>
<tr>
<td>• Offer fluid with every contact</td>
</tr>
<tr>
<td>• Provide assistance to drink fluids with and in between meals</td>
</tr>
<tr>
<td>5. Set up a hydration station: Self-serve juice/beverage machine in common area</td>
</tr>
<tr>
<td>6. Be sure those on thickened liquids receive adequate fluids as they may be at greater risk for dehydration.</td>
</tr>
<tr>
<td>7. Obtain beverage preferences and offer a variety of fluids: Any food that is fluid at room temperature is considered a fluid; carbonated beverages, coffees, teas, gelatin, ice cream, fruit ices, juice, milk, milkshakes, sherbet, soup or broth, water.</td>
</tr>
</tbody>
</table>
Fluids at the Bedside

Policy:

All individuals will be provided with a fresh supply of water at the bedside unless 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, scheduled snack passes, and other times throughout the day.

Procedure:

1. Staff will provide and fill water containers with fresh ice and water at least twice daily.

2. Staff will collect all containers (excluding disposable containers) for cleaning and sanitizing in the food and nutrition services department on a daily basis. The food and nutrition services staff will deliver the containers to the nursing department or notify the nursing department when the procedure has been completed.

3. 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.

4. If disposable water containers are used, they should be replaced daily.
Encourage Fluids Order

Policy:

When the physician orders “encourage fluid” the 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 nutritional assessment.

2. 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.

3. “Encourage fluids” can also be a nursing measure, and this policy should be followed by offering fluids at each nursing contact.

4. The food and nutrition services department will provide a minimum of 1440 mL fluid on meal trays daily (16 oz. per meal). Nursing will provide the remaining fluids.
   a. Water will be provided at the bedside.
   b. Nursing will provide additional fluids at medication pass, HS, and other times throughout the day as needed.

Note: See Resource: Sample Distribution of Fluids on next page.
Fluid Restrictions and Sample Distribution of Fluids

Policy:

Fluid restrictions will be followed as per physician’s orders and following the procedures below.

Procedure:

1. The amount of fluid allowed per 24-hour period will be specified in a written physician’s order and sent to the food and nutrition service department in writing.

2. The food and nutrition services department and the nursing department will determine how much fluid will be provided at meals and medication passes. See below for Sample Distribution of Fluids.

3. No water will be provided at the bedside unless calculated into the daily total fluid restriction.

Sample Distribution of Fluids

<table>
<thead>
<tr>
<th>Fluid Restriction</th>
<th>Nursing Total, mL</th>
<th>By Shift, mL</th>
<th>Food Service Total, mL</th>
<th>Breakfast, mL</th>
<th>Lunch, mL</th>
<th>Dinner, mL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1st</td>
<td>2nd</td>
<td>3rd</td>
<td></td>
<td>1st</td>
</tr>
<tr>
<td>1000 ml</td>
<td>160</td>
<td>80</td>
<td>80</td>
<td>0</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1100 ml</td>
<td>260</td>
<td>130</td>
<td>130</td>
<td>0</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1200 ml</td>
<td>360</td>
<td>120</td>
<td>120</td>
<td>120</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1300 ml</td>
<td>460</td>
<td>150</td>
<td>150</td>
<td>160</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1400 ml</td>
<td>560</td>
<td>190</td>
<td>190</td>
<td>180</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1500 ml</td>
<td>660</td>
<td>220</td>
<td>220</td>
<td>220</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1600 ml</td>
<td>760</td>
<td>260</td>
<td>260</td>
<td>240</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1700 ml</td>
<td>860</td>
<td>290</td>
<td>290</td>
<td>280</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1800 ml</td>
<td>960</td>
<td>320</td>
<td>320</td>
<td>320</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>1900 ml</td>
<td>1060</td>
<td>360</td>
<td>360</td>
<td>340</td>
<td>840</td>
<td>360</td>
</tr>
<tr>
<td>2000 ml</td>
<td>1160</td>
<td>390</td>
<td>390</td>
<td>380</td>
<td>840</td>
<td>360</td>
</tr>
</tbody>
</table>

Adapted with permission from Nutrition Alliance, LLC.
Pressure Injuries

Policy:

Medical nutrition therapy (MNT) will be provided for those who are at risk of, or have a diagnosed pressure injury. The goal is to promote healing and restore the individual to optimal nutritional status if possible. The RDN or designee should follow relevant and evidence-based guidelines on nutrition and hydration for individuals at risk or for those who have a pressure injury (1).

Procedure:

Nutrition Protocols for Individuals at High Risk of Pressure Injuries or with Stage 1, 2, 3, 4, Suspected Deep Tissue Injury or Unstageable Pressure Injuries are as follows:

1. Upon admission or re-admission and as needed thereafter, nursing staff will screen each individual for risk of skin breakdown using the tool assigned by the facility for predicting risk of pressure injuries. The registered dietitian nutritionist (RDN) or designee will review the screening tool, the medical record and the pressure injury report to assess/reassess the individual's nutrition status.

2. The RDN or designee is a member of the wound care team and will receive referrals and/or a copy of the pressure injury/impaired skin integrity report from nursing. All individuals with stage 1, 2, 3, 4, suspected deep tissue injury or unstageable pressure injuries will be referred to the RDN or designee. The RDN or designee will review all stage 3, 4 and unstageable pressure injuries and provide appropriate medical nutrition therapy (MNT).

3. The MNT assessment on these high risk individuals will include a review of the following factors (1,2,3):
   a. Pre-admission illness, medical history, diagnosis, and recent changes in condition.
   b. Risk factors for pressure injury development, including history of pressure injuries.
   c. Height, current weight, usual body weight and significant changes in weight (>5% in 30 days or >10% in 180 days).
   d. Current food/fluid intake and adequacy of total intake compared to calculated nutritional needs.
   e. Eating ability (able to feed self, requires assistance, needs total assistance).
   f. Medications that may affect food/fluid intake or tolerance (food-medication interactions).
   g. Other factors which may impact nutritional status (chewing/swallowing ability, GI problems, depression, etc.).
   h. Signs/symptoms of dehydration (poor skin turgor, flushed dry skin, coated tongue, oliguria, irritability, confusion).
   i. Interview with the individual, family, caregiver, and/or staff for food and beverage preferences and food intolerances.

4. Based on the individual’s food intake and on interview with the individual, nutrient needs will be calculated. Nutrients (calories, protein, fluids, etc.) will be increased as needed through additional food/fluid items on the tray, substitutions for foods not eaten and/or between meal supplements. Nutrition interventions may include:
   a. Nutrient/intake study (if deemed appropriate).
   b. Calories, protein, fluids to meet needs.
   c. Individualization/liberalization of diet restrictions.
   d. Encouragement of food/fluid intake. Assistance at mealtime (encourage, prompt, assist or provide adaptive eating devices).
   e. Fortified foods and/or oral nutrition supplements if needed.
Pressure Injuries

f. Adequate fluids for hydration.
g. Multivitamin/mineral if intake is poor and nutritional deficiency is identified or suspected.
h. If intake does not support nutritional needs (calories, protein, fluids, and other nutrients), the interdisciplinary healthcare team may wish to recommend nutrition support.

5. Nutrition interventions will be implemented using facility protocols. The RDN or designee will educate and counsel the individual and/or family as appropriate on nutritional needs related to the pressure injury.

6. A progress note will be written in the individual's chart indicating the plan of care and that the individual will be reviewed again within 1 to 4 weeks based on need.

7. The care plan will be changed to reflect interventions put in place to prevent pressure injuries or to support wound healing.

8. The RDN 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 for pressure injury:
a. 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.

For those with pressure injuries:
a. If the pressure injury 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.
b. If the pressure injury 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.
c. If the pressure injury 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.

9. The RDN 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 injuries occur.)

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

See *Calorie Boosters and Protein Boosters* Resource in this chapter of this manual for ideas on how to increase calories and protein.
As part of a comprehensive assessment, it is vital to identify risk factors for pressure injury development and assess pressure injury risk using a validated tool. The Braden Scale: Predicting Pressure Injury Risk includes a subscale for nutrition and can be helpful in determining not only pressure injury risk, but nutritional risk. The following risk factors should be evaluated during the screening and assessment process:

<table>
<thead>
<tr>
<th>Risk Factors For Developing Pressure Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Impaired/decreased mobility and decreased functional ability</td>
</tr>
<tr>
<td>• Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus</td>
</tr>
<tr>
<td>• Drugs such as steroids that may affect wound healing</td>
</tr>
<tr>
<td>• Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency</td>
</tr>
<tr>
<td>• Resident refusal of some aspects of care and treatment</td>
</tr>
<tr>
<td>• Cognitive impairment</td>
</tr>
<tr>
<td>• Exposure of skin to urinary and fecal incontinence</td>
</tr>
<tr>
<td>• Undernutrition, malnutrition, and hydration deficits</td>
</tr>
<tr>
<td>• A healed injury (areas of healed Stage 3 or 4 pressure injuries are more likely to have recurrent breakdown)</td>
</tr>
<tr>
<td>• Obesity (increases risk due to decreased mobility, increased incidence of diabetes, cardiovascular and pulmonary problems)</td>
</tr>
<tr>
<td>• Other risk factors: diabetic neuropathy, frailty</td>
</tr>
</tbody>
</table>

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:**

Energy Intake:
1. Provide individualized energy intake based on underlying medical condition and level of activity.
2. Provide 30 to 35 kcalories (kcal)/kg body weight for adults at risk of a pressure injury who are assessed as being at risk of malnutrition.
3. Provide 30 to 35 kcal/kg body weight for adults with a pressure injury who are assessed as being at risk for malnutrition.
4. Adjust energy intake based on weight change or level of obesity. Adults who are underweight or who have had significant unintended weight loss may need additional energy intake.
5. Revise and modify/liberalize dietary restrictions where limitations result in decreased food and fluid intake. These adjustments should be made in consultation with a medical professional and managed by a registered dietitian whenever possible.
6. Offer fortified foods and/or high calorie, high protein oral nutritional supplements between meals if nutritional requirements cannot be achieved by dietary intake.
7. Consider enteral or parenteral nutritional support when oral intake is inadequate. This must be consistent with the individual’s goals.

Protein Intake
1. Provide adequate protein for positive nitrogen balance for adults assessed to be at risk of a pressure injury.
2. Offer 1.25 to 1.5 grams (g) protein/kg body weight daily for adults at risk of a pressure injury who are assessed to be at risk of malnutrition when compatible with goals of care, and reassess as condition changes.
3. Provide adequate protein for positive nitrogen balance for adults with a pressure injury.
4. Offer 1.25 to 1.5 g protein/kg body weight daily for adults with an existing pressure injury who are assessed to be at risk of malnutrition when compatible with goals of care, and reassess as condition changes.
5. Offer high calorie, high protein nutritional supplements in addition to the usual diet to adults with nutritional risk and pressure injury risk, if nutritional requirements cannot be achieved by dietary intake.
6. Assess renal function to ensure that high levels of protein are appropriate for the individual.
7. Supplement with high protein, arginine and micronutrients for adults with a pressure injury Category/Stage III or IV or multiple pressure injuries when nutritional requirements cannot be met with traditional high calorie and protein supplements.

Hydration
1. Provide and encourage adequate daily fluid intake for hydration for an individual assessed to be at risk of or with a pressure injury. This must be consistent with the individual's comorbid conditions and goals (recommend 1 mL/kcal consumed, to be adjusted based on fluid loss).
2. Monitor individuals for signs and symptoms of dehydration including change in weight, skin turgor, urine output, elevated serum sodium, and/or calculated serum osmolality.
3. Provide additional fluid for individuals with dehydration, elevated temperature, vomiting, profuse sweating, diarrhea, or heavily exuding wounds.

Vitamins and Minerals
1. Provide/encourage individuals assessed to be at risk of pressure injuries to consume a balanced diet that includes good sources of vitamins and minerals.
2. Provide/encourage an individual assessed to be at risk of a pressure injury to take vitamin and mineral supplements when dietary intake is poor or deficiencies are confirmed or suspected.

3. Provide/encourage an individual with a pressure injury to consume a balanced diet that includes good sources of vitamins and minerals.

4. Provide/encourage an individual with a pressure injury to take vitamin and mineral supplements when dietary intake is poor or deficiencies are confirmed or suspected.

Reference:

Additional Resources:
For more detailed information such as nutrient needs, vitamin/mineral sources, and other nutrition interventions for pressure injuries, refer to the following publications available at www.beckydorner.com:
Individuals on Unsupplemented Clear Liquids or NPO

Policy:

All individuals who are NPO (nothing per oral or nothing by mouth) or on a clear liquid diet without supplements formulated for clear liquids for longer than three (3) days will be evaluated for nutrition risk by the registered dietitian nutritionist (RDN) or designee.

Procedure:

1. Nursing will monitor individuals on NPO or on a clear liquid diet without supplements formulated for clear liquids on a daily basis and refer to the RDN or designee.

2. The RDN or designee will review the medical record of each individual who is NPO or on a clear liquid diet without a supplement formulated for clear liquids diet for longer than three (3) days, and assess the individual’s nutritional status.

3. The RDN or designee will document assessment of nutrition status in the medical record. Document recommendations for addressing nutrition status, which may include:
   a. An alternate feeding route (e.g. enteral or parenteral nutrition)
   b. Progression of diet
   c. Addition of nutrition supplements specifically for clear liquid diets
   d. Referral to RDN or designee

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Policy:
Individuals experiencing swallowing difficulties will be evaluated to determine the cause and possible interventions for dysphagia. Interventions should be consistent with an individual’s medical condition, goals, and preferences.

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 testing, diet consistency changes, fluid consistency changes, adaptive feeding equipment, or referral to physician after the evaluation and with input from the individual.
3. The director of food and nutrition services will:
   a. Follow written orders for diet and fluid consistency.
   b. Provide adaptive feeding devices as ordered.
   c. Educate staff and supervise preparation of altered consistency diets.
   d. Communicate concerns with tolerance or acceptance of food and/or fluid consistencies.
4. The nursing staff will:
   a. Assure appropriate communication of referrals and recommendations to the physician.
   b. Assure appropriate diet order is obtained from the physician or designee and communicated to the food and nutrition services department.
   c. Follow written diet orders.
   d. Supervise individuals at meal time to assure orders are followed and suggested feeding techniques are being practiced.
   e. Communicate concerns to the registered dietitian nutritionist (RDN) or designee, SLP and/or director of food and nutrition services as appropriate.
5. The SLP and/or RDN 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 on the next page.)
6. The RDN or designee will:
   a. Follow physicians and SLP orders for diet modification.
   b. Monitor tolerance and acceptance of ordered diet. Notify the appropriate discipline (nursing, social service, SLP) of swallowing problems they identify.
   c. Evaluate the need for diet changes or alternate feeding methods and make appropriate recommendations and referrals.
   d. Work closely with SLP and director of food and nutrition services to ensure appropriate diet/alternate feeding are provided as ordered.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), directors of food and nutrition services, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Warning signs of dysphagia include:

- Coughing frequently or a weak cough (before, during or after a swallow)
- Delayed or absent swallow reflex
- Difficulty controlling liquids or solids in the mouth
- Facial weakness/difficulty chewing
- Slurred speech
- Frequent throat clearing
- Nasal regurgitation
- Pocketing food in the mouth
- Mucositis, xerostomia, or oral lesions
- Repeated or persistent pneumonia or repeated upper respiratory infections
- Poor tongue control
- Sensation of food sticking in the throat or sternal area
- Unexplained loss of appetite or unintentional weight loss
- Wet/gurgly voice or hoarse or breathy voice
- Poor control of head or body position

Source:
EAT-10 Swallowing Screening Tool

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.


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www.nestlenutrition-institute.org
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

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 individual. 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/resident. 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.

Source:
Thickened Liquids

Policy:

All individuals requiring thickened liquids as recommended by the speech/language pathologist (SLP), ordered by the physician or designee, and accepted by the individual will be served according to the physician’s (or designee’s) order.

Procedure:

1. The food and nutrition services department will receive a written order for individuals requiring thickened liquids.

2. The director of food and nutrition services will record the ordered consistency on the individual’s meal identification (ID) card or tray ticket.

3. The food and nutrition services 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).

<table>
<thead>
<tr>
<th>Thin</th>
<th>Nectar-like</th>
<th>Honey-like</th>
<th>Spoon Thick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broth, Bouillon</td>
<td>Apricot nectar</td>
<td>Commercially prepared honey-like thick products</td>
<td>Commercial product needed to achieve desired consistency</td>
</tr>
<tr>
<td>Carbonated beverages</td>
<td>Eggnog, thick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coffee or Tea</td>
<td>Peach nectar</td>
<td>Commercially prepared nectar-like thickened products</td>
<td></td>
</tr>
<tr>
<td>Gelatin</td>
<td>Pear nectar</td>
<td>Commercial thickeners may be used to achieve nectar-like consistency</td>
<td></td>
</tr>
<tr>
<td>Ice or ice chips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ice cream, frozen yogurt,</td>
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<td></td>
<td></td>
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<tr>
<td>Fruit ices, sherbet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frozen fruit bars</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milkshakes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional supplements -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unless specified by</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>manufacturer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Popsicles™</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soda</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Soups, thin broth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tomato juice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watermelon</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Thickened Liquids

4. The SLP may request a variety of fluid consistencies based on the individual’s condition and/or need. The SLP will notify and instruct the food and nutrition services department of exceptions for thickened liquids. For example, individual receiving thickened liquids may be allowed thin liquids under specific conditions or under the care of the SLP.

5. The facility will determine whether nursing or food and nutrition services will thicken the liquids or if pre-thickened products will be used.

6. Manufacturer’s instructions will be followed when thickening fluids using commercial thickeners that require mixing in the facility.

7. The registered dietitian nutritionist (RDN) and/or nursing supervisor will monitor staff competency regarding thickening liquids as part of quality assurance.

8. The RDN, nursing supervisor, or designee will monitor staff competency regarding preparation of thickened liquids as part of the facility Quality Assurance and Performance Improvement Program.

References:

Note: In 2015 the International Dysphagia Diet Standardization Initiative (IDDSI) developed standardized terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and all cultures. These standards will gradually be adopted in U.S. health care settings. For more information, visit www.iddsi.org.
End of Life Decisions

Policy:

The interdisciplinary team will work with each individual at the end of life to determine interventions that meet the goals and preferences of each person. End of life decisions made by individuals will be respected and carried out by facility and staff.

Procedure:

1. End of life nutrition care planning 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 should contain the living will, the durable power of attorney (DPOA) for healthcare, and other advance directive documents that apply to an individual’s end of life decisions. If those documents are not on file, the facility will take steps to obtain the information needed to implement end-of-life care. Information can be obtained through a conference with the individual and/or family or health care power of attorney. See Sample Decline of Life-Prolonging Procedures and Treatments Form next page.

3. If no advance directives regarding artificial nutrition and hydration are on file, and if it appears necessary to initiate such interventions to sustain life, the IDT should consult with the individual and/or surrogate or proxy to determine the individual’s wishes and desires. The individual’s choices for end of life care should be documented in the medical record.

4. If the individual and/or surrogate are in agreement that comfort is the goal of care, the physician (or designee) should write an order for “comfort measures” or “palliative care” (depending on facility protocols) and facility staff will honor the written order and provide care accordingly.

5. If tube feeding is desired, the physician (or designee) should write an order for tube feeding and flushes (with input from the RDN as needed) and orders should be carried out as per facility protocols.

6. The care plan will be updated to reflect end of life decisions made by the individual or individual’s surrogate. Palliative interventions as described in the care plan will be implemented and revised as necessary to reflect the individual’s needs and goals. The care plan will direct daily care to maintain the comfort and highest quality of life possible for the individual.

Note: For more detailed information regarding nutrition interventions at the end of life, including comfort care and nutrition interventions for specific end of life symptoms, please refer to the following publications available at http://www.beckydorner.com/dietmanuals:

Sample Decline of Life-Prolonging Procedures and Treatments Form

I, ___________________________________________________ (Patient/Resident), or I ___________________________________________________ (Surrogate/Legal Guardian/Responsible Party) on this ______ day of ____________, 20_____, request that the attending physician use the following guidelines for interventions, treatments and procedures.

Indicate yes or no for each item listed.
Yes = treatment/procedure will be done, no = intervention/procedure/treatment will not be done):

<table>
<thead>
<tr>
<th>Intervention, Procedure or Treatment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition/Hydration:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thickened liquids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous Fluids (IVs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naso Gastric (NG) feeding tube</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percutaneous endoscopic gastrostomy tube (PEG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotic medications for infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of meds other than those needed for pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedures:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood draw for lab tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine sample for lab tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xray, CT scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer to an acute care hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer to hospice or palliative care unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please list):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I fully understand the impact and potential consequences of my refusal for the above procedures and treatments. I have been informed of the risks versus benefits of the above named interventions/procedures/treatments. I have been advised of the adverse effects that may happen if I refuse any of these interventions/procedures/treatments. I understand that by refusing the above listed interventions/procedures/treatments that death may occur. I understand that I may change any or all of these requests by notifying staff in writing, and I will be required to complete a new request form with any changes I desire.

_______________________________________________________     ___________________  
Signature                                               Date

Circle one: Patient     Resident     Surrogate     Legal guardian     Responsible party

_______________________________________________________     ___________________  
Witness                                               Date

Policy & Procedure Manual   10-29
Guidelines for Enteral Feeding Eligibility

Policy:

The interdisciplinary team will evaluate each individual prior to recommending an enteral feeding tube. A variety of interventions should have been attempted before tube feeding is considered. Advance directive documents will be thoroughly reviewed as appropriate, and a conference with the individual, the family, or durable power of attorney (DPOA) for healthcare will take place before a decision regarding tube feeding is made.

Procedure:

1. The interdisciplinary team (IDT) will contact the physician and the registered dietitian nutritionist (RDN) or designee when an individual’s food and fluid intake is severely impaired and/or nutritional status is declining.

2. The physician will complete an evaluation of the individual’s condition.

3. The RDN or designee will complete a thorough medical nutrition therapy (MNT) assessment. If oral food/fluid intake cannot sustain healthy life, the RDN should recommend enteral feeding if it is consistent with the individual’s goals.

4. The IDT team and/or ethics team will discuss options with the individual, family and/or DPOA as appropriate and provide information on the risks and benefits of enteral feeding and surgical tube placement. The care plan team will provide a thorough discussion on the process of tube insertion, feeding methods, risks versus benefits of tube feeding, effects on quality of life, etc.

5. If the individual/family/DPOA choose enteral feeding, a meeting with the individual’s physician will be suggested or the physician will be contacted regarding a request for enteral feeding orders.

6. Assessment criteria for enteral feeding include:
   a. Inadequate oral intake.
   b. Physical signs/symptoms of malnutrition, or at risk of malnutrition with inability to consume adequate nutrients by mouth.
   c. Swallowing difficulty with evaluation, testing and a diagnosis of dysphagia.
   d. Individual is determined to be at risk of aspiration or choking and considered unsafe to consume food/fluid by mouth.
   e. Significant unplanned weight loss that is not improved with other interventions.

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 Jejunostomy (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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition service directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
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 nutritionist (RDN) 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 RDN 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 RDN or designee as needed.

2. The RDN or designee will be informed by nursing of any changes that occur with the formula or route of administration.

3. The RDN 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 RDN or designee will visit the individual to confirm 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 RDN 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 recommendations.

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), gastroenterostomy (G-tube or PEG tube) or Jejunostomy (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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition service directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.

Basic Guidelines for Enteral Feeding

Policy:
Staff delivering care to enterally fed individuals will follow basic guidelines for enteral feeding. Nursing staff is responsible for the routine daily care of individuals receiving enteral feeding.

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. Check the tube placement regularly (every shift or more frequently as indicated).

3. Check for gastric residual (every shift or more frequently as indicated), and follow 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.
   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. Monitor the individual’s response to enteral feeding. Any signs of excessive nausea, vomiting, diarrhea, abdominal distention, or gas warrant a referral to the registered dietitian nutritionist (RDN) or designee.

5. Tube feeding should be delivered by nursing as ordered by the physician. If necessary, bolus feeding or an 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. All changes in tube feeding should be accompanied by a physician’s order.

6. 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.

References:

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition service directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Documentation for Enteral Feeding

Policy:

Nutrition documentation of enteral feedings should include specific information on the nutritional assessment and progress notes.

Procedure:

The registered dietitian nutritionist (RDN) or designee will document:

1. The reason for enteral feeding.
2. Problems/limitations as a result of enteral feeding.
3. Changes in condition (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 and/or increase oral intake.
6. Estimated nutritional needs (calories, protein, fluids).
7. Enteral feeding order from physician including:
   a. Feeding status (diet order if applicable, or NPO order)
   b. Formula type (generic name such as isotonic, or standard or commercial name)
   c. Administration (pump, bolus, intermittent)
   d. Rate of delivery (mL per hour or per feeding if bolus)
   e. Number of mL for flush, including amount of flush with medications

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

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 nutritionist (RDN) or designee will perform an MNT assessment and/or reassessment that will include:

1. A review of the nurse’s notes on administration of the formula.

2. A review of the medication/treatment record to note that the formula is being given as ordered. If not, the RDN should inform the nursing supervisor and/or DON.

3. A review of how nursing staff is administering the formula. The RDN or designee should visit the individual to check the enteral feeding flow rate, assess down times, assess to ensure the pump is functioning properly (if applicable), check input and output records, and medicine administration records (MAR) for amount of feeding administered. If there are discrepancies between what is ordered, what is documented, and what is actually being done, the RDN should inform the nursing supervisor and/or DON.

4. 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.

5. Calculation of the individual’s energy, protein, and fluid requirements upon initiation of enteral feeding. Comparison of the individual’s nutrient requirements and the physician-ordered enteral formula and flushes.

6. Ideally, the RDN 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 RDN or designee as needed.

7. Nursing Communications:
   a. The RDN or designee will be informed by nursing of any changes that occur in the formula or route of administration.
   b. The nursing staff will communicate any concerns to the RDN or designee regarding changes in condition such as weight loss, diarrhea, nausea, vomiting, bloating, gas, and high residual levels.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition service directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Transitioning From Enteral Feedings to Oral Feedings

Policy:

When an individual has the potential to be transitioned off of an enteral feeding, the following guidelines will be followed as indicated by the registered dietitian nutritionist (RDN), speech/language pathologist (SLP), nursing supervisor and physician or designee.

Procedure:

1. The RDN 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. A 3 to 5 day nutrient intake assessment of food/fluid intake records can be conducted to assess the adequacy of the individual’s oral intake, or food intake records over several days should be reviewed to determine oral intake.

5. The RDN 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 nocturnal 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 RDN. Weights may be done more often if deemed necessary.

7. The RDN and SLP will determine when the individual no longer requires 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 RDN, 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 RDN 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 RDN and the SLP to assure the best quality of care for the individual involved.

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Enteral Feedings

Insert facility enteral formularies here.

Manufacturers:
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 nutritionist (RDN) will be notified that total or peripheral parenteral nutrition (TPN or PPN) is being considered for the individual. The RDN will fully assess the nutrition status of the individual within 24 hours of this notification. Conversely, the RDN 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 should have a non-functioning GI tract for TPN/PPN to be considered. A review of the individual’s current laboratory values, weight status, and physical activity will be completed.

3. The RDN will calculate nutrition needs (calories, protein, fluids, nutrients) based on individual assessment using acceptable procedures.

4. The RDN 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 RDN to assure adequacy. Recommendations for changes in the parenteral prescription will be made to the physician following the MNT assessment.

5. The RDN will monitor and evaluate individuals receiving TPN or PPN closely to assure the goals of nutrition support are 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 RDN 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; a 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 arrhythmias 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 facility diet/nutrition care manual for more details.
Total or Peripheral Parenteral Nutrition

Source:

References:
Food-Medication Interactions

Policy:

The registered dietitian nutritionist (RDN) will work with the nursing department and/or pharmacy to identify and/or address food/medication interactions. 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:

Nursing Responsibilities:
1. Upon an individual’s admission to the facility, nursing will notify the food and nutrition services department of foods to be avoided due to food/medication interactions. Common examples include:
   a. Avoidance of grapefruit when taking several medications.
   b. Need for a consistent, portion-controlled use of some vegetables and beverages when taking Coumadin (such as kale, spinach, Brussels sprouts, parsley, collard greens, mustard greens, chard, and green tea).
2. Meal ID cards/tray tickets will reflect need to avoid these foods.
3. During routine MNT assessment, the RDN follow up as needed to identify and/or update food/medication interactions.

Registered Dietitian Nutritionist Responsibilities:
4. The registered dietitian nutritionist (RDN) will review the prescribed drug regime of individuals as part of the assessment process to maintain best nutrition practice guidelines.
5. The RDN or designee will notify the appropriate discipline (i.e. nursing, physician, IDT, social service) if adverse food medication interaction potential is present.
6. The RDN or designee will educate the individual on potential food-medication interactions as appropriate. (See Education for Food-Medication Interactions on the next page.)
7. The RDN or designee will document the potential food-medication interaction information in the medical record as appropriate.

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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 will be 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 medications as needed. 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 nutritionist (RDN) or designee, or pharmacist.

6. The RDN 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 discharging nurse will enter the appropriate documentation pertaining to education on medication-nutrient interaction on the discharge instructions sheet.

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Quality Assurance and Performance Improvement

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Quality Assurance and Performance Improvement (QAPI)

Policy:

Each year, the nutrition and food service department will define yearly goals for performance improvement. Goals include: to assure quality and safety of food served, to assure the best possible food quality and food delivery, to assure timely and accurate nutrition documentation in the medical record, and to provide quality nutrition care for facility residents. Food and nutrition services department systems will be reviewed to evaluate performance and will be included in the facility’s quality assurance and performance improvement (QAPI) program.

Procedure:

1. The director of food and nutrition services and registered dietitian nutritionist (RDN) or designee will define department goals for performance improvement for the year. (See sample forms on the following pages.)

2. The RDN or designee will conduct quality assurance and performance improvement (QAPI) surveys. This may be done on a regular basis as defined by facility policy, or when problems are identified.

3. Copies of QAPI reports will be given to the administrator, the director of food and nutrition services, and/or the director of nursing, as appropriate.

4. Food and nutrition services QAPI programs may include but are not limited to:
   a. Sanitation inspection and follow up.
   b. Evaluation of food temperature, safety, quality, and efficiency of meal preparation and service.
   c. Evaluation of dining services through meal rounds and conversations with patients/residents.
   d. Timeliness and accuracy of routine temperature log recording for refrigerators and freezers.
   e. Timeliness and accuracy of routine levels of sanitizing solutions logs for dishwashers, pot sink, and sanitizing cloths.
   f. Timeless and accuracy of adherence to cleaning schedules.
   g. Food satisfaction questionnaire for patients/residents and families.
   h. Use of test trays, to evaluate accuracy of trays and food temperatures upon receipt by patients/residents.
   i. Evaluation of timeliness and accuracy of nutrition documentation in the medical record.
   j. Audit of orders for and delivery of oral nutrition supplements.
   k. Audit of diet orders on file in medical record versus information on file in food and nutrition services department.
   l. Meal quality survey.
   m. Audit of thickened liquids to assure proper consistency is provided as ordered.
   n. Medical record audits to evaluate timeliness and accuracy of nutrition documentation.

5. As problems are identified, corrective action should be taken, systems implemented as needed, and routine monitoring of corrective action should be conducted.

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Sample Quality Assurance and Performance Improvement Goal Worksheet

The registered dietitian nutritionist (RDN) works with the facility administrator, director of nursing and director of food and nutrition services to define the nutrition and food service department annual goals and areas for performance improvement. The goal worksheet should include goals, methods of accomplishment (steps), estimated date of completion, and who will be responsible for each step.

The following areas may require performance improvement:

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<thead>
<tr>
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<tbody>
<tr>
<td>• Sanitation</td>
<td>• Person Centered Dining</td>
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<tr>
<td>• Meal Preparation and Service</td>
<td>• Food Quality</td>
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<tr>
<td>• Steam Table and Tray Line Accuracy</td>
<td>• Food Costs</td>
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<td>• Dining Service</td>
<td>• Unintended Weight Loss/Pressure Injuries</td>
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<td>• Customer Satisfaction</td>
<td>• Menus/Recipes</td>
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<td>• Medical Records/Documentation</td>
<td>• Policies and Procedures</td>
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<td>• Nourishments</td>
<td>• Nutrition Care Process</td>
</tr>
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<td>• Food Service staff Education</td>
<td>• Nursing Education</td>
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Sample Facility Goals Form

Facility __________________________ Year __________

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<tr>
<th>Goals</th>
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<th>Assigned to</th>
<th>Due Date</th>
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Developed by: __________________________ Approved by: __________________________
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<th>Month</th>
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<tbody>
<tr>
<td>January</td>
<td>Chart Audit (Dates of NA, POC, PN's)</td>
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<tr>
<td></td>
<td>Weight, Pressure Injury and Tube Feeding Audit</td>
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<tr>
<td></td>
<td>Sanitation</td>
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<tr>
<td></td>
<td>Test Tray: Regular Diet</td>
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<tr>
<td></td>
<td>Pressure Injury Audit</td>
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<tr>
<td>February</td>
<td>Meal Service Audit</td>
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<td>Weight, Pressure Injury and Tube Feeding Audit</td>
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<td>Nourishments (Timely pass, Match Doc., Consumed)</td>
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<td></td>
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RDN Signature/Date  Administrator Signature/Date  Director of Food and Nutrition Services Signature/Date
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<td>Nutrition Services</td>
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<td>August</td>
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<td>Pressure Injury Audit</td>
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<tr>
<td>September</td>
<td>Nourishments (Timely pass, Match Doc., Consumed)</td>
<td>Facility Concerns</td>
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<td>Weight, Pressure Injury and Tube Feeding Audit</td>
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<td>Nutrition Services</td>
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<td>October</td>
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<td>Nutrition Services</td>
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<td>Pressure Injury Audit</td>
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<td>November</td>
<td>Meal Service Audit</td>
<td>Facility Concerns</td>
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<td>Weight, Pressure Injury and Tube Feeding Audit</td>
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<td></td>
<td>Pressure Injury Audit</td>
<td>Administrator</td>
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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 nutritionist (RDN) or designee will conduct the sanitation audit. The auditor will:

1. Perform the sanitation audit without giving prior notice to the staff.
2. Complete forms while touring the kitchen. Be as specific as possible with comments, and include positive comments where appropriate.
3. Review the report with the director of food and nutrition services and/or staff.
4. The director of food and nutrition services 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.

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# Sample Sanitation Audit Form 1

Facility ___________________  Completed by ___________________  Date ____________

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
<th>Mgr Initials/Comments</th>
</tr>
</thead>
</table>

## 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
## Sample Sanitation Audit Form 1

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<th>Yes</th>
<th>No</th>
<th>Comments</th>
<th>Mgr Initials/Comments</th>
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### Equipment:

<table>
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<th>Clean and in good repair</th>
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<tbody>
<tr>
<td>Proper handling/storage of equipment</td>
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### Personnel:

<table>
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<tbody>
<tr>
<td>Hands washed as needed</td>
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<tr>
<td>Clean clothes, aprons, and appropriate shoes worn</td>
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### Dining Room:

<table>
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<tr>
<th>Appearance of dining room is acceptable</th>
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### Dish Room:

<table>
<thead>
<tr>
<th>Proper 3-sink method</th>
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<tbody>
<tr>
<td>Proper clean dish handling and storage</td>
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### Food Safety:

<table>
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<tr>
<th>Leftovers promptly stored</th>
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</thead>
<tbody>
<tr>
<td>Gloves worn when needed</td>
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<tr>
<td>Steps to prevent cross contamination posted and followed</td>
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### Other Comments:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Sample Sanitation Audit Form 2

Date ____________  Time __________

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Sample Sanitation Audit Form 2

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Date ____________  Time __________

Policy & Procedure Manual  11-10
## Sample Sanitation Audit Form 2

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Sample Sanitation Audit Form 2

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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.
Sanitation Audit Form

Insert facility detailed sanitation audit form here.
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 nutritionist (RDN) or designee will conduct the meal preparation and service audit. The auditor will:

1. Observe meal preparation and gather information as noted on the Sample Meal Preparation and Service Audit Form. This may include questions with the cooks/chefs, dietary aides and/or the director of food and nutrition services in regard to meal preparation and service. Comments will be documented as appropriate.

2. Observe meal service and dining, noting information on the Sample Meal Preparation and Service Audit Form. Comments will be documented as appropriate.

3. Review findings with the director of food and nutrition services, 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
### Sample Meal Preparation and Service Audit Form

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<tr>
<th>Date:</th>
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#### Menus:

- Current day’s menu posted
- Extensions for all diets
- Followed for all diets
- Appropriate menu substitutions/alternates
- 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

#### Meal:

- Appealing appearance
- Proper portions
- Acceptable taste
- Acceptable temperatures

Comments:

Completed by ____________________________  Date ____________________

*Policy & Procedure Manual 11-15*
## Sample Meal Preparation and Service Audit Form

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<th>Yes</th>
<th>No</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>Meal Service (Meal times followed):</strong></td>
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<tr>
<td>Served in timely manner</td>
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<tr>
<td>Served in sanitary manner</td>
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<tr>
<td>Served at a temperature that is acceptable to patients/residents</td>
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<tr>
<td>Proper meal distribution</td>
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<tr>
<td>Comments:</td>
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</table>

| **Dining Room:** | | | |
| Efficient service | | | |
| Diet tray card/selective menu followed | | | |
| Food well accepted by patients/residents | | | |
| Alternates or replacements are offered, appropriate, and documented | | | |
| Adequate assistance provided to individuals as needed | | | |
| Texture-modified foods served at correct texture | | | |
| Thickened liquids served at correct consistency | | | |
| Employees are courteous | | | |
| Acceptable dining room atmosphere | | | |
| Special self-help feeding devices are appropriate | | | |
| Individuals are spoken to and encouraged to eat | | | |
| Efficient dining room clean up | | | |
| Comments: | | | |

Completed by ___________________________________________  Date __________________________
Tray Line Audit

Policy:

A tray line audit will be conducted a minimum of once per quarter or more often as deemed necessary.

Procedure:

The registered dietitian nutritionist (RDN) or designee will conduct the tray line audit. The auditor will:

1. Observe tray line and service at mealt ime, documenting information as noted on Sample Tray Line Audit Form on the following page.

2. Discuss findings with appropriate personnel (director of food and nutrition services, nutrition and dining 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
### Sample Tray Line Audit Form

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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</table>

#### Breakfast

- 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
- Steam table turned on and at appropriate temperature for holding food
- Temperatures of hot foods recorded
- Temperatures of milk, juice, and cold items checked
- Diets and food preferences 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)

#### Lunch/Dinner

- Comments:

  __________________________________________________________

  __________________________________________________________

  __________________________________________________________

  __________________________________________________________

  __________________________________________________________

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Meal Round Audit

Policy:

The registered dietitian nutritionist (RDN) or designee will conduct meal rounds a minimum of once per month (preferably weekly) or more often as deemed necessary.

Procedure:

The RDN or designee will conduct a meal round audit. The auditor will:
1. Conduct meal rounds 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. Document findings on the Sample Meal Round Audit Form. Discuss findings with the appropriate personnel (director of nursing, director of food and nutrition services, 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
# Sample Meal Round Audit Form

<table>
<thead>
<tr>
<th>No.</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1.</td>
<td>Do trays arrive on time?</td>
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<td>2.</td>
<td>Are individuals ready to receive trays?</td>
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<td>3.</td>
<td>Is adequate staff available to pass trays?</td>
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<td>4.</td>
<td>Do staff members pass trays efficiently?</td>
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<td>5.</td>
<td>Are all individuals at a table given their meal at the same time?</td>
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<td>6.</td>
<td>Do staff members present the trays/meals pleasantly?</td>
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<td>7.</td>
<td>Do staff members assist individuals to set up the meal, (open, cut, and pour) only as needed?</td>
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<td>8.</td>
<td>Are individuals positioned appropriately? (as close to a 90° angle as possible)</td>
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<td>9.</td>
<td>Are table heights appropriate for all individuals?</td>
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<td>10.</td>
<td>Do staff members give verbal cues to encourage eating when needed?</td>
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<td>11.</td>
<td>Do staff members give physical prompts to encourage eating when needed?</td>
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<td>12.</td>
<td>Is enough staff available to assist and feed those who need it?</td>
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<td>13.</td>
<td>Do staff members treat individuals with respect and dignity?</td>
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<td>14.</td>
<td>Do staff members wash hands between assisting/feeding each individual?</td>
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<td>15.</td>
<td>Is dining room atmosphere generally pleasant?</td>
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<td>16.</td>
<td>Is dining room well lit?</td>
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<td>17.</td>
<td>Is noise level acceptable?</td>
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<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
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<td>18. Are food alternates offered if an individual does not like or does not eat food served?</td>
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<td>19. Are replacements offered if less than 50% of food is eaten?</td>
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<td>20. Is the dining room set up to allow individuals to move in and out easily and safely?</td>
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<td>21. Are individual's hands/mouths wiped as needed?</td>
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<td>22. Are assistive feeding devices available and used when needed?</td>
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<td>23. Is food consistency appropriate for each individual?</td>
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<td>24. Is the menu posted?</td>
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<td>25. Is menu followed?</td>
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<tr>
<td>26. Are therapeutic or consistency-modified diets delivered as ordered? Are trays accurate?</td>
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<td>27. Do staff members know what alternatives or replacement foods are available?</td>
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<td>28. Are individual food preferences, allergies, or intolerances honored?</td>
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<td>29. Are supplement recommendations and/or orders followed as noted in the care plan or on the tray card?</td>
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<td>30. Are liquids thickened as ordered and to correct consistency?</td>
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<td>31. Do staff members know what to do if an individual is choking?</td>
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<td>32. Are food temperatures acceptable to individuals?</td>
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<td>33. Do staff members avoid mixing foods when feeding?</td>
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<tr>
<td>34. Do staff members converse with individuals?</td>
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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 director of food and nutrition services or designee, or registered dietitian nutritionist (RDN) or designee to assure customers are satisfied with the quality of meals and dining services.

Procedure:

The director of food and nutrition services or designee or registered dietitian nutritionist (RDN) or designee will conduct the audit using the Food Satisfaction Questionnaire Form. The auditor will:

1. **Interview one-on-one or in a small group.**

2. **Interview a varied sample of individuals in the facility.** Select objectively to get a fair range of people in the 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. **Summarize results and determine what action will be taken to address concerns.** Assign action steps to specific staff with a time frame for completion; follow up to assure that concerns were addressed 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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Sample Food Satisfaction Questionnaire Form

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
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</thead>
<tbody>
<tr>
<td>Do you like the food here? If not, why not?</td>
<td></td>
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<tr>
<td>Do you like the service here? If not, why not?</td>
<td></td>
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<tr>
<td>Is the hot food HOT?</td>
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<tr>
<td>Is the cold food COLD?</td>
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<tr>
<td>Is there a choice available if you dislike the food?</td>
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<tr>
<td>Are portion sizes adequate?</td>
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<tr>
<td>Is the dining atmosphere pleasant?</td>
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<tr>
<td>What items would you take off the menu if you were preparing the meals?</td>
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<tr>
<td>Are there any other comments you’d like to share?</td>
<td></td>
</tr>
</tbody>
</table>

**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:**
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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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 timely delivery, appetizing temperatures, and acceptable quality of all foods served.

Procedure:

The director of food and nutrition services or designee or the registered dietitian nutritionist (RDN) or designee will conduct the audit using the Test Meal/Tray Audit Form. The auditor will:

1. Request one or more test meals/trays from the kitchen. Test meal/trays will vary to represent different meals, different textures, different days of the week, and different wings and/or dining areas.

2. Note the week and menu cycle, the meal being audited, and the type of diet.

3. Request that the meal/tray line personnel assemble each test meal/tray in the usual manner. The test meal/tray should be the last one placed on the cart or the last one delivered. Using the Test Meal/Tray Audit Form, the auditor will:
   - Check scoop sizes used 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.

4. Remove the meal/tray from the cart (after all customers have been served) and begin the evaluation process using the Test Meal/Tray Audit Form.

5. Review and record the following information:
   a. Note the food and beverage items served.
   b. Record ratings for the appearance and color of each item.
   c. Take temperatures of all foods and beverages and record them on the form.
   d. Verify that all portion sizes match those noted on the menu.
   e. Assess quality by appearance, texture and taste.
   f. Taste each item and rate for flavor.
   g. Note accuracy of the meal/tray. Foods should match the items noted on the menu.

6. Summarize findings and develop a plan of correction for each problem noted.

7. Review the audit with director of food and nutrition services, staff, and/or administrator as appropriate.

8. Follow up on corrections within 1 to 2 weeks.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Sample Test Meal/Tray Audit Form

Date: _________________________  Diet Order: ________________________________

Week of Menu Cycle: ______  Meal: _____________________  Wing or Dining Area: ________________

Time Meal/Tray: ________________________________  Arrived: __________  Served: __________

Left Kitchen: __________

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

<table>
<thead>
<tr>
<th>Food Item</th>
<th>Appearance Color</th>
<th>Temperature</th>
<th>Portion Control</th>
<th>Quality</th>
<th>Flavor</th>
<th>Meal/Tray Accuracy</th>
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Comments: ____________________________  Plan of correction (if needed): ____________________________

__________________________________________________________________________

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Signature: ____________________________  Date: ____________________________
Medical Record and Documentation Audit

Policy:

The registered dietitian nutritionist (RDN) or designee will conduct an audit of medical record documentation a minimum of once per quarter or more often as deemed necessary.

Procedure:

The registered dietitian nutritionist (RDN) or designee will conduct an audit using the appropriate Sample Chart Audit Forms on the following pages. The auditor will:

1. Review the medical records and note:
   a. Name
   b. Room number
   c. Date of initial nutrition assessment (NA)
   d. Date of most recent plan of care (POC)
   e. Date of most recent progress note (PN)

2. Audit medical record for timeliness of nutrition assessment, and appropriate nutrition interventions and/or follow through.
   a. Initial nutritional assessments must be completed within 14 days of admission, and annually thereafter.
   b. Initial plans of care must be completed within 7 days of completion of the initial nutritional assessment.
   c. Progress notes and care plans require updating every three months or more often if problems or significant changes occur.
   d. Intermittent problems such as significant weight change, abnormal lab values, poor food intake, or pressure injuries, etc. should have progress notes to reflect plan of care.

   Assess the dates of documentation for timeliness and check the following to assure a consistent and accurate delivery of care. The auditor should:
   a. Check the diet order in the documentation against the physician’s order for accuracy.
   b. Check the diet order in the documentation against the meal identification (ID) card/ticket and cardex.
   c. Compare documented oral nutrition supplements/nourishments to the physician’s order.
   d. Compare documented oral nutrition supplements/nourishments to the lists in the kitchen (cardex or computer record).
   e. Compare documented enteral/parenteral feeding against the physician’s order.

3. Document problems, including:
   a. Incorrect diet orders.
   b. New problems or significant changes that may have occurred since the last update (significant weight changes, pressure ulcer, new enteral feeding, etc.).
   c. Documentation dates that are out of compliance.

4. Report findings to the appropriate people (director of food and nutrition services, nutrition support staff, nursing, administrator, or others).

5. Develop a plan of correction:
   a. Update any documentation that is out of compliance. Request updated physicians orders as needed to assure physicians orders for diets and supplements, information on file in dietary, and meal trays are all in agreement.
b. Follow up to assure changes are made as requested.

6. Develop a spreadsheet of when yearly assessments and quarterly updates are due for each individual.

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## Sample Chart Audit Form

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>NA Date</th>
<th>POC Date</th>
<th>PN Date</th>
<th>NCP Followed</th>
<th>Comments</th>
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</table>

NA = Nutritional Assessment  
POC = Care plan  
PN = Progress Notes  
NCP = Nutrition Care Process
Sample Diet Order Audit Form

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Diet Order or Enteral/Parenteral Feeding Order</th>
<th>Matches Physician Order</th>
<th>Matches Meal ID Card/Ticket</th>
<th>Matches Cardex/Computer Record</th>
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Sample Supplements/Nourishments Audit Form

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Supplement/Nourishment Order</th>
<th>Matches Physician Order</th>
<th>Matches Meal ID Card/Ticket</th>
<th>Matches Cardex/Computer Record</th>
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### Sample In-Depth Documentation Audit Form

**Name:** ________________________________  **Room:** ______  **Date:** __________

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<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tr>
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<tr>
<td>Current/Annual Assessment in Chart</td>
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<td>Complete</td>
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<tr>
<td>Appropriate Information</td>
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<tr>
<td><strong>Care Plan:</strong></td>
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<td>Current</td>
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<tr>
<td>Consistent with Nutritional Assessment and Progress Notes</td>
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<tr>
<td>Measurable Goals</td>
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<td><strong>Progress Notes:</strong></td>
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<td>Current</td>
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<td>Diet Order (Acceptable to Resident)</td>
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<tr>
<td>Weight Status</td>
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<tr>
<td>Eating Ability</td>
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<td>Food Intake</td>
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<tr>
<td>Skin Condition</td>
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<tr>
<td>Appropriate Interventions</td>
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<td></td>
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<tr>
<td>Appropriate Referrals to Registered Dietitian</td>
<td></td>
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<tr>
<td><strong>Diet Tray Card/Ticket:</strong></td>
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<tr>
<td>Name</td>
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<tr>
<td>Food Preferences</td>
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<tr>
<td>Special Needs</td>
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<tr>
<td>Diet Order/Supplement Info Current</td>
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</table>
Oral Nutritional Supplement (ONS)/Snack Audit

Policy:

The registered dietitian nutritionist (RDN) or designee will audit oral nutrition supplement (ONS)/snacks provided by the food and nutrition services department 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 oral nutritional supplements or snacks according to the plan of care and/or orders on file in medical record. List the ONS or snack 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 documentation on file in the food and nutrition services department. Review with the director of food and nutrition services and make adjustments as needed.

3. Observe ONS/snack delivery between meals and note:
   a. Time of arrival of snacks and supplements and amount of time taken to pass all nourishments.
   b. Adequacy of assistance given.
   c. Refusal of ONS or snacks by individuals.

4. Review findings on refusals with direct care staff. If refusal is frequent and consistent, snacks or supplements should be discontinued or changed.

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 nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Sample Oral Nutritional Supplement/Snack Audit Form

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>Breakfast</th>
<th>10:00</th>
<th>Lunch</th>
<th>2:00</th>
<th>Dinner</th>
<th>HS</th>
<th>Matches Orders</th>
<th>Matches Cardex/Computer</th>
<th>Matches Meal ID Card/Ticket</th>
</tr>
</thead>
</table>

Facility ______________________ Wing __________ Date __________
Sample Oral Nutrition Supplement/Snack Pass Audit Form

Facility ____________________  Wing __________  Date __________

<table>
<thead>
<tr>
<th>Room</th>
<th>Name</th>
<th>% of Intake of Supplement</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>100</td>
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</table>
Sample Meal Quality Survey Form

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
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<tbody>
<tr>
<td>If you were going to improve the quality of the food, what would you do?</td>
<td></td>
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<tr>
<td>What is your overall impression of the “food service”?</td>
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<tr>
<td>Is the hot food HOT?</td>
<td></td>
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<tr>
<td>Is the cold food COLD?</td>
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<tr>
<td>Is there a choice available if you dislike the meal?</td>
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<tr>
<td>Are portion sizes adequate?</td>
<td></td>
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<tr>
<td>Does the food taste good?</td>
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<tr>
<td>Is the dining atmosphere pleasant?</td>
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<tr>
<td>What items would you delete from the menu if you were preparing the meals?</td>
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</tbody>
</table>

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:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
**Individual Interviews to Determine Customer Satisfaction and Person-Centered Care**

Interview the individual, and/or the individual’s representative or family:

1. Is 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, beverage, and dining preferences addressed (e.g., is the person offered alternates 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 required 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 nutritionist, director of food and nutrition services, charge nurse, social worker, occupational therapist, attending physician, medical director, etc.) to determine, how:

1. Food and fluid intake, 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 recognized standards of practice, interview one or more health care practitioners as necessary (e.g., physician, hospice nurse, registered dietitian nutritionist, charge nurse, director of nursing or medical director). Depending on the issue, ask about:

1. The rationale for chosen interventions.
2. How changes in condition that may justify additional or different interventions were addressed.
3. How the interdisciplinary team decided to maintain or change interventions.
4. Rationale for decisions not to intervene to address identified needs.
5. How staff evaluated the effectiveness of current interventions.

**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.

---

*Policy & Procedure Manual 11-36*

Resource: Audit to Assess Quality of Care Provided and to Prepare for Surveys

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 documentation, and nursing, registered dietitian nutritionist, 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 or usual weight range, and identify weight loss/gain?
2. Did the facility identify the significance of any weight changes, and what interventions were needed?
3. Did the facility notify the individual and/or family and physician of significant weight loss or gain?

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 and beverage 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 stable or improving towards goals established by the care team?
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:

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Guide to Developing Facility’s Annual QAPI Plan

Policy:

The food and nutrition services department will participate in developing the facilities annual quality assurance and performance improvement (QAPI) plan.

Procedure:

1. The director of food and nutrition services and the registered dietitian nutritionist (RDN) or designee, as members of the leadership team, will review data from employee and customer satisfaction survey, quality measures, survey reports and any data related to performance improvement projects (PIPs).

2. The food and nutrition services manager will attend the monthly QAPI Committee meetings.

3. The RDN or designee will attend when applicable (when the PIP involves nutrition such as reducing pressure ulcers or weight loss).

4. If the PIP involves the food and nutrition services department, the director of food and nutrition services manager and the RDN or designee will develop and/or conduct any education or training necessary to achieve the QAPI goal.

5. If the PIP has a nutrition component, the RDN will develop and/or conduct any education or training necessary to achieve the QAPI goal (for example, the importance of calories and protein to heal pressure injuries).

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff include nutrition and dietetic technicians, registered (NDTR), nutrition associates (four year degree in nutrition/dietetics), certified dietary managers (CDM), food and nutrition directors, etc. The RDN may delegate certain tasks based on the scope of practice and competency levels of each member of the nutrition team.
Sample QAPI Plan for Unintended Weight Loss (UWL)

Step 1: QAPI Meeting
- RDN identified UWL on monthly audit
- Director of food and nutrition services noted an increase in the number of supplement orders
- Resident/family satisfaction survey noted a high percentage of respondents documented poor food quality and food preferences/choices not honored

Step 2: QAPI Steering Committee
- UWL is a high-risk problem
- UWL can lead to decreased quality of life
- UWL can lead to additional clinical concerns such as mobility issues, falls and pressure injuries
- Committee voted to launch a Performance Improvement Project (PIP) on UWL

Step 3: Root Cause Analysis Identified
- No process to identify and address risk for UWL
- No system to honor food choices
- Food delivery carts sat in the hall for 30+ minutes prior to service

Step 4: PIP Team Identified
- Representative from nursing department
- Director of food and nutrition services
- RDN
- Representative from the certified nursing assistants (CNAs)
- Resident and family representative

Step 5: Action Plan
- Nutrition risk team initiated with protocols to identify risk and implement plans to address problem
- Computerized weight tracking implemented
- Menus revised with resident, family, staff involvement to reflect choices
- Selective menus phased into service
- Open dining phased into service
- Meal times staggered for residents who needed assistance or preferred to dine at an alternate time

Step 6: Monitoring and Evaluation-Data Collected by Steering Committee
- Food acceptance as noted by food intake records
- Food waste evaluated
- Supplement orders collected
- Weight data reviewed
- Satisfaction survey distributed and evaluated
- Food and nutrition services staff and CNAs observed and noted resident satisfaction

Step 7: Six-Month Review of Results
- UWL had declined from 3.5% to 3% of targeted residents
- Food satisfaction scores had increased by 2%
- Supplement cost had declined by 10%
- No survey deficiencies involving UWL

Note: PIP will be evaluated annually
Sample QAPI Plan for Unintended Weight Loss (UWL)

Resources:
- OAPI: Quality Assurance and Performance Improvement Resources
- American Health Care Association: Quality Assurance and Performance Improvement

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

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Emergency and 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 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 director of food and nutrition services will coordinate the function of the food and nutrition services department during an emergency. In the absence of the director of food and nutrition services or designee, a senior cook/chef will be responsible for the department. If neither is available, the administrator will assign a person to be responsible for the food and nutrition services department.

Procedure:

The following will be available during an emergency or disaster:

1. Emergency food, water and supplies for the planned menu pattern for 3 to 7 days.* This should include adequate water for additional people (staff, family members, rescue workers, and evacuees). The menu should be palatable even if repetitious. Food that can be transported in case of an evacuation should be available.

2. Emergency enteral supplies for tube fed individuals for at least 3 to 7 days.*

3. Disposable dishes, disposable wipes, hand sanitizer, and extra disposable supplies as necessary to support nursing and other staff needs for 3 to 7 days.

4. A list of organizations and vendors/suppliers that agree to provide assistance in case of an emergency.

5. A list of food and nutrition services department employees’ names and telephone numbers.

6. A preplanned disaster-staffing schedule of employees who agree to work during and/or following the disaster which is maintained with current contact information. Note: This schedule must remain flexible depending on circumstances and availability at the time of the disaster.

7. A copy of all documents needed for meal service and regulatory purposes (such as menus, recipes, temperature logs, diet orders, tray tickets, policies and procedures) in electronic format. Use facility protocols for backing up electronic documents (system mainframe, the “cloud”, DVD’s, or thumb drives).

8. In the event of a reduction of food and nutrition services department personnel and/or product deliveries:
   a. The administrator will contact the director of food and nutrition services and the registered dietitian nutritionist (RDN) or designee.
   b. If the director of food and nutrition services is unavailable, the administrator will assign a responsible person to direct the department.
   c. Volunteers may be assigned to the food and nutrition services department as necessary during the emergency.
   d. Vendors will be notified of the emergency status of the facility.
Emergency and Disaster Planning

e. The administrator may request that staff members pick up supplies for the food and
nutrition services department if vendors are unable to make deliveries.

*Check state regulations and if they are different than federal regulations or Joint Commission
regulations, follow the most stringent of the recommendations. Note: Joint Commission requires
a minimum of 4 days of food, water and supplies.
Back-up for Electronic Files

Policy:

Electronic files needed for operation of the food and nutrition services department will be backed up periodically so that files will be accessible from a remote location in the event of an emergency.

Procedure:

1. Consult with the facility IT department to obtain information on:
   a. Preferred method to back up information that contains protected patient/resident information (diet orders, food preferences, diagnosis, etc.) on the facility server, main-frame computer, or “cloud” back up.
   b. Preferred method to back up and access other department files from the facility server, main-frame computer, or “cloud” back up.

2. Follow facility protocols for backing up all information and files pertinent to the day to day operation.

3. If possible, store copies of data offsite in the “cloud”, on DVD’s, or thumb drives as instructed by the IT department.

4. Print a hard copy of emergency menus and emergency procedures and store with the emergency food supply.

5. Consult with the maintenance department to determine if department computers have power if the facility emergency generator is running.
Employee Training

Policy:

Employees will be prepared for unexpected events.

Procedure:

1. 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.

2. To ensure that employees are prepared for the unexpected events that may occur, in-service on the following items:
   a. Overview of the emergency and disaster plan.
   b. Overview of the emergency food and water plan, menus and recipes.
   c. Location of stored supplies including food, water, drinking water, all-purpose water, enteral feeding supplies, paper products, etc.
   d. Location of emergency equipment and first aid supplies.
   e. Water purification techniques and supply locations.
   f. Sanitation/food safety during a disaster.
   g. Responsibilities in relationship with other departments.
   h. Coordinator of each department and location of contact information in case of unexpected events or emergency situations.
   i. Location of emergency contact numbers.
   j. How to locate and use the firefighting equipment.
   k. Evacuation routes, routines, and maps with directions.
   l. All alarm and signal systems.
   m. Management of casualties, first aid training.
   n. Use of generators and/or review of equipment on the emergency generator.
   o. How to access back-ups of electronic files.

3. Emergency disaster drills should be conducted at least twice per year, in advance of potential threats. For example, if the facility is in a geographic area that is prone to hurricanes, a drill should be conducted prior to hurricane season.

4. 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).

5. Staff should be able to answer the following questions:
   a. If the fire alarm goes off, what should you do?
   b. What would you do if you discovered a fire in the kitchen? In a dining area? In a resident’s/patient’s room?
   c. Where are the fire alarms and fire extinguisher located in the kitchen? Dining area? Near resident’s/patient’s rooms?
   d. How do you use the fire extinguisher? (Please demonstrate).
   e. Where is the emergency disaster plan kept?
   f. Where are the emergency food, water, and supplies stored? How do you access them?
   g. How can you purify contaminated water?
   h. What is the procedure in case of evacuation?
   i. Also add questions related to geographically specific disasters (hurricanes, tornadoes, floods, earthquakes, winter storms, etc.).
Employee Training

Source:

Resources:
General Instructions for Person in Charge
Check 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. Access back-ups of electronic files (menus, recipes, tray tickets/ID cards, etc.) as needed.

4. Develop a plan to use food in stock (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

5. Maintain well-balanced meals with as normal a menu as possible. Texture modifications, allergy and food intolerance concerns are most important. 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.

6. 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 the policy on Water Purification in this chapter for instructions).
   - Do not use 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 emergency supply of disposable dishes and utensils when necessary.

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 that 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. Offer assistance with serving trays and assisting individuals who need help (within scope of practice/competence).

2. No Water Supply or Water Supply is Shut Off:
   - The facility should have bottled water in the storeroom (0.5 gallons per person/day). 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.
Resource: Food and Nutrition Service Disaster Plan

- Other sources of fluids which should be on hand in kitchen, storeroom, and freezer include:
  - Fruit/vegetable juices
  - Canned soups and broth
  - Soft drinks (item kept on hand for liquid diets)
- 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 in cooking to avoid thirst sensation.
- Monitor all individuals to ensure they are receiving adequate hydration.

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.
- Assure department computers containing files necessary for operations are plugged into an outlet serviced by auxiliary power.

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. A local restaurant, school or church may be an appropriate alternate supplier if delivery trucks cannot get through with supplies.

See Sample Letter of Intent for Provision of Emergency Supplies in this chapter of the manual.

5. Combination of Situations:
- If a combination of these situations exists, combine instructions as needed.

*Check state regulations and follow the more stringent recommendations. Joint commission requires a minimum of 4 days of food, water and supplies.
Coordination of Emergency and Disaster Plan

Policy:

The director of food and nutrition services or designee will coordinate the function of the food and nutrition services department during an emergency.

Procedure:

The director of food and nutrition service’s responsibilities during an emergency will 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 (3 to 7) 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. Access back-ups to electronic files (menus, tray tickets/ID cards, etc.) if necessary.
5. Provide a list of food and nutrition services department employees’ names and telephone numbers to be utilized if additional staff is needed.
6. Notify vendors of the emergency status of the facility and any pressing needs. (See the policy on Emergency Contact Information in this chapter.)
7. Assign volunteers in each department as necessary to work during the emergency.
8. Request that staff members bring supplies if vendors are unable to make deliveries.
   a. Determine how to use perishable food items on hand in the coolers and freezers in the first and second day (based on keeping qualities): Food in refrigerators – check food temperatures to ensure food safety.
   b. Food in freezers – check food temperatures to ensure food safety.
   c. Canned and dry foods – use last.
   d. Packaged nutritional supplements and enteral formulas – see manufacturer’s instructions.

*Check state regulations and follow the more stringent recommendations. Joint commission requires a minimum of 4 days of food, water and supplies.
## Sample Disaster Responsibilities and Assignments Form

<table>
<thead>
<tr>
<th>Done</th>
<th>Duties</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Prior to Disaster:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recruit experienced staff and/or volunteers (i.e. from restaurants,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>schools, Red Cross, churches) to serve during an emergency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Train staff and/or volunteers (including disaster drills)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assign responsibilities of staff, volunteers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain backup computer files for department, through the facility’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>mainframe system, and/or on portable media (DVD’s, thumb drives),</td>
<td></td>
</tr>
<tr>
<td></td>
<td>as per facility protocols</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purchase emergency water, food and supplies (see *Sample Letter of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intent for Provision of Emergency Supplies* in this chapter of the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>manual)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Store and rotate of emergency water, food and supplies (3 to 7 days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of supplies including cleaning supplies)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan emergency menus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contract with a generator supply company to provide electricity as</td>
<td></td>
</tr>
<tr>
<td></td>
<td>needed and request administration have at least 50% of equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>on emergency generator such as refrigerators, freezers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plan for mobile feeding if kitchen/food/supplies are damaged beyond</td>
<td></td>
</tr>
<tr>
<td></td>
<td>use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meet with director of local Red Cross and develop written agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to specify responsibilities/expectations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain a list of emergency contact information for key personnel,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>county emergency manager, Red Cross, vendors (cell numbers whenever</td>
<td></td>
</tr>
<tr>
<td></td>
<td>available)—verify list at least annually</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document location of keys to doors, coolers, freezers, storage areas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain a list of electrical equipment, lighting, and outlets that</td>
<td></td>
</tr>
<tr>
<td></td>
<td>will function in the event that auxiliary power is used.</td>
<td></td>
</tr>
</tbody>
</table>

**Source:**
Sample Letter of Intent for Provision of Emergency Supplies

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 and nutrition services 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. Civil Defense, Federal, State, County or City authorities may control supplies and products. 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:  

______________________________  __________________________  
Food Service Vendor  Facility Representative

_______  ________  
Date  Date
Emergency Contact Information

Policy:

When the registered dietitian nutritionist (RDN), nutrition and dietetic technician registered (NDTR) and/or director of food and nutrition services are not in the building, emergency services are provided to answer questions that need immediate attention.

An employee phone roster is maintained with current cell phone and home phone numbers for use in a phone tree.

Procedure:

1. Use the form below or refer to the Emergency Contacts Policy and Procedure on the following page.

Employee Contact Information Sample Form

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Cell Phone Number</th>
<th>Home Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Copy this form onto brightly colored paper and place a copy of the completed form in an area where staff can utilize it in case of emergency.
Emergency Contacts

Policy:

When the director of food and nutrition services and/or the registered dietitian nutritionist (RDN) are not in the building, emergency services will be 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 director of food and nutrition services may be reached by calling ________________. Calls are returned as quickly as possible.

3. The RDN may be reached by phoning _________________. Calls are returned as quickly as possible.

4. American Red Cross – Local Chapter Number _________________.

5. Food Service Supplier _________________.

6. Local Health Department _________________.

7. State Health Department _________________.

8. Additional emergency contacts (may include vendors/suppliers, local restaurants, professionals, or others who have agreed to assist in an emergency):

   ________________  ________________  
   ________________  ________________  
   ________________  ________________  
   ________________  ________________  
   ________________  ________________  
   ________________  ________________  
   ________________  ________________  

Copy this form onto brightly colored paper and place a copy of the completed form in an area where staff can utilize it in case of emergency.
## Sample Medical Nutrition Therapy Information Form

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Gender: M  F</th>
<th>DOB: _________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Directives for Nutrition/Hydration:</td>
<td>Contact Info for Family or Guardian (name/phone/cell phone):</td>
<td></td>
</tr>
<tr>
<td><strong>Diet Order</strong>: Reg / No Added Salt / LCS / Mech Soft / Puree / Modified Renal Diet</td>
<td><strong>Supplement orders</strong>:</td>
<td></td>
</tr>
<tr>
<td><strong>Food allergies/ intolerances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alternate Feeding Orders</strong> (Tube feeding, TPN if applicable):</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Feeding ability</strong>: Self fed / Needs assistance / Needs to be fed / Needs adaptive equipment to feed self</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Status</strong>: Alert / Confused / Unable to communicate</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skin Condition</strong>: Intact / Wounds present</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulation</strong>: Ambulatory / Wheelchair / Confined to bed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weight</strong>: ________(pounds) _________ (date)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Weight History</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition Risk Factors (circle all that apply)</strong>: Malnutrition / Dehydration / Swallowing problems / Chewing problems / Refusal of foods/ fluids / Cultural food issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Notes</strong>:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature: _____________________________   Date: __________________

Place a copy of this form in an area where staff can utilize it in an emergency.
### Sample Location of Needed Items and Information During a Disaster Form

<table>
<thead>
<tr>
<th>Item</th>
<th>Location of Item or Information</th>
<th>Responsible Person</th>
<th>Cellular Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keys to storage areas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire extinguisher</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main power switch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuse or breaker boxes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard first aid kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disaster manual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cellular phone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keys to storerooms, freezers, coolers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency generators</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracted local vendor for a generator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air conditioning units</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flashlights, candles, lanterns, matches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weather radio, portable, battery operated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Battery operated clocks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra batteries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blankets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toolbox: adjustable wrench to turn off gas, crow bar, hammer, screwdrivers, heavy tape</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attach a basic floor plan for the kitchen and storeroom.

Copy this form onto brightly colored paper and place a copy of the completed form in an area where staff can utilize it in case of emergency.
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 and nutrition services 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 three to seven-(3-7) day emergency supply of water is recommended. Water should be stored in a cool, dry area away from heat sources.

Procedure:

1. A minimum 3 day supply of water, and preferably a 7 day supply of water, should be available. The quantity of water that is needed can be determined by the following calculations:

<table>
<thead>
<tr>
<th>Type of Water</th>
<th>Amount Needed</th>
<th>Formula</th>
<th>Example (7 day supply) for 100 People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking Water</td>
<td>2 quarts</td>
<td># of people* X 0.5** gallons X 3 days (or 7 days) = gallons of drinking water needed</td>
<td>100 people X 0.5 gallon X 7 days = 350 gallons of drinking water</td>
</tr>
<tr>
<td>All-purpose Water</td>
<td>1 gallon</td>
<td># of people* X 1 gallon X 3 days (or 7 days) = gallons of all-purpose water needed</td>
<td>100 people X 1 gallon X 7 days = 700 gallons of all-purpose water</td>
</tr>
</tbody>
</table>

*Include residents/patients, staff, visitors, evacuees and rescue workers as appropriate in estimate of water needed. Include nursing needs as necessary (medication pass, etc.). A good estimate is number of residents/patients plus 50 to 100%.

**Hot climates can double the amount of fluid needed for drinking. If 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. (Again, add extra as noted above in *.)

Note: Please check 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.

4. During an emergency, staff will be provided 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. Bottled water is expensive so a written plan to use, rotate and replace the water should be part of the disaster plan.
Water Requirements

Preparing/Using Water Containers
1. Use food grade water storage containers made specifically for water storage.

2. Clean and sanitize containers prior to use.

3. Fill water containers with tap water from a source that has been commercially treated with chlorine from a water utility.
   - If the water is from a source not treated with chlorine (i.e. well water), add 2 drops non-scented household chlorine bleach to each 1 gallon of water being careful not to contaminate the inside of the cup.

4. Tightly seal the container (being careful not to contaminate the inside of the cup) and store for later use.

5. Date the outside of the container clearly.

6. Store in a cool dark place.

Source:

How to Turn Off the Main Water Valves
Water already inside the facility will need to be protected from contamination in the event of broken water or sewage lines, or if local officials advise there is a problem. To close the incoming water source, locate the incoming valve and turn it to the closed position. Be sure key staff members know how to perform this important procedure.

1. To use the water in the pipes, let air into the plumbing by turning on the faucet at the highest level. A small amount of water will trickle out. Then obtain water from the lowest faucet in the facility.

2. To use the water in the hot-water tank, ask for assistance from the maintenance department as needed.
   - Be sure the electricity or gas is off.
   - Open the drain at the bottom of the tank.
   - Start the water flowing by turning off the water intake valve at the tank and turning on the hot water faucet.
   - Do not turn on the gas or electricity when the tank is empty.
   - Refill the tank before turning the gas or electricity back on. If the gas is turned off, a professional will need to turn it back on.
Sources of Water During an Emergency

Policy:

In an emergency situation, supplemental 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 facilities 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 use of water barrels or water bladders, which can be filled with water in advance of an emergency.

Emergency Water Sources*

Safe Sources
- Safe uncontaminated melted ice cubes.
- Liquids from canned goods such as fruit or vegetable juices.
- Water drained from clean, safe, pipes.
- Undamaged hot water heaters can contain water. Remember, though, that this water is not purified and should be used as all-purpose water, not drinking water.

Unsafe Sources
- Radiators and 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:

See next page for information on water purification.
Water Purification

Policy:

If instructed by local officials, the water supply must be purified before using.

Procedure:

Water Purification - Strain the water through cheesecloth, paper towel or coffee filter to remove dirt or other particles if needed. Choose one of the following three (3) ways to purify the water.

Boiling
Boiling is one of the most common and safest ways to purify water. Steps for purifying water using the boiling method include:
1. Pour water into an appropriate cooking container, place on the stovetop, and bring to a rolling boil.
2. Boil vigorously for one full minute.
3. To prevent evaporation, put a lid on the container after the water has been boiled to trap any evaporating steam.
4. Cool the water for 30 minutes to a safe handling temperature before transferring it into clean containers.
5. To improve the taste of the water, pour it from one container to another several times.

Note: A loss of utilities may result in not having a heat source available to boil the water.

Water Purification Tablets
Water purification tablets can be purchased locally at most sporting goods stores, camping supply stores or drug stores. An Internet search of “water purification tablets” will result in several sources. These tablets release chlorine or iodine for purification. Keep water purification tablets with other emergency supplies to ensure they are on hand when needed. Follow the manufacturer’s directions for use. Usually one tablet is enough for one quart of water. Double the dose of purification tablets for cloudy water.

Bleach Purification
Another purification method is the use of liquid household bleach. Follow these steps:
1. Use household bleach in liquid form that contains 5.25 to 6.0% sodium hypochlorite. Do not use color safe bleaches or bleach with added cleaners, soaps or scents. Use bleach from an unopened or newly opened bottle (bleach’s potency reduces over time). Important: Be sure to use bleach that contains 5.25 or 6.0% sodium hypochlorite as the only active ingredient.
2. Before treating, let any suspended particles settle to the bottom or strain them through coffee filters, paper towel or layers of clean cloth to remove dirt or particles.
3. Measure bleach carefully (over or under measuring may be harmful).
   a. Add 16 drops (1/8 teaspoon) of bleach per 1 gallon of water and mix well.
   b. Let stand for 30 minutes.
Water Purification

c. The water should have a slight bleach odor. If it doesn’t, then repeat the dosage and let stand another 15 minutes.
d. If it still does not smell of chlorine, discard it and find another source of water.

4. Seal containers tightly, label them clearly, and store in a cool, dark place.

<table>
<thead>
<tr>
<th>Amount of Water</th>
<th>Amount of Bleach Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 quart</td>
<td>4 drops*</td>
</tr>
<tr>
<td>1 gallon</td>
<td>16 drops* (1/8 teaspoon)</td>
</tr>
<tr>
<td>5 gallons</td>
<td>5/8 teaspoon</td>
</tr>
</tbody>
</table>

* An eyedropper is ideal to measure the number of drops.

Source:

Resource:

Safe Water After a Disaster
After a boil water advisory has been lifted, follow these steps. Do not resume using water for drinking until authorities have announced it is safe.
1. Empty any automatic filling ice trays in ice machines. Discard three (3) full runs of ice before allowing ice consumption.

2. Run refrigerated water lines for 5 minutes to remove contaminated water from lines. Replace or thoroughly clean water filters.

3. Well water: If floodwaters have contaminated wells, disinfect and test after floodwaters have receded. For other types of contamination, check with authorities prior to use to assure water safety.
Examples of Non-Perishable Foods
The following foods are easily inventoried, generally have a long shelf life, and can be easily incorporated into the menu or snack schedules prior to their expiration dates. Be sure to follow inventory rotation and monitor expiration dates. Keep a hard copy of emergency menus and a manual can opener with the canned goods supply.

### Canned Goods

<table>
<thead>
<tr>
<th>Canned Meats, Poultry, Fish</th>
<th>Canned Beans</th>
<th>Pureed Foods</th>
<th>Canned or Aseptically Packaged Nutritional Supplements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken</td>
<td>Baked</td>
<td>Chicken</td>
<td>Milkshakes</td>
</tr>
<tr>
<td>Deviled ham</td>
<td>Black</td>
<td>Fruits</td>
<td>Puddings</td>
</tr>
<tr>
<td>Ham</td>
<td>Butter</td>
<td>Meats</td>
<td></td>
</tr>
<tr>
<td>Peanut butter</td>
<td>Cannelloni</td>
<td>Vegetables</td>
<td></td>
</tr>
<tr>
<td>Salmon</td>
<td>Chick Peas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuna</td>
<td>Kidney</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vienna sausage</td>
<td>Navy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Fruit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applesauce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apple slices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit cocktail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandarin oranges</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pineapple</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Vegetables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>German potato salad</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Green beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pickled vegetables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potatoes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spaghetti sauce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three bean salad</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tomatoes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tomato sauce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Pie Filling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apple</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blueberry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cherry</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Peach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Prepared Foods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheese sauce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken &amp; dumplings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chili</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ravioli</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stew</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Pudding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chocolate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lemon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vanilla</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broths</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beef</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Canned or aseptic packs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit Juices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apple</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apricot nectar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cranberry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grape</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pear nectar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prune</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Canned or aseptic packs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condiments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chocolate syrup</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jam and jelly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maple syrup</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mayonnaise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mustard</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salad dressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaporated milk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweetened /condensed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beverages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruit punch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iced tea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other beverage drinks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soda pop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bottled Water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 or 20 ounces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Gallon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Gallon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50 Gallon Drums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Larger Containers as needed</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Resource: Non-Perishable Foods List for Emergency Supply

### Non-Perishable Foods List

#### Shelf Stable Items

<table>
<thead>
<tr>
<th>Convenience Foods</th>
<th>Supplements/Proteins</th>
<th>Therapeutic Items</th>
<th>*Condiments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instant mashed potatoes</td>
<td>Egg whites, dried</td>
<td>Modified food starch or gel thickener</td>
<td>Coffee creamer</td>
</tr>
<tr>
<td>Instant mashed sweet potatoes</td>
<td>Instant breakfast mix</td>
<td></td>
<td>Honey</td>
</tr>
<tr>
<td>Instant pudding</td>
<td>Milkshake mix</td>
<td>or gel thickener</td>
<td>Jelly</td>
</tr>
<tr>
<td>Powdered cheese sauce mix</td>
<td>Soy Protein</td>
<td>Sweetener</td>
<td>Ketchup</td>
</tr>
<tr>
<td>Refried Beans</td>
<td></td>
<td></td>
<td>Mustard</td>
</tr>
<tr>
<td>Soy Protein</td>
<td></td>
<td></td>
<td>Salt and pepper</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crackers/Chips</th>
<th>Snacks</th>
<th>Soup</th>
<th>Coffee/Tea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butter crackers</td>
<td>Cereal/snack bars</td>
<td>Bouillon</td>
<td>Instant coffee</td>
</tr>
<tr>
<td>Cheese puffs</td>
<td>Cheese crackers</td>
<td></td>
<td>Tea bags</td>
</tr>
<tr>
<td>Graham crackers</td>
<td>Granola bars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potato chips</td>
<td>Peanut butter crackers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saltine crackers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Starches</th>
<th>Cookies</th>
<th>Thickened Beverages</th>
<th>Beverages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pasta</td>
<td>Chocolate chip</td>
<td>Thicken juice</td>
<td>Large and small aseptic packs of juice</td>
</tr>
<tr>
<td>Noodles</td>
<td>Filled cookies</td>
<td>Thicken milk</td>
<td>Powdered beverage mixes (regular and sugar free):</td>
</tr>
<tr>
<td>Rice</td>
<td>Shortbread cookies</td>
<td>Thicken water</td>
<td>Fruit flavored iced tea or punch</td>
</tr>
<tr>
<td></td>
<td>Sugar cookies</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vanilla wafers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milk</th>
<th>Cereal</th>
<th>Nuts and Seeds</th>
<th>Dried Fruit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pasteurized nonfat dry milk</td>
<td>Dry (bulk or in single serve containers)</td>
<td>Almonds</td>
<td>Apples</td>
</tr>
<tr>
<td>Canned evaporated milk</td>
<td>Hot (cream of rice, cream of wheat, grits oatmeal)</td>
<td>Mixed nuts</td>
<td>Apricots</td>
</tr>
<tr>
<td>Shelf stable milk</td>
<td></td>
<td>Peanut butter</td>
<td>Bananas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peanuts</td>
<td>Cranberries</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Walnuts</td>
<td>Prunes or Raisins</td>
</tr>
</tbody>
</table>

* 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:

<table>
<thead>
<tr>
<th>Bread Items</th>
<th>Produce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread</td>
<td>Potatoes</td>
</tr>
<tr>
<td>Buns/Rolls</td>
<td>Onions</td>
</tr>
<tr>
<td>Pita bread</td>
<td>Apples</td>
</tr>
<tr>
<td>Muffins/ English muffins</td>
<td></td>
</tr>
<tr>
<td>Parmesan cheese</td>
<td></td>
</tr>
</tbody>
</table>

Resource: Emergency Menu and Supplies

The following pages contain a therapeutic 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. 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 might not be met.

**Sample Emergency Menus**
For detailed plans and 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. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Naples, FL. 2014. Available at [http://www.beckydorner.com/products/82](http://www.beckydorner.com/products/82).
In an emergency adhere to texture and consistency modifications, food allergies, and food intolerances. Adaptive equipment should be used, if possible. Therapeutic diets should be adhered to when feasible, or use the liberalized as outlined in the table above.

For individuals with diabetes, 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 chapter if the water supply is unsafe for drinking.

### Suggested Emergency Menu Pattern

<table>
<thead>
<tr>
<th></th>
<th>Regular</th>
<th>Mechanical Soft</th>
<th>Puree</th>
<th>LCS</th>
<th>LCS Puree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meal</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Breakfast</strong></td>
<td>Juice, 6 oz.</td>
<td>Juice, 6 oz.</td>
<td>Juice, 6 oz. Smooth Hot Cereal, 1 c</td>
<td>*Juice, 6 oz.</td>
<td>*Juice, 6 oz.</td>
</tr>
<tr>
<td></td>
<td>Cereal, 1 serving</td>
<td>Soft Cereal, 1 serving</td>
<td>*Cereal, 1 serving</td>
<td>*Cereal, 1 serving</td>
<td>*Cereal, 1 serving</td>
</tr>
<tr>
<td></td>
<td>Starch, Bread or Other, 1 serving</td>
<td>Soft Starch, Bread or Other, 1 serving</td>
<td>*Starch, Bread or Other, 1 serving</td>
<td>*Starch, Bread or Other, 1 serving</td>
<td>*Starch, Bread or Other, 1 serving</td>
</tr>
<tr>
<td></td>
<td>Milk or Nutrition</td>
<td>Milk or Nutrition</td>
<td>Milk or Nutrition</td>
<td>Milk or Nutrition</td>
<td>Milk or Nutrition</td>
</tr>
<tr>
<td></td>
<td>Supplement, 8 oz.</td>
<td>Supplement, 8 oz.</td>
<td>Supplement, 8 oz.</td>
<td>Supplement, 8 oz.</td>
<td>Supplement, 8 oz.</td>
</tr>
<tr>
<td></td>
<td>Coffee/Tea</td>
<td>Coffee/Tea</td>
<td>Coffee/Tea</td>
<td>Coffee/Tea</td>
<td>Coffee/Tea</td>
</tr>
<tr>
<td><strong>Lunch</strong></td>
<td>Protein Source, 2-3 oz. equivalent</td>
<td>Ground Protein Source, 2-3 oz. equivalent</td>
<td>Pu Protein Source, 2-3 oz. equivalent</td>
<td>Pu Protein Source, 2-3 oz. equivalent</td>
<td>Pu Protein Source, 2-3 oz. equivalent</td>
</tr>
<tr>
<td></td>
<td>Starch, 1 serving</td>
<td>Soft Starch, 1 serving</td>
<td>Pu Starch, 1 serving</td>
<td>Pu Starch, 1 serving</td>
<td>Pu Starch, 1 serving</td>
</tr>
<tr>
<td></td>
<td>Starchy Vegetable, ¾ c</td>
<td>Soft Starchy Veg, ¾ c</td>
<td>Pu Starchy Veg, ¾ c</td>
<td>Pu Starchy Veg, ¾ c</td>
<td>Pu Starchy Veg, ¾ c</td>
</tr>
<tr>
<td></td>
<td>Vegetable, ¾ c</td>
<td>Soft Vegetable, ¾ c</td>
<td>Pu Vegetable, ¾ c</td>
<td>Pu Vegetable, ¾ c</td>
<td>Pu Vegetable, ¾ c</td>
</tr>
<tr>
<td></td>
<td>Fruit, ¾ c</td>
<td>Soft Fruit, ¾ c</td>
<td>Pu Fruit, ¾ c</td>
<td>Pu Fruit, ¾ c</td>
<td>Pu Fruit, ¾ c</td>
</tr>
<tr>
<td></td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
</tr>
<tr>
<td><strong>Dinner</strong></td>
<td>Protein Source, 2-3 oz. equivalent</td>
<td>Ground Protein Source, 2-3 oz. equivalent</td>
<td>Pu Protein Source, 2-3 oz. equivalent</td>
<td>Pu Protein Source, 2-3 oz. equivalent</td>
<td>Pu Protein Source, 2-3 oz. equivalent</td>
</tr>
<tr>
<td></td>
<td>Starch, 1 serving</td>
<td>Soft Starch, 1 serving</td>
<td>Pu Starch, 2 servings</td>
<td>Pu Starch, 2 servings</td>
<td>Pu Starch, 2 servings</td>
</tr>
<tr>
<td></td>
<td>Starchy Vegetable, ¾ c</td>
<td>Soft Starchy Veg, ¾ c</td>
<td>Pu Vegetable, ¾ c</td>
<td>Pu Vegetable, ¾ c</td>
<td>Pu Vegetable, ¾ c</td>
</tr>
<tr>
<td></td>
<td>Vegetable, ¾ c</td>
<td>Soft Vegetable, ¾ c</td>
<td>Pu Fruit, ¾ c</td>
<td>Pu Fruit, ¾ c</td>
<td>Pu Fruit, ¾ c</td>
</tr>
<tr>
<td></td>
<td>Fruit, ¾ c</td>
<td>Soft Fruit, ¾ c</td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
</tr>
<tr>
<td></td>
<td>Water, 8 oz.</td>
<td>Water, 8 oz.</td>
<td>Milk, 8 oz.</td>
<td>Milk, 8 oz.</td>
<td>Milk, 8 oz.</td>
</tr>
<tr>
<td></td>
<td>Milk, 8 oz. or Nutrition Supplement, 6-8 oz.</td>
<td>Milk, 8 oz. or Nutrition Supplement, 6-8 oz.</td>
<td>Milk, 8 oz. or Nutrition Supplement, 6-8 oz.</td>
<td>Milk, 8 oz. or SF Nutrition Supplement, 6-8 oz.</td>
<td>Milk, 8 oz. or SF Nutrition Supplement, 6-8 oz.</td>
</tr>
<tr>
<td><strong>Snack</strong></td>
<td>Starch, 1 serving</td>
<td>Soft Starch, 1 serving</td>
<td>*Starch, 1 serving</td>
<td>*Starch, 1 serving</td>
<td>*Starch, 1 serving</td>
</tr>
<tr>
<td></td>
<td>Milk, 8 oz. or Nutrition Supplement, 6-8 oz.</td>
<td>Milk, 8 oz. or Nutrition Supplement, 6-8 oz.</td>
<td>*Pu Starch, 1 serving</td>
<td>*Pu Starch, 1 serving</td>
<td>*Pu Starch, 1 serving</td>
</tr>
</tbody>
</table>

*SF = Sugar Free/LCS = Low Concentrated Sweets/ Pu = Pureed/ *Low in Simple Sugars  
Note: All liquids offered must be thickened to the ordered consistency  
Note: Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily as per ChooseMyPlate guidelines if possible.

*Policy & Procedure Manual  12-25  
Suggested Serving Sizes for Starch Portions for Diabetic Diets

1 serving = approximately 15 grams carbohydrates

<table>
<thead>
<tr>
<th>Portions for Diabetic Diets Low Concentrated Sweets (LCS)/Consistent Carbohydrate(CCHO)</th>
<th>Regular Portions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bread 1 slice</td>
<td>Bread 1 slice</td>
</tr>
<tr>
<td>Cold Cereal (no added sugar) 1 oz.</td>
<td>Cold Cereal 1 oz.</td>
</tr>
<tr>
<td>Hot Cereal (no added sugar) 6 oz.</td>
<td>Hot Cereal 6 oz.</td>
</tr>
<tr>
<td>Crackers 6</td>
<td>Crackers 6</td>
</tr>
<tr>
<td>Rice 1/3 cup</td>
<td>Rice 1/2 cup</td>
</tr>
<tr>
<td>Noodles 1/2 cup</td>
<td>Noodles 1/2 cup</td>
</tr>
<tr>
<td>Coffee Cake (no frosting or sugar topping) 2 x 2 “</td>
<td>Coffee Cake 2 x 2 “ squares</td>
</tr>
<tr>
<td>Muffin 1 small</td>
<td>Muffin 1 medium</td>
</tr>
<tr>
<td>Plain Cookie 2 small</td>
<td>Cookies 2 medium</td>
</tr>
<tr>
<td>Graham Crackers 2-2” squares</td>
<td>Graham Crackers 4 - 2” squares</td>
</tr>
<tr>
<td>Roll 1 small</td>
<td>Roll 1 medium</td>
</tr>
<tr>
<td>Pudding, sugar free 1/2 cup</td>
<td>Pudding 1/2 cup</td>
</tr>
<tr>
<td>Vegetable Soup 1 cup</td>
<td>Vegetable Soup 1 cup</td>
</tr>
<tr>
<td>Noodle Soup 1 cup</td>
<td>Noodle Soup 1 cup</td>
</tr>
</tbody>
</table>

Source:
### Day 1 Emergency Meal Plan – Assumes No Utilities

<table>
<thead>
<tr>
<th>REGULAR/NAS MECH SOFT PUREE</th>
<th>LCS</th>
<th>LCS PUREE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BREAKFAST</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muffin 1</td>
<td>Soft Muffin, No Nuts 1</td>
<td>Hot Cereal 1 c</td>
</tr>
<tr>
<td>Dry Cereal ¾ c</td>
<td>Dry Cereal (soft) ¾ c</td>
<td>None</td>
</tr>
<tr>
<td>Cottage Cheese ½ c</td>
<td>Cottage Cheese ½ c (if available)</td>
<td>Yogurt (smooth) ½ c (if available)</td>
</tr>
<tr>
<td>Bananas (if available) or Canned Fruit ¾ c</td>
<td>Bananas (if available) or Canned Fruit ¾ c</td>
<td>Applesauce, Smooth ¾ c (if available)</td>
</tr>
<tr>
<td>Instant Breakfast 8 oz.</td>
<td>Instant Breakfast 8 oz.</td>
<td>Instant Breakfast 8 oz.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>LUNCH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Deviled Ham Spread 3 oz.</td>
<td>Canned Deviled Ham Spread 3 oz.</td>
<td>Pureed Canned Beef #8s</td>
</tr>
<tr>
<td>Bread 2 sl</td>
<td>Bread 2 sl</td>
<td></td>
</tr>
<tr>
<td>Canned 3 Bean Salad ¾ c</td>
<td>Canned 3 Bean Salad ¾ c</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td>Vegetable salad ¾ c</td>
<td>Soft Vegetable Salad ¾ c</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td>Canned Fruit ¾ c</td>
<td>Canned Fruit ¾ c</td>
<td></td>
</tr>
<tr>
<td>Water 8 oz.</td>
<td>Water 8 oz.</td>
<td></td>
</tr>
<tr>
<td>Milk 8 oz.</td>
<td>Milk 8 oz.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DINNER</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canned Chicken Salad 3 oz.</td>
<td>Canned Chicken Salad, (soft) 3 oz.</td>
<td>Pureed Canned Chicken #8s</td>
</tr>
<tr>
<td>Bread 2 sl</td>
<td>Bread 2 sl</td>
<td></td>
</tr>
<tr>
<td>Cheese Puffs 1 oz.</td>
<td>Cheese Puffs 1 oz.</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td>Canned Pickled Beets ¾ c</td>
<td>Canned Pickled Beets ¾ c</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td>Mashed Potatoes ¾ c</td>
<td>Mashed Potatoes ¾ c</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td>Assorted Beverages 8 oz.</td>
<td>Assorted Beverages 8 oz.</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td>Nutritional Supplement 6-8 oz.</td>
<td>Nutritional Supplement 6-8 oz.</td>
<td>Pu Cnd Green Beans #8+16s</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HRS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal Bar 1</td>
<td>Cereal Bar (soft) 1</td>
<td>Ready to Eat Pudding ½ c</td>
</tr>
<tr>
<td>Water 8 oz.</td>
<td>Water 8 oz.</td>
<td></td>
</tr>
</tbody>
</table>

SF = Sugar Free  
LCS = Low Concentrated Sweets  
Pu = Pureed  
ONS = Oral Nutritional Supplement  
*Low in Simple Sugars  
Note: All liquids offered must be thickened to the ordered consistency. Note: Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily as per ChooseMyPlate guidelines if possible.

Policy & Procedure Manual  12-27  
## Day 2 Emergency Meal Plan – Assumes No Utilities

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>REGULAR/NAS</th>
<th>MECH SOFT</th>
<th>PUREE</th>
<th>LCS</th>
<th>LCS PUREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assorted Dry Cereals</td>
<td>¾ c</td>
<td>Assorted Dry Cereals</td>
<td>¾ c</td>
<td>Hot Cereal (if able)</td>
<td>1 c</td>
</tr>
<tr>
<td>Donuts</td>
<td>1</td>
<td>Donuts (soft, no nuts)</td>
<td>1</td>
<td>Pu Canned Pineapple</td>
<td>#8+16s</td>
</tr>
<tr>
<td>Canned Fruit</td>
<td>¾ c</td>
<td>Canned Fruit (soft)</td>
<td>¾ c</td>
<td>SF Pu Cn Pineapple</td>
<td>#8+16s</td>
</tr>
<tr>
<td>Instant Breakfast</td>
<td>8 oz.</td>
<td>Instant Breakfast</td>
<td>8 oz.</td>
<td>SF Instant Breakfast</td>
<td>8 oz.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lunch</th>
<th>REGULAR/NAS</th>
<th>MECH SOFT</th>
<th>PUREE</th>
<th>LCS</th>
<th>LCS PUREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creamy Peanut Butter</td>
<td>2 Tbs</td>
<td>Canned Beef Stew</td>
<td>6 oz.</td>
<td>Creamy Peanut Butter</td>
<td>2 Tbs</td>
</tr>
<tr>
<td>Jelly</td>
<td>1 Tbs</td>
<td></td>
<td></td>
<td>SF Jelly Bread</td>
<td>1 Tbs</td>
</tr>
<tr>
<td>Bread</td>
<td>2 sl</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cheese Puffs</td>
<td>1 oz.</td>
<td>Canned Fruit</td>
<td>¾ c</td>
<td>V-8 Juice</td>
<td>6 oz.</td>
</tr>
<tr>
<td>Canned Fruit</td>
<td>¾ c</td>
<td></td>
<td></td>
<td>Pu Canned Peaches</td>
<td>#8+16s</td>
</tr>
<tr>
<td>Assorted Cookies</td>
<td>2</td>
<td>Assorted Cookies (no nuts or chips)</td>
<td>2</td>
<td>Puréeed Bread Mix</td>
<td>#8s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dinner</th>
<th>REGULAR/NAS</th>
<th>MECH SOFT</th>
<th>PUREE</th>
<th>LCS</th>
<th>LCS PUREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuna Salad Bread</td>
<td>3 oz.</td>
<td>Tuna Salad Bread</td>
<td>3 oz.</td>
<td>Pu Canned Chicken</td>
<td>#8s</td>
</tr>
<tr>
<td>Canned Bean Salad</td>
<td>¾ c</td>
<td>Canned Bean Salad</td>
<td>¾ c</td>
<td>Cnd Pu Green Beans</td>
<td>#8+16s</td>
</tr>
<tr>
<td>Canned Fruit</td>
<td>¾ c</td>
<td>Canned Fruit</td>
<td>¾ c</td>
<td>Applesauce</td>
<td>¾ c</td>
</tr>
<tr>
<td>Assorted Beverages</td>
<td>8 oz.</td>
<td>Assorted Beverages</td>
<td>8 oz.</td>
<td>Assorted Beverages</td>
<td>8 oz.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HS</th>
<th>REGULAR/NAS</th>
<th>MECH SOFT</th>
<th>PUREE</th>
<th>LCS</th>
<th>LCS PUREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cookies</td>
<td>2</td>
<td>Cookies (soft)</td>
<td>2</td>
<td>Ready to Eat Pudding</td>
<td>½ c</td>
</tr>
</tbody>
</table>

SF = Sugar Free  
LCS = Low Concentrated Sweets  
Pu = Pureed  
ONS = Oral Nutritional Supplement  
*Low in Simple Sugars  
Note: All liquids offered must be thickened to the ordered consistency. Note: Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily as per ChooseMyPlate guidelines if possible.

*Policy & Procedure Manual  12-28*  
### Day 3 Emergency Meal Plan – Assumes No Utilities

<table>
<thead>
<tr>
<th></th>
<th>REGULAR/NAS</th>
<th>MECH SOFT</th>
<th>PUREE</th>
<th>LCS</th>
<th>LCS PUREE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BREAKFAST</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cereal Bar</td>
<td>1</td>
<td>Cereal Bar (soft)</td>
<td>1</td>
<td>Hot Cereal</td>
<td>8 oz.</td>
</tr>
<tr>
<td>Canned Fruit</td>
<td>⅓ c</td>
<td>Canned Fruit</td>
<td>⅓ c</td>
<td>Pu Canned Peaches</td>
<td>#8+16s</td>
</tr>
<tr>
<td>Assorted Dry Cereals</td>
<td>⅓ c</td>
<td>Assorted Dry Cereals</td>
<td>⅓ c</td>
<td>Pureed Bread</td>
<td>#8s</td>
</tr>
<tr>
<td>Instant Breakfast</td>
<td>8 oz.</td>
<td>Instant Breakfast</td>
<td>8 oz.</td>
<td>Assorted Dry Cereals</td>
<td>Unsweetened</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Instant Breakfast</td>
<td>8 oz.</td>
</tr>
<tr>
<td><strong>LUNCH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peanut Butter</td>
<td>2 Tbs</td>
<td>Pu Canned Chicken</td>
<td>#8s</td>
<td>Peanut Butter</td>
<td>2Tbs</td>
</tr>
<tr>
<td>Jelly</td>
<td>1 Tbs</td>
<td>Pureed Canned Peas</td>
<td>#8s</td>
<td>SF Jelly</td>
<td>1Tbs</td>
</tr>
<tr>
<td>Bread</td>
<td>2 sl</td>
<td>Bread</td>
<td>2 sl</td>
<td>Bread</td>
<td>2 sl</td>
</tr>
<tr>
<td>Canned Fruit</td>
<td>⅓ c</td>
<td>Canned Fruit</td>
<td>⅓ c</td>
<td>SF Canned Fruit</td>
<td>¾ c</td>
</tr>
<tr>
<td>Ready to Eat Pudding</td>
<td>½ c</td>
<td>Ready to Eat Pudding</td>
<td>½ c</td>
<td>SF Ready to Eat Pudding</td>
<td>½ c</td>
</tr>
<tr>
<td>Water</td>
<td>8 oz.</td>
<td>Water</td>
<td>8 oz.</td>
<td>Water</td>
<td>8 oz.</td>
</tr>
<tr>
<td>Milk</td>
<td>8 oz.</td>
<td>Milk</td>
<td>8 oz.</td>
<td>Milk</td>
<td>8 oz.</td>
</tr>
<tr>
<td><strong>DINNER</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deviled Ham Salad</td>
<td>3 oz.</td>
<td>Deviled Ham Salad</td>
<td>3 oz.</td>
<td>Deviled Ham Salad</td>
<td>3 oz.</td>
</tr>
<tr>
<td>Bread</td>
<td>2 sl</td>
<td>Bread</td>
<td>2 sl</td>
<td>Bread</td>
<td>2 sl</td>
</tr>
<tr>
<td>Applesauce</td>
<td>⅓ c</td>
<td>Applesauce</td>
<td>⅓ c</td>
<td>SF Applesauce</td>
<td>¾ c</td>
</tr>
<tr>
<td>Cheese Puffs</td>
<td>1 oz.</td>
<td>Cheese Puffs</td>
<td>1 oz.</td>
<td>Pureed Bread Mix</td>
<td>#8s</td>
</tr>
<tr>
<td>Assorted Cookies</td>
<td>2</td>
<td>Cookies (soft, no nuts)</td>
<td>2</td>
<td>Cheese Puffs</td>
<td>1 oz.</td>
</tr>
<tr>
<td>Assorted Beverages</td>
<td>8 oz.</td>
<td>Assorted Beverages</td>
<td>8 oz.</td>
<td>Plain Cookies</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SF Asstd Beverages</td>
<td>8 oz.</td>
</tr>
<tr>
<td>Cookies</td>
<td>2</td>
<td>Cookies, soft, no nuts</td>
<td>2</td>
<td>SF Asstd Beverages</td>
<td>8 oz.</td>
</tr>
<tr>
<td>Juice</td>
<td>6 oz.</td>
<td>Juice</td>
<td>6 oz.</td>
<td>SF Shelf Stable ONS</td>
<td>6-8 oz.</td>
</tr>
</tbody>
</table>

SF = Sugar Free  
LCS = Low Concentrated Sweets  
Pu = Pureed  
ONS = Oral Nutritional Supplement  
*Low in Simple Sugars  
Note: All liquids offered must be thickened to the ordered consistency. Note: Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily as per ChooseMyPlate guidelines if possible.
Hand Washing During a Disaster

Policy:

Safe and effective hand washing and/or sanitizing techniques will be utilized during emergency situations.

Procedure:

1. The director of food and nutrition services 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. Handwashing technique will be as follows:
   a. Remove debris from hands using a paper towel.
   b. One staff person will pour water over the hands of the person washing his/her hands.
   c. Soap will be applied and thorough washing above wrists, between fingers, under nails, etc. will occur for a minimum of 20 seconds.
   d. Again, one staff person will pour water from the clean water container to rinse the other staff person’s hands.
   e. A clean towel or paper towel will be used to dry hands. 
   **Note:** Do NOT wash and rinse hands in the bucket and then reuse the water.

3. Alternative to hand washing:
   If hands are not heavily soiled with debris, an instant hand sanitizer (hand cleaner) that does not require rinsing can 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. Consult the facility’s policies and procedures and state and local regulations on the use of hand sanitizer.

   Follow manufacturers’ directions for use.
Dishwashing Without Electricity

Policy:

If there is no electricity for dishwashing, hand dishwashing will be implemented.

Procedure:

A 3 sink dishwashing system will be set up in a safe, clean area, close to dining areas. The procedure used is as follows:

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 hot water (if available).

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 and use test strips to assure proper level of sanitizer is used.

Note: Use disposable dishes and utensils when possible and/or necessary during emergency situations.
Resource: 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 of items used daily should last three (3) to seven (7) days at all times.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Items Needed – Food Safety/Sanitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thermometers</td>
</tr>
<tr>
<td></td>
<td>Alcohol swabs</td>
</tr>
<tr>
<td></td>
<td>Hand sanitizer</td>
</tr>
<tr>
<td></td>
<td>Hand soap</td>
</tr>
<tr>
<td></td>
<td>Hand sanitizing wipes</td>
</tr>
<tr>
<td></td>
<td>Bleach (recommended 5.25% concentration of hypochlorite without soap or additives)</td>
</tr>
<tr>
<td></td>
<td>Water purification tablets</td>
</tr>
<tr>
<td></td>
<td>Dish soap</td>
</tr>
<tr>
<td></td>
<td>Sanitizer</td>
</tr>
<tr>
<td></td>
<td>Food handling gloves</td>
</tr>
<tr>
<td></td>
<td>Aluminum foil</td>
</tr>
<tr>
<td></td>
<td>Plastic wrap</td>
</tr>
<tr>
<td></td>
<td>Plastic food bags (sandwich, quart, gallon size)</td>
</tr>
<tr>
<td></td>
<td>Paper towels</td>
</tr>
<tr>
<td></td>
<td>Towels and dish rags</td>
</tr>
<tr>
<td></td>
<td>Rubber gloves</td>
</tr>
<tr>
<td></td>
<td>Large plastic bags for trash</td>
</tr>
<tr>
<td></td>
<td>Clean up supplies – broom, shovel, buckets, rags, mops</td>
</tr>
</tbody>
</table>

Source:
## Resource: General Disaster Supplies

<table>
<thead>
<tr>
<th>Amount</th>
<th>Food Preparation/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hard copies of emergency menus</td>
</tr>
<tr>
<td></td>
<td>Styrofoam or plastic take out containers for food</td>
</tr>
<tr>
<td></td>
<td>Foil pans for cooking and serving</td>
</tr>
<tr>
<td></td>
<td>Straws</td>
</tr>
<tr>
<td></td>
<td>Coolers</td>
</tr>
<tr>
<td></td>
<td>Manual can opener</td>
</tr>
<tr>
<td></td>
<td>Egg beater or whisk</td>
</tr>
<tr>
<td></td>
<td>Potato masher</td>
</tr>
<tr>
<td></td>
<td>Battery operated equipment (heating elements, whisks, etc.)</td>
</tr>
<tr>
<td></td>
<td>Barbeque grill—portable, outdoor grill</td>
</tr>
<tr>
<td></td>
<td>Charcoal</td>
</tr>
<tr>
<td></td>
<td>Lighter fluid</td>
</tr>
<tr>
<td></td>
<td>Sterno fuel and containers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Amount</th>
<th>Emergency Supplies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fire Extinguisher</td>
</tr>
<tr>
<td></td>
<td>First aid kit and first aid book</td>
</tr>
<tr>
<td></td>
<td>Weather radio, portable</td>
</tr>
<tr>
<td></td>
<td>Portable flashlights and headlamp flashlights</td>
</tr>
<tr>
<td></td>
<td>Battery operated lanterns</td>
</tr>
<tr>
<td></td>
<td>Extra batteries</td>
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<tr>
<td></td>
<td>Blankets</td>
</tr>
<tr>
<td></td>
<td>Adjustable wrench to turn off gas</td>
</tr>
<tr>
<td></td>
<td>Tool box: hammer, screw drivers, crowbar, adjustable wrenches, etc.</td>
</tr>
<tr>
<td></td>
<td>Heavy tape</td>
</tr>
<tr>
<td></td>
<td>Matches in water proof container</td>
</tr>
<tr>
<td></td>
<td>Battery operated clock</td>
</tr>
</tbody>
</table>

**Source:**
Internal Policies

Insert Facility Policies Here (as required by OSHA, JCAHO, CMS)

1. Procedures for reporting a fire or other emergency.

2. Procedures for emergency evacuation, including type of evacuation and exit route assignments.

3. Procedures to be followed by employees who remain in the facility to operate critical plant operations before they evacuate.

4. Procedures to account for all employees after evacuation.

5. Procedures to be followed by employees performing rescue or medical duties.

6. The name or job title of every employee who may be contacted by employees who need more information about the plan or an explanation of their duties under the plan.
Fire Prevention Plan (FPP):
A FPP is a hazard prevention plan that is to assure advanced planning for evacuations in fire and other emergencies. An FPP is a written document that is required by a particular OSHA standard. The elements of the plan shall include but are not limited to:

1. A list of major workplace fire hazards and their proper handling and storage procedures, potential ignition sources, their control procedures, and the type of fire protection equipment or systems that can control a fire.

2. Names or job titles of those persons responsible for maintenance of equipment and systems installed to prevent or control ignition of fires.

3. Names or job titles of those persons responsible for control of fuel source hazards.
Resources for More Information on Dealing with Emergencies

Disaster Resources

References and Resources

General References:

Professional Organizations

Food Safety and HACCP
- National Institute of Health), International Association for Food Protection (IAFP), www.foodprotection.org.
- International Association for Food Protection (IAFP), www.foodprotection.org.
References and Resources

• Safe Food Information Line: 1-888-SAFEFOOD (1-888-723-3366).

Nutrition
• Centers for Disease Control and Prevention. www.cdc.gov.
• Food and Nutrition Information Center, http://www.choosemyplate.gov.
• National Heart, Lung, and Blood Institute www.nhlbi.nih.gov.
• National Institute on Deafness and Other Communication Disorders (NIDCD) (part of the National Institute of Health, www.nih.gov.
• The National Pressure Ulcer Advisory Panel (NPUAP), www.npuap.org.