Policy & Procedure Manual

Food and Nutrition Services in Healthcare Facilities

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Director of Nursing	Date
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Flash Drive

Customizable Policy and Procedure Word Files
Sample Job Descriptions, Work Schedules and Competency Checklists for the Food and Nutrition Services Department

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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, and subsequent updates in November of 2017. 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 "patients/residents" 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. This manual can serve as a companion piece to the Becky Dorner & Associates *Diet and Nutrition Care Manual*, which provides resources to support many of the policies and procedures included. Visit www.beckydorner.com for details. 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

The accompanying flash drive contains additional resources including CS forms, sample job descriptions and work schedules and more (see the table of contents for details).

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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 patient/resident 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 to:

1. Provide food and drink that is nutritious, palatable, attractive, and at a safe and appetizing temperature to meet individual needs.

2. 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. Provide the highest quality food possible at a cost consistent with the facility's budget guidelines.

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

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

6. 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 patient/ resident satisfaction.
- Participates in resident care planning and assists with clinical documentation in the medical record (nursing facilities).
- 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 dietetics 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.

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CMS Guidelines

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" (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)].

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Definitions

Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) (2)**:** Registered by the Commission on Dietetic Registration (CDR) of the Academy of Nutrition and Dietetics (minimum of bachelor's 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

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 dietetics technician, 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) (3)**:** 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 dietetics 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 Technician, Registered (NDTR)* or a Dietetic Technician, 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
- Remitted the annual registration maintenance fee
- Complied with the Professional Development Portfolio (PDP) recertification
  OR
- Completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent

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- 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."

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

Medical Nutrition Therapy (MNT) (4)**:** 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 (4)**:** 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 alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be part of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0500D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).
- A mechanically altered diet should not automatically be considered a therapeutic diet (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 (5):

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"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" (6).

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2. Who is a Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) Commission on Dietetic Registration Web Site: https://www.cdrnet.org/pub/search.cfm?keyword=Who+is+a+registered+dietitian%3F. Accessed February 26, 2019.
3. Nutrition and Dietetics Technician Registered Fact Sheet. Accreditation Council for Education in Nutrition and Dietetics web site. https://www.eatrightpro.org/acend/students-and-advancing-education/information-for-students/nutrition-and-dietetic-technician-registered-fact-sheet. Accessed February 26, 2019.
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5. Centers for Medicare and Medicaid Services. MDS 3.0 RAI Manual, Chapter 3, Section K: Swallowing/Nutritional Status.) https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. Accessed February 26, 2019.
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Menu Planning

Policy:
Nutritional needs of individuals will be provided in accordance with the established national standards 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 population served, as well as input received from individuals and 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.
   a. 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.
   b. 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.
   a. Menus will include at least three meals daily at regular times comparable to the normal mealtimes in the community or in accordance with the individual's needs and preferences.
   b. A substantial evening meal consisting of three or more menu items will be offered, one of which includes high quality protein.
   c. The meal will contain no less than 20% of the day's total nutritional requirements.
   d. 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. For nursing facilities, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a patient/resident group agrees to this plan.

3. Individuals who prefer to eat at non-traditional times or outside of scheduled meal times will be offered suitable nourishing alternative meals, consistent with the individual's care plan.
   a. Suitable and nourishing alternative meals or snacks are of similar nutritive value as the meals or snacks normally scheduled and are consistent with the individual's care plan.
   b. 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."

4. 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.

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5. Menus will be posted in areas that are accessible to patients/residents, and at heights where all individuals can easily view them.

6. Temporary changes in the menu will be noted on the menu substitution sheets and posted so that facility staff is aware of changes. (See *Sample Menu Substitution Sheet* later in this chapter.) The RDN or designee will approve all permanent menu changes.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Menu Shell for Menu Overview

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
B R E A K F A S T							
	Alternates:						
L U N C H							
	Alternates:						
D I N N E R							
	Alternates:						
H S							

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Sample Menu Shell for Diet Extensions

	REGULAR/Regular No Salt Packet	MECHANICAL SOFT/Moist/Minced/ Ground	PUREED	CONSISTENT CARBOHYDRATE	CONSISTENT CARBOHYDRATE PUREE
B R E A K F A S T					
	Alternates:				
L U N C H					
	Alternates:				
D I N N E R					
	Alternates:				
H S					

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Sample Production Sheet

Menu Cycle _______________ **Week Number** _______________ **Day** ______________

Food Item to be Produced	Recipe Number	Portion Size	Forecast Amount	Amount Prepared	Amount Used	Amount Discarded	Leftover Use

Freezer Pull	Pre-preparation

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Select Menus

Policy:

If select 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. Select 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 select 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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.

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Menu Substitutions

Policy:

Menu substitutions will be made after discussion with the director of food and nutrition services whenever possible. Last-minute 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, ⅓ cup yams, etc.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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.

Food and Amount Equivalent to ½ Cup	
Fresh • 1 cup raw vegetables (salad greens, tomatoes, carrots, broccoli, cauliflower, etc.)	**Canned, Cooked, Frozen or Juice** • ½ cup (broccoli, carrots, greens, peas, spinach, sweet potatoes, etc.)

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.

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

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 grains.

Food and Amount Equivalent to 1 Ounce	
Breads • 1 slice bread; ½ bun, bagel or English muffin, 1 small pancake, waffle, taco or tortilla shell, 6” across **Cereals** • 1 cup dry cereal or 1¼ cups puffed cereal • ½ cup cooked cereal	**Crackers** • 7 round or square crackers, 5 whole wheat crackers **Grains** • ½ cup pasta, rice, couscous, barley, bulgur, risotto, polenta

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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.

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

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

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

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

Food and Amount Equal to 1 Serving (1 teaspoon each)	
Monounsaturated oils • Canola, olive, peanut, safflower	**Polyunsaturated oils** • Corn, cottonseed, soybean, sunflower

Note: 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.

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Sample Menu Substitution Sheet

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

Maintain this record on file for quality assurance.

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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 established national standards.
   c. Have a revision/review date that is less than 5 years old (or according to state regulations for each state). 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 orders.

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 annually):
   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.

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

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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 in writing before serving a meal.

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.

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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. Available 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 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 correspond 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 *Chapter 8: Clinical Documentation* for policy on *Order Writing Privileges for Clinically Qualified Nutrition Professionals*.)

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 physician, or RDN will change the diet order if order-writing privileges are in place (see *Chapter 8: Clinical Documentation* for policy on *Order Writing Privileges for Clinically Qualified Nutrition Professionals*). This includes liberalization/individualization of the diet to maximize food and fluid intake.

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

7. An individual has the right to refuse a therapeutic diet order. (See policy on *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 *Introduction* for *Definition of Therapeutic Diets and Nutritional Supplements.*

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Right to Refuse a Diet

Policy:
An individual has the right to refuse and/or discontinue medical treatment, including therapeutic or consistency-modified diets. The individual's choices should be incorporated into treatment and person centered care plan. If an individual cannot speak for himself or herself, their representative can make decisions on their behalf.

Procedure:

1. Individuals should be included in decisions regarding the ordering of therapeutic and/or consistency-modified diets or thickened liquids.

2. If the individual chooses not to follow a recommended intervention, caregivers should discuss the risks and benefits of refusing the specific medical treatment with the individual and/or their surrogate.

3. The individual 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 individuals make will be documented in the medical record.

5. The person centered care plan will be updated to reflect changes to the individual's diet orders.

6. The individual's food preferences will be kept on file in the food and nutrition department and efforts will be made to provide preferred foods within reason.

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Policy & Procedure Manual

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 malnutrition - 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 Salt Packet
   c. Mechanical Soft. Moist, minced
   d. Pureed
   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 High Sodium Meats, Vegetables, Soups (i.e. ham, bacon, sausage, lunchmeat, sauerkraut, canned soup)
   b. No Sugar Packet, Unsweetened Beverages, Small portions of Regular Desserts
   c. Chopped, Minced Meat
   d. Pureed Meat
   e. Other:

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Sample Diet Order Form

Name ____________________________________ Room ______________

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

Signature Date

Sample Diet Order Form

Name ____________________________________ Room ______________

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

Signature Date

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Diet Order Form

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

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Diet Order Audit

Policy:

The individual's medical record and/or the physician's diet 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 order 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 that are not listed on the menu so that menu extensions can be developed as appropriate, or changes to diet orders can be requested.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Diet Order Audit Form

Room	Name	Diet Order on Medical Record	Diet Report	Food and Nutrition Services Records

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Sample Nutrition Supplement Audit Form

Room	Name	Order for Nutrition Supplement	Nutrition Supplement List on File in Food and Nutrition Services

Note: This information may be computerized.

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Sample Weekly Diet Census Sheet

Week of: ______________________

Diets	Sun	Mon	Tue	Wed	Thu	Fri	Sat
Regular							
Regular No Salt Packet							
Mechanical (Dental) Soft							
Pureed							
Chopped/Minced Meat							
Ground Meat							
Pureed Meat							
Consistent Carbohydrate							
Consistent Carbohydrate Puree							
Other:							
Guest Meals							
Staff Meals							
Daily Totals							

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

Note: This information may be computerized.

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Patient/Resident Making Choices That Are In Conflict With The Diet Order

Policy:
If an individual exhibits a pattern of requesting foods or a food texture or fluid consistency that is inconsistent with the diet order, 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's/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 included on the menu extensions for each therapeutic or consistency-modified diet. 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. However, the individual has the right to refuse the diet or food served. If the individual continues to request the food item staff should request input from the physician, RDN and/or SLP. 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:
   a. 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.
   b. 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.
   c. If an individual has an order for a pureed diet, the SLP may request a trial diet of another consistency.

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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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.

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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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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 patients/residents, causing reduced food intake, unintended weight loss and malnutrition. It is the individual's right to refuse any therapeutic diet. It is the RDN's role to educate and counsel on the risks of not following the diet, 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 comprehensive nutrition 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.

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

4. 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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 malnutrition. In these cases, patient's/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.

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.

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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 person centered 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 can be 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 1½ to 2 times larger than a regular portion.

4. The individual's choice for altered portion sizes should be reviewed with the individual, and the care plan should be updated as appropriate.

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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 receive 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 smaller portions of sweet desserts, snacks and low calorie beverages. Consistencies will be provided to meet individual needs (i.e. clear or full liquid diets, and dysphagia or modified consistency diets).

For more ideas, refer to *Making Mealtime Magic with Person Centered Dining*, Becky Dorner & Associates, Inc. found at http://www.beckydorner.com.

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Food and Beverages for Activities

Policy:
Therapeutic and modified consistency 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.

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Clear Liquid and Full Liquid Diet

Policy:
Food and beverages for liquid diets will be available as needed. Liquid diets will be provided when needed due to illness, 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 individual, the diet, and when it should be started and stopped. See below for examples of clear liquid and full liquid diet supplies that should be available at all times.

2. A 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.

Supplies	Clear Liquid	Full Liquid
Soft Drinks		
Ginger ale or lemon lime soda	√	√
Other carbonated beverages	**No**	√
Juices		
Apple, cranberry, grape and/or orange (no pulp)	√	√
Peach, pear, apricot nectars	**No**	√
Tomato juice, vegetable juice	**No**	√
Broth/Bouillon		
Chicken, beef and/or vegetable	√	√
Gelatin		
Cherry, lime, orange, raspberry, strawberry	√	√
Hot Cereal		
Cream of rice or cream of wheat	**No**	√
Grits, fortified cereal	**No**	√
Oral Nutritional Supplements/Shakes		
Instant breakfast mix, commercial supplements, milkshakes, commercial egg nog	**No**	√
High calorie/protein clear liquid supplements (variety of types and flavors)	√	√
Desserts		
Fudgesicles®	**No**	√
Fruit ices	√	√
Ice cream	**No**	√
Plain popsicles®	√	√
Plain, smooth pudding (vanilla, chocolate, butterscotch)	**No**	√
Sherbet, plain, smooth (no chunks of fruit)	**No**	√

Source:
Dorner, Becky, *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*, Becky Dorner & Associates, Inc., Dunedin, FL. 2019.

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NPO Diet Orders (Nothing by Mouth)

Policy:
The food and nutrition services 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 in writing that the individual is able to eat. This shall also include NPO orders needed for lab tests.

3. Any individual on NPO more than 1 to 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Resident's Choice Meals in Nursing Facilities

Policy:
In nursing facilities, residents may have input into menu planning and may 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.

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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, focus on - listen, pay attention, and converse with each individual (rather than 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 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. Select 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, safe, functional, sanitary, home-like or restaurant-like dining environment (depending on the facility) that is roomy, comfortable with nice décor, contrasting colors, and appropriate furniture for patients/residents, staff and the public.
   c. Providing comfortable sound levels, adequate lighting, furnishing, ventilation, space and absence of odors to accommodate dining. Providing adequate space for storing wheelchairs, walkers or other mobility devices for individuals who prefer to sit in a dining room chair.

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 and preferences 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, director of nursing, registered dietitian nutritionist (RDN) or designee, or other staff as appropriate.

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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. Patients/residents will have adequate space to enter or exit the dining area with ease.

3. Dining areas will have adequate space for staff to access and assist patients/residents quickly in the event of an emergency.

4. Tables 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.

5. Individuals will be involved in choosing where to eat and service staff is notified of location selected.

6. 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.

7. 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 wheelchairs 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). Staff will offer assistance as needed in order to maintain, improve and prevent decline in eating ability.

8. Use of napkins will be encouraged, and dignified clothing protectors will be available as needed or requested.

9. Individuals will be provided with the proper assistive devices and utensils identified by the care plan. Staff will provide support with assistive devices as needed.

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10. Staff will provide cueing, prompting, or assistance as needed in order to maintain, improve and prevent decline in eating ability

11. Staff will sit next to a person when assisting them with eating (rather than standing over them).

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

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

14. 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 separate entrée items (except when meant to be combined food such as stews, casseroles, etc.).

15. 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.

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

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

18. 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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 includes 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 (some may prefer first names, while others may prefer more formal address using Mr. or Mrs.).
   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 be thanked for coming.

6. Seating preferences, food and beverage preferences, and special dietary needs should be met based on individual choice and/or physician's order.

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Resource: Traits of Great Person Centered Service

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

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

1. 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).

2. 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.

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

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

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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 wheelchairs can fit underneath them. If possible, individuals should be encouraged to sit in a dining room chair.

3. Staff should check the 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 food preferences and for therapeutic or modified consistency diets.

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.

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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 non-disposable, clean, eye appealing, matched, without chips, and of appropriate color to match the dining room decor.
   b. Flatware should be non-disposable, clean, neatly placed, and in good condition. All meals served must include a fork and spoon (and knife as appropriate).
   c. Glasses should be non-disposable, clean and free of stains or spots.
   d. Placemats, tablecloths and napkins should be clean and wrinkle-free.
   e. Items should be neatly arranged and placed so they are convenient for the individual to reach.
   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 and practice appropriate hand hygiene after direct care with an individual's skin or secretions.

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 should be clean and appearance should be acceptable to the individuals being served.

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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 clean, 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 a choice of beverage, salad or fruit, bread, entrée, starch, vegetable, dessert and/or soup of the day. 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.

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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 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 clean and professional appearance at all times. 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 clean, neat 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.

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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. Develop and implement systems 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. A quality assessment and performance improvement (QAPI) program should be implemented for areas needing improvement.
   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 QAPI. (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.

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Sample Dining Satisfaction Form

Name (Optional)**:** _________________________________ **Date** ______________

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

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Sample Dining Satisfaction Meal Evaluation Form

Name (optional)_____________Dining Area______________ Date____________

	Yes	No
Do the meal selection of food and beverage choices meet your needs? If no, please explain:		
Is the quality and presentation of the food colorful and appealing?		
Are foods and beverages served at the proper temperature? If no, please explain:		
Is the staff friendly and attentive to your needs? If no, please explain:		
Is the service timely? If no, please explain:		
Is the dining room clean and well organized? If no, please explain:		
Do the hours of service meet your needs? If no, please explain:		
Suggestions/Comments:		

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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 centerpieces 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 and should be non-disposable.

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

8. Dishes, glasses, and silverware should be placed appropriately (see graphic below) 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 spoon 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.

   Example of an appropriate place setting:

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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 consistency 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 as needed.

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.

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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 patients/residents of upcoming meals. Nursing staff will be responsible for assisting those needing help to the dining room. Individuals will be assisted as needed with meal preparation (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 food and nutrition service staff serving the meal.

5. Food and nutrition services staff members will serve the food choices made with consideration given to dietary restrictions/consistency 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 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.

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.

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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 patients/residents of upcoming meals. Nursing staff will be responsible for assisting those needing help to the dining room. Individuals will be assisted as needed with meal preparation (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 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 an 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.

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Buffet Style Dining

Policy:
Buffet style dining offers numerous 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 staff will be responsible for assisting those needing help to the dining room. Individuals will be assisted as needed with meal preparation (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. Individuals should be encouraged to plate their own hot and cold food items. Nursing staff will provide assistance with self-selection and plating of hot and cold food items from the buffet line as needed. Most individuals will require tray service for food/beverages selected and assistance to their dining table.

5. If an 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 and nutrition services staff will place the food items from the tray to each patient's/resident'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° F for hot foods ≤41° F for cold foods. Food should not be held longer than 2 hours.

11. Sneeze guards should be installed on the buffet.

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

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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.

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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 dine with.

Procedure:
1. Open dining will be available during breakfast, lunch and dinner.
   a. The dining room will be open for a minimum of 1 ½ to 2 hours at each meal. Individuals should choose the time they prefer to eat meals; that time may vary from day to day.
   b. Independent diners have the opportunity to start meals early or finish late.
   c. Individuals are unable make the choice of time to eat will be served meals at times chosen by the director of food and nutrition services (i.e. 7:30 AM, 11:30 AM, 5:30 PM).
2. Nursing staff will be responsible for assisting people who need help to the dining room, and with meal preparation (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, and report an individual's food and beverage choices to the staff members responsible for serving the food. Food and nutrition services staff will serve food and beverage choices made with consideration given to any dietary restrictions and/or texture modifications.
4. If an 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.
5. Nursing staff will be responsible for recording food and beverage intake as per facility policy.
6. Individuals will be encouraged to linger and socialize throughout the meal.
7. Individuals should be offered (or assisted to use) a hand wipe or cloth to wipe their hands prior to leaving the dining room.
8. Staff will clear, clean, sanitize, and reset tables between services.
9. The director of food and nutrition services will observe the meals served for preferences, portion sizes, temperature, flavor, variety and service accuracy.

Note: Federal nursing home tag F803 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 patient/resident group agrees to this span, and a nourishing snack is served.

Reference:
Center for Medicare & Medicaid Services. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 6, 2019.

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In-Room Dining (Room Service)

Policy:

In-room dining (room service) will be served in a way to compliment the primary dining program. Individuals admitted for short-term rehab therapy may have little interest in socializing and may request meals in their room. This style dining may also be used for critically ill/bed-bound patients/residents 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. 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 select 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, 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 with tray set up and uncovering food items will be provided as needed.

2. 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 non-disposable, clean, eye appealing, matching, and without chips or stains.
   b. Flatware will be non-disposable, clean, without spots, neatly placed, and in good condition. All meals served must include at minimum, a fork and spoon (and knife as appropriate).
   c. Glasses will be non-disposable, 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.
      - 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 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.

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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 food choices 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 numerous 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 patients/residents 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 an 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 an 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.

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Special Occasions – Holiday and Theme Meals

Policy:

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

Procedure:

1. 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 annual 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.

Ideas for theme meals:

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

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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 per State regulatory requirements (some states have state-approved training courses), 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 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 of §488.160 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 should focus on avoiding 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.
      - 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. Eligible residents include those who are dependent in eating and/or those who have some degree of dependence, such as needing cueing or partial assistance.
      - Paid feeding assistants are not permitted to assist residents who have complicated eating or drinking 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.
        - 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 care plan.

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- 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 state-approved 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. The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest care plan. Appropriateness for the program is reflected in the comprehensive care plan.

5. 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:

Center for Medicare and Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 6, 2019.

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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 staff will deliver the carts to the wings. Nursing or food and nutrition services staff 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 the patients/residents and customary practice. (Not to be confused with proper holding temperatures – as outlined in *Chapter 3: Food Production and Food Safety* for information on proper temperature monitoring and recording).

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Policy & Procedure Manual

Meal Times and Frequency

Policy:

The facility will provide at least three meals daily at regular times comparable to standard mealtimes 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. In nursing facilities, 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 bedtime 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 or federal regulations may also outline additional requirements for spacing of meals and snacks.

Reference:

Center for Medicare and Medicaid Services. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 6, 2019.

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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 staff 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 the nursing staff to see that the meals are passed and individuals receive assistance as quickly as possible.

Late Trays:

1. Food and nutrition services staff will pull the meal identification (ID) cards/tickets for those who need to have their meal held. Meal cards will be placed in a designated area in the kitchen. The 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 communicates that a certain individual is ready to eat, the cook/chef will prepare the meal and the food and nutrition services staff will deliver it to the proper nursing station, assuring that the meal is properly labeled with the name and room number of the individual. The nursing staff on the unit will prompt serve the meal to assure proper food temperatures.

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Select Menus

Policy:

If select menus are offered, they will be provided to meet each individual's dietary modifications and preferences. Menus may 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. 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 deliver the menus and assist with menu selection as needed. 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 collection.

3. Menus marked in advance will be checked to be sure that each individual has a completed menu (except those who are NPO), and menus are marked correctly 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. Do not add menu items without checking with the individual. It is their right to make their own selections.
   d. Check therapeutic menus for accuracy, and completeness using the individual's records and the diet/nutrition care manual if needed.
   e. Check all menus within the parameters of the individual's recorded likes/dislikes, food intolerances and allergies.
   f. Verify and honor requests that the individual may write on the menu per facility policy.
   g. Verify that each food item marked on the menu is legible.
   h. Refer complicated therapeutic diets to the registered dietitian nutritionist (RDN) or designee as needed to review and approve.

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5. If an individual is unable to mark a menu, staff will make menu selections using the guidelines on the previous page.

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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Meal Identification and Preference Cards/Tickets

Policy:

A meal identification 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 cleaned and sanitized and in the correct serving order following each meal.

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

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

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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 to the food that was 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 *Chapter 1: Menus and Therapeutic Diets* for *Menu Substitution Lists*). 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 the 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. A food replacement will be prepared as soon as possible and 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 adjustments are needed.

7. When food replacements are consistently refused, the staff will notify the 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 director of food and nutrition services 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 the 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Resource: Sample Available Food Replacements

When a patient/resident chooses not to eat a certain food, a food replacement (or substitute) should be offered to assure 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, unless this is the usual pattern for that individual. If an individual routinely consumes 50% of the food served, this should be noted on the individual's person centered care plan.

Note: Patients/residents 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

When an Individual Consumes <50% of:	Offer This Instead:
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 the individual chooses not to eat the food replacement, facility staff may offer:**

- 6 to 8 ounce milkshake or high calorie/protein supplement
- ½ cup pudding made with milk or milk substitute which provides a minimum of 4 to 5 grams protein per serving
- Other supplement of choice

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Displaying the Menu

Policy:
The planned menus will be posted each week, and the daily menus will be posted daily in an area where patients/residents and visitors can see them.

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 a menu board.

3. The food and nutrition services staff is responsible for posting revisions to the planned menu in a timely manner.

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Policy & Procedure Manual

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 for accuracy by the food and nutrition services staff, and by the service staff prior to serving the meal 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 Chapter 1: Menus and Therapeutic Diets* for *Menu Substitution Lists*.)

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.

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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 so staff can refer to the 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 receive training on proper portion sizes at regular intervals by the director of food and nutrition services. The director of food and nutrition services, registered dietitian nutritionist (RDN) or designee will observe meals on a routine basis to assure quality control of portion sizes.

Serving Utensils		
Utensils	**Cup/Tbsp Amount**	**Ounce Amount**
# 5 scoop	¾ cup	6 ounces
# 6 scoop	⅔ cup	5.34 ounces
# 8 scoop	½ cup	4 ounces
# 10 scoop	2/5 to ⅜ cup	3 ¼ ounces
# 12 scoop	⅓ cup	2.67 ounces
# 16 scoop	¼ cup	2 ounces
# 20 scoop	3 ⅛ Tbsp	1 ¾ to 2 ounces
# 24 scoop	2 ⅔ Tbsp (1/6 cup)	1 ½ to 1 ¾ ounces
# 30 scoop	2 Tbsp	1 ounce
# 40 scoop	1 ½ Tbsp	¾ ounce
6 ounce ladle	¾ cup	6 ounces
8 ounce ladle	1 cup	8 ounces

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Adaptive (Assistive) Eating Devices

Policy:

The facility will provide special eating equipment, utensils, and assistance as appropriate to assure that each individual 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, the physician or designee, the 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 person centered care plan and/or in the medical record.

5. The food and nutrition services department will be responsible for ensuring that each individual receives the appropriate 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Meal 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 in the dining rooms and resident/patient rooms during meal times. (See *Chapter 11: Quality Assurance and Performance Improvement* for policy and sample forms.)

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, food preferences, and service, with therapeutic or consistency altered diets delivered as ordered.

4. As necessary, referrals will be made to the appropriate staff for difficulty chewing or 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 consistency altered diets will be monitored.

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

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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 service.

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 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 service.

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Packed Meals Available for Transport

Policy:
Individuals requiring a meal while away from the facility will be provided with a packed 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 meal, if possible.

2. Nursing will include the individual's diet order for the meal, and the time the packed meal needs to be delivered to the unit.

3. Food and nutrition services staff will prepare a packed meal according to the individual's diet order and 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, and as appropriate for the diet order. If clear or full liquids are required, the meal may include a liquid oral nutritional supplement.

4. Food and nutrition services staff 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 notify the food and nutrition services department upon the individual's return to the facility for normal resumption of meals and/or any change in diet orders.

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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 annually on the facility's policies and procedures for pets and service animals.

2. Food and nutrition services staff may not care for or handle animals 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, storage, 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 well-groomed, and properly restrained so they do not to create a safety hazard (i.e. tripping over animals).
   a. Service animals may be allowed in the dining room during meal service as long as their handler controls them and there are no health and safety hazards to others.

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:
US Department of Health and Human Services, US Federal Food and Drug Administration.
2017 Food Code. Available at
https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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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 staff will send a diet change order 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. Staff 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).

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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 meal 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 meals is credited to the food service department.

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

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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 to be maintained in the food pantries. The director of food and nutrition services will determine food and beverage quantities provided.

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 *Chapter 3: Food Production and Food Safety* for *Sample Refrigerator and Freezer Temperatures Forms.)*
   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.

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Nourishments and Supplements

Policy:
The director of food and nutrition services will assure that a supply of nourishments, snacks and/or nutritional supplements are available between meals. Nursing staff will deliver the appropriate foods/beverages and assist individuals with set-up and/or assist them to eat/drink 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 the 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 for 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).

8. The facility may not charge for special food and meals including medically prescribed dietary supplements ordered by the individual's physician, physician assistant, nurse practitioner, or clinical nurse specialist.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Nourishments and Supplements Form

Date: ___________________________

Room	Name	Diet Order	10 AM	2 PM	HS

This form may be computerized.

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Chapter 3: 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.

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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/evening 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.

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Director of Food and Nutrition Services Responsibilities

Policy:
A well-trained director of food and nutrition services will assure that instructions for the 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 foodborne 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, and prepared 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. Appropriate internal cooking temperature for finished product.
   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.

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Inventory and Cost Control

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

Procedure:
The director of food and nutrition services or designee will:

1. Meet routinely with the administrator (or designee) 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. Return damaged products to vendors, and assure refunds are granted as appropriate.
8. Review 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 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.

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HACCP and Food Safety

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 foodborne illness.

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 foodborne illness (FBI): older adults, children, pregnant women, immune-compromised individuals, and 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/or food source and handle them carefully. The following foods are referred to as time/temperature controlled for safety (TCS) foods and include:

   - 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. The direct of food and nutrition services and the registered dietitian nutritionist (RDN) should determine the appropriate temperature ranges for the food service operation.

   Note: 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. Some people find that a temperature danger zone of 40° F to 140° F is easier for staff to learn and remember.

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Resource: Foodborne Illness Basics

Foodborne illness (FBI) is an illness that is transmitted to humans through food. A foodborne 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 a 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).

Bacterial growth: Bacteria need certain things to reproduce: warmth, moisture, food, and time. It is helpful to remember the acronym, FAT TOM:

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

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

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 TDZ 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.

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Sources:

- Food Code 2017. US Department of Health and Human Services, Food Drug Administration, Washington, DC, 20204. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.
- Center for Medicare & Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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Policy & Procedure Manual

Resource: Critical Control Points

There is a flow of food as it goes through kitchens:

Receive ⇒ Store ⇒ Prepare ⇒ Cook ⇒ Hold ⇒ Serve ⇒ Cool ⇒ Re-heat.

Most operations handle food at every step.

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

2. 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

3. 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:

- Food Code 2017. US Department of Health and Human Services, Food Drug Administration, Washington, DC, 20204. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.
- Centers for Medicare & Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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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.

Organism	Common Name of Illness	Onset Time After Ingesting	Signs & Symptoms	Duration	Food Sources
Bacillus cereus	*B. cereus* food poisoning	10 to 16 hours	Abdominal cramps, watery diarrhea, nausea	24 to 48 hours	Meats, stews, gravies, vanilla sauce
Campylobacter jejuni	Campylobacteriosis	2 to 5 days	Diarrhea, cramps, fever, and vomiting; diarrhea may be bloody	2 to 10 days	Raw and undercooked poultry, unpasteurized milk, contaminated water
Clostridium botulinum	Botulism	12 to 72 hours	Vomiting, diarrhea, blurred vision, double vision, difficulty in swallowing, muscle weakness. Can result in respiratory failure and death	Variable	Improperly canned foods, especially home-canned vegetables, fermented fish, baked potatoes in aluminum foil
Clostridium perfringens	Perfringens food poisoning	8 to 16 hours	Intense abdominal cramps, watery diarrhea	Usually 24 hours	Meats, poultry, gravy, dried or precooked foods, time and/or temperature-abused foods
Cryptosporidium	Intestinal cryptosporidiosis	2 to 10 days	Diarrhea (usually watery), stomach cramps, upset stomach, slight fever	May be remitting and relapsing over weeks to months	Uncooked food or food contaminated by an ill food handler after cooking, contaminated drinking water
Cyclospora cayetanensis	Cyclosporiasis	1 to 14 days, usually at least 1 week	Diarrhea (usually watery), loss of appetite, substantial loss of weight, stomach cramps, nausea, vomiting, fatigue	May be remitting and relapsing over weeks to months	Various types of fresh produce (imported berries, lettuce, basil)

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Organism	Common Name of Illness	Onset Time After Ingesting	Signs & Symptoms	Duration	Food Sources
E. coli (Escherichia coli) producing toxin	*E. coli* infection (common cause of "travelers' diarrhea")	1 to 3 days	Watery diarrhea, abdominal cramps, some vomiting	3 to 7 or more days	Water or food contaminated with human feces
E. coli O157:H7	Hemorrhagic colitis or *E. coli* O157:H7 infection	1 to 8 days	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.	5 to 10 days	Undercooked beef (especially hamburger), unpasteurized milk and juice, raw fruits and vegetables (e.g. sprouts), and contaminated water
Hepatitis A	Hepatitis	28 days average (15 to 50 days)	Diarrhea, dark urine, jaundice, and flu-like symptoms, i.e., fever, headache, nausea, and abdominal pain	Variable, 2 weeks to 3 months	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
Listeria monocytogenes	Listeriosis	9 to 48 hours for gastro-intestinal symptoms; 2 to 6 weeks for invasive disease	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.	Variable	Unpasteurized milk, soft cheeses made with unpasteurized milk, ready-to-eat deli meats
Noroviruses	Variously called viral gastroenteritis, winter diarrhea, acute non- bacterial gastroenteritis, food poisoning, and food infection	12 to 48 hours	Nausea, vomiting, abdominal cramping, diarrhea, fever, headache. Diarrhea is more prevalent in adults, vomiting more common in children.	12 to 60 hours	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
Salmonella	Salmonellosis	6 to 48 hours	Diarrhea, fever, abdominal cramps, vomiting	4 to 7 days	Eggs, poultry, meat, un-pasteurized milk or juice, cheese, contaminated raw fruits and vegetables

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Organism	Common Name of Illness	Onset Time After Ingesting	Signs & Symptoms	Duration	Food Sources
Shigella	Shigellosis or Bacillary dysentery	4 to 7 days	Abdominal cramps, fever, and diarrhea. Stools may contain blood and mucus.	24 to 48 hours	Raw produce, contaminated drinking water, uncooked foods and cooked foods that are not reheated after contact with an infected food handler
Staphylococcus aureus	Staphylococcal food poisoning	1 to 6 hours	Sudden onset of severe nausea and vomiting. Abdominal cramps. Diarrhea and fever may be present.	24 to 48 hours	Unrefrigerated or improperly refrigerated meats, potato and egg salads, cream pastries
Vibrio parahaemolyticus	*V. parahaemolyticus* infection	4 to 96 hours	Watery (occasionally bloody) diarrhea, abdominal cramps, nausea, vomiting, fever	2 to 5 days	Undercooked or raw seafood, such as shellfish
Vibrio vulnificus	*V. vulnificus* infection	1 to 7 days	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.	2 to 8 days	Undercooked or raw seafood, such as shellfish (especially oysters)

Source:
US Food and Drug Administration. Available at http://www.fda.gov/Food/ResourcesForYou/Consumers/ucm103263.htm.

Note: Available in PDF format and in Spanish from the above website.

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Resource: Pathogenic Microorganisms and Strategies for Their Control

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

Source of Contamination	Primary Agents of Concern	Primary Control Strategies
A. Hazards that are likely to occur/strategies that must be in place to prevent foodborne illness		
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 foodborne illness transmission.		
Fruits and vegetables, fresh	• E. coli 01507:H7 • Salmonella • Norovirus • Hepatitis A virus • Shigella	• Wash prior to use (unless pre-washed) • Keep cut and raw fruits and vegetables refrigerated
Ready-to-eat meat and poultry products	• Listeria monocytogenes	• Proper refrigeration during storage • 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: Center for Medicare & Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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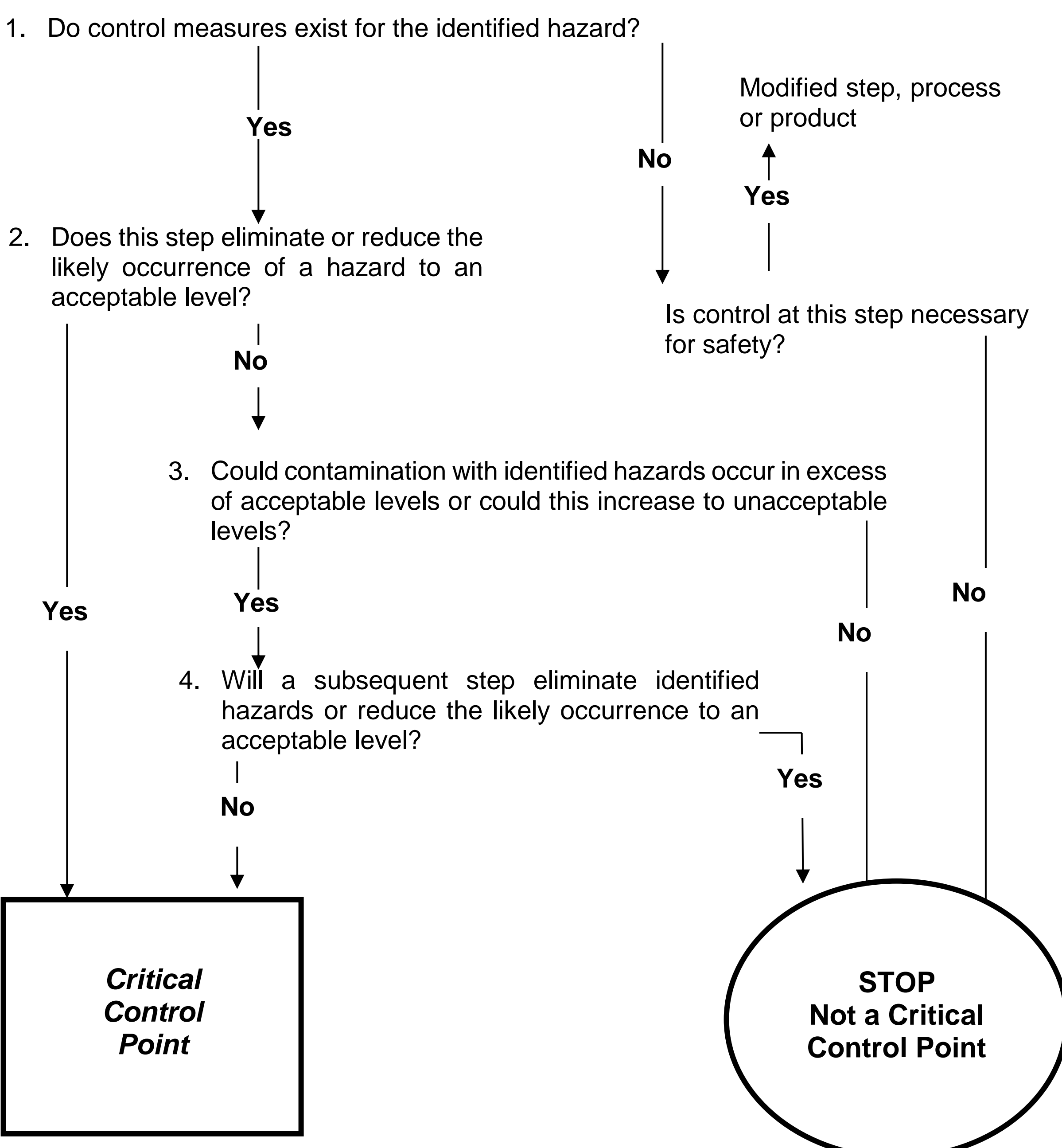
Resource: CCP Decision Tree Table



Adapted from Food Code 2017. US Department of Health and Human Services, Food Drug Administration, Washington, DC, 20204. Appendix F. Example II of a CCP Decision Tree. https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm. Accessed March 6, 2019.

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Policy & Procedure Manual

HACCP Principles

Policy:
The facility food and nutrition services department will utilize a hazardous analysis critical control points (HACCP) centered system to prevent foodborne illness (FBI). HACCP is a food safety system with a focus on preventative controls. The goal is to prevent foodborne illness before it can occur by implementing an effective system of controls.

Note: HACCP helps to identify time/temperature control for safety (TCS) foods; identify points at which foods may become unsafe; 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 states to update their individual state laws and inspection processes to incorporate HACCP procedures. 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 TCS foods, or complicated multiple step recipes that can be influenced by time or temperature.
   b. Review how staff handles non-TCS 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.

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- 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 or TDZ).
- 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 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 records indicate potential problems.
   c. Have a thorough HACCP manual available for reference.
   d. Keep all records on file.
   e. Keep all food service related laws available as a reference.

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

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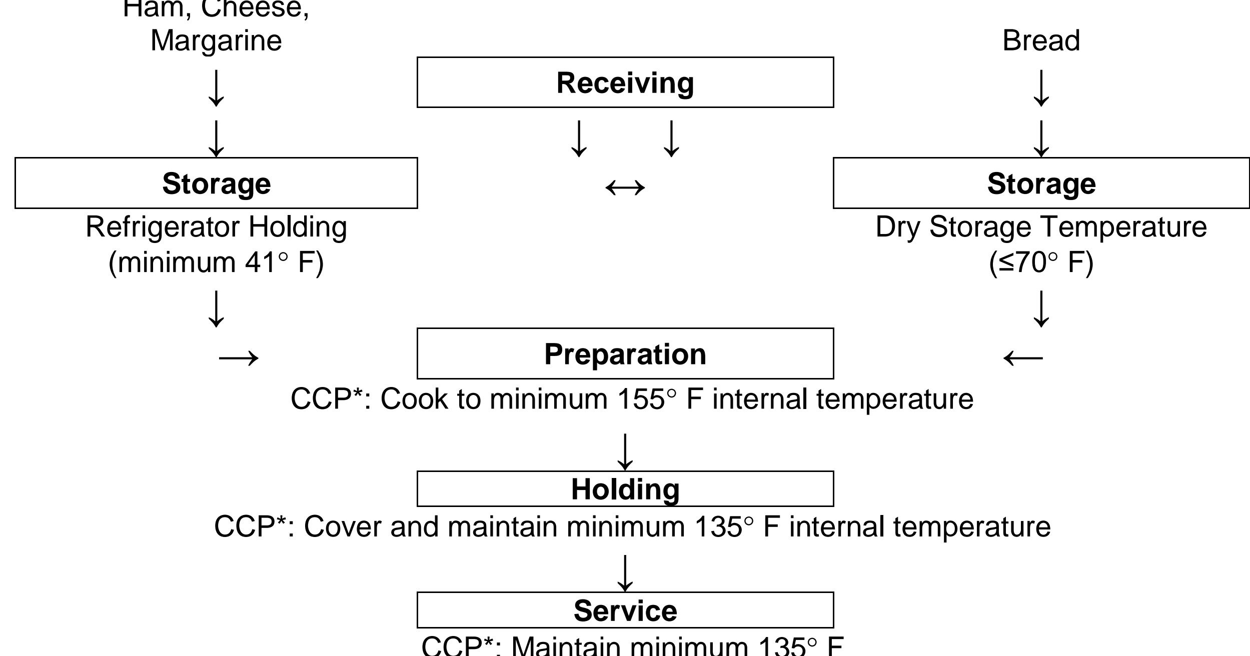
Resource: Sample HACCP Recipe

Recipe that has been converted to the HACCP system:

Grilled Ham and Cheese Sandwich

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



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

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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.

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

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

Source:

Food Code 2017. US Department of Health and Human Services, Food Drug Administration, Washington, DC, 20204. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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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. Limit the time that food is in the temperature danger zone (TDZ).
   b. The TDZ: Food must be held at >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 casseroles, stews, soups and similar foods 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 (<70º F) that is running fast enough to agitate and float off loose ice particles.

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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 not acceptable, take immediate action.
   b. Consider taking the problem to the quality assurance performance improvement (QAPI) 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 not acceptable (<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 (see manufacturer's information).
    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 under-cooked eggs (sunny side up fried eggs, soft cooked eggs, etc.)

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Resources on Food Safety:

- Food Code 2017. US Department of Health and Human Services, Food Drug Administration, Washington, DC, 20204. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.
- Centers for Disease Control and Prevention. Food safety at CDC. Available at http://www.cdc.gov/foodsafety/.
- FoodSafety.gov. Your gateway to government food safety information. Available at http://www.foodsafety.gov/.
- National Restaurant Association Educational Foundation. ServeSafe®. Available at http://www.servsafe.com/.
- U.S. Department of Agriculture, Food Safety and Inspection Service. Protecting public health through food safety and defense. Available at http://www.fsis.usda.gov/wps/portal/fsis/topics/food-safety-education.
- U.S. Department of Agriculture, National Agricultural Library. HAACP. Available at https://www.nal.usda.gov/fsrio/haccp.
- U.S. Department of Health and Human Services. FDA Center for Food Safety and Applied Nutrition—CFSAN/FDA. Available at http://www.healthfinder.gov/orgs/HR2504.htm.

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Policy & Procedure Manual

Food Procurement and Facility Gardens

Policy:

Food produced by local produce venders and/or harvested from facility gardens will be safe for human consumption in accordance with state and local laws and regulations.

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 foodborne 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 laws and regulations for any additional requirements.

Source:

Center for Medicare and Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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Policy & Procedure Manual

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.

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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. Storage areas will be free from rodent and insect infestation; and will be treated for pests and vermin on a regular schedule.

2. Dry storage rooms must be well ventilated and illuminated, with adequate temperature and humidity controls to prevent condensation of moisture and growth of mold. The storeroom temperature should be 50° to 70° F. A thermometer will be present in the storeroom, and will be monitored on a regular basis.

3. 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.

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

5. Food will be purchased in quantities that can be stored properly; and arranged in food groups for organized storage and inventory.

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

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). Supervise the person designated to put stock away to make sure it is rotated properly.
   b. Food should be dated as it is placed on the shelves if required by state regulation.
   c. Date marking will be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS food should be consumed, sold, or discarded.
   d. 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.

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

9. 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 washed and sanitized on a regular basis.

9. Food will be stored a minimum of 6 inches above the floor, 18 inches from the ceiling and 2 inches from the wall with adequate space on all sides of stored items to permit ventilation. Racks and other storage surfaces will be clean and protected from splashes, overhead pipes, or other contamination (ceiling sprinklers, sewer/waste disposal pipes, vents, etc.).

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10. 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.

11. 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 2017 Federal Food Code. (Also see policy on *Use of Leftovers* later in this chapter.) Check state regulations as some states may allow shorter time frames for use of leftovers.

12. Refrigerated food storage:
    a. All refrigerator units will be kept clean and in good working condition at all times.
    b. TCS foods must be maintained at or below 41° F unless otherwise specified by law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41° F. Temperatures for refrigerators should be between 35 to 39° F. Thermometers should be checked at least two times each day. (See *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.

13. 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 of the floor.
    h. Safe thawing: If thawing frozen meat, poultry, and fish in a refrigerator, allow a minimum of 24 to 48 hours, and cook immediately after thawing.

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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).

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

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.

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Sample Freezer and Refrigerator Temperatures Form 2

Unit: ________________________________ Month/Year:________________________

Take AM Temperatures at ____AM Take PM temperatures at ____PM

Day	AM Temp.	Corrective Action	Initials	PM Temp.	Corrective Action	Initials
1						
2						
3						
4						
5						
6						
7						
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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 (TCS) 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, swollen or dented cans, cans with a compromised seal, or food with an abnormal appearance or odor will be discarded.

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 TCS 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 until all parts are firm. 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 dishwasher 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. Disposable gloves are a single use item and should be discarded after each use. Employees should wash hands prior to putting gloves on and after removing gloves.
   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.

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i. Tasting must be done with a tasting spoon. Follow proper tasting procedures: Remove the food with a serving spoon and transfer it to a tasting spoon. Always use clean spoons.
j. Any food that is dropped on the floor must be discarded.
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 ½ 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 patients/residents assist in food preparation and handling, the staff will assist and supervise to see that the above procedures are followed.

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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 TCS 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.)

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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 (for a minimum of 15 seconds) 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 *Resource: Taking Accurate Temperatures* and *Resource: 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 follow these methods:
   a. Hold foods at or below 41° F for cold foods and at or above 135° F for hot foods (to keep food out of the temperature danger zone).
   b. Hold foods on a steam table for less than 4 hours (preferably less than 2 hours).
   Note: Do **not** use the steam table to heat foods.

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.

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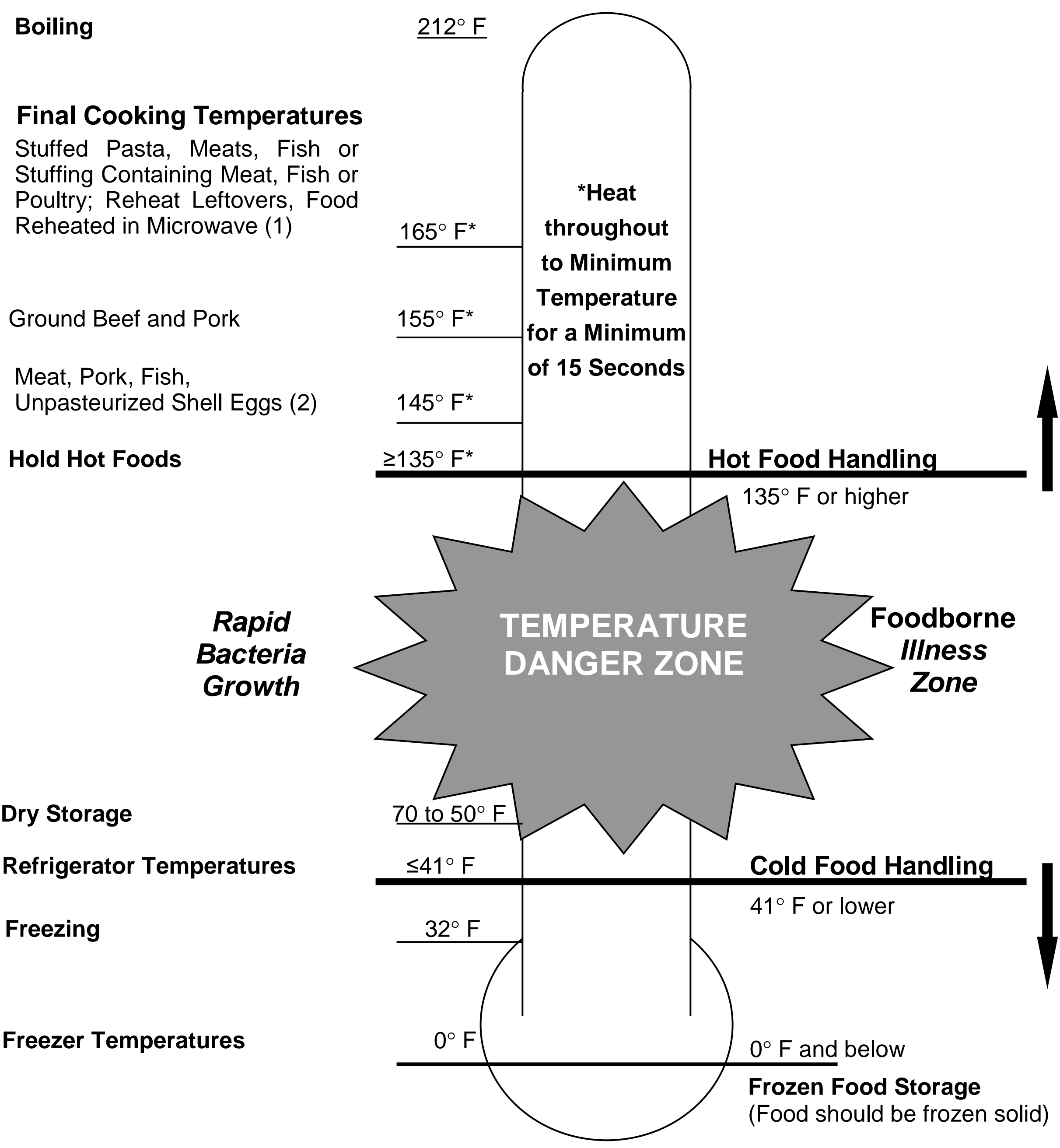
Resource: Critical Temperatures for Safe Food Handling



(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.

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Resource: Taking Accurate Temperatures

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

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

- The digital thermistor is usually battery powered, takes only a few seconds to register the temperature, and the sensor is near the tip of the probe.
- The thermocouple has two wires of dissimilar metals joined together at both ends. When one end is heated, the difference that is generated is proportional to the junction of temperature. Their small size makes them very sensitive to temperature fluctuations.
- The digital thermocouple thermometer gives the quickest temperature response, has the widest temperature range, and is 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 Method
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 the 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 Method
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.

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

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

Taking Accurate Temperatures using Metal Stem Thermometers

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

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

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

4. Temperatures should be taken periodically to assure hot foods stay above 135° F and cold foods stay below 41° F during the serving process.
   - Maintain a cold enough holding temperature to assure foods are maintained at or below 41° 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/fsis-educational-campaigns/thermy/types-of-food-thermometers/CT_Index.

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Resource: Minimum Cooking, Holding and Reheating Temperatures

Cooking is a critical control point in preventing foodborne 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

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

Source:
US Department of Health and Human Services. US Food and Drug Administration. Food Code 2017. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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

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

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

Source:

US Department of Health and Human Services. US Food and Drug Administration. Food Code 2017. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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Sample Food Temperatures Form

Week of: ___________________

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

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

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

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

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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.

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

CCP Items Any foods containing the following:

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

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

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Policy & Procedure Manual

Handling Cold Foods for Trayline

Policy:
Proper cold food temperatures will be maintained during meal service.

Procedure:
Prior to service:
1. Cold food items (such as canned fruits, desserts, salads, puddings, cottage cheese, juice, milk) will be placed in the refrigerator at least 3 to 4 hours before serving. Food should be chilled to ≤41° F.

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

At the time of service:
1. Cold food items will be taken from the refrigerator one tray at a time to be used at the meal service (unless a reach-in refrigerator 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 food temperatures will be taken and recorded prior to and halfway through service to assure foods are ≤41° F.

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Taste Testing

Policy:
All food will be taste-tested for quality 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 new, clean spoon will be used to taste the food.

3. All food which does not pas the taste test due to seasoning, toughness, color, or other negative factors will not be served until or unless the problem has been corrected.

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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 can be used within 7 days (the day of preparation is counted as day 1 (according to the 2017 Federal Food Code) and if reheated to 165° F for a minimum of 15 seconds for hot foods*.
   b. Leftovers are not to be used as pureed food.
   c. 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.

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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 patient/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, these 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 patient/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 food and nutrition services 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 staff using documentation systems including the meal identification (ID) card/ticket.

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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:

Food Allergy Research and Education. Food Allergy Training Guide for Hospital and Food Service Staff: *A Comprehensive Program for Training Hospital Staff to Safely Prepare and Serve Food to Patients with Food Allergies.* Available at https://www.foodallergy.org/sites/default/files/migrated-files/file/hospital-food-training-faan.pdf.

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Food Brought in from Outside Sources and Personal Food Storage

Policy:

Food brought to the facility by family members or friends for a loved one or for a special event 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. Families, volunteers and others not employed by the facility will be educated on safe food handling and storage techniques by designated facility staff. Staff will examine food for quality (visual, smell, packaging) to identify potential concerns.

2. The food and nutrition services department will ensure that once food is brought to the facility from an outside source that reheating and hot/cold handling of leftovers is appropriate.

3. If facility equipment is used to prepare or reheat visitor food, the food and nutrition services staff will ensure steps are taken to prevent contamination of facility food.

4. 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 apart from facility food. Food prepared for events such as parties will be also identified and stored apart from facility food.

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

6. Staff will provide information on safe food storage and handling as deemed appropriate. (See *Resource: Food Safety for Your Loved One* on the following page.)

7. 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.

8. 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).

9. 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. Note: Staff may need to heat food for a patient/resident who is not able to perform this task safely.

10. Reheated food should be cooled to a palatable temperature prior to eating to prevent burns.

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Resource: Food Safety for Your Loved One

If you plan to bring food into the facility for your loved one, please be sure that the food is handled safely.

Food or beverages should be labeled and dated to monitor for food safety:

- Food or beverages in the original containers marked with manufacturer expiration dates and unopened do not have to be re-labeled for storage.
- Raw eggs or dishes made with raw eggs for consumption (i.e. eggnog, poached eggs) are not permitted.
- Foods or beverages that have 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 patient's/resident'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 the director of food and nutrition services.

*Per 2017 Food Code. Please check state regulations as some state regulations may differ.

Foods should be cooked to safe internal temperatures:

- Ground meats: 155° F for a minimum of 15 seconds.
- Fish, pork and other meats: 145° F for a minimum of 15 seconds.
- Stuffed meat, poultry, fish or pasta: 165° F for a minimum of 15 seconds.
- Eggs: 145° F if cooked for immediate service, 155° F if held for service.
- Food cooked in microwave: 165° F (and let stand for 2 minutes).
- Cooked food that is cooled and reheated: 165° F for a minimum of 15 seconds.

Foods should be stored at the appropriate temperature to maintain safety:

- Cold foods: Less than 41° F.
- Hot foods: Hold at 135° F or higher.
- Foods that are leftover should be stored promptly and cooled to 41° F or less within 4 hours.
- Foods that are leftover should be reheated to an internal temperature of 165° F for a minimum of 15 seconds.

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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 director of food and nutrition service 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 and provide for safe hot/cold holding to keep foods safe 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.

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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:

Meal **Buffet** **Snack** **Coffee/Tea** **Other** ______________

Food Requested	**Cost**
Appetizer:	
Entrée/Meat:	
Side Dish:	
Side Dish:	
Salad:	
Starch/Bread:	
Dessert/Fruit:	
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:** ______________

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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.)

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Sample Floor Stock Supply Form

Nursing Station_______________**Date**__________**Personnel**_____________________

Food Item	Par Level	Sun		Mon		Tues		Weds		Thurs		Fri		Sat	
		OH	D	OH	D	OH	D	OH	D	OH	D	OH	D	OH	D
Preparer's Initials															

OH = On Hand D = Delivered

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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 director of food and nutrition services in a timely manner.

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

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

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Policy & Procedure Manual

Reporting a Foodborne Illness (FBI)

Policy:
Facility staff will follow the proper procedure to report, investigate, document, and follow up on suspected or confirmed foodborne illness (FBI) outbreaks.

Procedure:
1. Staff will report any possible FBI incidents or outbreaks to the director of food and nutrition services. Potential concerns may come from a variety of sources including nursing staff, patient/resident, 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.

3. 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.

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

5. 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.
   i. Assuring proper use of sanitizer and sanitizing cloths.

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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.

6. 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).

7. Follow the facility's procedures for handling inquiries from staff, family members, concerned citizens, and/or the media.

Resources:

- Centers for Disease Control and Prevention: How to Report a Foodborne Illness. Available at http://www.cdc.gov/foodsafety/outbreaks/investigating-outbreaks/report-illness/index.html.

- Center for Medicare and Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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Policy & Procedure Manual

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 food and beverage temperatures at the point of service.

2. Food will be cooked to safe food temperatures to prevent foodborne illness. Hot food will be held and plated at a minimum of 135° F, as per accepted food safety guidelines.

3. 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.

4. Hot beverages will be produced at 160° F to 185° F, the optimum temperature for patient/resident satisfaction. Hot beverages will be handled carefully during food delivery and meal set-up in an attempt to avoid spills that could cause burns.

5. 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.

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

7. Patient's/resident's 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.

Water Temperature	Time to Receive Second Degree Burn	Time to Receive Third Degree Burn
120° F	8 minutes	10 minutes
124° F	2 minutes	4.2 minutes
131° F	17 seconds	30 seconds
140° F	3 seconds	5 seconds

Source: Burn Care, Everywhere Foundation 2016. Available at http://www.burncarefoundation.org/safety/hot-water-exposure.html.

Additional Sources:

- American Burn Association. Scald Injury Prevention Educator's Guide. Available at http://ameriburn.org/wp-content/uploads/2017/04/scaldinjuryeducatorsguide.pdf.
- Brown F, Diller KR. Calculating the optimum temperature for serving hot beverages. *Burns*. 2008: 34(5): 648-654.Available at http://www.sciencedirect.com/science/article/pii/S0305417907002550.

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Food Safety: 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 Chapter 5: *Cleaning Instructions* for cleaning instructions for *Ice Machines and Equipment*.)

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.

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Food Safety and Sanitation

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

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 the 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 the 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.

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- 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, sunny side up, fried and poached eggs.
- Home-canned products are not purchased or used, with the exception of facility-grown produce or local produce from approved sources that is properly handled (see *Chapter 3: Food Production and Food Safety* for *Food Procurement and Facility Gardens*).
- Bulging or leaking cans, cans with severe dents on the seams, or broken containers of food will not be used.

4. Food Storage (see *Chapter 3: Food Production and Food Safety* for *Food Storage*)
   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:** 2017 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 foods with expiration dates are used prior to the use by date on the package.
      - Canned and dry foods without expiration dates are used within six months of delivery or according to the manufacturer’s guidelines.

Note: In order to assure that the 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 *Chapter 11: Quality Assurance and Performance Improvement* for *Sample Audit Forms*.

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Food Safety – Director of Food and Nutrition Services' Responsibilities

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. All HACCP procedures will be followed.
2. Sanitary conditions will be maintained in the food storage, preparation and serving areas.
3. All refrigerated and frozen foods will be stored and handled properly. All dry and staple food items will be stored properly.
4. Employees will follow sanitary practices and good personal hygiene at all times.
5. Employees will follow proper cleaning and sanitizing instructions for all kitchen equipment.
6. 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.
7. The director of food and nutrition services or designee will conduct regular inspections to assure proper food handling.
8. Dishwashing guidelines and techniques will be understood by staff and carried out in compliance with the state and local health codes.
9. Cleaning schedules will be posted and followed.
10. Proper waste disposal methods will be used.

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Employee Sanitary Practices

Policy:
All food and nutrition services 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 fingernails 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 2017 Federal Food Code.

5. Use utensils to handle food, avoiding bare hand contact with food. Disposable gloves are a single use item and should be discarded after each use. Hands must be washed prior to using gloves and after removing gloves.

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

7. Use clean cloths when handling hot utensils.

8. When tasting food, it should be transferred to a clean dish or spoon. A soiled utensil must never be dipped back in the food.

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

10. Use these guidelines in handling clean dishware, glasses and flatware:
    a. Use 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.

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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 and dietetics technician, registered (NDTR), maintenance, and delivery personnel are exceptions to this policy.

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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. Methods 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 *Chapter 5: Cleaning Instructions* for *Sample Cleaning Schedule* and *Sample Cleaning Forms*.)

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:
OSHA Quick Card. Hazard Communication Safety Data Sheets. Available at https://www.osha.gov/Publications/HazComm_QuickCard_SafetyData.html.

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Personal Hygiene and Health Reporting

Policy:
All food and nutrition services employees will be trained on appropriate personal hygiene and health reporting.

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 Chapter 4: *Sanitation and Infection Control* for the *Hand Washing* policy.

11. Employees will not report to work if ill, but are expected to call off per facility procedure 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	Fever and sore throat
Hepatitis A	Diarrhea lasting over 24 hours
Norovirus	Vomiting lasting over 24 hours
Hemorrhagic Colitis (E. coli)	Salmonellosis

I have received a copy of the personal hygiene requirements and understand what is expected of me.

____________________________________ ____________________
Signature Date

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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:

Hands and exposed portions of arms (or surrogate prosthetic devices) should be washed 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 disposable gloves for working with food and after gloves are removed.
   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 or use a hand blow dryer.
   f. Use the paper towel to turn the faucet off and open the door if needed, and then discard it.

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

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

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

Resource:
Poster on How to Wash Hands from the World Health Organization. Available at http://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf.

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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 2017 Food Code. Hand antiseptic solution used as a hand dip shall be maintained clean and at 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:

   a. Apply to the palm of one hand and rub to cover all areas of the hands until dry.
   b. Rub between fingers, finger tips, back of fingers and hands.
   c. Volume of hand sanitizer used is based on the manufacturer's recommendations.

Resources:

- Centers for Disease Control. Hand Hygiene in Healthcare Settings. Available at www.cdc.gov/HandHygiene/index.html.
- Hand Antiseptics. Food Code 2017, Section 2-301.16. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.
- Hand Rub Poster from the World Health Organization. Available at http://www.who.int/gpsc/5may/How_To_HandRub_Poster.pdf.
- State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.
- 2017 Food Code. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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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) and after removing single use gloves.

5. Clean barriers such as single-use gloves are to be used when:
   a. Handling ready-to-eat foods.
   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. Bagging bread or cookies.
   f. 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, and hands must be washed:**
   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. Any time a contaminated surface is touched.

7. Wash hands after removing gloves.

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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 these 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, washed and rinsed in the 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: once by laying it out onto a flat dish machine tray and again 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 the 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). 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).

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Resource: Sanitation of Dishes/Dish Machine

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

Sources:

- State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.
- 2017 Food Code. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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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 problems 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.

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Sample Dish Machine Temperature and Sanitizer Log Form

Facility: ______________________________ **Month:**_______________ **Year:**______

Date	Meal	Wash	Final Rinse	Sanitizer Concentration (PPM)	Thermal Strip	Corrective Action If needed	Initials
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
	B L D						
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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.

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Resource: Dish Machine Problems and Solutions

Problems	Reasons	Possible Solutions
Scale in machine	Water hardness Wrong kind or amount of detergent	Soften water Select detergent better for your situation (consult supplier) De-lime the machine
Greasy film	Poor cleaning guidelines; Water not hot enough Not enough detergent	Improve job of cleaning Check that wash and rinse cycle temperature is appropriate Use additional detergent
Cloudy film on glasses; dirty soap film on dishes	Final rinse jets clogged	Be sure jets are clean and that the spray reaches all dishes Be sure scrap traps are emptied and cleaned often
Water spots and film on glasses and dishes	Too short a rinse time Pressure of rinse Water hardness Drying time	Lengthen time: If time is too short, soil is not removed Adjust pressure: If pressure is too low, the rinse is poor; if pressure is too high, dishes tend to fog Soften water If drying time is too long, water remaining will cause spots A rinse additive would be indicated to produce “sheeting off” of the rinse water to produce a dry dish

Sources:

- State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.
- 2017 Food Code. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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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.

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Policy & Procedure Manual

Cleaning Dishes - Manual Dishwashing

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

Procedure:
1. Scrape dishes into a clean waste basket 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 into the sink at a time. 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 frequently using a test strip to assure the level of sanitizing solution is appropriate. Follow chemical manufacturer's guidelines to prepare sanitizing solution.

Sink 1: Wash	Sink 2: Rinse	Sink 3: Sanitize
Wash dishes in detergent and warm water to remove all soil: 1. Prepare the clean sink by measuring the appropriate amount of water into the sink and marking the sink with a water line. 2. Determine the appropriate amount of detergent to be used, and follow the manufacturer's directions for use. 3. Water should be 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:

Disinfectant	Strength	Minimum Temperature	Contact Time
Hot Water	N/A	171° F	30 seconds
Chlorine	50 to 100 PPM	75° F	10 seconds
Quaternary Ammonium	150 to 200 PPM	75° F	Per manufacturer
Iodine	12.5 PPM	75° F	30 seconds

Source: 2017 Food Code. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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Resource: Sanitation of Dishes/Manual Washing

	Temperature
Manual Washing Using Hot Water to Sanitize • For sanitizing using immersion in hot water, water must be maintained at	171° F for 30 seconds
Manual Washing Using Chemicals to Sanitize • An exposure time of at least 10 seconds for a chlorine solution of 50 mg/L that has a pH of 10 or less and a temperature of at least • Or a pH of 8 or less and a temperature of at least • An exposure time of at least 30 seconds for other chemical sanitizing solutions	100° F 75° F Per Manufacturer

Chlorine Solutions
Chlorine solutions must have a minimum temperature based on concentration and pH of the solution.

Minimum Concentration Mg/L	Minimum Temperature in ° F	
	pH 10 or Less	pH 8 or Less
25	120	120
50	100	75
100	55	55

Iodine Solutions
• Minimum 68° F • pH of 5.0 or less or pH no higher than level specified by the manufacturer • Concentration between 12.5 mg/L and 25 mg/L

Quaternary Ammonium Compound Solutions
• Minimum 75° F • Concentration as indicated by manufacturer • Used only in water with 500 mg/L hardness or less, or in water with a hardness no greater than specified by the manufacturer

Source:
2017 Food Code. Available at https://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm595139.htm.

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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.

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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 should be replaced daily.

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Dry Storage Areas

Policy:

Dry storage areas will be maintained to keep food safe and free of infestation or contamination.

Procedure:

1. Floors, walls, shelves and other storage areas will be kept clean.

2. 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.

3. Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods.

4. Ceilings must be free from water and heating pipes to protect the food from leaking pipes, heat, or contamination.

5. 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.

6. Smoking is not allowed in storage rooms.

7. 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. 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 *Chapter 5: Cleaning Instructions* for a *Sample Cleaning Schedule*.

Note: Please refer to *Food Storage* in *Chapter 3: Food Production and Food Safety* for more information on proper food storage.

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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 *Chapter 5: Cleaning Instructions* for *Cleaning Ice Machines and Equipment*.

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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.

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Insert facility's isolation meal policy here.

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Clean-up Procedures for Vomit/Fecal Accidents

Policy:
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 Resources:

- Ohio Uniform Food Safety Code: http://codes.ohio.gov/oac/3717-1.
- Ohio Department of Health Food Safety Program: https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/food-safety-program/welcome-to
- Ohio Department of Agriculture Division of Food Safety: https://agri.ohio.gov/wps/portal/gov/oda/divisions/food-safety/!ut/p/z0/fY27DoJAEAB_BQtKshsFE8sTjI-IxA63Mae8VsktyAXI70UrK8tJJjNAkAIZ3XOpLYvR9cgnmp-

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- Center for Disease Control (CDC): Preventing Norovirus Infection: http://www.cdc.gov/norovirus/preventing-infection.html.
- U.S. Environmental Protection Agency (EPA) - Registered Hospital Disinfectants Effective against Norovirus (Norwalk-like virus): https://www.epa.gov/sites/production/files/2016-06/documents/list_g_norovirus.pdf.

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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 *Chapter 5: Cleaning Instructions* for *Cleaning Cloths, Pads, Mops and Buckets.*)

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Waste Disposal

Policy:
Garbage will be disposed of 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.

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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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Chapter 5: Cleaning Instructions

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Cleaning and Sanitation of Dining and Food Service Areas

Policy:
The food and nutrition 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 methods 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.

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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, Griddle)
- 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

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Sample Daily Cleaning Schedule Form

		Initials and Dates							
Item	**Responsible Party**	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**	**DFNS**

DFNS = Director of food and nutrition services or designee (initial here after checking to assure work was done satisfactorily)

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Sample Weekly Cleaning Schedule Form

		Initials and Dates					
Item	**Responsible Party**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**DFNS**

DFNS = Director of food and nutrition services or designee (initial here after checking to assure work was done satisfactorily)

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Sample Monthly Cleaning Schedule Form

		Initial and Dates											
Item	Responsible Party	January	February	March	April	May	June	July	August	September	October	November	December

Director of food and nutrition services or designee: Check to assure work was done satisfactorily.

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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.

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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 annually 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 a chemical injury occurs.

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.

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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.

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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.

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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

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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.

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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.

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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.

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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.

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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, clean, and odor-free 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.

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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. Deep-clean food carts at least weekly (preferably daily) in a designated area using a power washer as available.

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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.

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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.

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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 poor oil down the sink drains.

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

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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.

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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.

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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.

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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.
6. Sanitize.
7. Leave the door ajar until the interior dries.
8. Wipe the exterior including the selection panel or keypad with a clean, wet cloth. Wipe dry. Clean the area underneath and around the machine.
9. Clean the exterior of the glass door with an approved glass cleaner.
10. Replace the trays or shelves.

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

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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.

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Cleaning Instructions: Ranges/Griddles

Policy:
The cook/chef on each shift is responsible for keeping the range and/or griddle as clean as possible during the preparation of the meal. The range/griddle will be cleaned after each use. Spills and food particles will be wiped up as they occur.

Procedure:
1. Turn the range/griddle 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.

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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.

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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.

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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.

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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.

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Chapter 6: 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 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.

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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.

Water Temperature	Time to Receive Third Degree Burn
120° F	5 minutes
124° F	3 minutes
133° F	15 seconds
140° F	5 seconds
148° F	1 second

Source:
Center for Medicare & Medicaid Services. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed November 27, 2018.

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

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Safety in Food Preparation

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 should not be used to clean food preparation equipment or utensils.

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

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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 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.

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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.

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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).

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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.

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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.

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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. Lower the object 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.

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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.

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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. (The maintenance department usually does this task).

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. Also refer to Chapter 12: Disaster Planning.

Resource:
National Fire Safety Association, Free Safety Tip Sheets. http://www.nfpa.org/public-education/resources/safety-tip-sheets.

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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 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.
        - Take the posted staffing schedule to serve as a reference for head count.
        - 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

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.

Also refer to *Chapter 12: Emergency/Disaster Planning*.

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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.

Also refer to *Chapter 12: Emergency/Disaster Planning.*

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Resource: Helpful Fire Safety Information

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.

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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.

Also refer to *Chapter 12: Emergency/Disaster Planning.*

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Facility Specific Policy and Procedure for Fires

Insert facility fire policy and procedure here.

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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.

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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.

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Insert a copy of facility eye wash/station instructions here.

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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.

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Insert a copy of facility's accident/incident report here.

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Equipment Malfunctions and Repairs

Policy:
All equipment 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. The administrator must approve services or purchase of parts or outside repair according to facility policy.

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Insert a copy of facility's maintenance work order here.

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Insert facility's policy and procedure for repairs that involve use of companies outside of facility here.

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Chapter 7: Personnel/Training

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Personnel - General

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 to allow the kitchen to be open for a period of no less than 12 hours. A department employee shall be present in the kitchen during hours of operation. (See *Chapter 3: Food Production* and *Food Safety* policy and procedure on *Hours of Operation*.)

3. A clearly written job description for each position will be on file and available for staff to review.

4. Food and nutrition services staff will be trained to perform assigned duties and will be expected to participate in inservice programs. The director of food and nutrition services and/or designee will conduct these programs.

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.

Note: See sample job descriptions, work schedules, and competencies on the flash drive provided with this manual.

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Policy & Procedure Manual

Director of Food and Nutrition Services

Policy:
The director of food and nutrition services will be responsible for all aspects of the food and nutrition services department including but not limited to food safety, staff safety, cost management, and meeting nutritional needs of patients/residents served.

Procedure:
1. The director of food and nutrition services will be hired by corporate staff, the administrator, or by the immediate supervisor of the position as deemed appropriate by the facility.

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. A facility that does not have a full time dietitian (registered dietitian nutritionist or RDN) or clinically qualified nutrition professional must designate a person to serve as director of food and nutrition service. According to the CMS State Operations Manual for Nursing Homes F tag 801, the director of food and nutrition service hired prior to November 28, 2016 must meet the following requirement no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for those hired or designated to that position after November 28, 2016:
    a. Is a certified dietary manager (CDM); or
    b. Is a certified food service manager; or
    c. Has a 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
    e. In states that have established standards for food service managers or dietary managers, must meet state requirements for food service managers or dietary managers.

3. If there is not a full time dietitian or clinically qualified nutrition professional, the director of food and nutrition services will receive frequently scheduled consultation from the dietitian (RDN), nutrition and dietetics technician, registered (NDTR), or clinically qualified nutritional professional.

4. The director of food and nutrition services:
    a. Will carry out his or her daily activities according to the job description, work schedule, and list of duties.
    b. Or designee will be considered the immediate supervisor of the cooks/chefs and other food and nutrition services staff.
    c. Will cooperate with other department heads and other professionals, including RDN, NDTR, or clinically qualified nutrition professional for the health and welfare of the patients/residents.

5. 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.

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e. Infection control and/or safety committee, emergency preparedness plan meetings and activities.
f. 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.
i. Annual facility-wide assessment as required by the Centers for Medicare & Medicaid Services (CMS) and directed by facility administration, if applicable.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Note: Also see sample job descriptions, work schedules, and competency checklists in Appendix.

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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. Qualified dietitian (if available)
2. Assistant director of food and nutrition services
3. 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 patients/residents.
   b. Completing diet changes to assure that all patients/residents 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 unless absence is extensive. 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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 corporate, 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. The director of food and nutrition services will schedule interviews for top candidates. (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. Resident's or patient's rights information

5. The director of food and nutrition services, with input from administration as appropriate, will hire the most qualified applicants.

6. The director of food and nutrition services will complete employee orientation, competency training and work schedules.

Note: See sample job descriptions, work schedules, and competencies on the flash drive provided with this manual.

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Facility Personnel Forms/Policies

Insert facility personnel forms or policies here.

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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. Why do you want to make a job change?

9. What do you want from this job that is lacking in your present job?

10. Describe a situation when you had several deadlines to meet and explain how you handled it.

11. Describe a time when the quality of your work was not up to standards. Explain what happened and how you handled the situation.

12. Describe a situation when you had to respond to a customer request or complaint.

13. What are your salary expectations? Benefits?

14. What is your availability? (Current job notice, etc.)

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Training/Orientation

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 competency training of new staff.

Procedure:

Staff will be trained on the following (as they apply to the position):

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
   g. Meal service/tray line training
   h. Health Insurance Portability and Accountability Act (HIPAA)

2. **Introduction to Food Service**
   Goal: To provide proper procedures for maintaining an efficient operation, practicing mechanical safety, and performing general cleaning duties.
   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

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5. **Food Preparation and Food Safety (including HAACP Principles)**
   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 including leftover 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

9. **Review of Policies and Procedures**
   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 assessment/performance improvement

Note: See *Sample Training/Orientation Form* later in this chapter of the manual for recording each new employee's training. Also see sample job descriptions, work schedules, and competencies on the flash drive provided with this manual.

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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 care plan.

Procedure:
1. The director of food and nutrition services will coordinate training on resident's rights with facility staff development department.

Resources:
- Information from Center for Medicare & Medicaid Services (CMS): https://www.medicare.gov/NursingHomeCompare/Resources/Resident-Rights.html
- Sample Nursing Home Resident Bill of Rights: http://www.amerilawyer.com/nh_bill_of_rights.htm.

Hospitals: Patient's Rights Training

Policy:
All staff working in the hospital system will be made aware of patient's rights.

Note: The American Hospital Association (AHA) has changed from Patient's Rights to "The Patient Care Partnership: Understanding Expectations, Rights and Responsibilities". For more information visit AHA's website at http://www.aha.org/aha/issues/Communicating-With-Patients/pt-care-partnership.html.

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Insert a copy of facility's *Nursing Home Resident's Rights Document* here.

OR

Insert a copy of the facility's *Hospital's Patient's Rights Information* here.

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Facility-Wide Inservice Training

Policy:

The facility will follow the Occupational Safety and Health Administration (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.

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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.

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Health Insurance Portability and Accountability Act (HIPAA)

Insert Facility-Wide HIPAA Compliance Policy here.

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Sample Training/Orientation Form

Name ________________________ Position __________________ Date of Hire ___ _ _____

Subject	Date	Instructor Initials	Employee Initials	Review Date	Instructor Initials	Employee Initials
Resident's or Patient's Rights						
Overview of Food Service						
Introduction to Food Service						
Sanitation						
Safety						
Food Prep/Safety						
Standard Measurements						
Nutrition						
Menus/Therapeutic Diets						
Review of Policies and Procedures						
Review of Competency Checklists						

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 Services Signature:	Date:

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Resource: Facilitating Adult Learning

Adult learners are often juggling many responsibilities, including jobs and families. Everyone learns differently; some people prefer visual learning (such as slides or handouts), some 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 work place can facilitate learning.

Source:
Vandenberg L. Facilitating Adult Learning: How to Teach So People Learn. http://www.canr.msu.edu/od/uploads/files/PD/Facilitating_Adult_Learning.pdf.

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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 inservice 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 foodborne illness outbreaks)
   i. Work place safety
   j. Quality assurance and performance improvement projects
   k. Survey readiness
   l. 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. Emergency Preparedness Plan (including fire and 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 (HIPAA)
   f. Abuse and neglect
   g. Ethics training

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)

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Resource: Inservice Training

Introduction
- Organizational charts
- Employee policy manual
- Job descriptions
- References
- Records
- Communication with nursing department
- Residents'/Patients' Rights**
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- Survey preparedness*

Sanitation
- Infection control**
- Personal hygiene/hand washing*
- Equipment
- Food safety*
- Food preparation
- Prevention of foodborne diseases
- Pest control
- Dishwashing - hand and machine
- Pot and pan washing
- Facility pets

Safety
- General safety guidelines
- Fire safety and procedures**
- Emergency Preparedness 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*

**Mandatory Annual Inservices
*Recommended Annually

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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:

____

____

____

____

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____

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Recommendations/Follow-Up:

____

____

____

____

____

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____

____

____

Conducted by

____

Title

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Sample Inservice Sign in Form

Date:_____________ Time:_________ Inservice Title: _________________________________

Name	Title/Position	Shift

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Evaluating Food and Nutrition Services and Clinical Nutrition Personnel

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. The employee competency checklist will be completed at the end of 30/60/90 days and periodically as needed.

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 will be used. 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 Personnel:

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 evaluations 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.

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Employee Evaluation Forms

Insert facility employee competency and evaluation forms and employee coaching or discipline forms here.

Note: See sample job descriptions, work schedules, and competencies on the flash drive provided with this manual.

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Sample Vacation/Leave Request Form

Employee ________________________________ Request Date ______________

Position _________________________________

This is for vacation __________________ Leave of absence __________________

1. Date(s) Requested:

   From _____________________________ to ______________________________

2. Alternate Dates Acceptable:

   From _____________________________ to ______________________________

   From _____________________________ to ______________________________

3. Reasons (for leave of absence):

   ____

   ____

   ____

   ____

4. Comments:

   ____

   ____

   ____

   ____

Employee Signature:	Date:
Approved by/Title/Signature:	Date:

Supervisor: Please send copy of approved request to payroll.

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Sample Employee Request for Leave Form

Name_______________________________________ Date ____________________

I request the following time off:

Type **Date(s)**

☐ Vacation ____

☐ Other ____

Employee Signature:	Date:
Approved by/Title/Signature:	Date:

Name_______________________________________ Date ____________________

I request the following time off:

Type **Date(s)**

☐ Vacation ____

☐ Other ____

Employee Signature:	Date:
Approved by/Title/Signature:	Date:

Supervisor: Please send copy of approved request to payroll.

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Employee Vacation Request and Request for Leave Forms

Insert facility vacation and leave request forms here.

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Policy & Procedure Manual

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Note: Also see Sample Job Descriptions, Work Schedules and Competency Checklists for the Food and Nutrition Services Department on the flash drive provided with this manual.

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Right to Deviate from Clinical Policies and Procedures

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 policies and procedures and will need to be addressed as deviations from the policy and procedure. The registered dietitian nutritionist (RDN) has the right to deviate from policies and procedures 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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 identified as "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, medical and nursing staff, food and nutrition services 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 other aspects of food service and delivery 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, and 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Documenting in the Medical Record

Policy:
All information regarding nutrition care and medical nutrition therapy (MNT) will be documented in the individual's medical record utilizing a facility-approved form of documentation.

Procedure:
The registered dietitian (RD) or designee shall:

1. Document all pertinent information regarding nutrition care and 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 for paper medical record: 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Diet History

Policy:
Information will be gathered upon admission to inform the 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 an electronic form (if applicable) or a *Food Preferences Form* (see 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. Preferred meal time
   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. If the individual is unable to provide the information, a food preferences form may be distributed to the family or significant other upon admission.

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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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)

Breakfast	Juice	Milk	Coffee	Reg/Decaf	Hot Tea	Reg/Decaf	Water	Soda Pop	Iced Tea
Lunch	Juice	Milk	Coffee	Reg/Decaf	Hot Tea	Reg/Decaf	Water	Soda Pop	Iced Tea
Dinner	Juice	Milk	Coffee	Reg/Decaf	Hot Tea	Reg/Decaf	Water	Soda Pop	Iced Tea

Food Dislikes (Circle)

Meat/Substitutes	Vegetables	Fruits	Starches	Cereal
Bacon	Beets	Apples	Baked Beans	Cream of Wheat
Beef, Ground	Broccoli	Applesauce	Black-eyed Peas	Grits
Beef Liver	Brussels Sprouts	Apricots	French Fries	Malt-O-Meal
Beef Patty	Cabbage	Bananas	Lima Beans	Oatmeal
Beef, roast	Carrots	Cantaloupe	Macaroni	Dry Cereal
Cheese	Corn	Grapefruit	Mashed Potatoes	
Chicken	Coleslaw	Mango	Navy Beans	
Chicken Liver	Green Beans	Oranges	Noodles	
Chili	Green Peas	Papaya	Pancakes	
Cottage Cheese	Greens	Peaches	Pinto Beans	**Milk/Dairy**
Eggs	Lettuce	Pears	Potatoes	1% 2%
Enchiladas	Lima Beans	Pineapple	Rice	Skim Whole
Fish	Okra	Plums	Sweet Potatoes	Buttermilk
Ham	Onions	Prunes	Tator Tots	Chocolate Milk
Lamb	Peas	Tangerines	Waffles	Kefir
Luncheon Meat	Sauerkraut	Watermelon		Rice Milk
Nuts	Spinach			Soymilk
Pork Loin	Tomatoes			Yogurt
Pork Chop	Yellow Squash	**Juices**	**Bread**	**Desserts**
Sausage Link	Wax Beans	Apple	Bagels	Cakes
Sausage Patty	Zucchini	Cranberry	Biscuits	Cookies
Shellfish		Grape	Cornbread	Fruit Crisp
Shrimp		Grapefruit	Crackers	Gelatin
Soy Burgers		Orange	Coffee Cake	Ice Cream
Tofu		Prune	Muffins	Pudding
Tuna		Tomato	Pancakes	Pie
Turkey	**Soups**	Vegetable	Pita Bread	Sherbet
	Bean		Raisin Bread	
	Beef Noodle/Veg.	**Spicy Foods**	Rolls	
	Broth	Chili	Rye Bread	
	Lentil	Sauce	Toast	
	Potato	Tacos	Tortillas	
	Split Pea	Tomato Sauce	Wheat Bread	
	Tomato		White Bread	
	Vegetable			
	Cream Soups			

Special meal preferences or pattern if different from menu (including cultural/religious preferences):

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Alternate Foods

Policy:

Appropriate alternate foods will be prepared and offered at each meal for food preferences, allergies, cultural and religious preference and/or intolerances.

Procedure:

1. Individual food preferences, cultural and religious, 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* (see *Chapter 1: Menus and Therapeutic Diets*) 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 those with allergies or multiple food dislikes.

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System for Recording Food Preferences

Policy:
Food and beverage preference notes must be kept on file, recorded on the meal identification (ID) card/ticket, or kept in a computerized 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.

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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.

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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 or computerized records. If electronic meal intake reporting is used, recording should be completed using electronic format. 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.)

Procedure:
The documentation of a total meal will be based on basic food groups: milk, meat, fruits 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 available 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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.)

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Food Intake Record/Total Meal Percentage Form

		Breakfast						Lunch						PM Snack						Dinner						H.S. Snack							
Rm	Name	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	0 %	25 %	50 %	75 %	100 %	Fluid in mLs	Total Fluid mLs	Comments

0%	- Refused
25%	- Poor
50%	- Fair
75%-100%	- Good

Comments can include meal replacement, preferences, etc.

A = Accepted
R = Refused

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Sample Food Intake Record/Points System Form

Date______________		Breakfast	Fluids	Lunch	Fluids	2:00pm	Fluids	Dinner	Fluids	HS	Fluids
Rm	Name	Points	mLs	Points	mLs	Points	mLs	Points	mLs	Points	mLs

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Food Intake Record

Insert a sample of facility food intake record form here if applicable.

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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, those transitioning from tube feeding to oral feeding, 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 provide the forms to the appropriate 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 document in the medical record accordingly. Specific interventions will be determined based on the medical nutrition therapy assessment or re-assessment and the nutrient intake study.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Food Intake Study Form

Name__________________________ Date________________

	Amount Eaten							For Dietitian		
Food Item and Amount Served	**0**	**25%**	**50%**	**75%**	**100%**	**Fluids mLs**	**Initials**	**Calories**	**Protein**	**Fluids**
Breakfast:										
10:00 AM Snack or Supplement:										
Lunch:										
2:00 PM Snack or Supplement:										
Dinner:										
HS Snack or Supplement:										
Totals										

Instructions:

1. Food 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.

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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 individual has the right to choose substitutions, or to refuse 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/nutrition care manual or other accepted food substitution resources along with the individual's preferences.

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.

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Nutrition Screening for Referrals to the Registered Dietitian Nutritionist

Policy:

Facility staff will screen individuals for nutrition risk upon 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. 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/.

2. The facility will designate responsibility for completing the nutrition screening form. 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 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. And other criteria as determined by a facility's screening tools or protocols (see policy on *Referral to RDN* in this chapter).

5. The RDN, nutrition support staff and/or nurse manager will initiate appropriate interventions, as necessary, for the individual patient/resident. The RDN or designee will complete a comprehensive nutrition assessment and determine appropriate nutrition interventions.

6. The facility staff or RDN or designee should notify the physician in writing, when an individual's nutrition screening indicates malnutrition (MNA® score of 7 or less). The physician should review the information during the next scheduled visit.

   a. 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. In this case, 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 psycho-social issues that increase malnutrition risk for older adults; it does not address inflammation. The MNA can be accessed at http://www.mna-elderly.com/.

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Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Referrals to the Registered Dietitian Nutritionist (RDN)

Policy:
Facility staff will refer high-risk individuals to the RDN for assessment and nutrition intervention 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)
      - 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*, 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Referrals for Registered Dietitian Nutritionist Form (1)

Facility Name:____ **Date:**_______________________

Referral Date	Completed	Room Number	Name	New/ Re-admit	Screened for Referral (MNA® Score of 11 or less)	Physician Ordered Consult	Enteral / Parenteral Feeding	Significant Weight Loss or Gain (or insidious loss)	Pressure Injury or Wound	Dehydration risk	Dialysis or Renal Diet	Terminal Condition	Annual Assessments	Needs Nutrition Education	Fluid Restriction	Desire to Refuse Physician-Ordered Diet	Other	Comments

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Sample Referrals for Registered Dietitian Nutritionist Form (2)

Facility: Name____ **Date:**______________________

Room/Name		New/ Re-admit	MD Consult Order	Significant Weight Loss/Gain	Pressure Injury or Wound	Risk of or Resolving Dehydration	Terminal Condition	Enteral/ Parenteral Feeding	Needs Nutrition Education	Fluid Restriction	Desire to Refuse Diet	Other	Comments

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Sample Letter to Physician

(Letterhead)

Date

Dear Dr. ________________________,

___________________________ (facility name) has adopted the Mini Nutritional Assessment - (MNA®) to screen for malnutrition in the elderly. The MNA® (https://www.mna-elderly.com/forms/mini/mna_mini_english.pdf) 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/resident.

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/resident appropriate nutrition intervention based on the results of the screen and full nutritional assessment. We will also closely monitor their response to medical nutrition therapy.

Our goal is to provide each patient/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)

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Sample Physician Communication Mini Nutritional Assessment® Report for Malnutrition

Facility ______________________________ Physician ____________________________

Room #	Patient Name	Review Date	*MNA Score	Intervention(s)	Physician Initials

*Score of 0-7 indicates patient has triggered ‘Malnourished”

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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 or other clinically qualified nutrition professional, 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 (Academy) Nutrition Care Process of: Nutrition Assessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation. Many health care facilities and RDNs have implemented the Academy's Nutrition Care Process (NCP). The Academy encourages all RDNs and health care facilities 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 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 residents in nursing facilities, a base line care plan that includes the admission diet is completed within 48 hours, and the initial comprehensive 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 residents, the initial comprehensive 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.)

   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

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is re-admitted, has a significant change in condition, and as deemed necessary by federal and state guidelines or the RDN or designee.

MNT re-assessments will be completed according to federal guidelines, at a minimum of quarterly, upon identification of significant change, or at a minimum of yearly intervals.

2. **Person Centered 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 facility must provide the individual and their representative if applicable, a summary of the comprehensive care plan in a language and conveyed in a manner the individual and/or representative can understand. Patients/residents should remain actively engaged in his or her care planning process.

The person centered 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.

    a. 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.).
    b. Specific and measurable goals should be stated to maintain or achieve optimal nutritional status. Goals and approaches (interventions) should be individualized, person centered and should be coordinated with the interdisciplinary team. In consultation with the individual and/or their representative, the individual's goals for admission and desired outcomes, including preference and potential for future discharge, are reflected in the person centered care plan.
    c. The patient/resident has the right to refuse treatment and the care plan should reflect whether or not the individual is in acceptance of the care plan. For example: the individual may refuse to eat three meals a day but prefers to eat two meals and a nourishing mid-morning snack. The person centered care plan should reflect the individual's preference.
    d. Each time a care plan is updated a re-assessment or progress note should be completed or revised as appropriate and the updates conveyed to the individual and/or their representative.

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/representative 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 medical condition, diet order, food intake, and

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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:

- A base-line care plan is competed within 48 hours by nursing staff. This includes the admitting diet order.
- The initiation of the comprehensive nutrition assessment should be completed within 5 days of admission for Medicare 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.

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Resource: Role Delineation (Division of Responsibility for Documentation)

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), dictate role delineation. 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:

- Gathers information for the food preferences and gathers facts for the medical nutrition (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.
- 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.
- 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.
- Communicates and implements the RDN or designee recommendations as appropriate.

The Nutrition and Dietetics Technician Registered (NDTR), Dietetic Technician Registered (DTR), Nutrition Associate, Licensed Dietitian (LD) and/or Registered Dietitian Nutritionist (RDN):

- Completes the MNT assessment and initial care plan, and revises all care plans when additional problems, approaches and goals are added.
- May 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.

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For more information on Role Delineation:

- Individual State Dietetic Licensure or Certification Board.
- Academy of Nutrition and Dietetics. Scope of Practice. http://www.eatrightpro.org/resources/practice/quality-management/scope-of-practice.
- Association of Food and Nutrition Professionals:
  - CDM standards of practice: http://www.anfponline.org/news-resources/standards-of-practice.
  - ANFP Practice Standard: Documenting in the Medical Record: http://www.anfponline.org/docs/default-source/default-document-library/practice-standard-documenting-in-the-medical-record.pdf?sfvrsn=0.
  - CDM Nutrition Care Self-Assessment tool: http://www.anfponline.org/docs/default-source/legacy-docs/docs/self_assessment_tool.pdf?sfvrsn=0.

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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 the comprehensive assessment.

Procedure:

1. An in-depth 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, observations, and individual and family interviews. (*See Resource: Medical Nutrition Therapy Assessment: Components of a Comprehensive Assessment* later in this chapter.)

2. The registered dietitian nutritionist (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 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* earlier in this chapter).

4. Interventions and goals will be developed based on the 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 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

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nutrition issues through additional clinical evaluation and evidence such as food intake, underlying medical condition, etc.

a. 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 malnourished 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).
b. 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 fRDN 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 RDN will develop the specification of the nutrition concern or nutrition diagnosis 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:

1. Academy of Nutrition and Dietetics. Nutrition Terminology Reference Manual (eNCPT): Dietetics Language for Nutrition Care. NCP Step 1: Nutrition Assessment. http://ncpt.webauthor.com/pubs/idnt-en/category-1. Accessed March 1, 2019.
2. Covinsky KE, Covinsky MH, Palmer RM, & Sehgal AR. (2002). Serum albumin concentration and clinical assessments of nutritional status in hospitalized older people: Different sides of different coins? Journal of the American Geriatrics Society, 50(4) 631-637).

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3. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 1, 2019.
4. White JV, Guenter P, Jensen G, Malone A, Schofield M. Academy of Nutrition and Dietetics Malnutrition Work Group, et al. Consensus statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics recommended for the identification and documentation of adult malnutrition (undernutrition). *J Acad Nutr Diet*. 2012;112(5):730–738.

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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.
   i. Usual body weight and comparison of usual body weight to current body weight.

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 *Chapter 9: Anthropometrics* for *Obtaining Accurate Heights* and *Resource: How to Obtain Accurate Heights*.

Weight:
Significant unintended changes in weight (loss or gain) or gradual weight loss. Refer to *Chapter 9: Anthropometrics* for policies/procedures and resources on *Obtaining Accurate Weights*, *How to Obtain Accurate Weights, Adjusting Weights for Amputees, Significant Weight Changes, Tracking Weight Changes, Significant Weight Loss, Significant Weight Gain*.

Biochemical Data, Medical Tests, and Procedures:
a. Lab data, such as electrolytes, laboratory indicators of anemias, 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.

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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 of medications (see below).
   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.

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a. A hypermetabolic state results from an increased demand for energy and protein and may increase the risk of weight loss or malnutrition. 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. Common causes can include stroke, Parkinson's disease, multiple sclerosis, tardive dyskinesia, or other neuromuscular disorders or 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:

1. Academy of Nutrition and Dietetics. Nutrition Terminology Reference Manual (eNCPT): Dietetics Language for Nutrition Care. NCP Step 1: Nutrition Assessment. http://ncpt.webauthor.com/pubs/idnt-en/category-1. Accessed March 1, 2019.
2. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 1, 2019.
3. Bellows R, Moore L. Nutrient-Drug Interactions and Food. Colorado State University Extension. http://extension.colostate.edu/topic-areas/nutrition-food-safety-health/nutrient-drug-interactions-and-food-9-361/. Updated August 8, 2014. Accessed March 1, 2019.

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Resource: Nutrition-Focused Physical Examination/Assessment

Nutrition-focused physical examination (NFPE) or Nutrition focused physical assessment (NFPA) is an emerging area of nutrition and dietetics practice for RDNs and nutrition and dietetics 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. NFPE goes beyond the traditional measurement of height, weight, body fat, arm and calf circumference and is considered an adjunct to traditional nutrition assessment. The NFPE 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 (Academy) and the American Society for Enteral and Parenteral Nutrition (A.S.P.E.N.).

The 2013 Academy *International Dietetics and Nutrition Terminology (IDNT) Reference Manual* defines NFPA as: "findings from an evaluation of body systems, muscle and subcutaneous fat wasting, oral health, suck, swallow/breathe ability, appetite, and affect" (2) More in depth forms of NFPA require training and assessment of competency.

Performing a Nutrition-Focused Physical Assessment

Nutrition-focused physical assessment is a hands-on assessment that uses four steps (1).

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 a physician's order that might indicate ketosis or alcohol use and observing visually for signs of malnutrition or wasting.
2. **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.
3. **Percussion:** Assessment of body sounds to detect gas in the abdomen, fluid in the lungs, or other issues.
4. **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 examinations. However, RDNs can embrace a hands-on approach and incorporate NFPE 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 NFPE, 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

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quality outcomes in the delivery of food and nutrition services" (6). This applies to all areas of nutrition and dietetics practice including the NFPE.

It is imperative for RDNs who plan to conduct NFPE 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 NFPE (1,3,7)

Physical Appearance	**Nerves and Cognition**
• Body size • Body type • Appearance of wasting or obesity • Level of consciousness • Paralysis or involuntary movement • Amputations or contractures • Affect • Condition of hair and nails	• Ability to communicate • Cognitive status • Reflexes • Ability to feel pain in extremities • Gross and fine motor skills
Vital Signs • Blood pressure • Heart rate • Oxygen saturation/respiratory rate • Temperature	**Extremities, Muscles, and Bones** • Hand grip strength • Range of motion • Subcutaneous fat • Muscle mass • Edema • Ability to stand and walk
Skin • Skin turgor • Skin color • Presence of surgical wounds, pressure injuries, stasis ulcers, or diabetic foot ulcers • Poor or delayed wound healing	**HEENT (Head, Eyes, Ears, Nose, and Throat)** • Ability to smell and taste • Loss of orbital (around the eye), buccal (around the cheeks), facial fat • Vision and hearing • Chewing or swallowing problems
Digestive System • Condition of teeth, presence of dentures and/or partials • Condition of oral cavity and tongue • Inflamed or bleeding gums • Bowel sounds • Abdominal pain	**The Cardiopulmonary System** • Ability to breathe • Breath sounds • Regular heart rhythm

References for NFPE/NFPA

1. Furhman MP. Nutrition-Focused Physical Assessment. In Charney P, Malone AM. ADA Pocket Guide to Nutrition Assessment, 2nd ed. Chicago IL: American Dietetic Association, 2009;40-61.

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2. Academy of Nutrition and Dietetics. Nutrition Terminology Reference Manual (eNCPT): Dietetics Language for Nutrition Care. http://ncpt.webauthor.com. Accessed March 1, 2019.
3. Litchford MD. Nutrition Focused Physical Assessment: Making Clinical Connections. Greensboro, NC: Case Software; 2012.
4. Litchford MD. *Common Denominators of Declining Nutritional Status*. CASE Software and Books: Greensboro, NC; 2013.
5. National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide. Emily Haesler (Ed.). Cambridge Media: Osborne Park, Western Australia; 2014.
6. Academy of Nutrition and Dietetics: Scope of Practice for the Registered Dietitian. *J Acad Nutr Diet*. 2013;Suppl 2(1):S17-S28.
7. Mordarski B, Wolff J, Nutrition Focused Physical Exam Pocket Guide.2nd ed. Chicago, IL: Academy of Nutrition and Dietetics; 2018.

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Comprehensive Care Plan

Policy:

The facility will develop a comprehensive person centered 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 (IDT) 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 person centered, which involves the individual and their representative if applicable, and multiple disciplines. "I" care plans are totally focused on the wants, needs, and desires of the individual 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. For example: the individual may refuse to eat three meals a day but prefers to eat two meals and a nourishing mid-morning snack. The person centered care plan should reflect the individual's preference.
   b. The care plan reflects an individual's choices including tube feedings, 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.

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- When preferences are not specified beforehand, decisions related to the possible provision of supplemental or artificial nutrition should be made in conjunction with the individual or individual's representative in accordance with state law. This decision should take into account relevant considerations such as the individual's condition, prognosis, and known values and choices.

5. A variety of interventions should be used to meet the individuals' nutritional needs and patient's/resident's rights 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, and 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 recognizing 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 the care plan should be modified 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 palliative care).

References for Comprehensive Care Plan:

1. Litchford M. *MDS 3.0 & Nutrition Care Plans*. St. Charles IL: Dietary Managers Association; 2011.
2. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-

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Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 1, 2019.

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:

- Dorner B. *Diet and Nutrition Care Manual: Comprehensive Edition*. Becky Dorner & Associates, Inc. Dunedin, FL. 2019.
- Dorner B. *End of Life Nutrition and Hydration: Comprehensive Nutrition Assessment and Intervention for Older Adults*. Becky Dorner & Associates, Inc. Naples, FL. 2016.

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Resource: Weight-Related Nutrition Interventions

Usual Body Weight
For many individuals (including overweight individuals), usual body weight prior to decline or admission rather than ideal body weight (IBW) is the most relevant basis for weight-related interventions.
- Basing interventions on IBW can be misleading, because IBW has not been definitively established for the frail elderly and those with chronic illnesses and disabilities.

Care Plan and Care Area Assessment (CAA)
The care plan includes nutrition interventions that address underlying risks and causes of unplanned weight loss (e.g., the need for eating assistance, reduction of medication side effects, and additional food that the individual will eat) or unplanned weight gain.
- It is important that the care plan address insidious, abrupt, or sudden decline in intake or insidious weight loss that does not trigger review of Care Area Assessment (CAA); for example, by intensifying observation of intake and eating patterns, monitoring for complications related to poor intake, and seeking underlying cause(s).
- Many risk factors and some causes of weight loss can be addressed, at least partially, while others may not be modifiable. In some cases, certain interventions may not be indicated or appropriate, based on individual goals and prognosis.
- Weight stability, rather than weight gain, may sometimes be the most pertinent short-term or long-term objective for the nutritionally at-risk or compromised individual. After an acute illness or as part of an advanced or end-stage medical condition, the individual's weight and other nutrition parameters may not return to previous levels and may stabilize at a lower level, sometimes indefinitely.

  Note: There should be a documented clinical basis for any conclusion that nutrition status or significant weight change are unlikely to stabilize or improve (e.g., physician's documentation as to why weight loss is medically unavoidable).

Environmental Factors
Appetite is often enhanced by the appealing aroma, flavor, form, and appearance of food. Practices that may help improve intake include providing a pleasant dining experience (e.g., flexible dining environments, styles and schedules), providing meals that are palatable, attractive and nutritious (e.g., preparing 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.

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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

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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:

1. Food, Eating, and Alzheimer's. Alzheimer's Association. https://www.alz.org/care/alzheimers-food-eating.asp. Accessed March 1, 2019.
2. Pioneer Network New Dining Practice Standards. Pioneer Network Food and Dining Clinical Standards Task Force. 2011. https://www.pioneernetwork.net/wp-content/uploads/2016/10/The-New-Dining-Practice-Standards.pdf. Accessed March 1, 2019.
3. Loeb MB, BeckerM, Eady A, et al. Interventions to prevent aspiration pneumonia in older adults: A systematic review. Jour Amer Geriatr Soc. 2003; 51(7), 1018-1022.
4. Russell MK. Complications of enteral feedings. in Charney P, Malone A. *Pocket Guide to Enteral Nutrition*. 2nd ed. Chicago IL: Academy of Nutrition and Dietetics; 2013.
5. Dorner B. Diet and Nutrition Care Manual. Becky Dorner & Associates, Inc. Naples, FL. 2016.
6. Campbell-Taylor I. Oropharyngeal dysphagia in long-term care: Misperceptions of treatment efficacy. *J Am Med Dir Assoc. 2008; 9*: 523–531.
7. Thomas D R Hard to swallow: management of dysphagia in nursing home residents. *J Am Med Dir Assoc. 2008; 9*, 455–457.
8. Pronsky ZM, Elbe D, Ayoob K. *Food-medication interactions*. 18th ed. Birchrunville, PA:. Food Medications Interactions; 2015.

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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 or electronic documentation procedures.

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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 in a timely manner.

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. The physician may delegate order-writing privileges to the RDN 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 the physician. (Also see *Order Writing Privileges* policy and procedure at the end of this chapter.)

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Nutrition Recommendations Form

Facility: **Wing:**

Please complete and return to registered dietitian nutritionist or designee. Thank You!

Name________________________ Room__________ New____ Re-admit____ Update___

Food and Nutrition Service	Nursing	Physician Please Consider
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Comments:	**Comments:**	
Manager's Signature/Date:	Nursing Signature/Date:	

Name__________________________ Room__________ New____ Re-admit____ Update___

Food and Nutrition Service	Nursing	Physician Please Consider
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Comments:	**Comments:**	
Manager's Signature/Date:	Nursing Signature/Date:	

Name__________________________ Room__________ New____ Re-admit____ Update___

Food and Nutrition Service	Nursing	Physician Please Consider
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Comments:	**Comments:**	
Manager's Signature/Date:	Nursing Signature/Date:	

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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, and as appropriate to their scope of practice.
   b. Nutrition support staff will follow up on communications as needed and serve as a liaison between the RDN and the IDT as needed when the RDN is not readily available.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Order Writing Privileges for Clinically Qualified Nutrition Professional

Policy:

Consistent with F808 §483.30 in long term care and A-0630 §482.28 in hospitals, a patient's/resident's attending physician may delegate the task of writing dietary orders, including a therapeutic diet, 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 the physician.
- The licensee shall adhere to acceptable standards for that licensee's area of practice and be designated to deliver services as approved by their facility.
- The authority and privilege to practice within the scope shall be consistent with the standards of practice of the Academy of Nutrition and Dietetics and other regulatory agencies such as, but not limited to, the Centers for Medicare and Medicaid Services (CMS) guidelines as published in the Federal Register.

Procedure:

1. The licensee shall adhere to acceptable standards for that licensee's area of practice and be designated to deliver services as approved by their facility.
2. The authority and privilege to practice within the scope shall be consistent with the standards of practice of the Academy of Nutrition and Dietetics and other regulatory agencies such as, but not limited to, the Centers for Medicare and Medicaid Services (CMS) guidelines as published in the Federal Register.
3. The physician must supervise the dietitian and remains responsible for the patient's/resident's care even if the task is delegated.
4. The physician is able to modify a diet order with a subsequent order, if necessary.

References:

- Federal Register. Vol. 79, No. 91. Monday, May 12, 2014. Rules and Regulations: Hospital Rules. https://www.gpo.gov/fdsys/pkg/FR-2014-05-12/pdf/2014-10687.pdf. Accessed March 1, 2019.
- Federal Register. Vol. 81, No. 192. Tuesday, October 4, 2016. Rules and Regulations. Medicare and Medicaid Programs; Reform of Requirements for Long- Term Care Facilities. https://www.gpo.gov/fdsys/pkg/FR-2016-10-04/pdf/2016-23503.pdf. Accessed March 1, 2019.
- State Operations Manual. Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Rev. 183, 10-12-18. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf. Accessed March 1, 2019.
- State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table. Rev. 173, 11-22-17. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf. Accessed March 1, 2019.

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Resources:

- PRACTICE TIPS: Hospital Regulation. https://www.eatrightpro.org/-/media/eatrightpro-files/advocacy/practicetipshospitalregulationorderingprivilegesfortherdn.pdf?la=en&hash=39ED49F34AF49C619BC9B521A0308A0F6B0C1894.
- PRACTICE TIPS: Implementation Steps – Ordering Privileges for the RDN. Academy of Nutrition and Dietetics. https://www.eatrightpro.org/-/media/eatrightpro-files/advocacy/practicetipsimplementationstepsorderingprivilegesfortherdn.pdf?la=en&hash=D5EA65A10486EA214BC471B51B57436318DEC036.
- PRACTICE TIPS: Reform Requirements for RDNs and NDTRs in Long Term Care Facilities. https://www.eatrightpro.org/-/media/eatrightpro-files/practice/quality-management/quality-care-basics/practicetips-reformrequirementsltcfacilities.pdf?la=en&hash=EE376133A1F892FB89FF682D3BC49ADD80FDC3D0.

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Sample Order Writing Privileges for Clinically Qualified Nutrition Professional Policy and Procedure Approval Form

By delegation of the attending physician, the clinically qualified nutrition professional, including the registered dietitian nutritionist (RDN) or licensed dietitian, may order, clarify, and or change diet orders.

This includes general diets, therapeutic diets, mechanically altered diets, fortified foods, oral nutrition supplements, and enteral nutrition.

The delegating physician remains responsible for the patient's/resident's care and may modify a diet order with a subsequent order.

Title	Signature	Date
Medical Director		
Attending Physician		
Administrator		
Director of Nursing		
Clinically Qualified Nutrition Professional		

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Chapter 9: Anthropometrics

- Obtaining Accurate Heights 9-1
- Resource: How to Obtain Accurate Heights 9-1
- Obtaining Accurate Weights 9-2
- Resource: How to Obtain Accurate Weights 9-3
- Resource: Height/Weight Tables for Determining Body Weight Ranges 9-4
- Adjusting Weights for Amputees 9-5
- Measurements for Those Who Cannot be Weighed 9-6
- Sample Measurements Tracking for Individuals Who Cannot be Weighed Form 9-8
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- Sample Weight Change Notification and Recommendations Form 9-17
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- Immediate Temporary Interventions for Unintended Significant Weight Loss 9-19
- Significant Weight Loss 9-20
- Significant Weight Gain 9-23

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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 remeasured each year or upon a significant change such as double amputation.

Procedure:

1. Nursing will be responsible for the initial determination of each individual's height. This will be included in the initial nursing assessment and/or admission note, Minimum Data Set/ Resident Assessment Instrument (MDS/RAI) for skilled nursing facilities, initial medical nutrition therapy (MNT) assessment, and in a designated location in the electronic medical record.

2. Nursing will re-measure each individual's height annually or with significant changes such as a double amputation. Annual height will be documented as outlined above.

3. Staff will follow acceptable procedure to obtain accurate heights.

Resource: How 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 head, using the yardstick as a guide.
  - Measure from the floor to the mark (where the top of the 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 what the individual's normal height was (family may need to help with this answer).
- Document that the height was verbally provided, and the reason it was not possible to obtain an accurate height on the individual.

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Obtaining Accurate Weights

Policy:
Each individual's weight will be obtained and documented upon admission to the facility.

Procedure:
1. Nursing will be responsible for obtaining each individual's initial weight. This will be included in the initial nursing assessment and/or admission note, Minimum Data Set/ Resident Assessment Instrument (MDS/RAI) for skilled nursing facilities and in the medical nutrition therapy (MNT) assessment. Initial and subsequent measurements for weight will also be documented on the appropriate designated form or tracked in the electronic medical record and/or computer database.

2. In nursing facilities, weights 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 weight measurements.

3. The registered dietitian nutritionist (RDN) or designee will be responsible for determining the desirable weight range or usual body weight range. This will be documented on the initial MNT assessment and reassessments.

4. Staff will follow acceptable procedure to obtain accurate weights.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Resource: How to Obtain Accurate Weights

Follow these best practices:

- Balance the scale back to 0 before and after weighing each time.
- If possible, the scale should remain stationary and not be moved.
- Record the weight immediately after weighing using the documentation system provided by the facility.
- Weigh each individual at the same time each month, and at approximately the same time of day each time a weight is taken.
- 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.

Wheelchair Scale Weights

- Be sure the chair is free of extra weight (i.e. side bags, catheter bags, cushions or other items).
- Roll the wheelchair onto the wheelchair scale platform. Center the wheelchair on the scale.
- Weigh the wheelchair and record the total weight of the wheelchair and the individual.
- Remove the individual from the wheelchair. Weigh the wheelchair by itself.
- Carefully subtract the weight of the wheelchair and record the actual weight.
- Balance the scale back to 0 before and after weighing each time.

Bed Scale Weights

- Follow the 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.

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Obtaining Measurements for Individuals who Cannot be Weighed

- For those 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.
- 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.

Resource: Height/Weight Tables for Determining Body Weight Ranges

Adult Ideal Weight Ranges 51 + Years

Females:

Height	Weight Range	Mean Weight
4'8"	81-99	90
4'9"	83.5-102	92.5
4'10"	85-105	95
4'11"	87.5-107	97.5
5'0"	90-110	100
5'1"	94-116	105
5'2"	99-121	110
5'3"	104-127	115
5'4"	108-132	120
5'5"	112-138	125
5'6"	117-143	130
5'7"	121-149	135
5'8"	126-154	140
5'9"	130-160	145
5'10"	135-165	150

Males:

Height	Weight Range	Mean Weight
5'0"	95-117	106
5'1"	100-123	112
5'2"	106-130	118
5'3"	111-136	124
5'4"	117-143	130
5'5"	122-150	136
5'6"	127-156	142
5'7"	133-163	148
5'8"	139-169	154
5'9"	144-176	160
5'10"	149-183	166
5'11"	154-189	172
6'0"	160-196	178
6'1"	166-202	184
6'2"	171-209	190

This chart is based on the following formula:

Female:
100 pounds for the first five feet of height plus five pounds for each inch over five feet of height; minus 2½ pounds for every inch under five feet of height; plus or minus 10% to give the range.

Male:
106 pounds for the first five feet of height plus six pounds for each inch over five feet of height; minus 2½ pounds for every inch under five feet of height; plus or minus 10% to give the range.

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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* earlier in this chapter.)

Average Weight Percentage of Body Segments	
Foot	1.5%
Lower Arm and Hand	2.3%
Entire Arm and Hand	5.0%
Lower Leg and Foot	5.9%
Entire Leg	16%

Procedure:

1. Using the *Height/Weight Tables for Determining Body Weight Ranges* to determine the individual's normal IBW for height.

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#

References:

1. Lefton JC. Anthropometric measurements. In: Charney P, Malone A. Academy of Nutrition and Dietetics Pocket Guide to Nutrition Assessment. Chicago IL: Academy of Nutrition and Dietetics. 2016;50-75.
2. Elliot CH, ed. Dietetics in Health Care Communities Pocket Resource for Nutrition Assessment, 2017 edition. Chicago IL: Academy of Nutrition and Dietetics; 2017.

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Measurements for Those Who Cannot 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.

- Methods to be used: mid-arm circumference, mid-thigh circumference, mid-calf circumference, waist/abdominal (girth) circumference (https://www.nhlbi.nih.gov/health-pro/guidelines/current/obesity-guidelines/e_textbook/txgd/4142.htm and https://www.nhlbi.nih.gov/health/educational/lose_wt/risk.htm).

Procedure:
Procedure for Mid-Arm Circumference

- Using a tape measure find the mid-point of the 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 Waist (Abdominal) 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 remeasured for accuracy.
- For accuracy and reliability each measurement should be taken three times, yielding similar readings, measurements should be taken by two separate professionals and 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.

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- The registered dietitian nutritionist (RDN) or designee will review these measurements monthly and assess the need for changes in medical nutrition therapy (MNT).

Reference:
Mitchell CO. Nutritional Assessment of Elderly Adults. In: Chernoff R, ed. *Geriatric Nutrition: The Health Professional's Handbook.* 4th ed. Burlington MA: Jones and Bartlett Learning: 2014:449-451.

See *Sample Measurement Tracking for Individuals Who Cannot Be Weighed Form* next page.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Measurements Tracking for Individuals Who Cannot be Weighed Form

Body Measurements

Date	Waist / Abdominal Circumference*	Arm (Mid-Point)		Mid-Thigh (Mid-Point)		Mid-Calf (Widest Point)	
		R	LT	R	LT	R	LT

*Measure waist/abdominal girth just above the bony crease of the hip. Measure upper arm, calf and thigh at the midpoint.

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Determining Body Mass Index

Policy:
All individuals will be assessed for indicators of nutritional 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 injuries, infection and other complications. A BMI of 19 or less may indicate nutritional depletion, while a BMI of 30 or above indicates obesity.

Classification	BMI (kg/m^2)	
	Principal cut-off points	**Additional cut-off points**
Underweight	**<18.50**	**<18.50**
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
Normal range	**18.50 - 24.99**	**18.50 - 22.99**
		23.00 - 24.99
Overweight	**≥25.00**	**≥25.00**
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
Obese	**≥30.00**	**≥30.00**
Obese class I	30.00 – 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

Source: World Health Organization. http://www.assessmentpsychology.com/icbmi.htm. Accessed November 27, 2018.

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). In some instances, computer programs utilized by the RDN or designee will calculate the BMI automatically when weights and heights are recorded.

BMI = weight (kg)/height (meters squared)

Current weight in kilograms divided by the square of the height in meters

OR

BMI = weight (lbs.)/height (inches squared) x 705

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3. The RDN or designee will provide appropriate nutrition 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:

Neidert K, ed. *Nutrition Care of the Older Adult: A Handbook for Nutrition Throughout the Continuum of Care*. 3rd. ed. Chicago IL: Academy of Nutrition and Dietetics;2016:80-81.

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Resource: Significant Weight Change

Significant and severe weight change is defined as follows:

Time Interval	Significant Change	Severe Change
1 Week	1-2%	Greater than 1-2%
1 Month	5%	Greater than 5%
3 Months	7.5%	Greater than 7.5%
6 Months	10%	Greater than 10%

Weights should be monitored monthly for significant/severe change and documented accordingly. If the weight is in question, first ask appropriate staff to obtain a reweight 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* found later in this chapter.

To calculate significant weight change, use the following formula:

$$\frac{\text{Recent body weight} - \text{current body weight}}{\text{Recent body weight}} \times 100 = \text{percent weight change}$$

Example:
Weight January 1 was 152 pounds
Weight February 1 was 142.5 pounds

152 – 142.5 = 9.5 pounds

9.5 ÷ 152 = 0.0625

0.0625 x 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.

Also refer to the *Resource: Significant Weight Change Chart* at https://www.beckydorner.com/wp-content/uploads/2018/04/ResourceSignificantWeightChange-3033.pdf.

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Tracking Weight Changes

Policy:

Weights will be documented for all individuals, for the purpose of assessing significant and gradual weight changes.

Procedure:

1. The facility will be responsible for obtaining accurate weights on a regular basis, and for keeping accurate records. This includes having adequate weight scales, bed scales, lift scales, and/or wheelchair 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 or designee. 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 gradual (insidious) 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 plan 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 gradual 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Monthly Weight Record Form

Monthly Weight Record for ___________ Year **Facility/Wing ______________________**

Room	Name	Ht	UBW	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Ht = Height UBW = Usual body weight

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Sample Individual Weight Chart Form

Name ____________________________ Ht _________ UBW _______ Year _________

Time Interval	Significant Change	Severe Change
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

Month/ Date	Weight	% Wt. Change Past Month	% Wt. Change Past 3 Months	% Wt. Change Past 6 Months	Date Resident, Family, RD & Physician Notified	Comments
Jan						
Feb						
Mar						
April						
May						
June						
July						
Aug						
Sept						
Oct						
Nov						
Dec						

UBW = Usual body weight

Formula to determine weight loss:
Percentage Weight Change = Previous Weight - Current Weight ÷ Previous Weight x 100

Circle % weight change if significant or severe.

Comments should reflect identified causes and/or interventions implemented for significant weight loss or gain.

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Sample Weekly Weight Record Form

Room	Name	Previous Weight	Date	Wt	Date	Wt	Date	Wt	Date	Wt	Date	Wt	Date	Wt	Date	Wt	Date

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Sample Significant Weight Changes Form

Facility__________________ Wing_______ Monthly / Quarterly / Six Month (*Circle Choice)* Month/Year____________

Room No.	Name	Previous Month Weight	Present Month Weight	↑ ↓ % Gain or Loss	Re-weigh Required	Re-weigh Weight/ Date	Notified			Comments
							MD	Family	RDN	

+ For significant weight gain of greater than or equal to 5%
- For significant weight loss of greater than or equal to 5%

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Sample Weight Change Notification and Recommendations Form*

Patient/Resident Name ________________________________ Date ________________

Physician ____ Room ID_____________

Significant Weight Change	Recommendations

Thank you,

(Signature/credentials) ______________________________________

Physician's Response Yes No

New Order ____

Physician Signature ____ Date _________________

Signature of Nurse Accepting Order ____________________________ Date __________________

□ IDT Notified Yes No Date _______________
Notes ____

□ Family Notified Yes No Date ________________
Notes ____

□ 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.

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Sample Significant Weight Loss Form

Name____

Weight loss _____% loss in _____ months   Clinically Unavoidable Yes No

Interventions attempted to address weight loss ____
____
____

Identified Concerns

- ☐ Inadequate food/fluid intake: ____
- ☐ End-stage disease state: ____
- ☐ Increased nutritional needs associated with pressure injuries, burns, fractures or surgery: ____
- ☐ Prolonged nausea, vomiting or diarrhea not relieved by treatment provided
- ☐ Radiation or Chemotherapy
- ☐ Medications with weight loss implications
- ☐ Other: ____

Food/Nutrition Services Notes	Nursing Notes	Social Service Notes	Physician Notes

_______________________________________   ________________
RDN Signature   Date

_______________________________________   ________________
RN Signature   Date

_______________________________________   ________________
SS Signature   Date

_______________________________________   ________________
Physician Signature   Date

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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 the individual 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 2% or whole milk or foods made with 2% or whole milk (pudding, yogurt, milkshakes, cream soups), fortified foods, or extra portions as appropriate.

3. Food and nutrition services will be notified using facility procedures (communication form or electronic communication as appropriate) to request this temporary intervention.

4. Food and nutrition services staff will change the temporary intervention if they are not appropriate for the individual. For example, if the individual is lactose intolerant or has milk allergy but a milk-based nourishment or supplement has been ordered, the registered dietitian nutritionist or designees (nutrition support staff) have the authority to change this to an appropriate intervention based on information regarding allergies, intolerances, and food and beverage preferences.

5. The 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Policy & Procedure Manual

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 (IDT) will:

1. Identify individuals with significant/severe weight losses.

Significant Weight Loss	Severe Weight Loss
5% weight loss in 1 month	>5% weight loss in 1 month
7.5% weight loss in 3 months	>7.5% weight loss in 3 months
10% weight loss in 6 months	>10% weight loss in 6 months

   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 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 malnutrition and 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 and alter interventions as needed.
   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 or expected (such as resolution of severe edema), and document accordingly.

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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 nutritional snacks between meals or six small meals per day
   - Calorie boosters (i.e. extra margarine, mayonnaise, gravy, etc.)
   - Protein boosters (i.e. whole milk, half & half or cream, pudding, ice cream, milk shakes)
   - Enhanced/fortified foods (high calorie/high protein)
   - Brightly colored napkins on tray to signify that the 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 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/representative'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 if this is what the individual/representative wants. Continue to encourage oral feeding if nutrition support is not desired.
n. If the individual is to be provided comfort care, 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.

Definitions:

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.

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Usual body weight is the individual's usual weight through adult life or a stable weight over time.

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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 (IDT) will:

1. Identify individuals with significant/severe weight gain.

Significant Weight Gain	Severe Weight Gain
5% weight gain in 1 month	>5% weight gain in 1 month
7.5% weight gain in 3 months	>7.5% weight gain in 3 months
10% weight gain in 6 months	>10% weight gain in 6 months

   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 the 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 outcomes 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 patient/resident enjoy food and get pleasure from eating? Is the patient/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, wheelchair 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.

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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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Policy & Procedure Manual

Chapter 10: Nutrition Interventions

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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 dietetics technician, registered NDTR), registered dietitian nutritionist (RDN), director of nursing (DON), charge nurses, and/or restorative nurse 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 patients/residents.

3. The RDN or designee will provide the list of individuals to be discussed at the meeting to the appropriate committee members. This list can include but is not limited to:
   a. New:
      - Admissions/readmissions for 4 weeks or until the committee discontinues weekly weights
      - Tube feeding for the first 4 weeks on tube feeding or new formula changes in the first 4 weeks; or those transitioning from tube feeding to oral feeding with recent decreases in tube feeding orders to promote increased oral intake
   b. Individuals identified as being at risk or having:
      - Malnutrition
      - Significant unintended weight changes, or insidious weight loss, until stable
      - Pressure injuries
      - Fluid imbalance (i.e. dehydration, overhydration)
      - Fecal impaction
      - Less than 50% food intake for 3 days (9 consecutive meals), until intake is stable
   c. Individuals on:
      - Parenteral nutrition
      - Dialysis
      - Thickened liquids
      - Fluid restrictions

4. Each committee member will review the patient's/resident'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 hard copy of the medical record and/or electronic record will be available during the meeting.

5. Clinical documentation in the medical record will be completed according to the results of the IDT's decisions.

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Interventions for Unintended Weight Loss

Policy:

Unintended weight loss or gradual weight loss will be identified and monitored so that appropriate and individualized intervention can be implemented.

Procedure:

1. Patients/residents 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. Weekly weights may be ordered 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. 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., terminal illness, under 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 patient/resident 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 *Chapter 9: Anthropometrics* for *Obtaining Accurate Weights*.)

Based on the definition of resident's rights in the CMS federal nursing home requirement, the resident has the right to decline being weighed or may request to discontinue weights. To meet the requirement of ξ483.10(c)(5), the resident must be provided with the necessary information i.e. risks related to the discontinuation of weights, to make an informed decision and the resident's medical record should contain appropriate documentation of this process.

Note: The last weight obtained in the hospital may differ markedly from the initial weight upon admission to a nursing facility and is not to be used in lieu of actually weighing the individual.

Source:

Center for Medicare & Medicaid Services. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 1, 2019.

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Resource: Potential Interventions for Unintended Weight Loss in Older Adults

Individualized Diets

Research suggests that an individualized nutrition approach can enhance the quality of life and nutritional status of older adults in healthcare facilities (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 for tolerance (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 malnourished or at-risk individuals. When a poor intake or weight loss is observed, the interdisciplinary team (IDT) may temporarily remove dietary restrictions and individualize the diet to improve food intake to try to stabilize 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. Serving a therapeutic diet against the resident's wishes is a violation of a resident's rights.

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 the individual'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

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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.

Details on identification and treatment of unintended weight loss, high calorie/protein diet, calorie and protein boosters, and more are available in Becky Dorner & Associate's 2019 *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide, which is available at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.*

Note: There are many other Policies and Procedures and Resources in this manual that can help to address unintended weight loss.

References:

1. Position of the Academy of Nutrition and Dietetics: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post Acute Care, and other Settings. J.Acd.Nutr Dietetics.2018:118(4);724-734.
2. Pioneer Network New Dining Practice Standards. Pioneer Network Food and Dining Clinical Standards Task Force. August 2011. https://www.pioneernetwork.net/wp-content/uploads/2016/10/The-New-Dining-Practice-Standards.pdf. Accessed March 1, 2019.
3. Wilson M-M G, Purushothaman R, & Morley J E. Effect of liquid dietary supplements on energy intake in the elderly. *The American Journal of Clinical Nutrition*. 2002: 75(5): 944-947.
4. Thomas D.R. Guidelines for the use of orexigenic drugs in long-term care. *Nutrition in Clinical Practice*. 2006: 21(1) 82-87.
5. Sampson EL, Jones CB. Enteral tube feeding for older people with advanced dementia. *Cochrane Database Syst Rev*. 2009: CD007209. doi:10.1002/14651858.CD007209.pub2.

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High Calorie/High Protein Supplements

Policy:

Individuals needing supplemental nutrition 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. 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 requirements. Medical foods are for oral or enteral feeding and are intended to be used under medical supervision (1).

Source:

Medical Foods Guidance and Regulatory Information. U.S. Food and Drug Administration Web site. http://www.fda.gov/food/guidanceregulation/guidancedocumentsregulatoryinformation/medicalfoods/default.htm. Accessed March 1, 2019.

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Supplement Formulary

Insert facility formulary here.

Sources for oral nutritional supplements:

- Abbott Nutrition, (800) 227-5767, www.abbottnutrition.com
- Hormel Health Labs, (800) 523-4635, www.hormelhealthlabs.com
- Lyons Magnus, (800) 634-2345 (east), (800) 344-7130 (west), www.lyonsmagnus.com
- Nestle Clinical Nutrition, (800) 422-2752, www.nestleclinicalnutrition.com
- Nutricia North American, (800) 365-7354, http://www.nutricia-na.com/

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Dehydration

Policy:
Individuals at risk for dehydration will be identified 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 and/or clinical signs of dehydration will be identified through routine nursing assessment.

2. Adequate fluids should be offered based on a comprehensive nutrition assessment of factors affecting fluid needs and fluid intake.

3. Fluids should be provided based on each individual's beverage preferences and physician's orders for fluid consistency.
   - Fluids include milk, juice, coffee, tea, water, milkshakes, popsicles, ice cream, sherbet, gelatin, and soups.
   - Foods contain fluids which may also be included as part of the total daily fluid intake.
   - All individuals will have a water container at bedside (excluding those on fluid restrictions).
   - If thickened liquids have been ordered, fluids will be provided that are thickened to the consistency ordered.

4. If fluids intake is not adequate to meet needs, an IV or enteral feeding tube may be recommended. If IV fluids or tube feeding is initiated, adequate fluids will be provided. The registered dietitian nutritionist (RDN) or designee should determine and/or assess IV or enteral feeding/flush orders, and evaluate per facility policy and as needed.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Resource:
Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019. A*vailable at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.*

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Fluids at the Bedside

Policy:
All patient/residents 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 will be followed.

4. If disposable water containers are used, they should be replaced daily.

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Encourage Fluids Order

Policy:
When the physician orders “encourage fluids” 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 patient/resident’s nutrition assessment.

2. If the physician orders “encourage fluids” and the individual is not able to tolerate 1500 to 2000 mL per 24 hours, the physician will be notified.

3. 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, at each nursing contact, and other times throughout the day as needed to maximize fluid intake.

4. Fluids will be provided at the appropriate consistency per physician’s orders.

Note: See *Resource: Sample Distribution of Fluids* on the next page.

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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

Fluid Restriction	Nursing Total, mL	By Shift, mL			Food Service Total, mL	Breakfast, mL	Lunch, mL	Dinner, mL
		1st	2nd	3rd				
1000 ml	160	80	80	0	840	360	240	240
1100 ml	260	130	130	0	840	360	240	240
1200 ml	360	120	120	120	840	360	240	240
1300 ml	460	150	150	160	840	360	240	240
1400 ml	560	190	190	180	840	360	240	240
1500 ml	660	220	220	220	840	360	240	240
1600 ml	760	260	260	240	840	360	240	240
1700 ml	860	290	290	280	840	360	240	240
1800 ml	960	320	320	320	840	360	240	240
1900 ml	1060	360	360	340	840	360	240	240
2000 ml	1160	390	390	380	840	360	240	240

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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 patient/resident 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 (at minimum) all stage 3, 4 and unstageable pressure injuries and provide appropriate medical nutrition therapy (MNT).

3. The MNT assessment 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 patient/resident, family, caregiver, and/or staff for food and beverage preferences and food intolerances.

4. Based on information gathered, 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 at meals and snacks 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).

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e. Fortified foods and/or oral nutrition supplements if needed.
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 care team (IDT) may wish to recommend nutrition support.

5. Nutrition interventions will be implemented using facility protocols. The RDN or designee will educate and counsel the patient/resident and/or family as appropriate on nutritional needs related to the pressure injury.

6. A progress note will be written in the medical record indicating the care plan with a timeframe for follow-up based on condition and clinical judgement. The care plan will be changed to reflect interventions to prevent pressure injuries or to support wound healing.

   The RDN or designee will review effectiveness of nutrition interventions and adjust interventions as needed, and will continue to monitor those with a history of pressure injury based on changes in status, concerns reported by staff, and clinical judgement.

   For those at risk for pressure injury:
   a. If the skin remains intact, additional nutrition intervention may not be necessary. Assess/review again based on condition and clinical judgement.

   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 based on condition and clinical judgement.
   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 as appropriate.
   c. If the pressure injury is healed, additional nutritional intervention may not be necessary, or interventions may be discontinued if they are no longer deemed necessary. Adjust the care plan as needed.

References/Resources:

1. National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed). Cambridge Media: Perth, Australia; 2014.
2. Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019.
3. Posthauer ME, Banks M, Dorner B, Schols MGA, The Role of Nutrition for Pressure Injury Management: National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel, and Pan Pacific pressure Injury Alliance White Paper, Advance in Skin and Wound Care, 2015; 28(4): 175-188.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Individuals on Unsupplemented Clear Liquids or NPO

Policy:
All patients/residents 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 patients/residents 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 for longer than three (3) days, and assess their nutritional status.

3. The RDN or designee will document assessment of nutrition status in the medical record including recommendations for addressing nutrition status. Recommendations 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Dysphagia

Policy:
Individuals experiencing swallowing difficulties will be evaluated to determine the cause and possible interventions for dysphagia. Interventions should be consistent with their medical condition, goals, and preferences.

Procedure:
1. Individuals showing warning signs of dysphagia will be screened using a validated tool such as EAT 10: A Swallowing Screening Tool. Those 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 the physician after the evaluation and with input from the patient/resident.

2. The director of food and nutrition services will:
   a. Follow written orders for diet texture and fluid consistency and provide adaptive feeding devices as ordered.
   b. Educate staff and supervise preparation of altered consistency diets.
   c. Communicate concerns with tolerance or acceptance of food and/or fluid consistencies.

3. The nursing staff will:
   a. Assure appropriate communication of referrals and recommendations to the physician.
   b. Assure that the appropriate diet order is obtained from the physician or designee and communicated to the food and nutrition services department.
   c. Follow written diet orders and provide meal time supervision to assure orders are followed and suggested feeding techniques are being practiced.
   d. Communicate concerns to the registered dietitian nutritionist (RDN) or designee, SLP and/or director of food and nutrition services as appropriate.

4. The SLP 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.

5. The RDN or designee will:
   a. Follow the physician's and SLP's orders for diet modification.
   b. Educate the patient/resident on the risks and benefits of altered diet and respect their wishes to decline interventions as their right to select their preferred type of care.
   c. Monitor tolerance and acceptance of the ordered diet and notify the appropriate discipline(s) (i.e. nursing, social service, SLP) of swallowing problems.
   d. Evaluate the need for diet changes or alternate feeding methods and make appropriate recommendations and referrals.
   e. 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Resource: Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019. A*vailable at* https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.

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Eat-10 Swallowing Screening Tool

EAT-10:
A Swallowing Screening Tool

LAST NAME	FIRST NAME	SEX	AGE	DATE

OBJECTIVE:

EAT-10 helps to measure swallowing difficulties.
It may be important for you to talk with your physician about treatment options for symptoms.

A. INSTRUCTIONS:

Answer each question by writing the number of points in the boxes.
To what extent do you experience the following problems?

1 My swallowing problem has caused me to lose weight.
0 = no problem
1
2
3
4 = severe problem

2 My swallowing problem interferes with my ability to go out for meals.
0 = no problem
1
2
3
4 = severe problem

3 Swallowing liquids takes extra effort.
0 = no problem
1
2
3
4 = severe problem

4 Swallowing solids takes extra effort.
0 = no problem
1
2
3
4 = severe problem

5 Swallowing pills takes extra effort.
0 = no problem
1
2
3
4 = severe problem

6 Swallowing is painful.
0 = no problem
1
2
3
4 = severe problem

7 The pleasure of eating is affected by my swallowing.
0 = no problem
1
2
3
4 = severe problem

8 When I swallow food sticks in my throat.
0 = no problem
1
2
3
4 = severe problem

9 I cough when I eat.
0 = no problem
1
2
3
4 = severe problem

10 Swallowing is stressful.
0 = no problem
1
2
3
4 = severe problem

B. SCORING:

Add up the number of points and write your total score in the boxes.
Total Score (max. 40 points)

C. WHAT TO DO NEXT:

If the EAT-10 score is 3 or higher, you may have problems swallowing efficiently and safely. We recommend discussing the EAT-10 results with a physician.

Reference: The validity and reliability of EAT-10 has been determined.
Belafsky PC, Mouadeb DA, Rees CJ, Pryor JC, Postma GN, Allen J, Leonard RJ. Validity and Reliability of the Eating Assessment Tool (EAT-10). Annals of Otology Rhinology & Laryngology 2008;117(12):919-924.

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www.nestlenutrition-institute.org

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Policy & Procedure Manual

Implementation of the International Dysphagia Diet Standardisation Initiative

Policy:
The facility (with the approval of administration) will implement the International Dysphagia Diet Standardisation Initiative (IDDSI) as the foundation for texture modified diets and thickened liquids provided to patients/residents. The implementation process may take 12 to 18 months.

Procedure:
1. The clinical healthcare IDDSI implementation team will include the director of food and nutrition services, nutrition and dietetics technician, registered (NDTR), registered dietitian nutritionist (RDN) the speech language pathologist (SLP) the director of nursing (DON) and/or other clinical staff as determined by the team. If appropriate, ask a patient/resident or family member to join the team. The team will become familiar with the IDDSI framework by completing the following tasks:
   a. View webinars and/or read articles available on the topic.
   b. Access the website: https://iddsi.org/.
      - Review the key resources on the IDDSI website such as definitions, testing methods, FAQs, and Resources including recorded webinar trainings (including *From Framework to Food: Implementing the IDDSI in a Long-Term Care Facility* presentation), training tools, posters, etc.
   c. Sign up for the news bites (e-bites).
   d. Download the IDDSI App from the App Store if able.

2. Develop an implementation calendar of tasks including a timeline and responsibilities of team members.
   a. See sample *IDDSI Implementation Guide for Clinicians and Healthcare Providers* on the https://iddsi.org/ under Resources/General Resources, or http://ftp.iddsi.org/Documents/Clinicians%20and%20Health%20Care%20Providers_IDDSI%20Implementation%20Guide_Final_3April2018.pdf.

3. The clinical healthcare IDDSI implementation team will schedule a monthly meeting to review progress, update the plan and communicate progress to the medical director, administration and department heads as appropriate.

4. Introduce the food and nutrition services staff to the IDDSI framework and create a staff education plan over a period of months based on the implementation calendar.
   a. Laminate and post the *What is IDDSI?* poster in the kitchen. Access the poster at https://iddsi.org/ under the Resources section or directly at https://ftp.iddsi.org/Documents/IDDSI_Poster_What_is_IDDSI-Sep2018.pdf.
   b. Develop a presentation including a discussion of the rationale, terminology, descriptors and testing methods. Present this to the food and nutrition services staff first, and then present it to nursing and administration.
   c. Use a hands-on technique for education to engage staff in the process and make it interactive.
      - Use test materials, syringes, spoons, forks and foods, thickened drinks etc.
   d. Educate patients/residents and families (as appropriate) IDDSI terms and diet changes prior to the implementation of diet changes.
   e. Explain the diet and terminology changes to the residents' council (in nursing facilities).

5. Implement testing of current foods and drinks offered on the menu.
   a. Schedule adequate time to test products and document results.
   b. Prior to testing, staff will view the IDDSI flow test instruction videos.

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c. *IDDSI Framework Testing Methods* (instructions for testing food and drinks) can be accessed on the https://iddsi.org/ website at https://iddsi.org/Documents/IDDSIFramework-TestingMethods.pdf.
d. Access and use the IDDSI *Audit Tools* when testing food and drinks. These are available on the https://iddsi.org/ website under Resources: General Resources/Implementation/Audit Sheets for:
   - Liquids (Levels 0-3)
   - Level 4 - Puree
   - Level 4 - Extremely Thick
   - Level 5 - Minced and Moist
   - Level 6 - Soft and Bite sized
e. Access and print a copy of the *IDDSI Flow Test Card* and *Food Test Card* as a reference for staff during the training process. Cards are available on the https://iddsi.org/ website under Resources: General Resources/Implementation/Flow Test Cards, Food Test Cards and Reference Cards or
   - IDDSI Flow Test Card - Canada (pdf, Jan 2018)
   - IDDSI Flow Test Card - USA (pdf, July 2018)
   - Flow Test Card - Ordering Instructions (pdf, Jan 2018)
f. The director of food and nutrition services or team member responsible for testing will access the *FAQ* at https://iddsi.org/faq/ as questions arise during the testing process.
g. Recipes will be adjusted as needed following the testing process.

6. The IDDSI clinical healthcare team will visit the kitchen and observe the assembly, plating and delivery systems to understand the process.

7. Prior to implementing the IDDSI framework, the system will be pilot tested on one unit or area and evaluated for needed changes.

8. Develop a plan for the full-scale IDDSI diet entry, production, assembly and delivery system.
   a. Standardize diet orders prior to implementation and notify the medical director and physicians of the rationale for changes. Consider including the conversion charts: *NDD to IDDSI Framework for Food and Drink* as a reference for ordering IDDSI diets. These can be found on the https://iddsi.org/ website under Resources: General Resources/Implementation/Conversion Charts or:
      - NDD to IDDSI (Food)
      - NDD to IDDSI (Drinks)
   b. Also see *Sample Letter to Physician and/or Clinicians Ordering Consistency Modified Diets* on the next page.

9. The director of food and nutrition services will implement the tray card and/or diet identification system with the new terminology.

10. Prior to implementation, computer files and/or medical records will be updated to the IDDSI terminology. The *IDDSI Abbreviations Suitable for use with Foodservice Computer Software* can be accessed on the https://iddsi.org/ website under Resources: General Resources/ Implementation/Food Service or https://iddsi.org/wp-content/uploads/2018/01/IDDSI-Abbreviations-fact-sheet_final_18Jan2018.pdf.

11. The IDDSI clinical healthcare team will evaluate the process and recommend any adjustments as needed.

12. New employee orientation will include information about the IDDSI framework.

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Sample Letter to Physician and/or Clinicians Ordering Consistency Modified Diets

(Letterhead)

Date

Dear Doctor _______,

_________________________ (facility name) has adopted the International Dysphagia Diet Standardisation Initiative (IDDSI), which is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals of all ages who have dysphagia. The Academy of Nutrition and Dietetics and the American Speech-Language-Hearing Association have endorsed IDDSI and encourage implementation.

The clinical healthcare IDDSI implementation team which includes the director of food and nutrition services, nutrition and dietetics technician, registered (NDTR), registered dietitian nutritionist (RDN), speech language pathologist (SLP), director of nursing (DON) and other clinical staff dedicated time to educating key stake holders including the clinical staff, administration, patients/residents, and families on the IDDSI terminology and framework.

Food and drinks served to the patients/residents with dysphagia have been tested and recipes have been updated. We are now ready to launch IDDSI, which will replace the National Dysphagia Diet that was previously the standard. Please, refer to the table below when ordering texture modified food and/or drinks.

Current NDD Terminology	New IDDSI Terminology
Nectar-thick	Level 2 Mildly thick
Honey-thick	Level 3 Moderately thick
Spoon-thick	Level 4 Extremely thick
Dysphagia Advanced	Level 6 Soft and bite-sized
Dysphagia Mechanically-altered	Level 5 Minced and moist
Dysphagia Pureed	Level 4 Pureed

Our goal is to provide each patient/resident with the most appropriate nutritional care. The IDDSI framework and terminology will guide us in that direction and ensure that patients/residents with dysphagia receive the appropriate food and fluid texture for their specific physical condition.

Thank you for implementing the IDDSI terminology when ordering textured modified diets. If you have any questions, please feel free to contact me at __________________.

Sincerely,

____

Registered Dietitian Nutritionist
(Insert Title)

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Policy & Procedure Manual

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 thickened liquids.

4. The SLP may request a variety of fluid consistencies based on condition and/or need. The SLP will notify and instruct the food and nutrition services department of exceptions for thickened liquids. For example, despite an order for thickened liquids, 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 (QAPI) program.

Note: In 2015 the International Dysphagia Diet Standardisation 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 on IDDSI terminology and implementation of IDDSI terminology and standards, visit www.iddsi.org.

Resource:

Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019. A*vailable at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.*

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Policy & Procedure Manual

End of Life Decisions

Policy:
The interdisciplinary team (IDT) 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 IDT is confident that all other approaches, interventions, and considerations have been examined, implemented and exhausted.

2. Medical records 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 from the individual and/or family or health care power of attorney. See *Sample Decline of Life-Prolonging Procedures and Treatments Form* on the 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 wishes and desires. Choices for end of life care should be documented in the medical record.

4. If 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. Refer to *Guidelines for Enteral Feedings* in this chapter.

6. The care plan will be updated to reflect end of life advance directive decisions. 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.

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:

- Dorner B. *Diet and Nutrition Care Manual: Comprehensive Edition*. Becky Dorner & Associates, Inc. Dunedin, FL. 2019.
- Dorner B. *End of Life Nutrition and Hydration: Comprehensive Nutrition Assessment and Intervention for Older Adults*. Becky Dorner & Associates, Inc. Dunedin, FL. 2017.

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Sample Decline of Life-Prolonging Procedures and Treatments Form

I, ____ (patient/resident), or I ____ (surrogate/durable power of attorney/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

Intervention, Procedure or Treatment	Yes	No
Nutrition/Hydration:		
Thickened liquids		
Intravenous fluids (IVs)		
Naso gastric (NG) feeding tube		
Percutaneous endoscopic gastrostomy tube (PEG)		
Medications:		
Antibiotic medications for infections		
Administration of meds other than those needed for pain		
Procedures:		
Blood draw for lab tests		
Urine sample for lab tests		
Xray, CT scans		
Blood transfusion		
Transfer to an acute care hospital		
Transfer to hospice or palliative care unit		
Other (please list):		

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 Durable Power of Attorney Legal guardian Responsible party

____ ________________
Witness **Date**

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Policy & Procedure Manual

Guidelines for Enteral Feeding Eligibility

Policy:

The interdisciplinary team (IDT) will evaluate each individual prior to recommending an enteral feeding tube/artificial nutrition and hydration. A variety of interventions should have been attempted before tube feeding/artificial nutrition and hydration is considered. Advance directives will be thoroughly reviewed as appropriate, and a conference with the individual, the family, surrogate/durable power of attorney/legal guardian/responsible party (DPOA) for healthcare will take place before a decision regarding tube feeding/artificial nutrition and hydration is made.

Procedure:

1. The IDT will contact the physician and the registered dietitian nutritionist (RDN) or designee when a patient's/resident'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 clinical 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 patient/resident/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.

Note: The decision regarding the type of feeding tube depends on the patient/resident's medical status and the anticipated time that the enteral feeding will be required. Feeding tubes are classified as nasogastric (NG) (access to the gastrointestinal tract via the nose), gastro-enterostomy (G-tube or PEG tube) or Jejunoscopy (J-tube). In general, if the feeding tube is to be in place longer than 4 weeks, a G-tube is recommended.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Details on nutrition assessment parameters, risks and benefits of tube feeding, and other information on enteral nutrition can be found in Becky Dorner & Associate's 2019 *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide* that can be obtained at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.

Resource:

Center for Medicare & Medicaid Services. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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Policy & Procedure Manual

Enteral Nutrition Care

Policy:

Enteral nutrition will be available for individuals who are unable to meet their nutrition and hydration needs via oral intake. The registered dietitian nutritionist (RDN) or designee will complete an initial nutrition assessment and subsequent reviews to assure the feeding is appropriate for the individual.

Procedure:

1. The RDN or designee will perform an initial nutrition assessment that will include a calculation of energy, protein, and fluid requirements upon initiation of enteral feeding to assure the feeding meets the individual's nutritional needs.
   a. A comparison will be made between the individual's requirements and the physician ordered enteral formula.
   b. Ideally, the RDN or designee will assess and/or review the nutrition status of those receiving enteral nutrition support on a monthly basis. If there are circumstances that make this impossible, no more than three months should lapse without a thorough assessment or review.
   c. Systems should be in place to assure referral to the RDN or designee as needed between routine assessments.

2. At initial and subsequent assessments, the RDN or designee will review nurse's notes, physician's orders, and other documentation. The RDN or designee will:
   a. Review 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.
   b. If there are significant changes in weight, recalculate nutritional requirements and compare this to what the enteral feeding is providing.
   c. Confirm that the administration of enteral nutrition is consistent with and follows physician's orders and that the product has not exceeded the manufacturer's expiration date:
      i. Check the enteral feeding flow rate, assess down times, assess to ensure the pump is functioning properly (if applicable).
      ii. Check input and output records, and medicine administration records (MAR) for amount of feeding administered.
      iii. Inform the nursing supervisor and/or DON if there are discrepancies between what is ordered, what is documented, and what is actually being done.
   d. Ensure that additional water ordered for flushes is administered as ordered.
   e. Monitor weight, skin condition, labs, physical symptoms, tolerance to feeding, and oral food/fluid intakes when applicable.
   f. Address orders as needed to balance essential nutritional support with efforts to minimize complications.

3. Nursing staff will communicate to the RDN or designee:
   a. Any changes in the formula ordered or route of administration.
   b. Any concerns regarding changes in condition such as weight loss, diarrhea, nausea, vomiting, bloating, gas, and high residual levels.

4. Enteral formula should be administered at room temperature. Hang times for formulas are manufacturer specific. Discard formula according to the manufacturer's recommendations.

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Note: The decision regarding the type of feeding tube depends on the individual's medical status and the anticipated time that the enteral feeding will be required. Feeding tubes are classified as nasogastric (NG) (access to the gastrointestinal tract via the nose), gastro-enterostomy (G-tube or PEG tube) or Jejunoscopy (J-tube). In general, if the feeding tube is to be in place longer than 4 weeks, a G-tube is recommended.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Resource:

Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019. A*vailable at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.*

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Policy & Procedure Manual

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. Individuals who are tube fed should be positioned so that the head is elevated to 30 to 45 degrees at all times to reduce the risk of aspiration.

2. Nursing should monitor gastric residual volume as per MD orders.

3. Response to enteral feeding should be monitored. Any signs of excessive nausea, vomiting, diarrhea, abdominal distention, or gas warrant a referral to the registered dietitian nutritionist (RDN) or designee.

4. Tube feeding should be delivered by nursing as ordered by a physician. All changes in tube feeding should be accompanied by a physician's order.

5. If necessary, bolus feeding or an increase in feeding rate 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.

6. Enteral formula should be administered at room temperature. Hang times for formulas are manufacturer specific. Discard formula according to the manufacturer's recommended times.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Resource:
Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019. A*vailable at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.*

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Documentation for Enteral Feeding

Policy:
Nutrition documentation (nutritional assessment and routine progress notes) of enteral feedings should include specific information necessary to evaluate adequacy of feeding.

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 fluid flush(es), including amount of flush with medications

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

Resource:
Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019. A*vailable at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.*

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Policy & Procedure Manual

Transitioning from Enteral Feedings to Oral Feedings

Policy:

When an individual has the potential to be transitioned from an enteral feeding to oral 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 if a patient/resident might be a candidate for transition from an enteral feeding to oral food and fluid consumption. The SLP will obtain orders for dysphagia/swallowing evaluation to determine rehabilitation potential for food/fluid by mouth.
2. The SLP will determine the patient/resident'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 patient/resident, and with the staff who is responsible for assisting 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 can be conducted to assess the adequacy of the individual's oral intake, or food intake records over several days can be reviewed to determine oral intake.
5. The RDN will frequently reassess the patient/resident's oral food and fluid intake, 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 maximizing meal intake.
6. Weekly weights should be ordered 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 if and when enteral feeding can be discontinued, based on adequacy of oral diet, weight stabilization, and laboratory values. When appropriate, a physician's order should be written to discontinue enteral feeding.
8. The facility staff will intervene as appropriate for poor food/fluid intake, weight loss, or other negative reactions to discontinuing of the enteral feeding, and refer to the RDN, SLP and physician as needed.
9. The SLP will intervene as appropriate for intolerance to the food and fluids provided orally. The RDN and the SLP will work closely together to assure appropriate diet texture and thickness of fluids.
10. The nursing staff and physician will work closely with the RDN and the SLP to assure the best quality of care for the patient/resident involved.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Enteral Feedings

Insert facility enteral formularies here.

Manufacturers:

- Abbott Nutrition, (800) 227-5767, www.abbottnutrition.com
- Nestle Clinical Nutrition, (800) 422-2752, www.nestleclinicalnutrition.com

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Parenteral Nutrition

Policy:

Parenteral nutrition (PN) 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 fluids must be administered consistent with the professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the individual's goals and preferences. Parenteral nutrition therapy is appropriate when the gastrointestinal (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 PN is being considered for the individual. A comprehensive nutrition assessment will be completed within 24 hours. The RDN should contact the patient/resident and/or their representative to be sure they understand the rationale for PN. Conversely, the RDN may recommend PN in appropriate cases.

2. The medical nutrition therapy (MNT) assessment will include a review of the individual's medical condition and the reason for PN. A review of the individual's current laboratory values, weight status, and physical activity will be completed. Generally, the individual should have a non-functioning GI tract for PN to be considered.

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 PN 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 patients/residents receiving PN closely to assure the goals of nutrition support are met. Monitoring should include objective measures of nutrition status such as lab data, hydration status, and weight, and subjective data such as wound healing, functional capacity, and the individual's own sense of well-being and strength. PN may need to be initiated gradually to prevent refeeding syndrome, which can occur in individuals who were malnourished prior to initiation of PN.

6. The RDN will closely monitor the transitional phase of feeding from PN to enteral or oral feeding. PN should not be stopped abruptly; a gradual transitional feeding is preferred. Both clinical and biochemical indices will be monitored no less than weekly.

   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.

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Details on administering and monitoring enteral nutrition can be found in Becky Dorner & Associates 2019 *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide* that can be obtained at https://www.beckydorner.com/product/diet-and-nutrition-care-manual/.

Resources:

- Academy of Nutrition and Dietetics Nutrition Care Manual. www.nutritioncaremanual.org.
- Dorner B. *Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide*. Dunedin, FL: Becky Dorner & Associates, Inc., 2019.
- State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf.

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Policy & Procedure Manual

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.

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 foods that have the potential for food/medication interactions.

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:
   a. Notify the appropriate discipline (i.e. nursing, physician, IDT, social service) if adverse food medication interaction potential is present.
   b. Educate the individual on potential food-medication interactions as appropriate. (See *Education for Food-Medication Interactions* on the next page.)
   c. Document the potential food-medication interaction information in the medical record as appropriate.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Policy & Procedure Manual

Education for Food-Medication Interactions

Policy:

Adequate discharge planning and education for patients/residents, 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 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 patient/resident/caregiver will be supplied with written information pertaining to medications as needed. Verbal instruction will be given to the person 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 patient/resident or caregiver prior to the individual's discharge and appropriate documentation pertaining to the consultation entered into the medical record. Titles of written information, pamphlets, etc. pertaining to the medication-nutrient interaction provided 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 (QAPI)

Policy:

Each year, the food and nutrition services 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 patients/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 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. Timeliness 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 food and nutrition services 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:

• Sanitation	• Person Centered Dining
• Meal Preparation and Service	• Food Quality
• Steam Table and Tray Line Accuracy	• Food Costs
• Dining Service	• Unintended Weight Loss/Pressure Injuries
• Customer Satisfaction	• Menus/Recipes
• Medical Records/Documentation	• Policies and Procedures
• Nourishments	• Nutrition Care Process
• Food Service Staff Education	• Nursing Education

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Sample Facility Goals Form

Facility ____________________________ Year ________

Goals	Action Steps	Assigned to	Due Date

Developed by: ___________________________ Approved by: ____________________________

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Sample Monthly QAPI Reports Form

20__

Month	☐		☐		☐		☐		☐		☐	Facility Concerns:
January	☐	Chart Audit (Dates of NA, POC, PN's)	☐	Weight, Pressure Injury and Tube Feeding Audit	☐	Sanitation	☐	Test Tray: Regular Diet	☐	Meal Service Audit	☐	
February	☐	Pressure Injury Audit	☐	Weight, Pressure Injury and Tube Feeding Audit	☐	Sanitation	☐	Test Tray: Puree Diet	☐	Tray Line Audit	☐	
March	☐	Nourishments (Timely pass, Match Doc., Consumed)	☐	Weight, Pressure Injury and Tube Feeding Audit	☐	Sanitation	☐	Test Tray: Mechanical Soft Diet	☐	Meal Service Audit	☐	

Month	☐		☐		☐		☐		☐		☐	Facility Concerns:
April	☐	Chart Audit (Dates of NA, POC, PN's)	☐	Weight, Pressure Injury and Tube Feeding Audit	☐	Sanitation	☐	Test Tray: Regular Diet	☐	Tray Line Audit	☐	
May	☐	Pressure Injury Audit	☐	Weight, Pressure Injury and Tube Feeding Audit	☐	Sanitation	☐	Test Tray: Puree Diet	☐	Meal Service Audit	☐	
June	☐	Nourishments (Timely pass, Match Doc., Consumed)	☐	Weight, Pressure Injury and Tube Feeding Audit	☐	Sanitation	☐	Test Tray: Carb. Controlled Diet	☐	Tray Line Audit	☐	

______________________ RDN Signature/Date

______________________ Administrator Signature/Date

______________________ Director of Food/Nutrition Services Signature/Date

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20__

Month							Facility Concerns:
July	☐ Chart Audit (Dates of NA, POC, PN's)	☐ Weight, Pressure Injury and Tube Feeding Audit	☐ Sanitation	☐ Test Tray: Regular Diet	☐ Meal Service Audit	☐	
August	☐ Pressure Injury Audit	☐ Weight, Pressure Injury and Tube Feeding Audit	☐ Sanitation	☐ Test Tray: Puree Diet	☐ Tray Line Audit	☐	
September	☐ Nourishments (Timely pass, Match Doc., Consumed)	☐ Weight, Pressure Injury and Tube Feeding Audit	☐ Sanitation	☐ Test Tray: Mechanical Soft Diet	☐ Meal Service Audit	☐	

Month							Facility Concerns:
October	☐ Chart Audit (Dates of NA, POC, PN's)	☐ Weight, Pressure Injury and Tube Feeding Audit	☐ Sanitation	☐ Test Tray: Regular Diet	☐ Tray Line Audit	☐	
November	☐ Pressure Injury Audit	☐ Weight, Pressure Injury and Tube Feeding Audit	☐ Sanitation	☐ Test Tray: Puree Diet	☐ Meal Service Audit	☐	
December	☐ Nourishments (Timely pass, Match Doc., Consumed)	☐ Weight, Pressure Injury and Tube Feeding Audit	☐ Sanitation	☐ Test Tray: Carb. Controlled Diet	☐ Tray Line Audit	☐	

________________	________________	________________
RDN Signature/Date	Administrator Signature/Date	Director of Food and Nutrition Services Signature/Date

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Policy & Procedure Manual

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.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Sanitation Audit Form 1

Facility ____________________ Completed by ________________ Date __________

	Yes	No	Comments	Mgr Initials/Comments
Sanitation:				
Appearance of kitchen is acceptable				
Waste containers covered, clean				
Cleaning Schedule:				
Posted, and current				
Schedule followed				
Refrigerators:				
Clean				
Food dated, labeled, and covered				
Temperature acceptable				
Freezers:				
Clean				
Food dated, labeled, and covered				
Temperature acceptable				
Store Room:				
Clean / organized				
Food dated, labeled, and sealed; food off floor				
Stock rotated				
Cleaning supplies separated				

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Sample Sanitation Audit Form 1 (page 2)

	Yes	No	Comments	Mgr Initials/Comments
Equipment:				
Clean and in good repair				
Proper handling/storage of equipment				
Personnel:				
Hair acceptable/restrained				
Hands washed as needed				
Clean clothes, aprons, and appropriate shoes worn				
Dining Room:				
Appearance of dining room is acceptable				
Dish Room:				
Proper 3-sink method				
Proper clean dish handling and storage				
Food Safety:				
Leftovers promptly stored				
Gloves worn when needed				
Steps to prevent cross contamination posted and followed				

Other Comments:

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Sample Sanitation Audit Form 2

Date ____________   Time __________

Items Reviewed	S	NI	U	Comments
Personnel				
1. Hair/beard restraint				
2. Uniforms/apron				
3. Hand washing				
4. Non-latex gloves used when appropriate				
5. Jewelry per policy				
6. Personal hygiene appropriate				
7. Free of wounds				
8. Free of communicable disease				
9. Proper food handling				
10. Unauthorized traffic minimal				
11. Eating in designated area				
12. Proper beverage containers				
Food Production				
1. Hand washing sink				
2. Step can				
3. Prep sink				
4. Thermometer calibrated				
5. Cutting boards used properly				
6. Sanitizer buckets used properly				
7. Knife rack				
8. Utensils				
9. Spice rack				
10. Proper reheating				
11. Pasteurized eggs used				
Equipment				
1. Exhaust hood/fan				
2. Stove top				
3. Griddle				
4. Conventional oven				
5. Tilt skillet				
6. Convection oven				
7. Steamer				
8. Steam-jacketed kettle				
9. Steam table				
10. Pellet heater				
11. Tray dispenser				
12. Lid rack				

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Sample Sanitation Audit Form 2 (page 2)

Items Reviewed	S	NI	U	Comments
Equipment (continued)				
13. Toaster				
14. Microwave				
15. Blender				
16. Food processor				
17. Slicer				
18. Mixer				
19. Can opener				
20. Food scale				
21. Ingredient bins				
22. Juice machine				
23. Coffee urn				
24. Milk dispenser				
25. Ice machine				
26. Other				
Dry Storage				
1. 18” from ceiling				
2. 6” from floor				
3. Covered/labeled/dated				
4. FIFO				
5. No dented cans				
6. No dusty cans				
7. Non-food separate				
8. Disaster water/food available				
Refrigerator and Freezer				
1. Temperatures appropriate				
2. Temperature log maintained				
3. Internal food temperatures appropriate				
4. Doors				
5. Gasket				
6. No spills				
7. 6” from floor				
8. Covered/labeled/dated/old food discarded				
9. Proper storage				
10. Proper thawing				
11. Proper cooling				
12. Leftovers used properly				
13. Fan clean				
14. Ice build up				

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Sample Sanitation Audit Form 2 (page 3)

Items Reviewed	S	NI	U	Comments
Chemical Storage				
1. Chemicals labeled				
2. Off the floor				
3. SDS available				
4. Mop buckets clean				
5. Proper storage of mop				
Pot and Pan Sink				
1. Sanitizer-PPM appropriate				
2. Sanitizer log maintained				
3. Proper procedure				
4. Items clean, no grease				
5. Items air dried				
Dishwashing Area				
1. Temperature appropriate				
2. PPM correct				
3. Temperature log				
4. Proper dishwashing				
5. Dish machine clean				
6. No lime deposit				
7. Chemicals off floor				
8. Hood clean				
9. Fan clean				
10. Garbage disposal				
11. Hose/faucet sprayer				
12. Garbage covered and area clean				
Dishwasher/Utensils				
1. Clean				
2. Air-dried				
3. Broken glass/dish policy				
4. Chip/stain/lime free				
5. Proper storage				
6. Proper handling				
7. Adequate supply				

Code:
S = Satisfactory NI = Needs Improvement U = **Critical Violation** (Immediate Jeopardy)

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Sample Sanitation Audit Form 2 (page 4)

Items Reviewed	Food Prep			Dry Storage			Walk-ins			Dish-room			Chemical Closet			Comments
	S	NI	U	S	NI	U	S	NI	U	S	NI	U	S	NI	U	
General																
1. Floor																
2. Mats																
3. Baseboard																
4. Walls																
5. Ceiling																
6. Vents																
7. Sprinklers																
8. Lights																
9. Windows																
10. A/C																
11. Counter tops																
12. Drawers																
13. Cabinets																
14. Under shelves																
15. Table legs																
16. Carts & racks																
17. Shelves																
18. Safety																
19. Dumpsters																
20. Trash Cans																
21. Pest-free																
22. Sanitizer use																
23. Fire safety																
24. Drains clean																

Code:
S = Satisfactory
NI = Needs Improvement
U = **Critical Violation** (Immediate Jeopardy)

Actual Points ____
Total Possible Points ____
Total Score ____

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Sanitation Audit Form

Insert facility detailed sanitation audit form here.

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Policy & Procedure Manual

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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Meal Preparation and Service Audit Form

Date:	Yes	No	Comments
Menus:			
Current days 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 texture/consistency			
Leftovers - amount is appropriate and is properly stored			
Comments:			
Meal:			
Appealing appearance			
Proper portions			
Acceptable taste/temperature			
Comments:			

Completed by ________________________________ Date ______________________

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Sample Meal Preparation and Service Audit Form (page 2)

Date:	**Yes**	**No**	**Comments**
Meal Service (Meal times followed):			
Served in timely manner			
Served in sanitary manner			
Served at a temperature that is acceptable to patients/residents			
Proper meal distribution			
Comments:			
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 ______________________

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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 mealtime, 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.

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Sample Tray Line Audit Form

Breakfast ________ **Lunch** ________ **Dinner** ________

Supervisor ______________________________ **Date** __________

	Yes	No	Comments
Clothing appropriate and in accordance with policy			
Uniforms clean			
Clean aprons worn and in good condition			
Hands clean and gloves worn when necessary			
No excessive jewelry worn			
Proper shoes worn by all staff			
Hair nets and beard guards worn covering all hair			
No gum chewing, smoking, drinking, 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 recorded			
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)			

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.

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Sample Meal Round Audit Form

Facility ______________________________________ **Date** _______________________

Completed by ____________________ **Reviewed with** __________________________

	Yes	No	Comments
1. Do trays arrive on time?			
2. Are individuals ready to receive trays?			
3. Is adequate staff available to pass trays?			
4. Do staff members pass trays efficiently?			
5. Are all individuals at a table given their meal at the same time?			
6. Do staff members present the trays/meals pleasantly?			
7. Do staff members assist individuals to set up the meal, (open, cut, and pour) only as needed?			
8. Are individuals positioned appropriately? (as close to a 90° angle as possible)			
9. Are table heights appropriate for all individuals?			
10. Do staff members give verbal cues to encourage eating when needed?			
11. Do staff members give physical prompts to encourage eating when needed?			
12. Is enough staff available to assist and feed those who need it?			
13. Do staff members treat individuals with respect and dignity?			
14. Do staff members wash hands between assisting/feeding each individual?			
15. Is dining room atmosphere generally pleasant?			

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	Yes	No	Comments
16. Is dining room well lit?			
17. Is noise level acceptable?			
18. Are food alternates offered if an individual does not like or does not eat food served?			
19. Are replacements offered if less than 50% of food is eaten?			
20. Is the dining room set up to allow individuals to move in and out easily and safely?			
21. Are individual's hands/mouths wiped as needed?			
22. Are assistive feeding devices available and used when needed?			
23. Is food consistency appropriate for each individual?			
24. Is the menu posted?			
25. Is menu followed?			
26. Are therapeutic or texture-modified diets delivered as ordered? Are trays accurate?			
27. Do staff members know what alternatives or replacement foods are available?			
28. Are individual food preferences, allergies, or intolerances honored?			
29. Are supplement recommendations and/or orders followed as noted in the care plan or on the tray card?			
30. Are liquids thickened as ordered and to correct consistency?			
31. Do staff members know what to do if an individual is choking?			
32. Are food temperatures acceptable to individuals?			
33. Do staff members avoid mixing foods when feeding?			
34. Do staff members converse with individuals?			

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Policy & Procedure Manual

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 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.

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Sample Food Satisfaction Questionnaire Form

Name ______________________________ **Date** ___________________

Questions	Answers
Do you like the food here? Why?	
Does the food taste good?	
Is the hot food HOT? Is the cold food COLD?	
Are you offered a choice if you dislike the food?	
Are portion sizes adequate?	
Is the dining atmosphere pleasant?	
Do you like the service here? Why?	
What items would you take off the menu if you were preparing the meals?	
Are there any other comments you'd like to share?	

List Your 3 Favorite Meats/Entrees:

1. ____________________________
2. ____________________________
3. ____________________________

List Your 3 Favorite Vegetables:

1. ____________________________
2. ____________________________
3. ____________________________

List Your 3 Favorite Side Dishes:

1. ____________________________
2. ____________________________
3. ____________________________

List Your 3 Favorite Desserts:

1. ____________________________
2. ____________________________
3. ____________________________

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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Test Meal/Tray Audit Form

Date: ________________________ **Diet Order:** ________________________________

Week of Menu Cycle: ______ Meal: _______________ Wing or Dining Area: _______________

Time Meal/Tray Left Kitchen: _______ Arrived: _______ Served: _______

Tray Accuracy
Menu Followed for Diet Order: Y N Preferences Followed: Y N

Overall Tray Appearance/Neatness: Excellent Good Fair Poor

Ratings:
E = Excellent G = Good F = Fair P = Poor

Food Item	Appearance Color	Temperature	Portion Control	Quality	Flavor	Meal/Tray Accuracy

Comments: ______________________________

____
____
____
____
____
____
____

Plan of correction (if needed): ______________________________

____
____
____
____
____
____
____

Signature: ______________________________ Date: ______________________________

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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 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 the medical record for timeliness of nutrition assessment, and appropriate nutrition interventions and/or follow through.
   a. Initial nutrition assessments must be completed within 14 days of admission, and annually thereafter.
   b. Initial care plans 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 care plan.

   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 or electronic records.
   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 electronic 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 physician's orders as needed to assure physicians orders for diets and supplements, information on file in dietary, and meal trays are all in agreement.

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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.

Note: Support staff work under the supervision of the registered dietitian nutritionist (RDN). Support staff includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Chart Audit Form

Date __________________________ Completed by ____________________________________

Room	Name	NA Date	POC Date	PN Date	NCP Followed	Comments

NA = Nutritional Assessment
POC = Care plan
PN = Progress Notes
NCP = Nutrition Care Process

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Sample Diet Order Audit Form

Date ________________________ **Completed by** ________________________________

Room	Name	Diet Order or Enteral/Parenteral Feeding Order	Matches Physician Order	Matches Meal ID Card/Ticket	Matches Cardex/Electronic Records

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Sample Supplements/Nourishments Audit Form

Date ________________________ **Completed by** _________________________________

Room	Name	Supplement/ Nourishment Order	Matches Physician Order	Matches Meal ID Card/Ticket	Matches Cardex/Electronic Record

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Sample In-Depth Documentation Audit Form

Name: ___________________________________**Room:** ________ **Date:**_________

	Yes	No	Comments
Nutrition Assessment: Current/Annual Assessment in Chart			
Signed			
Dated/Timely			
Complete			
Appropriate Information			
Care Plan: Signed			
Dated/Timely			
Current			
Consistent with Nutritional Assessment and Progress Notes			
Measurable Goals			
Progress Notes: Signed			
Dated/Timely			
Current			
Diet Order (Acceptable to Resident)			
Weight Status			
Eating Ability			
Food Intake			
Skin Condition			
Appropriate Interventions			
Appropriate Referrals to Registered Dietitian			
Diet Tray Card/Ticket: Name			
Food Preferences			
Special Needs			
Diet Order/Supplement Info Current			

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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 ONS 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 care plan 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, ONS or snacks 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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Sample Oral Nutritional Supplement/Snack Audit Form

Facility ______________________ Wing __________ Date __________

Room	Name	Breakfast	10:00	Lunch	2:00	Dinner	HS	Matches Orders	Matches Cardex/ Electronic Records	Matches Meal ID Card/ Ticket

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Sample Oral Nutrition Supplement/Snack Pass Audit Form

Facility ____________________ **Wing** __________ **Date** __________

Room	Name	% of Intake of Supplement					Comments
		100	75	50	25	0	

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Audit to Assess Quality of Nutrition Care Provided

Policy:

The registered dietitian nutritionist (RDN) or designee will audit the food and nutrition services department prior to annual survey and/or as deemed necessary to assess the quality of nutrition care provided.

Procedure:

The auditor will:

1. Randomly select 25% of the facility's individuals. List individuals who are at nutrition risk. Use the CMS Roster Matrix to choose individuals with unintended weight loss, pressure injuries, those who are enterally fed or dehydrated, or who have other nutrition concerns.

2. Pull each individual's medical record:
   a. Review the nutrition documentation for accuracy and appropriateness of nutrition interventions. Use the information from *Resource: Audit to Assess Quality of Nutrition Care Provided* on the following pages as a guide.
   b. Note any discrepancies between the care plan and the documentation on file in the food and nutrition services department related to nutrition interventions from nursing (medication pass, enteral feedings, oral nutritional supplements, etc.).
   c. Note any discrepancies between the care plan and the documentation on file in the food and nutrition services department related to nutrition interventions from the kitchen (snacks, nourishments, extra food/fluid on meal trays, etc.).

3. If concerns are found, review with the director of nursing and/or the director of food and nutrition services as appropriate, and make adjustments as needed.

4. Develop a plan of correction for any problems.

5. Follow up on corrections within 1 to 2 weeks.

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Resource: Audit to Assess Quality of Nutrition Care Provided

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 or nutritional supplements 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, such as liberalized diet or other interventions offered?

Interviews with Health Care Practitioners
Interview interdisciplinary team (IDT) members on various shifts (e.g. nursing assistant, registered dietitian nutritionist or RDN, 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 or nutritional supplements, 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, RDN, 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.

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5. Has identified individual's triggered Resident Assessment Instrument (RAI) for nutrition status.
6. Has evaluated the effectiveness of the interventions.
7. Has monitored and modified approaches as indicated.

Assessment and Monitoring

Review information including the RAI, diet and medication orders, activities of daily living documentation, and nursing, RDN, 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, cultural and religious preferences, 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?

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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 the staff responsible for care planning about the rationale for the current care plan.

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:
Center for Medicare & Medicaid Services. State Operations Manual Appendix PP -Guidance to Surveyors for Long Term Care Facilities
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf. Accessed March 1, 2019.

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Guide to Developing Facility's Annual
Quality Assurance and Performance Improvement 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/quality assurance and assessment (QAA) committee meetings.

3. The RDN or designee will attend when applicable (when the PIP involves nutrition such as reducing pressure injuries 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 includes the nutrition and dietetics technician, registered (NDTR), certified dietary manager (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.

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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%

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- No survey deficiencies involving UWL

Note: PIP will be evaluated annually

Resources:

- QAPI: Quality Assurance and Performance Improvement Resources https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources.html.
- American Health Care Association: Quality Assurance and Performance Improvement https://www.ahcancal.org/quality_improvement/QAPI/Pages/default.aspx.

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Emergency and Disaster Planning

Policy:

The facility will have a written emergency preparedness plan that complies with federal, state and local laws and is evaluated annually. The plan will be available and used as needed. In the event of a disaster or emergency, the facility's written emergency preparedness plan includes emergency water and food needs. The four core elements of the CMS Emergency Preparedness Program include risk assessment and planning, policies and procedures, a communication plan, and training and testing. Refer to the facility's emergency preparedness 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 individuals on tube feedings 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. All contact information will be reviewed and updated annually.

5. A list of food and nutrition services department employees' names and telephone numbers. All contact information will be updated periodically and reviewed annually.

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", DVDs, 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.

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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.
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.

Definitions

- Emergency/Disaster:
  An event that can affect the facility internally as well as the overall target population or the community at large or community in a geographic area.

- Disaster:
  A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to respond rapidly and effectively. Despite a stepped-up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared with a smaller scale or lower magnitude impact (see "emergency" for important contrast between the two terms). Reference: Assistant Secretary for Preparedness and Response (ASPR) 2017-2022 Health Care Preparedness and Response Capabilities Document (ICDRM/GWU Emergency Management Glossary of Terms) (November 2016).

- Emergency Preparedness Program:
  The emergency preparedness program describes a facility's comprehensive approach to meeting the health, safety and security needs of the facility, its staff, their patient population and community prior to, during and after an emergency or disaster. The program encompasses four core elements: an emergency plan that is based on a risk assessment and incorporates an all hazards approach; policies and procedures; communication plan; and the training and testing program.

- Emergency Plan:
  An emergency plan provides the framework for the emergency preparedness program. The emergency plan is developed based on facility- and community-based risk assessments that assist a facility in anticipating and addressing facility, patient, staff and community needs and support continuity of business operations.

- All Hazards Approach:
  An all-hazards approach is an integrated approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capacities and capabilities that can address those as well as a wide spectrum of emergencies or disasters. This approach includes preparedness for natural, man-made, and or facility emergencies that may include but is not limited to care-related emergencies; equipment and power failures; interruptions in communications, including cyber-attacks; loss of a portion or all of a facility; and, interruptions in the normal supply of essentials, such as

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water and food. All facilities must develop an all-hazards emergency preparedness program and plan.

- Staff:
  The term "staff" refers to all individuals that are employed directly by a facility. The phrase "individuals providing services under arrangement" means services furnished under arrangement that are subject to a written contract conforming with the requirements specified in section 1861(w) of the Act.

Reference:

Center for Medicare & Medicaid Services. State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance. Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf. Accessed March 4, 2019.

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Policy & Procedure Manual

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 DVDs, 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.

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Employee Training

Policy:
Employees will be prepared for unexpected events.

Procedure:
1. Staff should be trained in the emergency preparedness plan as part of their initial orientation and annually thereafter. Mock disaster drills should be used to determine the impact of the training. Documentation of all training will be maintained.

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 preparedness 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). Documentation of all training will be maintained.

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 patient's/resident's room?
   c. Where are the fire alarms and fire extinguisher located in the kitchen? Dining area? Near patient's/resident'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?

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i. Also add questions related to geographically specific disasters (hurricanes, tornadoes, floods, earthquakes, winter storms, etc.).

Source:
Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

Resources:
- Keeping Food Safe During an Emergency: General Guidelines for Keeping Food Safe http://www.fsis.usda.gov/wps/portal/fsis/topics/food-safety-education/get-answers/food-safety-fact-sheets/emergency-preparedness/keeping-food-safe-during-an-emergency/CT_Index.
- Refrigerator Foods: When to Save and When to Throw Out (Handy Chart to Guide Decisions) http://www.foodsafety.gov/keep/charts/refridg_food.html.
- Frozen Foods: When to Save and When to Throw Out (Handy Chart to Guide Decisions) http://www.foodsafety.gov/keep/charts/frozen_food.html.

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Resource: Food and Nutrition Services Disaster Plan

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 the 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 minimum for drinking and 1 gallon/person per day for other uses). 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.

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- Other sources of fluids which should be on hand in the 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.

5. Combination of Situations:
   - If a combination of these situations exists, combine instructions as needed.

*Check state, federal and Joint Commission regulations and follow the more stringent recommendations. Joint Commission requires a minimum of 4 days of food, water and supplies.

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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 services' 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 on the first and second day (based on keeping qualities):
      - Food in refrigerators - check food temperatures to ensure food safety.
      - Food in freezers - check food temperatures to ensure food safety.
   b. Canned and dry foods - use last.
   c. Packaged nutritional supplements and enteral formulas - see manufacturer's instructions.

*Check state, federal and Joint Commission regulations and follow the more stringent recommendations. Joint Commission requires a minimum of 4 days of food, water and supplies.

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Sample Disaster Responsibilities and Assignments Form

Done	Duties	Responsible Person
X	**Prior to Disaster:**	
	Recruit experienced staff and/or volunteers (i.e. from restaurants, schools, Red Cross, churches) to serve during an emergency	
	Train staff and/or volunteers (including disaster drills)	
	Assign responsibilities of staff, volunteers	
	Maintain backup computer files for the department, through the facility's mainframe system, and/or on portable media (DVDs, thumb drives) per facility protocols	
	Purchase emergency water, food and supplies (see *Sample Letter of Intent for Provision of Emergency Supplies* in this chapter)	
	Store and rotate of emergency water, food and supplies (3 to 7 days of supplies including cleaning supplies)	
	Plan emergency menus	
	Contract with a generator supply company to provide electricity as needed and request administration have at least 50% of equipment on emergency generator such as refrigerators, freezers.	
	Plan for mobile feeding if the kitchen/food/supplies are damaged beyond use	
	Meet with director of the local Red Cross and develop a written agreement to specify responsibilities/expectations	
	Maintain a list of emergency contact information for key personnel, county emergency manager, Red Cross, vendors (cell numbers whenever available) - verify the list at least annually	
	Document location of keys to doors, coolers, freezers, storage areas	
	Maintain a list of electrical equipment, lighting, and outlets that will function in the event that auxiliary power is used.	

Source:

Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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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 the *facility*, to service the 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 the facility, we will make every attempt to satisfy the needs of the 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. The 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 the 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 the facility continues. If the prime vendor relationship is terminated, this agreement automatically terminates as well.

Accepted by:	**Accepted by:**
________________________	___________________________
Food Service Vendor	Facility Representative
__________	_________
Date	Date

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Emergency Contact Information

Policy:
When the registered dietitian nutritionist (RDN), nutrition and dietetics 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

Name	Title	Cell Phone Number	Home Phone Number

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.

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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.

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Sample Emergency Medical Nutrition Therapy Information Form

Name:______________________________ Gender: M F DOB: __________

Advanced Directives for Nutrition/Hydration:

Contact Info for Family or Guardian (name/phone/cell phone):

Diet Order: Reg / No Added Salt / CCHO / Mech Soft / Puree / Modified Renal Diet **Food allergies/ intolerances**:	**Supplement orders:**

Alternate Feeding Orders (Tube feeding, PN if applicable):

Feeding Ability: Self fed / Needs assistance / Needs to be fed /
Needs adaptive equipment to feed self

Mental Status: Alert / Disoriented / Unable to communicate

Skin Condition: Intact / Wounds present

Ambulation: Ambulatory / Wheelchair / Confined to bed

Weight: _________(pounds) _________ (date)

Weight History:

Nutrition Risk Factors (circle all that apply): Malnutrition / Dehydration /
Swallowing problems / Chewing problems / Refusal of foods/ fluids / Cultural food issues
Other:

Additional Notes:

Signature: ______________________________ Date: _______________

Place a copy of this form in an area where staff can utilize it in an emergency.

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Sample Location of Needed Items and Information During a Disaster Form

Item	Location of Item or Information	Responsible Person	Cellular Phone Number
Keys to storage areas			
Fire extinguisher			
Main power switch			
Fuse or breaker boxes			
Standard first aid kit			
Disaster manual			
Cellular phone			
Keys to storerooms, freezers, coolers			
Emergency generators			
Contracted local vendor for a generator			
Fans			
Air conditioning units			
Flashlights, candles, lanterns, matches			
Weather radio, portable, battery operated			
Battery operated clocks			
Extra batteries			
Blankets			
Toolbox: adjustable wrench to turn off gas, crow bar, hammer, screwdrivers, heavy tape			

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.

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Water Requirements

Policy:
The facility has a written procedure, which defines the source of water when there is a loss of normal water supply, including provisions for storing both potable and non-potable water, and a method for distributing the water. 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 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 3 to 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:

Suggested Water Requirements:

Type of Water	Amount Needed	Formula	Example (7 day supply) for 100 People
Drinking Water	2 quarts (0.5 gallon) per person per day**	# of people* X 0.5** gallons X 3 days (or 7 days) = gallons of drinking water needed	100 people X 0.5 gallon X 7 days = 350 gallons of drinking water
All-purpose Water	1 gallon per person per day	# of people* X 1 gallon X 3 days (or 7 days) = gallons of all-purpose water needed	100 people X 1 gallon X 7 days = 700 gallons of all-purpose water

*Include patients/residents, 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 patients/residents 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 and Joint Commissions 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.

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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 16 (1/8 teaspoon) drops non-scented household chlorine bleach to each 1 gallon of water being careful not to contaminate the inside of the container.

4. Tightly seal the container (being careful not to contaminate the inside) and store for later use.

5. Date the outside of the container clearly.

6. Store in a cool dark place.

Source:
Federal Emergency Management Agency. Ready.gov Web site. Water. Updated 4/9/14. http://www.ready.gov/water. Accessed March 4, 2019.

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.

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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 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:**

Emergency Water Storage and Purification Guidelines, Federal Emergency Management Agency available at http://www.fema.gov/pdf/library/f&web.pdf. Accessed March 4, 2019.

See the next page for information on water purification.

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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, with 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 bleaches 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.

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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.

Amount of Water	Amount of Bleach Needed
1 quart	4 drops*
1 gallon	16 drops* (1/8 teaspoon)
5 gallons	5/8 teaspoon

* An eyedropper is ideal to measure the number of drops.

Source:
FEMA Website: http://www.ready.gov/managing-water. Accessed March 4, 2019.

Resource:
Emergency Water Storage & Purification Guidelines, Federal Emergency Management Agency available at http://www.fema.gov/pdf/library/f&web.pdf.

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.

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Resource: Non-Perishable Foods List for Emergency Supply

Examples of Non-Perishable Foods

Food service suppliers have a variety of canned foods in stock that might be available in emergency circumstances. The following is a list of foods that 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. Other foods might need to be purchased. 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

Canned Meats, Poultry, Fish	**Canned Beans**	**Pureed Foods**	**Canned or Aseptically Packaged Nutritional Supplements**
Chicken Deviled ham Ham Peanut butter Salmon Tuna Vienna sausage	Baked Black Butter Cannelloni Chick Peas Kidney Navy	Chicken Fruits Meats Vegetables	Milkshakes Puddings
Canned Fruit Applesauce Apple slices Fruit cocktail Mandarin oranges Peaches Pears Pineapple	**Canned Pie Filling** Apple Blueberry Cherry Peach	**Canned Prepared Foods** Cheese sauce Chicken & dumplings Chili Ravioli Stew	**Soups** Chicken noodle Cream of celery Cream of chicken Cream of mushroom Cream of tomato Vegetable Vegetable beef
Canned Vegetables Corn German potato salad Green beans Peas Pickled vegetables Potatoes Spaghetti sauce Three bean salad Tomatoes Tomato sauce	**Canned Pudding** Chocolate Lemon Vanilla	**Broths** Beef Chicken Vegetable (Canned or aseptic packs)	**Fruit Juices** Apple Apricot nectar Cranberry Grape Orange Pear nectar Prune (Canned or aseptic packs)
Condiments Chocolate syrup Jam and jelly Maple syrup Mayonnaise Mustard Salad dressing	**Canned Milk** Evaporated milk Sweetened /condensed	**Beverages** Fruit punch Iced tea Other beverage drinks Soda pop	**Bottled Water** 16 or 20 ounces 1 Gallon 5 Gallon 50 Gallon Drums Larger Containers as needed

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Non-Perishable Foods List

Shelf Stable Items

Convenience Foods	Supplements/ Proteins	Therapeutic Items	*Condiments
Instant mashed potatoes Instant pudding Powdered cheese sauce mix Refried Beans Soy Protein	Egg whites, dried Instant breakfast mix Milkshake mix	Modified food starch or gel thickener Sweetener	Coffee creamer Honey Jelly Ketchup Mustard Salt and pepper Sugar
Crackers/Chips	**Snacks**	**Soup**	**Coffee/Tea**
Butter crackers Cheese puffs Graham crackers Potato chips Saltine crackers	Cereal/snack bars Cheese crackers Granola bars Peanut butter crackers	Bouillon Dried soup mix Soup base	Instant coffee Tea bags
Starches	**Cookies**	**Thickened Beverages**	**Beverages**
Pasta Noodles Rice	Chocolate chip Filled cookies Shortbread cookies Sugar cookies Vanilla wafers	Thickened juice Thickened milk Thickened water	Large and small aseptic packs of juice Powdered beverage mixes (regular and sugar free): Fruit flavored iced tea or punch
Milk	**Cereal**	**Nuts and Seeds**	**Dried Fruit**
Pasteurized nonfat dry milk Canned evaporated milk Shelf stable milk	Dry (bulk or in single serve containers) Hot (cream of rice, cream of wheat, grits oatmeal)	Almonds Mixed nuts Peanut butter Peanuts Walnuts	Apples Apricots Bananas Cranberries Prunes or Raisins

* Consider individual portion packs
**Shelf stable aseptic packages of milk may be available from food service vendors. These may be packed in individual portion sizes. They are shelf stable for approximately eight (8) months and include an expiration date.

Semi Perishable Foods:

Bread Items	Produce
Bread Buns/Rolls Pita bread Muffins/ English muffins Parmesan cheese	Potatoes Onions Apples

Source:

Dorner, B. *Emergency/Disaster Plan for Food and Dining Services*, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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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 the source below.

Source:
Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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Resource: Emergency Plan Special Diets Conversion Table

Original Order	Diet During Disaster
Sodium Restricted • 1500 mg Sodium • 2 gram Sodium • 3 to 5 gram Sodium • No added salt • Any other sodium restrictions	**No Added Salt** (No salt at table)
Diabetic • Carbohydrate Controlled • Consistent Carbohydrate	**Carbohydrate Controlled** (No sugar at table, Provide sugar substitute and sugar free foods if available)
Renal Diets 2 Gm Na, 2 Gm K, 60g Pro Potassium Restricted Sodium Restricted Protein Restricted Any other Renal Diet	**Modified Renal Diet** (No added salt; no prunes, prune juice, orange juice, oranges, potatoes or bananas; ½ c milk limit daily, Limit protein for pre-dialysis)
Consistency Alterations Mechanical Soft Ground/Minced Chopped Dysphagia Diet Level 3 IDDSI Soft and Bite-Sized IDDSI Minced and Moist	**Mechanical Soft or IDDSI Soft and Bite-Sized or Minced and Moist**
Puree Dysphagia Diet Level 1 Dysphagia Diet Level 2 IDDSI Puree	**Puree**
Full Liquid or IDDSI Liquidised	**Full Liquid**

In an emergency, adhere to texture and consistency modifications, food allergies, and food intolerances as much as possible. 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.

Source:

Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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Sample Menu Shell

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
BREAKFAST							
LUNCH							
SNACK							
DINNER							
HS							

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Suggested Emergency Menu Pattern

Meal	Diets				
	Regular	**Mechanical Soft**	**Puree**	**CCHO or CCDD**	**CCHO or CCDD Puree**
Breakfast	Juice, 6 oz. Cereal, 1 serving Starch, Bread or Other, 1 serving Milk or Nutrition Supplement, 8 oz. Coffee/Tea	Juice, 6 oz. Soft Cereal, 1 serving Soft Starch, Bread or Other, 1 serving Milk or Nutrition Supplement, 8 oz. Coffee/Tea	Juice, 6 oz. Smooth Hot Cereal, 1 c Pureed Starch, Bread or Other, 1 serving Milk or Nutrition Supplement 8 oz. Coffee/Tea	*Juice, 6 oz. *Cereal, 1 serving *Starch, Bread or Other 1 serving Milk or SF Nutrition Supplement 8 oz. *Coffee/Tea	*Juice, 6 oz. *Smooth Hot Cereal, 1c *Pureed Starch, Bread or Other, 1 serving Milk or SF Nutrition Supplement, 8 oz. *Coffee/Tea
Lunch	Protein Source, 2-3 oz. equivalent Starch, 1 serving Starchy Vegetable, ¾ c Vegetable, ¾ c Fruit, ¾ c Water, 8 oz.	Ground Protein Source, 2-3 oz. equivalent Soft Starch, 1 serving Soft Starchy Veg, ¾ c Soft Vegetable, ¾ c Soft Fruit, ¾ c Water, 8 oz.	Pu Protein Source, 2-3 oz. equivalent Pu Starch, 1 serving Pu Starchy Veg, ¾ c Pu Vegetable, ¾ c Pu Fruit, ¾ c Water, 8 oz.	Protein Source 2-3 oz. equivalent *Starch, 1 servings Starchy Vegetable, ¾ c *Vegetable ¾ c *Fruit, ¾ c Water, 8 oz.	Pu Protein Source 2-3 oz. equivalent *Pu Starch, 1 serving Pu Starchy Veg, ¾ c *Pu Vegetable, ¾ c *Pu Fruit, ¾ c Water, 8 oz.
Dinner	Protein Source 2-3 oz. equivalent Starch, 1 serving Starchy Vegetable, ¾ c Vegetable, ¾ c Fruit, ¾ c Water, 8 oz. Milk, 8 oz. or Nutrition Supplement, 6-8 oz.	Ground Protein Source, 2-3 oz. equivalent Soft Starch, 1 serving Soft Starchy Veg, ¾ c Soft Vegetable, ¾ c Soft Fruit, ¾ c Water, 8 oz. Milk, 8 oz. or Nutrition Supplement, 6-8 oz.	Pu Protein Source, 2-3 oz. equivalent Pu Starch, 2 servings Pu Vegetable, ¾ c Pu Fruit, ¾ c Water, 8 oz. Milk, 8 oz. or Nutrition Supplement, 6-8 oz.	Protein Source 2-3 oz. equivalent *Starch, 1 serving Starchy veg, ¾ c *Vegetable ¾ c *Fruit, ¾ c Water, 8 oz. Milk, 8 oz. or SF Nutrition Supplement, 6-8 oz.	Pu Protein Source 2-3 oz. equivalent *Pu Starch, 1 serving Pu Starchy Veg, ¾ c *Pu Vegetable, ¾ c *Pu Fruit, ¾ c Water, 8 oz. Milk, 8 oz. or SF Nutrition Supplement, 6-8 oz.
Snack	Starch, 1 serving	Soft Starch, 1 serving	Pu Starch, 1 serving	*Starch, 1 serving	*Pu Starch, 1 serving
	Milk, 8 oz. or Nutrition Supplement, 6-8 oz.	Milk, 8 oz. or Nutrition Supplement, 6-8 oz.	Milk, 8 oz. or Nutrition Supplement, 6-8 oz.	Milk, 8 oz. or SF Nutrition Supplement, 6-8 oz.	Milk, 8 oz. or SF Nutrition Supplement, 6-8 oz.

SF = Sugar Free/CCDD = Carbohydrate Controlled Diabetic Diet/ 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.

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Suggested Serving Sizes for Starch Portions for Diabetic Diets

1 serving = approximately 15 grams carbohydrates

Carbohydrate Controlled (CCDD) or Consistent Carbohydrate (CCHO) Portions		Regular Portions	
Bread	1 slice	Bread	1 slice
Cold Cereal (no added sugar)	1 oz.	Cold Cereal	1 oz.
Hot Cereal (no added sugar)	6 oz.	Hot Cereal	6 oz.
Crackers	6	Crackers	6
Rice	⅓ cup	Rice	½ cup
Noodles	½ cup	Noodles	½ cup
Coffee Cake (no frosting or sugar topping)	2 x 2”	Coffee Cake	2 x 2” squares
Muffin	1 small	Muffin	1 medium
Plain Cookie	2 small	Cookies	2 medium
Graham Crackers	2-2” squares	Graham Crackers	4 - 2” squares
Roll	1 small	Roll	1 medium
Pudding, sugar free	½ cup	Pudding	½ cup
Vegetable Soup	1 cup	Vegetable Soup	1 cup
Noodle Soup	1 cup	Noodle Soup	1 cup

Source:

Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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Day 1 Emergency Meal Plan – Assumes No Utilities

	REGULAR/NAS		MECH SOFT		PUREE		CCHO OR CCDD		CCHO or CCDD PUREE	
BREAKFAST	Assorted Juice	6 oz.	Assorted Juice	6 oz.	Assorted Juice	6 oz.	*Assorted Juice	6 oz.	*Assorted Juice	6 oz.
	Muffin	1	Soft Muffin, No Nuts	1	Hot Cereal	1 c	*Muffin or Toast	1	Cream of Wheat	1 c
	Dry Cereal	¾ c	Dry Cereal (soft)	¾ c	None		Dry Cereal	¾ c		
	Cottage Cheese (if available)	½ c	Cottage Cheese (if available)	½ c	Yogurt (smooth) (if available)	½ c	Cottage Cheese (if available)	½ c	*Yogurt (smooth) (if available)	½ c
	Bananas (if available) or Canned Fruit	¾ c	Bananas (if available) or Canned Fruit	¾ c	Applesauce, Smooth	¾ c	Bananas (if available) or SF Canned Fruit	¾ c	SF Applesauce, (smooth)	¾ c
	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	SF Instant Breakfast	8 oz.	SF Instant Breakfast	8 oz.
LUNCH	Canned Deviled Ham Spread	3 oz.	Canned Deviled Ham Spread	3 oz.	Pureed Canned Beef	#8s	Canned Deviled Ham Spread	3 oz.	Pu Canned Beef	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Canned 3 Bean Salad	¾ c	Canned 3 Bean Salad	¾ c	Pu Cnd Green Beans	#8+16s	Canned 3 Bean Salad	¾ c	Pu Cnd Green Beans	#8+16s
	Vegetable salad	¾ c	Soft Vegetable Salad	¾ c	Pu Canned Corn	#8+16s	Vegetable Salad	¾ c	Pu Canned Corn	#8+16s
	Canned Fruit	¾ c	Canned Fruit	¾ c	Pu Canned Pears	#8+16s	SF Canned Fruit	¾ c	SF Pu Canned Pears	#8+16s
	Water	8 oz.	Water	8 oz.	Water	8 oz.	Water	8 oz.	Water	8 oz.
	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.
DINNER	Canned Chicken Salad	3 oz.	Canned Chicken Salad, (soft)	3 oz.	Pureed Canned Chicken	#8s	Canned Chicken Salad	3 oz.	Pu Canned Chicken	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Cheese Puffs	1oz	Cheese Puffs	1 oz.	Pu Canned Peaches	#8+16s	Cheese Puffs	1 oz.	SF Pu Canned	#8+16s
	Canned Pickled Beets	¾ c	Canned Pickled Beets	¾ c	Pu Canned Beets	#8+16s	Canned Pickled Beets	¾ c	Pureed Canned Beets	#8+16s
	Mashed Potatoes	¾ c	Mashed Potatoes	¾ c	Mashed Potatoes	#8+16s	Mashed Potatoes	¾ c	Mashed Potatoes	¾ c
	Assorted Beverages	8 oz.	Assorted Beverages	8 oz.	Assorted Beverages	8 oz.	SF Asst Beverages	8 oz.	SF Asst Beverages	8 oz.
	Nutritional Supplement	6-8 oz.	Nutritional Supplement	6-8 oz	Nut Supplement	6-8 oz.	SF Nutr Supplement	6-8 oz.	SF Nutr Supplement	6-8 oz.
HS	Cereal Bar	1	Cereal Bar (soft)	1	Ready to Eat Pudding	½ c	Cereal Bar	1	SF Ready to Eat Pudding	6-8 oz.
	Water	8 oz.	Water	8 oz.	Nutr Supplement	8 oz.	Water	8	SF Shelf Stable ONS	½ c

SF = Sugar Free   CCHO Controlled Carbohydrate Diet   CCDD = Carbohydrate Controlled Diabetic Diet   Pu = Pureed   ONS = Oral Nutritional Supplement   *Low in Simple Sugars
Note: All liquids offered must be thickened to the ordered consistency. Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily per ChooseMyPlate guidelines if possible.

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Day 2 Emergency Meal Plan – Assumes No Utilities

	REGULAR/NAS		MECH SOFT		PUREE		CCHO OR CCDD		CCHO OR CCDD PUREE	
BREAKFAST	Assorted Juice	6 oz.	Assorted Juice	6 oz.	Assorted Juice	6 oz.	*Assorted Juice	6 oz.	*Assorted Juice	6 oz.
	Assorted Dry Cereals	¾ c	Assorted Dry Cereals	¾ c	Hot Cereal (if able)	1 c	*Assorted Dry Cereals	¾ c	*Hot Cereal (if able)	1 c
	Donuts	1	Donuts (soft, no nuts)	1						
	Canned Fruit	¾ c	Canned Fruit (soft)	¾ c	Pu Canned Pineapple	#8+16s	SF Canned Fruit	¾ c	SF Pu Cn Pineapple	#8+16s
	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	SF Instant Breakfast	8 oz.	SF Instant Breakfast	8 oz.
LUNCH	Creamy Peanut Butter	2 Tbs	Canned Beef Stew	6 oz.	Pu Canned Beef Stew	#8s	Creamy Peanut Butter	2 Tbs	Pu Canned Beef Stew	#8s
	Jelly	1 Tbs					SF Jelly	1 Tbs		
	Bread	2 sl					Bread	2 sl		
	Cheese Puffs	1 oz.			V-8 Juice	6 oz.	Cheese Puffs	1 oz.	V-8 Juice	6 oz.
	Canned Fruit	¾ c	Canned Fruit	¾ c	Pu Canned Peaches	#8+16s	SF Canned Fruit	¾ c	SF Pu Cnd Peaches	#8+16s
	Assorted Cookies	2	Assorted Cookies (no nuts or chips)	2	Pureed Bread Mix	#8s	Graham Crackers	2	Pureed Bread Mix	#8s
	Water	8 oz.	Water	8 oz.	Water	8 oz.	Water	8 oz.	Water	8 oz.
	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.	Milk	4 oz.	Milk	8 oz.
DINNER	Tuna Salad	3 oz.	Tuna Salad	3 oz.	Pu Canned Chicken	#8s	Tuna Salad	3 oz.	Pu Canned Chicken	#8s
	Bread	2 sl	Bread	2 sl			Bread	2 sl		
	Canned Bean Salad	¾ c	Canned Bean Salad	¾ c	Cnd Pu Green Beans	#8+16s	Canned Bean Salad	¾ c	Pu Cnd Green Beans	#8+16s
	Canned Fruit	¾ c	Canned Fruit	¾ c	Applesauce	¾ c	SF Canned Fruit	¾ c	SF Applesauce	#8+16s
					V-8 Juice	6 oz.				
	Assorted Beverages	8 oz.	Assorted Beverages	8 oz.	Assorted Beverages	8 oz.	SF Assorted Beverages	8 oz.	SF Asstd Beverages	8 oz.
	Nutr Supplement	6-8 oz.	Nutr Supplement	6-8 oz.	Nutr Supplement	6-8 oz.	SF Nutr Supplement	6-8 oz.	SF Nutr Supplement	6-8 oz.
HS	Cookies	2	Cookies (soft)	2	Ready to Eat Pudding	½ c	*Plain Cookies	2	SF Ready to Eat Pudding	6-8 oz.
	Water	8 oz.	Water	8 oz.	Nutr Supplement	6-8 oz.	Water	8 oz.	SF Shelf Stable ONS	½ c

SF = Sugar Free CCHO Controlled Carbohydrate Diet CCDD = Carbohydrate Controlled Diabetic Diet Pu = Pureed ONS = Oral Nutritional Supplement *Low in Simple Sugars

Note: All liquids offered must be thickened to the ordered consistency. Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily per ChooseMyPlate guidelines if possible.

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Day 3 Emergency Meal Plan – Assumes No Utilities

	REGULAR/NAS		MECH SOFT		PUREE		CCHO OR CCDD		CCHO OR CCDD PUREE	
BREAKFAST	Assorted Juices	6 oz.	Assorted Juices	6 oz.	Assorted Juices	6 oz.	*Assorted Juices	6 oz.	*Assorted Juices	6 oz.
	Cereal Bar	1	Cereal Bar (soft)	1	Hot Cereal	8 oz.	*Cereal Bar	1	*Hot Cereal	8 oz.
	Canned Fruit	¾ c	Canned Fruit	¾ c	Pu Canned Peaches	#8+16s	SF Canned Fruit	¾ c	SF Pu Canned Peaches	#8+16s
	Assorted Dry Cereals	¾ c	Assorted Dry Cereals	¾ c	Pureed Bread	#8s	Assorted Dry Cereals Unsweetened	¾ c	SF Supplement	8 oz.
	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	Instant Breakfast	8 oz.	SF Instant Breakfast	8 oz.
LUNCH	Peanut Butter	2 Tbs	Canned Chicken	#8s	Pu Canned Chicken	#8s	Peanut Butter	2Tbs	Pureed Canned Chicken	#8s
	Jelly	1 Tbs	Pureed Canned Peas	#8s	Pureed Canned Peas	#8s	SF Jelly	1Tbs	Pureed Canned Peas	#8s
			Bread	2 sl						
	Bread	2 sl	Canned Fruit	¾ c	Pu Canned Pears	#8+16s	Bread	2 sl		
	Canned Fruit	¾ c					SF Canned Fruit	¾ c	SF Pu Canned Pears	#8+16s
	Ready to Eat Pudding	½ c	Ready to Eat Pudding	½ c	Ready to Eat Pudding	½ c	SF Ready to Eat Pudding	½ c	SF Ready to Eat Pudding	½ c
	Water	8 oz.	Water	8 oz.	Water	8 oz.	Water	8 oz.	Water	8 oz.
	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.	Milk	8 oz.
DINNER	Deviled Ham Salad	3 oz.	Deviled Ham Salad	3 oz.	Pureed Canned Beef	#8s	Deviled Ham Salad	3 oz.	Pureed Canned Beef	#8s
	Bread	2 sl	Bread	2 sl	Pureed Canned Corn	#8s	Bread	2 sl	Pureed Canned Corn	#8s
	Applesauce	¾ c	Applesauce	¾ c	Applesauce (smooth)	#8+16s	SF Applesauce	¾ c	SF Applesauce (smooth)	#8+16s
	Cheese Puffs	1 oz.	Cheese Puffs	1 oz.	Pureed Bread Mix	#8s	Cheese Puffs	1 oz.	SF Pureed Bread Mix	#8s
	Assorted Cookies	2	Cookies (soft, no nuts)	2			Plain Cookies	2		
	Assorted Beverages	8 oz.	Assorted Beverages	8 oz.	Assorted Beverages	8 oz.	SF Asstd Beverages	8 oz.	SF Asstd Beverages	8 oz.
	Nutr Supplement	6-8 oz.	Nutr Supplement	6-8 oz.	Nutr Supplement	6-8 oz.	SF Nutr Supplement	6-8 oz.	SF Nutr Supplement	6-8 oz.
	Cookies	2	Cookies, soft, no nuts	2	Nutr Supplement	6-8 oz.	Graham Crackers	4	SF Shelf Stable ONS	6-8 oz.
	Juice	6 oz.	Juice	6 oz.	Juice	6 oz.	*Juice	6 oz.	*Juice	6 oz.

SF = Sugar Free CCHO Controlled Carbohydrate Diet CCDD = Carbohydrate Controlled Diabetic Diet Pu = Pureed ONS = Oral Nutritional Supplement *Low in Simple Sugars
Note: All liquids offered must be thickened to the ordered consistency. Goal is a minimum of 2½ cups of vegetables and 2 cups fruit daily per ChooseMyPlate guidelines if possible.

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Policy & Procedure Manual

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* in this chapter); 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.

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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, it is 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.

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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 at all times. This supply of items used daily should last three (3) to seven (7) days.

Amount	Items Needed – Food Safety/Sanitation
	Thermometers
	Alcohol swabs
	Hand sanitizer
	Hand soap
	Hand sanitizing wipes
	Bleach (recommended 5.25% concentration of hypochlorite without scents, soap or additives)
	Water purification tablets
	Dish soap
	Sanitizer
	Food handling gloves
	Aluminum foil
	Plastic wrap
	Plastic food bags (sandwich, quart, gallon size)
	Paper towels
	Towels and dish rags
	Rubber gloves
	Large plastic bags for trash
	Clean up supplies – broom, shovel, buckets, rags, mops

Source:

Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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Resource: General Disaster Supplies (continued)

Amount	Food Preparation/Service
	Hard copies of emergency menus
	Styrofoam or plastic take out containers for food
	Foil pans for cooking and serving
	Straws
	Coolers
	Manual can opener
	Egg beater or whisk
	Potato masher
	Battery operated equipment (heating elements, whisks, etc.)
	Barbeque grill—portable, outdoor grill
	Charcoal
	Lighter fluid
	Sterno fuel and containers
Amount	**Emergency Supplies**
	Fire Extinguisher
	First aid kit and first aid book
	Weather radio, portable
	Portable flashlights and headlamp flashlights
	Battery operated lanterns
	Extra batteries
	Blankets
	Adjustable wrench to turn off gas
	Tool box: hammer, screw drivers, crowbar, adjustable wrenches, etc.
	Heavy tape
	Matches in water proof container
	Battery operated clock

Source:

Dorner, B. Emergency/Disaster Plan for Food and Dining Services, Becky Dorner & Associates, Inc., Dunedin, FL. 2018 Edition. Available at https://www.beckydorner.com/product/emergency-disaster-plan-for-food-and-dining-services-2018-cpe-self-study-program/.

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Internal Policies

Insert Facility Policies Here (as required by OSHA, Joint Commission, Center for Medicare & Medicaid Services)

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 conduct critical 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.

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Resource: Fire Prevention Plan

Fire Prevention Plan

A fire prevention plan (FPP) is a hazard prevention plan 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.

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Disaster Resources

Resources for More Information on Dealing with Emergencies

- Quality, Safety, and Oversight Group-Emergency Preparedness https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.
- U.S. Department of Health and Human Services and CDC. Emergency Preparedness for Older Adults. Identifying Vulnerable Older Adults. Legal Options for Increasing Their Protection During All-Hazards Emergencies. http://www.cdc.gov/aging/emergency/.
- Centers for Disease Control and Prevention. Survey and Certification: Emergency Preparedness for Every Emergency. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html?redirect=/surveycertemergprep/.
- American Red Cross. Prepare for Emergencies. http://www.redcross.org/get-help/prepare-for-emergencies/be-red-cross-ready.
- Build a Kit. Ready.gov. http://www.ready.gov/build-a-kit.
- U.S. Department of Agriculture Food and Nutrition Services. Food Assistance for Disaster Relief. http://www.fns.usda.gov/disasters/disaster.htm.
- Institute of Child Nutrition. Emergency Readiness Plan: Guide and Forms for the School Foodservice Operation. https://theicn.org/icn-resources-a-z/emergency-readiness.
- National Emergency Management Association (NEMA). http://www.nemaweb.org.
- Federal Emergency Management Agency (FEMA) website. http://www.fema.gov.
- National Fire Safety Association, Free Safety Tip Sheets. http://www.nfpa.org/safety-information/safety-tip-sheets.
- American Red Cross. Flash Floods and Floods: The Awesome Power. http://www.nws.noaa.gov/os/water/ahps/resources/FloodsTheAwesomePowerMay2010.pdf.
- American Red Cross. Hurricanes: Unleashing Nature's Fury. https://permanent.access.gpo.gov/lps115208/HurricanesUNF07.pdf.
- APIC Bioterrorism Task Force, CDC Hospital Infections Program Bioterrorism Working Group. Bioterrorism Readiness Plan: A Template for Healthcare facilities. http://emergency.cdc.gov/bioterrorism/pdf/13apr99APIC-CDCBioterrorism.pdf.
- Castro C, Persson D, Bergstrom N, Cron S. Surviving the Storms: Emergency Preparedness in Texas Nursing Facilities and Assisted Living Facilities. https://www.aahd.us/abstract/surviving-the-storms-emergency-preparedness-in-texas-nursing-facilities-and-assisted-living-facilities/.
- Centers for Disease Control and Prevention. Emergency Preparedness and Response: Preparation and Planning. http://emergency.cdc.gov/planning/.
- Centers for Disease Control and Prevention. Keeping water and food safe after a disaster or emergency. https://www.cdc.gov/disasters/foodwater/facts.html.
- Federal Emergency Management Agency and The American Red Cross Food and water in an emergency. http://www.fema.gov/pdf/library/f&web.pdf.
- Landesman LY. Public Health Management of Disasters: The Pocket Guide. Washington DC: American Public Health Association. https://www.ready.gov/.
- Federal Emergency Management Association. Be Informed. Available at http://www.ready.gov/be-informed.
- Red Cross Family Disaster Planning: http://www.redcross.org/services/disaster/beprepared/familyplan.html.
- U.S. Department of Agriculture Food and Nutrition Services. Food Assistance for Disaster Relief. http://www.fns.usda.gov/disasters/disaster.htm.

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- Firewise. www.firewise.org which provides information to assure safety from fire.
- U.S. Fire Administration, Wildfire…Are you Prepared? FEMA FA-287/August 2004. https://webreq.propertyware.com/pw/setup/mail_merge_images/127698091/Wildfire+Are+You+Prepared.pdf.
- U.S. Department of Agriculture. Keeping food safe during an emergency. http://www.fsis.usda.gov/wps/wcm/connect/d3506874-2867-4190-a941-d511d3fcae71/Keep_Your_Food_Safe_During_Emergencies.pdf?MOD=AJPERES.
- U.S. Department of Agriculture. Keeping Food Safe During an Emergency: General Guidelines for Keeping Food Safe. http://www.fsis.usda.gov/wps/portal/fsis/topics/food-safety-education/get-answers/food-safety-fact-sheets/emergency-preparedness/keeping-food-safe-during-an-emergency/CT_Index.
- Refrigerated foods and power outages: When to save and when to throw out. Foodsafety.gov Web site. http://www.foodsafety.gov/keep/charts/refridg_food.html.
- Frozen Foods: When to Save and When to Throw Out (Handy Chart to Guide Decisions) http://www.foodsafety.gov/keep/charts/frozen_food.html.
- United States Environmental Protection Agency. Emergency Disinfection of Drinking Water. https://www.epa.gov/ground-water-and-drinking-water/emergency-disinfection-drinking-water.
- U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services. Emergency Preparedness Checklist: Recommended Tool for Effective Health Care Facility Planning. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/SandC_EPChecklist_SA.pdf.

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Policy & Procedure Manual

References and Resources

The Following Website Contains a Wealth of Information for Nursing Homes:
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html

There are important downloads* and related links found on this website.
(Note: These forms change frequently, so visit this site often.)

Downloads

- Revision History for LTC Survey Process Documents and Files - Updated 12/12/2018 [PDF, 132KB]
- LTC Survey FAQs - Updated 08/03/2018 [PDF, 525KB]
- Appendix PP State Operations Manual (Revised 11/22/2017) [PDF, 3MB]*
- List of Revised FTags [Effective November 28, 2017] [PDF, 152KB]
- F-Tag Crosswalk [XLSX, 495KB]
- New Long-term Care Survey Process – Slide Deck and Speaker Notes [PPTX, 8MB]
- LTC Survey Pathways - Updated 08/03/2018 [ZIP, 5MB]* – *Including important documents/forms that surveyors use such as: Dining Observation, Kitchen Observation; Critical Element Pathways for Nutrition, Pressure Ulcers, Hydration, Tube Feeding Status, Dental Status and Services, Dialysis, Hospice and End of Life Care and Services, etc.*
- LTCSP Procedure Guide - Updated 08/03/2018 [PDF, 877KB]
- LTCSP Initial Pool Care Areas - Updated 12/12/2018 [ZIP, 1MB]
- Survey Resources - Updated 12/12/2018 [ZIP, 14MB]
- CMS-802 - Updated 12/12/2018 [PDF, 178KB]
- LTCSP Interim Revisit Instructions - Updated 08/03/2018 [PDF, 71KB]
- Initial Surveys [ZIP, 734KB]

Related Links

- MLN – Long Term Care Facilities
- Final Rule for Long Term Care
- Electronic Code of Federal Regulations
- Nursing Homes

General References:

- State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. Centers for Medicare and Medicaid Services. Rev 173, 11-22-17. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
- Dorner B. Diet and Nutrition Care Manual: A Comprehensive Nutrition Care Guide. Dunedin FL: Becky Dorner & Associates, Inc. 2016. (Please refer to this publication for a complete list of references.)
- Dorner B. Emergency/Disaster Plan for Food and Dining Services. Dunedin FL: Becky Dorner & Associates; 2018.
- Posthauer ME, Banks M, Dorner B, Schols JM. The Role of Nutrition for Pressure Ulcer Management: National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, and Pan Pacific Pressure Injury Alliance White Paper. *Advances in Skin & Wound Care*: April 2015 - Volume 28 - Issue 4 - p 175–188. doi: 10.1097/01.ASW.0000461911.31139.62.
- Dorner, Becky, The Complete Guide to Nutrition Care for Pressure Ulcer Prevention and Treatment, Becky Dorner & Associates, Inc., Naples, FL. 2014.

- The Long Term Care Survey. American Health Care Association. (Revised Regularly.) http://www.ahcapublications.org/.

Professional Organizations

- American Diabetes Association, www.diabetes.org.
- Academy of Nutrition and Dietetics, www.eatright.org
- Dietetics in Health Care Communities, A dietetic practice group of the academy of nutrition and dietetics, www.dhccdpg.org
- Dietitians in Nutrition Support, a dietetic practice group of the Academy of Nutrition and Dietetics, www.dnsdpg.org.
- American Heart Association, www.americanheart.org.
- American Medical Association, www.ama-assn.org.
- American Public Health Association, www.apha.org.
- American Speech-Language Hearing Association, www.asha.org.
- American Society of Parenteral and Enteral Nutrition. (ASPEN). http://www.nutritioncare.org/.
- Association of Nutrition and Food Service Professionals, http://www.anfponline.org/.

Food Safety and HACCP

- Center for Food Safety and Applied Nutrition, http://www.healthfinder.gov/orgs/HR2504.htm.
- Centers for Disease Control and Prevention, www.cdc.gov.
- "Fight Bac" website, www.fightbac.org.
- Food Code 2017. U.S. Food and Drug Administration. https://www.fda.gov/downloads/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/UCM595140.pdf.
- Academy of Nutrition and Dietetics. Home Food Safety, http://homefoodsafety.org/.
- National Food Safety Information Network's Gateway to Government Food Safety Information, www.FoodSafety.gov.
- National Institute of Health), International Association for Food Protection (IAFP), www.foodprotection.org.
- United States Food & Drug Administration Hazard Analysis Critical Control Point. https://www.fda.gov/food/guidanceregulation/haccp/default.htm.
- International Association for Food Protection (IAFP), www.foodprotection.org.
- National Sanitation Foundation, www.nsf.org.
- Partnership for Food Safety Education, www.fightbac.org.
- USDA's Meat and Poultry Hotline: 1-888-MPHotline (1-888-674-6854).
- Safe Food Information Line: 1-888-SAFEFOOD (1-888-723-3366).

Nutrition

- Becky Dorner & Associates, Inc. www.beckydorner.com.
- Centers for Disease Control and Prevention. www.cdc.gov.
- Food and Nutrition Information Center, http://www.choosemyplate.gov.
- International Food Information Council Foundation, www.foodinsight.org.
- National Heart, Lung, and Blood Institutelwww.nhlbi.nih.gov.
- National Diabetes Education Initiative, www.ndei.org.
- National Institute of Diabetes and Digestive and Kidney Diseases, www.niddk.nih.gov.
- National Institute on Deafness and Other Communication Disorders (NIDCD) (part of the National Institute of Health), www.nih.gov.
- National Kidney Foundation, www.kidney.org.
- The National Pressure Ulcer Advisory Panel (NPUAP), www.npuap.org.
- U.S. Department of Health and Human Services, www.health.gov.
- U.S. Food and Drug Administration, Center for Food Safety and Applied Nutrition, http://www.healthfinder.gov/orgs/HR2504.htm.