

MANAGEMENT RECOMMENDATIONS OF KANSAS  
CONSULTING DIETITIANS

by 6291

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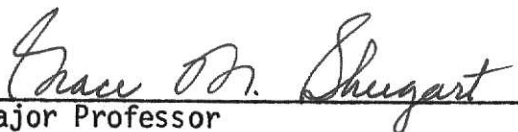
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## INTRODUCTION

The rapidly changing profession of dietetics has increased the opportunities and responsibilities of dietitians in the last decade. More recently the role of the dietitian as a consultant, a seldom considered speciality of dietetics in the past, has expanded. A consultant dietitian as defined for this report is a dietitian who advises and makes recommendations to the administrator concerning the services of the dietary department.

The change in the dietitian's role has been influenced by the enactment of Medicare and Medicaid and by the increased number of nursing homes and extended care facilities. The 1969 White House Conference on Food, Nutrition, and Health also focused attention on the profession of dietetics through its recommendations for nutrition education.

The demand for dietitians has been influenced by the increasing number of elderly people and subsequent legislation concerning their care. Conditions of Participation (United States Department of Health, Education and Welfare, 1966) of a Hospital and/or Extended Care Facility requires that "each facility have an organized dietary department directed by qualified personnel and integrated with other departments of the hospital. There is a qualified dietitian, full-time or on a consultant basis, and in addition, administrative and technical personnel competent in their respective duties."

Federal regulations were established in 1969 for skilled nursing homes for state requirement with respect to Medical Assistance under Title XIX of the Social Security Act, known as "Medicaid." Any skilled nursing home receiving payments under Medicaid must meet the following condition: "Food is prepared and served under competent direction, at regular and appropriate

times. Professional consultation is available to assure good nutritional standards and that the dietary needs of the patients are met."

To meet this challenge more qualified dietitians are needed who will continue to update their knowledge through workshops, meetings and professional education programs.

The Conditions of Participation for Hospitals and Extended Care Facilities under Medicare (1966) and Medicaid (1969) list standards that must be followed by the dietary service to participate in the federal program. Guidelines for consultants have been established by the American Dietetic Association (Robinson, 1966).

Articles about the role and duties of a consultant refer to the administrator of the facility as determining the effectiveness of the dietetic services. Many administrators, however, are apprehensive of the consultant's role because of a lack of understanding of the specific areas for which she is trained, especially in the field of institution management. An understanding of her role is necessary if she is to serve the facility effectively. At the present time, no research exists on the acceptance or effectiveness of the services and the knowledge in institution management that a consultant can offer.

Employment as a consultant dietitian in two facilities participating in the Medicare program was the incentive for this study. The objective of this report was to assess the use by Kansas nursing homes and small hospital dietary departments of the management recommendations made by consulting dietitians.

## REVIEW OF LITERATURE

### History of the Consultant Dietitian

A relative newcomer to the field of dietetics is the consulting dietitian according to Erlander (1970); however, the existence of a consultant can be traced back to 1917.

World War I gave the impetus to the first professional chartered organization of dietitians in 1917--the American Dietetic Association (Todhunter, 1965). During the 50th year anniversary celebration of the American Dietetic Association, Hart (1967) mentioned that from the beginning of the profession members were involved as consultants for hospital nutrition clinics and community health services.

In the 1920's according to Bowes (1961), nutrition consultations in child health centers and well baby clinics were important areas of service in the State Departments of Health.

During the early twenties to the mid-twenties, dietitians functioned as consultants to the directors of industrial cafeterias providing nutrition education programs and employee counseling (Barber, 1959). This activity led to the development of dietary consultation to institutions without trained personnel.

#### The 1930's

Brush (1965) stated that since 1932 there have been sporadic reports of diet counseling and consultation to nursing homes and small hospitals in therapeutics and food service administration especially in the western states.

In the 1930's steps were taken to establish the nutritionist as a member of the health team. A definite factor was provided with passage of the

Social Security Act of 1935 when the Children's Bureau gave financial assistance to all states and territories for nutrition services (Bowes, 1961).

Sadow (1956) reported a nutrition program for the New York City Relief Program which was initiated in 1934. Two years later the program was further developed and required a nutritionist in each district office. The nutritionist was equipped to act as a consultant on relief problems in family budgeting and nutrition.

The Visiting Nurse Association of Detroit in 1936 organized a nutrition program (Vaughn, 1966) in which a nutritionist provided consultation to staff and students and gave dietary instruction as prescribed by the physician for the patient in the home. The nutritionist, therefore, had a dual role--that of consultant and specialist ready to give direct service to patients when indicated.

#### The 1940's

In 1941, Mary I. Barber was called to Washington, D. C. to act as an advisor and connecting link between the Army Food Program and the parents of newly drafted soldiers (Barber, 1959). A little later her title became Food Consultant to the Secretary of War. She advised on the food to be sent to troops overseas and on the food included in prisoner of war packages. In 1942 the Tennessee Health Agency appointed a dietitian to its nutrition staff. Her primary function was to serve in a consultant capacity to two tuberculosis hospitals and three detention homes, all under the state's agency direction (Stacey, 1948).

Hall (1944) cited untapped possibilities for employment for dietitians. She predicted that a dietitian specializing in administration would have an enviable position as a consultant in the post war period and that consultation

services of the therapeutic dietitian and nutritionist in public health were being sought.

The need by members of the American Dietetic Association for consultation services in 1945 was cited by Barber (1959). To meet the need for assistance with the administrative problems growing out of building programs, the services of an administrative adviser were made available to members upon request without charge except for travel expenses (Anon., 1947).

In 1945, a dietitian was appointed as a consultant to the Illinois Health Agency to improve the quality of food service in hospitals caring for wives and infants of servicemen. Her services were made available to many hospitals in the state without a dietitian. Priority, however, was given to hospitals providing obstetrical service in accordance with the Maternity Hospital Law requiring that "satisfactory facilities shall be provided for the serving of well cooked, well planned meals." Such legal requirements gave the dietary consultant's recommendations to the administrator tremendous weight (Stacey, 1948). Furthermore, Herbolzheimer (1947) cited a statute governing the licensure of nursing homes in Illinois that specified the diet must be "related to the needs of each resident and based on good nutritional practice and on recommendations which may be made by the physician attending the resident." These legal requirements with regard to food service standards and specific regulations gave added confidence to the validity of recommendations made by the consultant.

Stacey (1948) described what one hospital administrator in Michigan did to improve food service in a small, twenty bed hospital during the war years. He prevailed upon a retired dietitian to spend one day a week at his hospital. From that informal beginning grew a plan whereby a dietitian was employed as a full time consultant.

In 1946, a food consultation service was provided for stewards on the Great Lakes Freighters (Stewart, 1946). The Nutrition Service of the Cleveland Health Council received a request from a personnel director of one of the lake shipping companies to assist the food stewards in selecting a more varied and nutritious menu.

The passage of the Hill Burton Act, Public Law 725, by Congress in 1946, also encouraged a few states to employ qualified dietitians. This law was designed to help states with the construction of hospitals and health centers and to meet the need for more hospital beds and for community health centers. As state health departments and special hospital commissions began to work with plans for remodeling and construction of new hospitals, they found it desirable to have qualified dietitians on the staff. The consultant dietitian conferred with architects, hospital board members, hospital administrators and members of the medical staff (Jones, 1950).

In January, 1946, the Journal of the Home Economics Association listed the qualifications for a nutritionist who acts primarily in a consultant capacity and has neither responsibility for supervision of a staff of workers nor close technical supervision. Two general types of services were outlined: (1) general consultation to a given area or (2) service limited to a special field such as consultation in group or institutional feeding. A recommendation was made that the nutrition consultant have two years' successful paid experience as a nutritionist in a health agency carrying on a nutrition and health program plus one of graduate study (Anon., 1946).

In 1947 Piper (1949) started an institution-nutrition consultant service. This was considered an entirely new nutrition service to the public, she was told. She would be pioneering the field in the Southwest. Her services

during the first year were centered on child-care institutions, state or private, convalescent homes, maternity homes, and tuberculosis hospitals. A letter was sent to the State Board of Public Affairs announcing her services. Private institutions learned of this new service either through the County Public Health Department or through introductory visits by the consultant.

In 1937, the nutrition program for Illinois hospitals began as a direct service from state level to local communities. Ten years later the program began to operate on an area basis with each nutritionist providing consultation in a region comprised of groups of local health units (Herbolsheimer, 1947). The consultants' services were originally planned to meet the needs of smaller hospitals without trained dietitians, but they have been used to a greater extent in larger hospitals with dietitians. The consultant visited the hospital by appointment and only one day was allowed for each visit. A later development in the Illinois hospital assistance program was a series of nine one-day conferences on Hospital Food Service. The series was co-sponsored by the American Hospital Association, Illinois Hospital Association, Illinois Dietetic Association, and the Division of Maternal and Child Health of the State Department of Public Health. Since there was not a precedent for this type of in-service training of voluntary and other hospital employees, these meetings were highly experimental. The objectives were to promote, foster and encourage interest in better food service by furnishing information on all phases of hospital food service. The purpose was to bring to the administrators, dietitians, food service supervisors, and other hospital personnel interested in food service, the latest information on hospital dietary management and to give those in attendance an opportunity to talk about their problems.



In July, 1948 a nutrition consultant was added to the three year old Nutrition Section of the Public Health Service, according to Barber (1959). The consultant was to assist the state and local health departments in development of local nutrition programs, staff education programs, and adaptation of methods and techniques of dietary appraisal.

According to the Public Health Reports (1955), the Indiana State Board of Health employed an institution-nutrition consultant to help hospitals, children's institutions and day nurseries, county homes for welfare recipients with their dietary and food service problems. Dunham (1955) reported that in 1953 mental and correctional institutions were included in the improved food program. The consultant's work covered four major areas: surveys to check compliance with the nutrition standards required for State annual licenses; consultant services to individual hospitals; consultation on dietary facilities in new or remodeled hospitals; and group instruction.

Van Cleft (1948) reported the employment of a dietary consultant by the Vermont Department of Public Health in 1948 to assist small, private hospitals, nursing homes and children's institutions. Dietary consultation services for the McCormick Fund began in Chicago in 1948 for children's institutions including camps and schools (Peterson, 1948).

Maryland State Department of Health hired a full-time dietary consultant in 1949. A flexible approach was used by the consultant to deal with typical problems in institutions ranging from a 500 bed hospital to a small nursing home (Heseltine, 1959).

Jones (1950), in reporting a survey of 25 per cent of the state health departments in 1949, had found it advisable to employ full-time qualified dietitians as consultants. These data were obtained by the Community



Nutrition Section of the American Dietetic Association from a survey of the dietary assistance being given to institutions without trained personnel.

The need for consultation service was the result of several factors:

1. In most states, the majority of hospitals were under 50 beds.
2. With the increasing recognition of nutritional requirements, higher standards for food service were being universally accepted.
3. The shortage of qualified dietitians has resulted in many small institutions being without full-time services of a dietitian.

In 34 of the 38 states studied, some kind of dietary assistance to small institutions was being offered. The need for assistance to tuberculosis and mental hospitals was recognized more quickly than the need for help in other types of institutions. However, many childrens' homes also had services of a consultant. The majority of requests for assistance were for menu planning, menu evaluation, and diet therapy. The amount of time spent by the consultants in the institutions varied, but in all instances it was quite limited because 81 per cent of the consultants spent one day or less.

#### The 1950's

The Food and Nutrition Board of the National Research Council was organized in 1950 to work toward the improvement of nutrition of people and of dietary management in various institutions (Jeans, 1950). Surveys showed that many institutions had poor dietary regimens and were lacking the services of a dietitian or a person having dietary training. A means of increasing the knowledge and improving the practices of those in charge of institutional diets were sought. Available suitable printed material for reference and instruction was indicated as a first step. The American Dietetic Association was requested by the Food and Nutrition Board to prepare a series

of articles to be used by and through the consulting dietitian.

Beeuwkes (1950) stated that a comparatively new field of dietetics--consulting dietetics--with its techniques and procedures needed to be developed. With these factors in mind, a series of articles on menu planning, food preparation, storage and waste, rules and problems of sanitation, layout and equipment, accounting and food cost control, and employee training was developed and published in the Journal of the American Dietetic Association in 1950.

In eastern Tennessee, according to Yeo (1951), the public health nutritionist worked in a consultant capacity. She worked with local personnel so that nutrition would become a part of their everyday health teaching. In the Rochester Child Health Institute, the nutritionist gave consultant services to public health nurses to enable them to instruct patients in clinics and improve diet counseling at the time of home visits (Lowenberg, 1951). Nutrition consultants gave indirect service to pregnant women, nursing mothers, and mothers of children through the public health nurses.

In 1951, a review of the shortage of dietitians showed 59 percent of the hospitals were located in towns of less than 5,000 people. The majority of these small hospitals could not afford trained dietitians even if they were available. Barber (1959) stated that this situation was being met in part by a new type of service--the development of consultant dietitians. The convention program of 1951 American Dietetic Association meeting included sessions on the development of dietary consultation to small hospitals.

Smith (1955) reported hiring of a consultant in Houghton, Michigan in 1955 for a home for the aged. Ohio State Health Department in 1955 began providing dietary consultation to the state's local institutions because the

local health departments could not always meet this need (Public Health Reports, 1955).

The Nursing Home Committee in Chicago has carried on education activities for nursing home food services since 1956 (Anon., 1966). By workshops and the bi-monthly publication of "Food Facts," the committee endeavored to promote a better working relationship between the nursing home administrator and the consulting dietitian. This was accomplished by giving the administrator a better understanding of the type of help the dietitian could provide.

Under the provision of a Public Health Service grant, the Connecticut Hospital Association in 1956 hired a consultant designated as a Food Service Specialist to begin work on a "Project for Improved Personnel and Dietary Administration." The initial action was to conduct a survey to determine specific areas of need in Connecticut hospitals. Recommendations were formulated by a project committee concerning areas for priority action. The committee recommended the specialist concentrate on these areas:

1. Provision of direct consultation with emphasis upon dietary costs.
2. Support and extension of state programs for training of food service supervisors.
3. Promotion of educational meetings.
4. Encouragement of inservice training of dietary workers.
5. Recruitment of qualified personnel to fill existing needs.
6. Maintenance of personal contact with other agencies and professional associations of potential help to the project (Foster and Hartman, 1959).

After 17 months of the project the study demonstrated that:

1. Utilization of the consulting service was not related to hospital size since larger hospitals had used the service as much as smaller hospitals.

2. Participation in educational meetings was related to hospital size--the larger the hospital, the greater the participation.
3. Both the consultation and training functions proved to be in such demand that it was doubtful one dietary consultant could handle a greater number of short-term hospitals or cover a larger geographical area than was represented by the Connecticut project.

During the 17 month study, the project sponsored a one week institute for dietitians and administrators covering the six specific needs as mentioned earlier. The Connecticut Hospital Association is believed to have provided the first trial of dietary consultation service (1) for all general hospitals of a state and (2) as a voluntary service without force of licensure.

In 1957, administrators in New Jersey were notified of the availability of a dietary consultant by their state hospital association. This was made possible by a grant-in-aid from the New Jersey Department of Health, according to Robertson (1959). The consultation service was provided at the request of the individual hospital administrator. In a 21 month period a total of 42 hospitals were visited. The dietary consultant found six major areas of dietary operation in which most of the dietary departments needed help: (1) initial preparation or revision of diet manual written in common terminology, (2) training personnel in the sanitary handling of food, (3) standardized recipes, (4) preparation of food closer to time of service, (5) job descriptions and work schedules for employees, and (6) patient visitation.

A nutrition consultant was employed in 1958 by the Health Insurance Plan of Greater New York, a voluntary community sponsored medical care program based on group practice and prepayment. In initiating nutrition services to its members, a program was projected for educating the physician and establishing the nutritionist as part of the group medical personnel. The

nutritionist gave diet therapy instruction and nutrition education to individual patients (Katz, 1963).

In 1959, a set of suggested guides for medical care in nursing homes and related facilities was developed jointly by the American Nursing Home Association and the Council of Medical Service of the American Medical Association (Anon., 1959). Among these guides was one relating to nutritional care: "Each nursing home shall consider using consultative services in nutrition and diet therapy provided by the state health department or by other agencies or persons qualified to perform such service and should assure that all dietary regimes ordered by the patient's physician are carried out."

#### The 1960's

Diet counseling was established in 1960 in New Jersey according to Brush (1965). This community service to aid the patient referred by his physician for help with special diets or normal nutrition was begun after a 1960 survey revealed inadequate nutrition service in one South Jersey County. Nutritionists interviewed non-hospitalized patients and instructed them in carrying out the physician's diet prescriptions. The counselor worked with the patient and his family and took into consideration factors that influence food habits in planning a therapeutic diet.

Brunini (1965) stated that financial grants-in-aid from the State of New Jersey Department of Health were used in 1960 to establish each service with future support gradually absorbed by the employing agency or other community funds or contributions. In nursing homes, the diet counselors were obtained to help with inservice training and with often encountered family nutrition problems. In hospital-based services, the counselor functioned as a consultant to members of the dietary department and other professional staff. In

the future, Brunini anticipated that the services might be expanded to include consultation to hospitals and institutions in the field of administrative dietetics.

Spears (1961), in recounting her experiences as a consultant-shared dietitian in four hospitals in Arkansas, stated that in some hospitals she was a consultant and in others a shared dietitian. Since there was lack of supervision in many hospitals, she insisted that there be a dietary supervisor before beginning any corrective measures. Her services would be useless if there was no one to carry out her plans when she was off duty. Menu writing was almost nonexistent and sanitation standards low. Spears conducted a class for food service managers dealing with special diets and problems of supervision of the dietary department.

Many convalescent and nursing homes for the aged did not employ well-trained personnel for food service according to Bowes (1961). Poorly planned meals, unsavory and unappetizing in appearance and/or service, were common problem areas. Nutrition consultant services and in-service education programs through conferences, workshops and institutes were sorely needed. She recommended that nutrition programs function by giving consultant service upon request to all units in official states agencies, local agencies, local school districts, voluntary agencies and industries. She contended this was the most efficient use of nutritionist's service in most states. She suggested sharing through participation in staff conferences nutrition information with other members of the health team who have broad contacts with groups and individuals.

The Nursing Home Standards Guide published by the United States Public Health Service in 1961 stated "it would be highly desirable to have the

services of a professionally qualified dietary consultant," state licensure regulations generally had not included a requirement for this service (Smith, 1966).

Piper (1964) reported that in 1963 one half of all the state health agencies employed dietary consultants and nutritionists to provide consultation to group care facilities.

In 1964, a dietitian joined the staff of the S.S. Hope, which according to Matthewson (1968) had as its mission the upgrading of medical knowledge in the countries visited. All visits were by invitation, and the dietitian ideally would train local dietitians on the hospital ship and would go to their hospitals as advisers.

Two workshop programs, one at the University of Maryland and the other at the University of Chicago, focused attention on the needs of nursing homes and related long-term care facilities for dietetic services. In addition, these programs provided an opportunity for dietitians to receive orientation in the special problems of nursing home food service and the difference between consultation and supervision (Smith, 1965). Both programs were planned to be responsive to three basic requirements: inculcation of the principles, procedures and attitudes of successful consultation; presentation, for refresher purposes, of material concerning new trends in food service equipment and management; and orientation concerning the nursing home as an institution and a place of work. Two additional goals of the program were listed: (1) to provide experiences in the consultation process for dietary consultants, and (2) to acquaint dietary consultants with techniques and materials for teaching adults and to increase their proficiency in teaching and in the use of visual aids.



Montag (1967) cited the definition for Dietary Consultant submitted to the Dictionary of Occupational Titles by the American Dietetic Association as:

DIETARY CONSULTANT (profess. & kin.) 077.128. consultant dietitian; institution-nutrition consultant. Advises and assists public and private establishments, such as child care centers, hospitals, nursing homes, and schools, on food service management and nutritional problems in group feeding: Plans, organizes, and conducts such activities as in-service training courses, conferences and institutes for food service managers, food handlers, and other workers. Develops and evaluates informational materials. Studies food service practices and facilities, and makes recommendations for improvement. Confers with architects and equipment personnel in planning for building or remodeling food service units.

Medicare, Title XVIII of Public Law 89-97, the Health Insurance for the Aged Program, was enacted in 1966 (United States Department of Health, Education and Welfare, 1966). The Medicare program has two parts--hospital insurance and medical insurance. The hospital insurance provides basic protection against cost of: (1) inpatient hospital care, (2) post-hospital extended care, and (3) post-hospital home health care. Everyone, 65 or older, who is entitled to monthly cash Social Security or railroad retirement benefits is eligible for hospital insurance. The second part of the Medicare program--medical insurance--is voluntary and is financed by monthly premiums shared by the enrollees and by the Federal Government. The medical insurance provides supplemental protection against cost of physicians services, medical services and supplies, home health care services, outpatient hospital services and therapy and other services (United States Department of Health, Education and Welfare, 1970).

Piper and Smith (1967) pointed out specific requirements that must be met by participating hospitals and extended care facilities, to assure that Medicare pays only for care that meets adequate standards. Requirements for participating hospitals and extended care facilities are listed in the



Appendices A and B. Conditions of Participation for the Dietary Department for a hospital (United States Department of Health, Education and Welfare, 1966) states that "the hospital has an organized dietary department directed by qualified personnel." Standard A in the Conditions states:

There is an organized department directed by qualified personnel and integrated with other departments of the hospital. There is a qualified dietitian, full-time or on a consultation basis, and in addition, administrative and technical personnel competent in their respective duties.

Factor 1. There are written policies and procedures for food storage, preparation, and service developed by a qualified dietitian (preferably meeting the American Dietetic Association's standards for qualification).

The Conditions of Participation for the Dietary Department for Extended Care Facility (United States Department of Health, Education and Welfare, 1966) states that "the dietary service is directed by a qualified individual and meets the daily dietary needs of patients." Standard A in the Conditions states:

A person designated by the administrator is responsible for the total food service of the facility. If this person is not a professional dietitian, regularly scheduled consultation from a professional dietitian or other person with suitable training is obtained. Factor 1. A professional dietitian meets the American Dietetic Association's qualification standards.

Factor 2. Other persons with suitable training are graduates of baccalaureate degree programs with major studies in foods and nutrition.

Factor 6. Consultation obtained from self-employed dietitians or dietitians employed in voluntary or official agencies is acceptable if provided on a frequent and regularly scheduled basis.

Birk, Piper and Smith (1967) describe regularly scheduled consultation as 4 hours or more each week as preferable; however, the United States Public Health Service recommends, as a minimum, one full day or two half-days per month.

Guidelines for Part-time and Consulting Service for dietitians (Appendix C) were developed under a contract with the United States Public Health

Service, Division of Medical Care Administration. Included also were these qualifications for part-time or consulting dietitians: (1) knowledge of the science of nutrition, (2) background in diet therapy, (3) experience in food service management, (4) mature judgement and adaptability, (5) basic understanding of the needs in the particular facility, and (6) interest in and understanding of people, their idiosyncrasies, problems, and needs (Robinson, 1967).

Lane (1967) reported a three day workshop, one of a nation-wide series of 27, at the University of Minnesota for consulting dietitians to nursing homes and small hospitals. Discussions at these workshops, which were supported by a short-term traineeship grant for the Public Health Service (Nyhus, 1967), centered around the interpretation of licensing regulations and the Conditions for Participation under Medicare, interpretation of food service in nursing homes, and discussion of the different ways a dietitian might provide service, salary levels, and resource materials.

Guidelines for developing dietary counseling service in the community were prepared in 1969 by the Community Nutrition and Diet Therapy sections of The American Dietetic Association. Suggested guidelines included determining the needs; defining, developing, promoting, and operating the service; and evaluating its effectiveness, and development of service to the community which included the use of outside personnel used as consultants (Anon., 1969).

Federal regulations for skilled nursing homes from the Federal Register recently set forth state requirements for Medicaid--Title XIX of the Social Security Act. Any skilled nursing home receiving payments under Medicaid must meet the following conditions: "Food is prepared and served under competent direction, at regular and appropriate times. Professional consultation

is available to assure good nutritional standards and that the dietary needs of the patients are met." Another condition requires skilled nursing homes to: "Make satisfactory arrangements for professional planning of menus and meal service for patients for whom special diets or dietary restrictions are medically prescribed." (Anon., 1969)

## Role of the Consultant

### Definition of Role

For a dietary consultant to serve an institution most effectively, the parties concerned should have a clear understanding and acceptance of the consultant's role according to Montag (1969). Time spent in developing an understanding of this role at the onset, before the consultant assumes her responsibilities in an institution, should prove to be most worthwhile for all concerned. Many authorities support her views (Hartman, 1966; Lane, 1966; and Henderson and Cook, 1967).

McWhorter (1966) asserted that the role of a consultant can be most challenging and, depending upon the explanation of what a consultant does, the work can be either gratifying or frustrating. She defined a dietetic consultant as a dietitian who renders service and gives advice. The role of the consultant is to open new horizons and to present alternatives or the advantages and disadvantages of any given situation without becoming personally involved. The consultant fulfills her role by working through others. Positive and constructive communications are particularly important for effectiveness. The consultant must gain the confidence of people on all levels with whom she has contact so that she is able to "sell" first herself and then her knowledge and ideas.

McMahon (1950) believed that a consultant must be able to evaluate a dietary department and interpret the situation or solution to lay personnel. This interpretation is one of the greatest advantages of the consultant's services.

Many authors have discussed the role of the dietary consultant. Stief (1967) identified the dietary consultant's role as one of helping an administrator of a small hospital, nursing home or child care facility to arrive at solutions to the problems of providing good food service and dietary management to the institutions' residents. Hartman and Foster (1959) reported that the major objective of the food service specialist was to improve the production and service of food and in so doing, improve all aspects in the management and control activities of the dietary department. Hille (1961) also stated that the consultant's ultimate goal is to increase the knowledge and practice of others.

Erlander (1970) described the role of the consultant dietitian as one who observes, evaluates, recommends and may instruct, but does not actually direct the food service or do any of the jobs involved. She is frequently the liaison between the kitchen and the patients, nursing staff, doctors, and administration. Consultants have been referred to as catalysts by Hille (1961) because they cause or accelerate action but do not necessarily participate in it. The facility, however, has the option of accepting or rejecting the consultant's suggestions. Van Cleft (1948) referred to the consultant most descriptively as a "listening" dietitian. In her work she discovered people wanted to talk over their problems with someone who has worked in institutions, who knows the daily difficulties and therefore provides a sounding board for their problems.

McWhorter (1966) contended that the consultant normally "wears many hats." She may be: (1) the eyes and ears of the dietary department informing the administration of internal problems; (2) a "trouble shooter" or mediator for the hospital, for the administrator, for the dietary department and for their personnel; (3) the "go-between" for the dietary department, the doctors, the nurses, and the administrator; (4) the financial expert recommending salaries, budgets, purchasing procedures and control methods; (5) the specialist on layout or design and work with architects during remodeling or planning of dining rooms and kitchens; (7) the personnel management authority recommending personnel, staffing patterns, changes in staffing patterns, job specifications, and job descriptions; (8) the teacher--planning and conducting in-service training programs for dietary personnel and professional staff; (9) the sanitarian-safety consultant; (10) the resource person with up to date information.

As early as 1947, the need for dietary consultation by small hospitals was recognized according to Bracken (1947) who also contended that directors of small institutions must realize the need for advice from a dietitian before consultation can be effective. Lane (1966) voiced similar contentions and further stated the nursing home administrator determines the effectiveness of the dietitian's knowledge and ideas and how she will work in the home. Robinson (1967) stated that effective communication between the administrator and the dietitian must be maintained if the objectives and goals of both parties are to be achieved.

Consultation is a two-way process, and it is essential for the dietary consultant to have one person in the facility with whom she will work and coordinate her activities (Hartman, 1968). Foster and Hartman (1959) found

in their survey of Connecticut hospitals that "it takes two to make a good consultation: the effective consultant and the receptive client."

#### Employment by the Facility

Consultation begins with the initial interview with the administrator. According to Robinson (1967), this interview centers around a discussion of current problems in the dietary department. The administrator will normally want information concerning the dietitian's qualifications. Montag (1969) advised that the administrator should develop a job description that would provide a basis for discussion in the initial interview with the administrator and the consultant. The interview should result in information about the job, about the level of objectives and future goals, and an accurate picture of the administrators' concept of the consultants' role in the facility. The administrator should be able to measure the consultant's qualifications and her ability to deal with interpersonal situations against the specific requirements of the job. Spears (1961) suggested that at the initial interview, the consultant should require that the administrator appoint a food service supervisor or cook manager through whom the consultant could function.

The first meeting between the administrator and dietary consultant is an important one according to Lane (1966). A mutual understanding and a spirit of cooperation must be established during the interview. The dietitian must explain her working techniques and her interpretation of the role. Hartman (1966) indicated the administrator should understand the dietary consultant's role in relation to her professional training and to the particular needs of the facility.

#### Administrator's Responsibilities

Before a dietitian makes a decision to serve a hospital or other small

institution as a consultant, she should be assured of the wholehearted support of the administrator. The success of a consultant's program depends upon the administrator's attitude in developing a dietary department which will fulfill standards of service to patients and personnel (Utah Dietetic Association, 1967). Marshall (1967) outlined the basic steps to be taken by a nursing home administrator in establishing a successful dietary program with a consulting dietitian. Initially, the administrator lends support to the consultant by creating an atmosphere for cooperation with the consultant and by backing up procedures introduced by the dietitian. Montag (1969) and Owen (1965) agreed that the consultant requires the full support and backing of the administrator to be accepted by the food service supervisor.

After the initial interview, the consultant and the administrator should agree on the extent of the services provided, time required, rate of pay, and method of payment (Montag, 1969). The agreement may be a written or verbal contract. The decision on the type of agreement rests with the individuals involved (Robinson, 1967).

Before the consultant begins work, the administrator should clearly explain the function of the consultant to the supervisor, as well as the two way relationship that should exist between them (Montag, 1969). Organizationally, the relationship is one that is complex in nature because both the consultant and the supervisor report directly to the administrator. The supervisor is responsible for the overall operation of the dietary department and the consultant is accountable only for the technical advice that she provides. The supervisor should be made aware that the consultant is able to supply information based on sound management practices and will be a source of help to the supervisor; that the hiring of a consultant is neither a



result of dissatisfaction with his performance nor a threat to his position and status.

### Effective Consultation

Developing and maintaining harmonious relationships is the responsibility of the consultant. The approach and attitude of the consultant set the tone and are important in the establishment of good rapport. The consultant must be accepted and respected by the hospital staff so that the staff accepts her suggestions. The consultant should proceed in a leisurely manner during her first contact with the dietary department personnel. If the first visit follows a request for assistance, Hille (1961) suggested that the problems causing the request be considered first before proceeding into other areas.

Hille (1961) also indicated that effective consultation depends on getting requests for help from hospitals that need and can profit from the service. Consultation depends on developing a two-way relationship so that the staff will make available to the consultant the information that is needed for evaluation. Current practices must be analyzed before practical, realistic and sound recommendations can be made. The dietary consultant must sincerely believe and convince the hospital staff that these workable solutions will improve practices. The staff must understand that the recommendations are based on established standards and not given in criticism. The consultant must continue to support the institution in carrying out her recommendations.

Communication with other professionals is essential in consulting, Robinson (1967) indicated. The dietitian should discover how the work of other health professionals relates to the dietary department. The director



of nurses is normally the coordinator of patient care in nursing homes and related facilities. The consultant should establish close working relationship with her and with all nursing service personnel. Communication should be frequent and informal because the nursing personnel normally have some responsibilities in the meal service to the patients. Nurses are concerned about the procedure and time schedule for serving meals, between meal feedings, and modification of diets. They also provide help for patients who can not feed themselves or who need assistance.

The goals for the dietary department are achieved only with the cooperation of the dietary department personnel. It is essential that effective communication be established with the food service supervisor because he is the person through whom recommendations must be implemented. The consultant should involve the food service personnel in planning because it will enable them to understand reasons for recommended changes. A wise approach for the consultant is to build on the system already in use with careful consideration of the practicality of the recommendations (Robinson, 1967).

Montag (1969) suggested that the consultant should work closely with the food service supervisor from the beginning. The consultant must convince the supervisor of her specialized skills and knowledge and how she can help the food service supervisor achieve his goals. The consultant can help the supervisor arrive at his own decisions, but the supervisor should regard any changes as his own and should assume responsibility for putting them into effect. Montag (1969) asserted that the success of the consultant depends largely upon her ability to develop in the food service the degree of self-sufficiency required to meet high standards of performance in her absence.

Since motivation is largely a matter of leadership, it is the responsibility of the consultant to motivate the supervisor and other food service

workers to adopt her recommendations. Finally, the consultant should bring such intangibles to the job as patience, reliability, tolerance, flexibility, understanding and professional ethics (Montag, 1967).

### Activities of the Consultant

Robinson (1965) reported that management now is definitely different from management when the first administrative dietetic internship began. Changes in labor costs and food processing, and incorporation of computers have changed the role of the food service administrator. Today the administrator must be knowledgeable and skilled in up-to-date planning for both effective and economical operations, in setting realistic goals for the future and implementing policies to attain these goals, and in developing educational programs for personnel. Dietitians must become business management experts to keep pace with industry and to maintain their own high standards.

The consultant, Montag (1967) contended, is only responsible for the technical advice she provides. The consultant may provide advice, counsel and service in the processes of management. The consultant may give recommendations for: (1) future proposed policies, procedures and plans; for example, the purchasing of new equipment for a new type of tray service; (2) establishment of new methods of accounting and budget records; (3) development of new programs and installation of them; for example, new employee job descriptions; (4) establishment of a new method of measuring performance; (5) determination of methods of control for the dietary department; for example, an inventory control; and (6) development of in-service training programs.

A list of the detailed activities or responsibilities of the consultant

is included in Appendix A, B, and C. The Utah Dietetic Association (1967) listed two additional responsibilities: establishing good rapport and making recommendation in writing. Daub (1968) also listed some additional responsibilities of the consultant: (1) listen to the employees or food service supervisors and what they have to say about their work situation, (2) gain the employees' confidence, and (3) designate an employee (if not already done) as the food service supervisor to be trained and to be responsible for the dietary department and carrying out the programs suggested by the consultant and approved by the administrator.

Stief (1967) listed four essential steps for effective dietary consultation: (1) request for assistance, (2) development of mutual respect which includes the dietitian's understanding of the consultee, (3) joint exploration of the problem, and (4) working through the problem to a solution. Stief (1967) stated that these steps are not discrete and often overlap and intertwine. These steps may be used as guides but it takes a person with ability to gain satisfaction from seeing others succeed and the forbearance to see others fail in a job that you could do. Consultation is a two-way relationship that requires sensitivity, alertness, and skill.

McWhorter (1966) asserted that a dietary consultant should be a competent dietitian who does her best to meet the goals and objectives of the dietary department, serving nutritionally adequate food, properly prepared, served in an attractive manner in pleasant surroundings, keeping in mind the availability of resources and the structure of the facility. Hille (1961) asserted that consultants can play an important role in acquainting the hospital staff with the resources of the community and in encouraging the consultants to provide a continuity of care from hospital to home.

### Types of Consulting Services

Pettee (1963) indicated that there were unlimited opportunities for the dietary consultants to establish various types of dietary services all over the country. Five types of consulting dietary services have been reported: (1) private practice, (2) self-employed, (3) legal partnership, (4) the "Package Plan," and (5) dietary consultation under one management.

The private patient who is not hospitalized is often in need of nutritional help but this assistance may not be available to him, according to Pettee (1963). A consultant dietitian in private practice can provide this service. The location of the consultant's office, acquainting the physicians in the area with her services and open communication with physician are essentials in establishing a private practice. Pettee lists the qualifications of the nutritional consultant as enjoyment from working with people, realization of the complexities of the psychological aspects of nutrition, experiences in working with physicians, ability to offer advice on menu planning and on food purchasing and preparation and knowledge of the economic factors involved in therapeutic modifications.

MacRea (1967) listed the steps in establishing a private dietary consulting service:

1. The consultant must have sound financial backing. If necessary, she must be able to live for at least a year with no income from her practice. She must also have funds in order to equip and operate her facility for a minimum of six months.
2. The consultant must canvass the area to determine the need for a dietary consulting service.
3. The consultant must select a location where public transportation is available and in close proximity to doctor's offices or clinics.

4. The consultant must be a good teacher, be familiar with foreign foods, dietary religious laws, basic food preparation, must meet people readily, have public speaking experience and if possible some general office training or experience.

The self-employed dietary consultant, as described by Williams (1967), is a consultant dietitian who advises a number of nursing homes or hospitals. She must arrive at an agreement with the administrator regarding her responsibilities, the goals of the department, the time needed for her services and her salary.

Woodward (1967) reported the experience of a group of dietitians who formed a company under their own name to study the nutritional needs of the nursing homes in their area. The goals of the company were: (1) to give aid, training, materials and guidance to the consultant dietitians; (2) to provide the consultant with professional recognition as a member of the health team; (3) to provide the consultant with a well paying position; and (4) to provide informative professional service to a nursing home in a short period of time at a reasonable cost. Steps were then taken to become a legal partnership. Group practice such as this has many advantages and disadvantages. The biggest advantage to the nursing home is that it receives the total company service, which includes the advice and the supervision of the company dietitians as well as the services of the consultant; also the company guarantees a continuity of service. The possible disadvantages of group practice are the amount of time and money spent in the operation and the difficulty in collecting fees.

Henderson and Cook (1967) established a business partnership as a consulting team composed of an administrative dietitian and therapeutic

dietitian with complementary knowledge that could be most effective to a nursing home and/or small hospital. Such a team can offer valuable service in providing better quality food, standardized recipes, accurate therapeutic diets, and cost control. The team approach can provide the necessary nutritional assistance without having dietitians on the staff of the nursing home, convalescent homes, or small hospitals. Knoll (1968), in reporting a consulting firm in California, cited a good background in hospital dietetics as essential for consulting work.

The "package plan" is for consulting dietitians who prefer a more structured approach (Marshall, 1968). The total "package" used by Food Art Horizons consists of six parts: (1) six week menu cycle covering all diets, (2) purchasing guide for weekly menus, (3) 325 standardized quantity recipes, (4) diet manual, (5) specifications for meats, and (6) a training guide. Marshall (1968) indicated the first step in putting the program into effect was selling the ideas and program to the administrator. The second step was to adapt the program to the particular facility. The third step was to furnish supervision weekly, for example, training personnel and supervising the kitchen. The advantages of the "package plan" have been time savings in development of the basic tools of management and the amount of control achieved of the dietary department activities. The disadvantages are the expense of purchasing the program and changing the staffs' habits to follow a new program.

Oliver (1968) described the consulting dietitian service to a group of nursing homes under one management in which the services of the consultant employed by one organization is the same type of service given by consultants employed under different types of arrangements. The number of facilities

served by the dietary consultant under one management may vary under different organizations, however this type of service has many distinct advantages. Oliver (1968) feels that it is necessary for the consultant to transmit information regarding the dietary department to the administrator via written reports. One of the greatest advantages is the flexibility of time so that the consultant can adjust her time to the facility according to their current needs. Other advantages may include group purchasing, inservice training, personnel administration, budgetary control and increased contracts with patients and physicians.

### Effect of Health Programs on the Consultant

#### Shortage of Dietitians

Several factors have brought about an increased demand for dietitians to provide service on a part-time or consulting basis, thus contributing to an existing shortage of professional dietitians (Robinson, 1967). Enactment of federal legislation of health insurance for the aged (Medicare) and an increase in the number and size of hospitals, nursing homes, and related facilities are forcing expansion of professional dietary services.

A significant shortage of professional dietitians existed before the enactment of Medicare. Heseltine (1958) and Barber (1959) suggested that the demand for dietitians was not only for their nutritional knowledge but also for knowledge of administration and flexibility of approach in dealing with problems in various size institutions.

Cashman (1967) cited a 1964 American Dietetic Association survey that estimated between 3000 and 3500 unfilled positions for full-time, part-time or consulting dietitians. In 1965, less than one percent of nursing homes



and related long-term care facilities employed professional dietitians. Cashman warned that a solution to the manpower shortage in dietetics must be sought immediately and that qualified professionals who are not working must be brought back into the field even if only on a part-time or consulting basis.

Piper and Youland (1968) reported results of a survey conducted jointly in 1967 by the American Hospital Association and Public Health Service indicating an acute need for 1600 hospital dietitians although for optimal care 3600 were needed. Also estimated was a need for 1000 dietitians to provide full or part-time consultation to extended care facilities.

In a study of dietary consultation in Iowa, only 19 of the 165 hospitals surveyed were not receiving some type of service from a dietitian (Piper and Youland, 1968). One hundred dietitians were professionally unemployed until the enactment of the Medicare legislation. Vaughn (1968) indicated that as care-at-home (home health) programs are developed or expanded, there will be an increasing need for nutritional consultation.

The most recent conditions (Anon., 1969) for skilled nursing homes serving Medicaid patients has placed an additional load on the dietitian's services to nursing homes therefore causing an even more acute shortage of professionally qualified dietitians.

A projection of dietitians' services for the period of 1966 to 1975, as reported by Graning (1970), indicated a need for 9,000 new dietitians plus the 8,000 dietitians who were already working in the field.

Three major roles were suggested by Piper and Youland (1968) for dietitians in the future: (1) executive and leadership, (2) medical care team and (3) consultant. In the executive and leadership role, dietitians must be



prepared to practice techniques and principles of management more efficiently and in the medical care team role, to increase contacts with patients and other members of the medical team. The consultant role has come into being because of the changing nature of health care.

#### Challenge to the Dietitian

Dietitians are faced with one of their greatest challenges since the beginning of the profession as a result of Medicare and other health programs (Nyhus, 1967). Dietitians must "sell" their profession and must perform in a manner that will convince those who use the services of dietitians that their contribution to patient care is indispensable. Nyhus (1967) also stated that many administrators have questioned the cost of services provided by dietitians.

Knoll (1968) observed that although administrators are required to request a consultant's services some are not familiar with the services they can render or what can be expected from them. Therefore it is the responsibility of dietitians as professionals to provide this information to administrators.

Nyhus (1967) indicated that the work of the dietitian is being examined very critically. The quality of work being done by dietitians will affect the status of dietetics as a profession. Consultant dietitians must concern themselves with professional standards in the practice of dietetics.

Piper and Youland (1968) contended that as an individual consultant to nursing homes, hospitals, and extended care facilities, dietitians must evaluate strengths, capabilities and the needs of the institutions to successfully accomplish the accepted responsibilities. These newly accepted responsibilities have opened up the new door of self-employment and as a

result, offered another new challenge. Many other authorities concurred with this view (Cashman, 1967; Smith, 1967; and Piper, 1967).

Consultants must be concerned with continuing education to update their knowledge and to meet the challenges of the many opportunities available. Several states have offered courses or workshops for consultant nutritionists and dietitians to help up-date and familiarize them with the duties of a consultant under the various health programs (Cashman, 1967).

#### Effect of Health Programs on the Dietary Department

The enactment of Medicare has had many positive results for dietary services. Facilities covered by Medicare and other health programs now employ a dietitian, nutritionist or other person with suitable training. Smith (1967) indicated that these facilities have upgraded all aspects of their dietary service. Lane (1969) stated that Medicare has brought to participating facilities a dietary consultant, which has been very badly needed, and that dietary consultation has resulted in an organized dietary department. Consultants, working mainly with administrators and food service supervisors, have provided dietary personnel with pertinent information and ideas and have developed training programs to guide employees. Another positive result is the assurance that patients are receiving adequate nutrition within the budget limitations of the facility. Effective communication has eased tension between the food service division and other departments in the facility, especially the nursing service.

The Hospital and Nursing Home Management Magazine (1966) wrote Medicare legislation would not appreciably affect the design of dietary department facilities, but would result in improved conditions and standards. It would

lead to the service of nutritionally adequate diet in facilities formerly offering substandard diets. In hospitals, there would be an increase in the number of special diet trays due to the increased numbers of older patients with special dietary problems.

Lane (1969) listed priorities for the dietitian: (1) assistance in planning or evaluating the general menu, (2) training programs for dietary employees, (3) coordinating the patient nutritional care with other staff members, (4) developing the dietary treatment of patient care policies, (5) attention to therapeutic diets and (6) visiting and counseling patients. Nyhus (1967) indicated that one of the most important by-products of Medicare is the close working relationships among dietitians.

## PROCEDURE

### Development of Questionnaire

A questionnaire was selected as the appropriate instrument for obtaining data on management policies and procedures from consultant dietitians. The questionnaire (Appendix E) consisted of a comprehensive checklist of 32 questions. Twenty eight covered general management facets of the dietary department. The remaining six questions requested additional information about the size and type of the facility, number of hours worked monthly by the consultant, and the respondent's education and professional background.

Questions were based on the Conditions of Participation of a hospital and/or extended care facility in the Medicare program (United States Department of Health, Education and Welfare, 1965) and on recommendations from a Dietitians' Role in Nursing Homes and Related Facilities (Robinson, 1967).

The questionnaire was pretested by five graduate students in the Institutional Management Department at Kansas State University who have been or are employed as consultant dietitians.

A cover letter (Appendix D) included a brief description of the study, a statement assuring respondents of anonymity and an appeal to encourage the respondents to complete and return the questionnaire. Brief instructions for completing and returning the data also were included. Self-addressed stamped envelopes were enclosed to facilitate response.

#### Selection of Study Sample

The study was limited to hospitals and nursing homes under 100 beds within the state of Kansas. Names and addresses of the hospitals were obtained from the American Hospital Association (Hospitals, 1969) and the Kansas State Department of Health (1970). Listings of nursing homes were obtained from the Kansas State Department of Health (1969). Names of the consultant dietitian in each facility were unavailable, so the questionnaire was directed to the Consultant Dietitian.

A total of 181 questionnaires were mailed, 99 to nursing homes and 88 to hospitals. To obtain a representative sampling of the state, questionnaires were sent to one hospital and one nursing home in each of the 104 counties where these facilities existed. When possible, the two questionnaires per county were sent to different cities within that county.

#### RESULTS AND DISCUSSION

Of the 181 questionnaires mailed to consultant dietitians, 92 were returned and 65 were useable for this study (Table 1). Questionnaires from

full-time and part-time dietitians were not included in the results of this study. Eight questionnaires returned by individuals without professional training but who considered themselves consultant dietitians also were deleted. Six of these respondents worked in nursing homes and two in small hospitals. Their educational background ranged from a high school diploma to two years of college. Four had some formal training in food service supervision and four had not. Also disqualified was one questionnaire from a dietitian who had no responsibilities other than checking menus.

Table 1. Responses to mailed questionnaire.

Respondents	No.
Consultant dietitians	65
Full-time dietitians	3
Part-time dietitians	8
Non-professional personnel	8
Facility without consultant dietitian	7
Responsibility limited to menu checking	1
Total	92

The remaining 65 questionnaires were from professional dietitians who served in a consultant capacity as identified for this study. Characteristics of the study sample are detailed in Table 2.

Sixteen consultants were employed in nursing homes and 49 in hospitals ranging from less than 40 beds to more than 100. Only 10 institutions employed a food service supervisor who had completed formal schooling. Six were in hospitals and four in nursing homes. In addition, employees in seven hospitals were currently enrolled in the Food Service Supervisors Correspondence Course of the American Dietetic Association (Appendix F).

Table 2. Characteristics of study sample.

	No.
Education of consultant	
B.S. and ADA membership <sup>1</sup>	35
B.S.	20
M.S. and ADA membership	8
M.S.	1
No answer	<u>1</u>
	65
Place of employment of consultant	
Nursing home	16
Hospital	<u>49</u>
	65
Staffing patterns	
FSS <sup>2</sup> employed	10
FSS not employed	<u>55</u>
	65
FSS and consultant	
ADA consultant with B.S.	2
ADA consultant with M.S.	2
Non-ADA consultant with B.S.	<u>6</u>
	10

<sup>1</sup>ADA = American Dietetic Association

<sup>2</sup>FSS = Trained food service supervisor

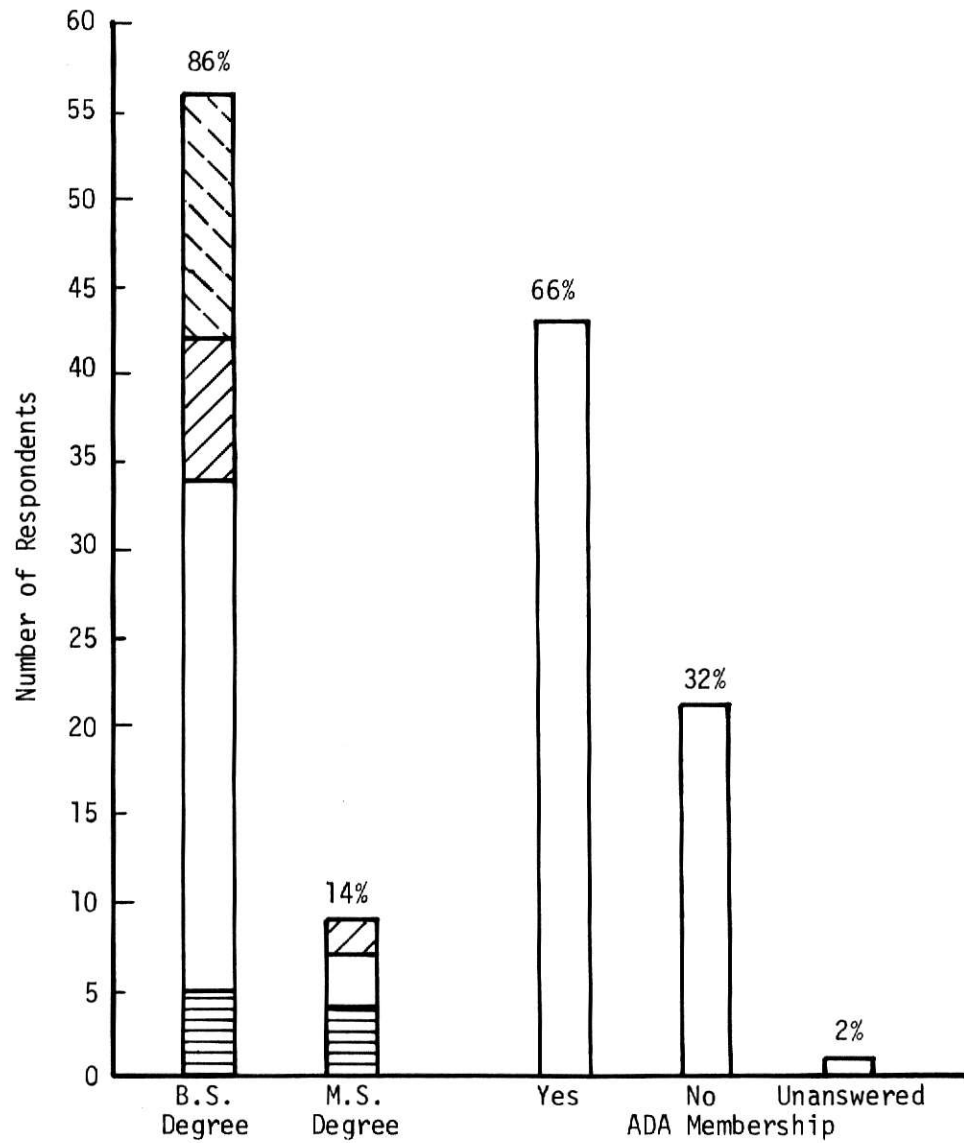
The educational and professional background of consultants are illustrated in Figure I. A total of 40 respondents (62%) majored in Institutional Management. Forty-three respondents were members of the American Dietetic Association.

Twenty-five consultants (38.5%) worked between 8 and 10 hours a month (Table 3). Although Medicare requires a consultant to work only eight hours monthly, 21 in this study worked more than 20 hours.

Numbers of employees in the dietary departments studied varied within

FIGURE I

Education and Professional Background of Consultant



Combination of 3 Fields



Foods and Nutrition



Institution Management and Dietetics



Home Economics

Table 3. Hours worked monthly by consultant.

Hours worked	Less than 40 beds		40-60 beds		60-80 beds		80-100 beds		More than 100 beds		Total	
	NH <sup>1</sup>	H <sup>2</sup>	NH	H	NH	H	NH	H	NH	H	No.	%
Less than 8	-	-	-	1	-	-	-	-	-	-	1	1.5
8-10	-	10	2	7	-	1	2	2	1	-	25	38.5
10-12	-	4	-	-	2	-	1	-	-	-	7	10.8
12-16	-	2	-	1	1	2	-	-	-	-	6	9.2
16-20	-	2	-	-	-	-	1	-	1	-	4	6.2
More than 20	-	7	1	6	-	1	3	3	-	-	21	32.3
No answer	-	-	-	-	-	-	1	-	-	-	1	1.5
Total	0	25	3	15	3	4	8	5	2	0	65	100.0

<sup>1</sup>NH = Nursing Home<sup>2</sup>H = Hospital

Table 4. Number of employees in facility.

Size of facility	No. of employees					Total
	1 to 4	4 to 8	8 to 10	10 to 15	More than 15	
Less than 40 beds	7	7	3	-	-	17
40 to 60 beds	1	5	4	1	1	12
60 to 80 beds	-	-	1	2	3	6
80 to 100 beds	-	3	1	1	8	13
More than 100 beds	-	-	-	-	2	2
Total	8	15	9	4	14	50



each of the size categories (Table 4). In the facilities with less than 40 beds, seven had one to four employees, seven had four to eight, and three had eight to ten employees. Similar variations were found in the other categories, with the greatest variation evident in the 80 to 100 beds, where three institutions had four to eight employees and eight had more than 15. Fifteen replies were not included because of apparent misunderstanding of the questions. Most of the facilities in this study apparently employed less personnel than those reported in a study by Vaden (1967). Based on statistics of the United States Public Health Service, staffing patterns of dietary departments in small hospitals were suggested as follows:

Beds	Less than 40	40 to 60	60 to 80	80 to 100	More than 100
Employees	6 or less	6-8	8-10	10-12	12 or more

Responses to questions concerning the consultants' knowledge of the facility prior to employment are included in Table 5. Almost 94 percent had

Table 5. Consultants' knowledge of facility.

Question		All respondents	
		No.	%
No. 5	Interview with administrator before accepting the position	61	93.8
No. 6	Duties outlined in interview with administrator	47	72.3
No. 7	Written job description of consultant	37	56.9

a pre-employment interview with the administrator with 72.3 percent indicating the administrator had outlined responsibilities in the interview. A pre-employment interview according to Montag (1969) should reduce the possibility of misunderstanding about her responsibilities after employment.

Montag also advises that the administrator should develop a job description for the consultant. In this study, however, only 56.9 percent of the consultants had written job descriptions developed by the consultant or consultant and the administrator in most cases (Table 6).

Table 6. Development of consultant's job description.

	No.	%
Respondent and administrator	13	35.1
Respondent	10	27.1
Previous consulting dietitian	5	13.5
Administrator	4	10.8
Unanswered	3	8.1
Previous consulting dietitian, respondent and administrator	1	2.7
Previous consulting dietitian, respondent and nursing service director	1	2.7
Total	37	100.0

#### Management Practices

In response to questions concerning written management policies, 73.8 percent of all respondents had written policies describing the purposes and objectives of the dietary department (Table 7). Almost 68 percent had organization charts for the dietary department, and 53 percent had written policies concerning meal service (i.e., tray service, dining room). Most had written policies governing meal hours. A higher percentage of consultants with Masters' degree, those working with trained Food Service Supervisors and current members of the American Dietetic Association had organization charts than the total studied respondents. Robinson (1967) stated written policies can aid in smooth operation of the dietary department, regardless of its size.

Table 7. Written management policies.

Question	All respondents		Respondents with M.S.		Respondents with FSS <sup>1</sup>		ADA respondents	
	No.	%	No.	%	No.	%	No.	%
No. 12 Purposes or objectives of dietary department	48	73.8	7	77.8	7	70.0	29	67.4
No. 14 Organization chart	44	67.7	8	88.9	8	80.0	32	74.4
No. 13 Type of meal service	35	53.8	7	77.8	7	70.0	20	46.5
No. 10 Governing meal hours	56	86.2	8	88.9	9	90.0	37	86.0
No. 11 Who eats in dietary department	49	75.4	7	77.8	9	90.0	29	67.4
No. 21 Job description of dietary department employees	57	87.7	7	77.8	9	90.0	38	88.4
No. 23 In-service training for dietary department employees	46	70.1	6	66.7	8	80.0	31	72.1
No. of respondents	65		9		10		43	

<sup>1</sup>FSS = Trained Food Service Supervisor

She further recommended that policies be approved by the administrator and coordinated with other departments because if properly used they represent the framework of the department. Many authorities support these views (Piper and Smith, 1968; Hartman, 1966; Owens, 1965; and United States Department of Health, Education and Welfare, 1966).

A high percentage of facilities had written job descriptions for their dietary departments (Table 7). Piper and Smith (1967) emphasized the importance of job descriptions for dietary department personnel that are written and available. Others share their views (Owen, 1965; and United States Department of Health, Education and Welfare, 1966).

In-service training was conducted in 70.1 percent of the dietary departments studied and in 80 percent of those in which consultants worked with trained food service supervisors. The majority of in-service training programs were conducted once a month as shown below:

Once a week	2
Once every 2 to 3 weeks	3
Once every month	30
Once every 2 to 3 months	10
As needed	1

Piper and Smith (1968) and others (Robinson, 1967; Montag, 1967; United States Department of Health, Education and Welfare, 1966) stated that there should be an in-service training program available for dietary employees.

#### Menu Planning

Menus were routinely evaluated by the consultant in 98.5 percent of the dietary departments (Table 8). Robinson (1967) indicated an appropriate responsibility of a consultant was routine evaluation of menus planned by

Table 8. Menu planning practices.

Question	All respondents		Respondents with M.S.		Respondents with FSS <sup>1</sup>		ADA respondents	
	No.	%	No.	%	No.	%	No.	%
No. 9 Routine evaluation of menu	64	98.5	9	100.0	10	100.0	43	100.0
14 hour span between evening meal and breakfast	39	60.0	5	55.6	5	50.0	24	55.8
No. 16 Use of cycle menu	56	86.2	8	88.9	10	100.0	39	90.7
No. 20 Use of standardized recipes								
all of the time	15	23.1	1	11.1	5	50.0	5	11.6
some of the time	44	67.7	7	77.7	5	50.0	35	81.4
none	5	7.7	1	11.1	-	-	2	4.7
no answer	1	1.5	-	-	-	-	1	2.3
No. of respondents	65		9		10		43	

<sup>1</sup>FSS = Trained Food Service Supervisor

the food service supervisor; however instruction or assistance with menu planning may be necessary.

Conditions of Participation for Extended Care Facilities (United States Department of Health, Education and Welfare, 1966) require a span of 14 hours between a substantial evening meal and breakfast. Only 60 percent of the consultants checked on this requirement (Table 8). The cycle menu was used in 86.2 percent of the facilities. Most of the menu cycles were two to three weeks in length.

2 to 3 weeks	32
4 to 5 weeks	18
6 weeks	4
more than 6 weeks	1

Smith (1967) and Robinson (1967) stated that a file of standardized recipes should be available in a dietary department. Many times, this file does not exist until a consultant is on the job. Standardized recipes were used some of the time in 67.7 percent of the dietary departments.

#### Food Preparation Practices

Sixty-two consultants observed food production and service procedures and evaluated the food being served during their schedule visits (Table 9). One of the consultant's responsibilities listed by Robinson (1967) was the observation of food production and service procedures also stressed by Robinson and United States Department of Health, Education and Welfare (1966) was the preparation of food by methods that conserve nutritive value, flavor, and appearance. Additional factors emphasized were temperature, size of serving and acceptability to the clientele.

Table 9. Food preparation practices.

Question	All respondents		Respondents with M.S.		Respondents with FSSI		ADA respondents	
	No.	%	No.	%	No.	%	No.	%
No. 9								
Observation of food production and service procedures	62	95.3	9	100.0	9	90.0	41	95.3
Evaluation of food (acceptability, taste, appearance, temperature, and size of servings)	62	95.3	9	100.0	9	90.0	40	93.0
Evaluation of sanitation of food handling procedure and practices	59	90.8	9	100.0	9	90.0	41	95.3
Evaluation of the adequacy and use of equipment	52	80.0	7	77.7	8	80.0	34	79.1
No. of respondents	65		9		10		43	

<sup>1</sup>FSS = Trained Food Service Supervisor

Sanitation of food handling procedures and practices were evaluated by the consultants in 90.8 percent of the dietary departments (Table 9).

Robinson (1967), Piper and Smith (1967) and Smith (1967) stated that maintenance of sanitary conditions in food storage, preparation and serving of food was an appropriate responsibility of the consultant.

Eighty percent of the consultants evaluated adequacy and use of equipment (Table 9). Robinson (1967) and United States Department of Health, Education and Welfare (1966) stressed the appropriate type, size, and layout of equipment provided for adequate food preparation.

#### Working Relationships in Facilities

Effective communication had been established between administrators and consultants in 93.8 percent of the dietary departments studied (Table 10). Robinson (1967) emphasized that a close working relationship between the consultant and the administrator is necessary if a service responsive to the objectives are to be achieved.

Seventy-eight percent of all consultants but only 50 percent of the consultants who had trained food service supervisors felt they had a close working relationship (Table 10). A higher percentage was noted in the respondents with master's degrees and those who were American Dietetic Association members. Montag (1969) and Robinson (1967) noted that the consultant must work closely with the food service supervisor from the onset.

Consultants worked satisfactorily with other key personnel contributing to total patient care in 75.3 percent of the dietary departments (Table 10). A higher percentage was found among respondents with master's degrees and those who had trained food service supervisors. A close working relationship should be established between the dietitian and physician and also nursing



Table 10. Working relationships.

Question	All respondents		Respondents with M.S.		Respondents with FSS <sup>1</sup>		ADA respondents	
	No.	%	No.	%	No.	%	No.	%
No. 9 Working relationships								
with administrator	61	93.8	9	100.0	10	100.0	33	76.7
with food service supervisor	51	78.5	8	88.8	5	50.0	40	93.0
with other key personnel providing service to promote coordination of dietary care	49	75.3	8	88.8	9	90.0	34	79.1
No. of respondents	65		9		10		43	

<sup>1</sup>FSS = Trained Food Service Supervisor

personnel especially with the director of nursing service according to Robinson (1967).

One half of the consultants reviewed the food budget with the administrator. A higher number of consultants who had master's degrees reviewed the food budgets. Robinson (1967) cited this responsibility was appropriate for the consultant.

### Management Recommendations

Almost 94 percent of the respondents were able to make management recommendations to the administrator (Table 11). A higher percentage was found in the subgroupings of respondents with master's degrees and with membership in the American Dietetic Association. A lower percentage was reported by the consultants who had trained food service supervisors employed in the dietary department.

One-half of all consultants felt that management recommendations were considered by their administrators (Table 11). A lower percentage was found among consultants with master's degrees. The highest percentage was reported by consultants who had trained food service supervisors employed.

Three-fourths of the consultants indicated that some of their management recommendations were actually adopted by the administrator while only 13.8 percent said the administrator adopted all of their recommendations (Table 11). All of the consultants with master's degrees reported that some of the management recommendations were adopted by the administrator. The highest percentage of administrators who adopted all recommendations was reported by consultants who had trained food service supervisors. Montag (1967) contends that the consultant should provide advice, counsel and services in the

Table 11. Consultant's management recommendations.

Question	All respondents		Respondents with M.S.		Respondents with FSS <sup>1</sup>		ADA respondents	
	No.	%	No.	%	No.	%	No.	%
No. 25 Able to make management recommendations to administrator								
yes	61	93.8	9	100.0	9	90.0	42	97.7
no	2	3.1	-	-	-	-	-	-
unanswered	2	3.1	-	-	1	10.0	1	2.3
total	65	100%	9	100.0	10	100.0	43	100.0
No. 26 Administrator's consideration of recommendations to management problems								
all	33	50.7	3	33.3	6	60.0	20	46.5
some	25	38.5	6	66.7	3	30.0	18	41.9
very few	3	4.6	-	-	-	-	3	6.9
unanswered	4	6.2	-	-	1	10.0	2	4.7
total	65	100%	9	100.0	10	100.0	43	100.0
No. 27 Administrator's adoption of recommendations to management problems								
all	9	13.8	-	-	3	30.0	4	9.3
some	49	75.4	9	100.0	6	60.0	34	79.1
very few	3	4.6	-	-	-	-	3	6.9
unanswered	4	6.2	-	-	1	10.0	2	4.7
total	65	100%	9	100.0	10	100.0	43	100.0

<sup>1</sup>FSS = Trained Food Service Supervisor

processes of management especially in the techniques and methods of planning, organizing, coordinating and controlling.

Sixty-nine percent (45) of the respondents submitted written reports to the administrator (Appendix F). Seventy-eight percent (7) of the consultants with master's degrees indicated that they submitted written reports to the administrator. The lowest percentage, 30 percent (3), was reported by consultants who had a trained food service supervisor employed. The Utah Dietetic Association (1967) suggested in their detailed list of responsibilities for the consultant that all recommendations to the administrator should be made in writing.

#### Comments of Respondents

A number of the respondents provided additional data about their jobs or the facility in which they were employed. Their comments provide additional insight into the role of the consultant, the employees, and the administration in the small hospital or nursing home in which they were employed. The more pertinent comments are quoted below:

"Cycle menus are completely impractical in this type of facility with no central buyer and several part-time cooks and sources of supply limited."

"Standardized recipes will be worked on but again it is difficult with several long time cooks. In a small town, cooks are hard to find so they can't be discouraged."

"The acting food service supervisor is not formally trained. She will retire in two years and be replaced by a cook who is presently enrolled in the ADA Food Service Supervisors Course."

"The acting food service supervisor is a former displaced person who cooked for officers in charge of a concentration camp and for the Army when they were liberated. She is now a Citizen of the U.S."

"Five of the nine employees who work in the dietary have a total of 71 years of experience working in food service. This includes,

restaurants, school lunch, and college cafeteria besides the time worked in the nursing home."

"The effectiveness of any recommendations being carried out depends on the food service supervisor. My acting supervisor in this institution has been here for a number of years and really isn't interested in making any changes. She is a good, faithful cook but weak as a supervisor."

"In my opinion, a consultant's job is most frustrating--I do not get the satisfaction from this type of position versus a full-time position. Perhaps it is the follow-through or maybe the feeling of not really BELONGING?"

"Since this new role is obviously for small facilities, I feel that any progress can be attained only by reaching the existing cooks who have "run" the kitchen heretofore. I am writing a cook's manual as needs and questions arise, to attempt to teach them in their language some basics of diet therapy, hoping they will refer to it when questions arise. Cooks in kitchens are not trained like we are and can't be expected to know all the whys and wherefores."

"The plan here was set-up as a training program for the dietary supervisor after which she was to take full responsibility for the operation of the department with the dietitian acting as a problem solver. As a consultant, the obligations have diminished as the association progressed and the dietary supervisor was better equipped to handle the department such as in-service training classes being offered weekly then every other week, then once each month until now quarterly. Thus when I first started here as a consultant, I visited the hospital twice each week then twice each month and starting in December will visit only once each month. However, I am on call for problems and still handle the in-service training for modified diets. The kitchen is staffed with long-term employees devoted to the job - unusual today."

"This is an exceptional facility in that the care would be rated excellent. The administrator and R.N. are very cooperative and always ready to try a new idea for continued improvement."

## CONCLUSIONS

The majority of the consultants in this study were able to make management recommendations to the administrator but it was obvious that the administrator did not always consider or implement the recommendations. It is apparent that the consultant needs to educate the administrator in the specific areas of management in which she is qualified. In turn the

consultant should evaluate the management practices within the dietary department of the facility. This study indicated that employment of a food service supervisor will benefit the consultant in implementing management practices and recommendations.

Consulting dietitians should keep abreast of the newest techniques and methods in management. This can be accomplished by continuing education in the form of workshops, college courses, professional education meetings or independent study.

#### SUMMARY

The purpose of this study was to assess the use by Kansas nursing homes and small hospitals dietary departments of management recommendations made by consulting dietitians. A questionnaire was mailed to the consultant dietitians in a selected sample of 181 nursing homes and small hospitals under 100 beds. The first part of the instrument was designed to gather classification data, the second part information concerning the various management practices in the dietary department, and the third part to determine the acceptance or adoption by the administrator of the consultant's management recommendations.

Ninety-two questionnaires were returned and 65 were useable. Classification data indicated eight respondents were individuals who considered themselves consultant dietitians; although they did not have the necessary professional qualifications.

The strongest area of management practices in the dietary department was reported in observation of food production and service procedures, evaluation of food, routine evaluation of the menu, and a close working relationship with the administrator.

The weakest area of management practices in the dietary department was reported in written job description of the consultant, a written policy for the type of meal service, use of standardized recipes in food preparation and review of the food budget with the administrator.

The study indicated that the majority of the consultants were able to make management recommendations to the administrators. However only one-half of the consultants felt the administrator considered all their recommendations. Three-fourths of the consultants indicated that only some of their management recommendations were adopted by the administrator.

In comparing the data between the various groups of the study sample, the management practices were higher in the dietary departments with consultants who had trained food service supervisors employed.

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## APPENDIX A

### Conditions of Participation for Hospitals (1966)

## APPENDIX A

## CONDITIONS OF PARTICIPATION FOR HOSPITALS (1966)

## VI. DIETARY DEPARTMENT

THE HOSPITAL HAS AN ORGANIZED DIETARY DEPARTMENT\*  
DIRECTED BY QUALIFIED PERSONNEL.

## Standard A

There is an organized department directed by qualified personnel and integrated with other departments of the hospital. There is a qualified dietitian, full-time or on a consultation basis, and in addition, administrative and technical personnel competent in their respective duties.

Factor 1. There are written policies and procedures for food storage, preparation, and service developed by a qualified dietitian (preferably meeting the American Dietetic Association's standards for qualification).

Factor 2. The department is under the supervision of a qualified dietitian who is responsible for quality food production, service, and staff education. The dietitian serves on a full-time basis if possible or, in smaller hospitals, on a regular part-time supervising or consulting basis.

Factor 3. In the absence of a full-time dietitian, there is a qualified person serving as full-time director of the department who is responsible for the daily management aspects of the department and the dietitian visits the hospital at intervals to supervise and instruct personnel.

Factor 4. The number of professional dietitians is adequate considering the size of the facility and the scope and complexity of dietary functions.

Factor 5. Supervisors, other than dietitians, are assigned in numbers and with ability to provide a satisfactory span of control to meet the needs of the physical facilities and the organization as well as coverage for all hours of departmental operation.

Factor 6. The number of personnel, such as cooks, bakers, dishwashers, and clerks, is adequate to perform effectively all defined functions.

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\*A hospital which has a contract with an outside food management company may be found to meet the conditions of participation if the company has a therapeutic dietitian who serves, as required by scope and complexity of the service, on a full-time, part-time, or consultant basis to the hospital and provided the company maintains the minimum standards as listed herein and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment.

Factor 7. Written job descriptions of all dietary employees are available.

Factor 8. There is an inservice training program for dietary employees which includes the proper handling of food and personal grooming.

#### Standard B

Facilities are provided for the general dietary needs of the hospital. These include facilities for the preparation of special diets. Sanitary conditions are maintained in the storage, preparation, and distribution of food.

Factor 1. All dietary areas are appropriately located, adequate in size, well lighted, ventilated and maintained.

Factor 2. The type, size, and layout of equipment provides for ease of cleaning, optimal work-flow and adequate food production to meet the scope and complexity of the regular and therapeutic diet requirements of the patients.

Factor 3. Equipment and work areas are clean and orderly. Effective procedures for cleaning all equipment and work areas are followed consistently to safeguard the health of the patient.

Factor 4. Lavatories specifically for handwashing, including hot and cold running water, soap and approved disposable towels, are conveniently located throughout the department for use by food handlers.

Factor 5. There are procedures to control dietary employees with infections and open lesions. Routine health examinations at least meet local, State, or Federal codes for food service personnel.

Factor 6. The dietary department is routinely inspected and approved by State or local health agencies as a food handling establishment. Written reports of the inspection are on file at the hospital with notation made by the hospital of action taken to comply with recommendations.

Factor 7. Dry or staple food items are stored at least 12 inches off the floor in a ventilated room which is not subject to sewage or waste water back-flow, or contamination by condensation, leakage, rodents or vermin.

Factor 8. All perishable foods are refrigerated at the appropriate temperature and in an orderly and sanitary manner.

Factor 9. Foods being displayed or transported are protected from contamination and held at proper temperatures in clean containers, cabinets or serving carts.

Factor 10. Dishwashing procedures and techniques are well developed, understood, and carried out in compliance with the State and local health codes and with periodic check on:



(1) Detergent dispenser operation; (2) Washing, rinsing, and sanitizing temperatures and cleanliness of machine and jets; (3) Routine bacterial counts on dishes, flatware, glasses, utensils and equipment; and (4) Thermostatic controls.

Factor 11. All garbage and kitchen refuse which is not disposed of through a disposal is kept in leakproof nonabsorbent containers with close fitting covers and is disposed of daily in a manner that will not permit transmission of disease, a nuisance, or a breeding place for flies. All garbage containers are thoroughly cleaned inside and out each time emptied.

### Standard C

There is a systematic record of diets, correlated, when appropriate, with the medical records.

Factor 1. Therapeutic diets are prescribed in written orders on the chart by the physician and are as instructive, accurate, and complete as possible; for example, bland low residue diet or, if a diabetic diet is ordered, the exact amounts of carbohydrate, protein, and fat allowed are noted.

Factor 2. Nutrition needs are met in accordance with the current Recommended Dietary Allowances of the Food and Nutrition Board, National Research Council, and in accordance with physician's orders.

Factor 3. The dietitian has available an up-to-date manual of regimens for all therapeutic diets, approved jointly by the dietitian and medical staff, which is available to dietary supervisory personnel. Diets served to patients are in compliance with these established diet principles.

Factor 4. The dietitian correlates and integrates the dietary aspects of patient care with the patient and patient's chart through such methods as patient instruction and recording diet histories and participates appropriately in ward rounds and conferences, sharing specialized knowledge with others of the medical team.

### Standard D

Departmental and interdepartmental conferences are held periodically.

Factor 1. The director of dietetics attends and participates in meetings of heads of departments and functions as a key member of the hospital staff.

Factor 2. The director of dietetics has regularly scheduled conferences with the administrator or his designee to keep him informed, seek his counsel, and present program plans for mutual consideration and solution.

Factor 3. Conferences are held regularly within the department at all levels of responsibility to disseminate information, interpret policy, solve problems, and develop procedures and program plans.

## APPENDIX B

Conditions of Participation for Extended  
Care Facilities (1966)

## APPENDIX B

CONDITIONS OF PARTICIPATION FOR EXTENDED  
CARE FACILITIES (1966)

## VI. DIETARY SERVICES

THE DIETARY SERVICE\* IS DIRECTED BY A QUALIFIED INDIVIDUAL  
AND MEETS THE DAILY DIETARY NEEDS OF PATIENTS.

## Standard A

## Dietary Supervision

A person designated by the administrator is responsible for the total food service of the facility. If this person is not a professional dietitian, regularly scheduled consultation from a professional dietitian or other person with suitable training is obtained.

Factor 1. A professional dietitian meets the American Dietetic Association's qualification standards.

Factor 2. Other persons with suitable training are graduates of baccalaureate degree programs with major studies in foods and nutrition.

Factor 3. The person in charge of the dietary service participates in regular conferences with the administrator and other supervisors of patient services.

Factor 4. This person makes recommendations concerning the quantity, quality, and variety of food purchased.

Factor 5. This person is responsible for the orientation, training, and supervision of food-service employees, and participates in their selection and in the formulation of pertinent personnel policies.

Factor 6. Consultation obtained from self-employed dietitians or dietitians employed in voluntary or official agencies is acceptable if provided on a frequent and regularly scheduled basis.

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\*Note - An extended care facility which has a contract with an outside food management company may be found to meet this condition of participation provided the company has a dietitian who serves, as required by the scope and complexity of the service, on a full-time, part-time or consultant basis to the extended care facility, and provided the company maintains standards as listed herein and provides for continuing liaison with the medical and nursing staff of the extended care facility for recommendation on dietetic policies affecting patient care.

## Standard B

### Adequacy of Dietary Staff

A sufficient number of food-service personnel are employed and their working hours are scheduled to meet the dietary needs of the patients.

Factor 1. There are food-service employees on duty over a period of 12 or more hours.

Factor 2. Food-service employees are trained to perform assigned duties and participate in selected inservice education programs.

Factor 3. In the event food-service employees are assigned duties outside the dietary department, these duties do not interfere with the sanitation, safety, or time required for dietary work assignments.

Factor 4. Work assignments and duty schedules are posted.

## Standard C

### Hygiene of Dietary Staff

Food-service personnel are in good health and practice hygienic food handling techniques.

Factor 1. Food-service personnel wear clean washable garments, hair nets or clean caps, and keep their hands and fingernails clean at all times.

Factor 2. Routine health examinations at least meet local, State or Federal codes for food-service personnel. Where food handlers' permits are required, they are current.

Factor 3. Personnel having symptoms of communicable diseases or open infected wounds are not permitted to work.

## Standard D

### Adequacy of Diet

The food and nutritional needs of patients are met in accordance with physicians' orders and, to the extent medically possible, meet the dietary

allowances of the Food and Nutrition Board of the National Research Council\* adjusted for age, sex, and activity.

### Standard E

#### Therapeutic Diets

Therapeutic Diets are prepared and served as prescribed by the attending physician.

Factor 1. Therapeutic diet orders are planned, prepared, and served with supervision or consultation from a qualified dietitian.

Factor 2. A current diet manual recommended by the State Licensure agency is readily available to food-service personnel and supervisors of nursing service.

Factor 3. Persons responsible for therapeutic diets have sufficient knowledge of good values to make appropriate substitutions when necessary.

### Standard F

#### Frequency and Quality of Meals

At least three meals or their equivalent are served daily, at regular times, with not more than a 14-hour span between a substantial evening meal and breakfast. Between-meal or bedtime snacks of nourishing quality are offered. If the "four or five meal a day" plan is in effect, meals and snacks provide nutritional value equivalent to the daily food guide previously described.

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\*The following daily food guide for adults is based on these allowances:

Milk - two or more cups.

Meat Groups - two or more servings: Beef, veal, pork, lamb, poultry, fish, eggs: occasionally dry beans, nuts, or dry peas may be served as alternates.

Vegetable and Fruit Group - four or more servings:

A citrus fruit or other fruit and vegetable important for Vitamin C.

A dark green or yellow vegetable for Vitamin A, at least every other day.

Other vegetables and fruits including potatoes.

Bread and Cereal Group - four or more servings of whole grain, enriched or restored.

Other foods to round out meals and snacks, to satisfy individual appetites and provide additional calories.

## Standard G

### Planning of Menus

Menus are planned in advance and food sufficient to meet the nutrition needs of patients is prepared as planned for each meal. When changes in the menu are necessary, substitutions provide equal nutritive value.

Factor 1. Menus are written at least 1 week in advance. The current week's menu is in one or more accessible places in the dietary department for easy use by workers purchasing, preparing, and serving foods.

Factor 2. Menus provide a sufficient variety of foods served in adequate amounts at each meal. Menus are different for the same days of each week and are adjusted for seasonal changes.

Factor 3. Records of menus as served are filed and maintained for 30 days.

Factor 4. Supplies of staple foods for a minimum of a 1-week period and of perishable foods for a minimum of a 2-day period are maintained on the premises.

Factor 5. Records of food purchased for preparation are on file.

## Standard H

### Preparation of Food

Foods are prepared by methods that conserve nutritive value, flavor, and appearance, and are attractively served at the proper temperatures and in a form to meet individual needs.

Factor 1. A file of tested recipes, adjusted to appropriate yield, is maintained.

Factor 2. Food is cut, chopped, or ground to meet individual needs.

Factor 3. If a patient refuses foods served, substitutes are offered.

Factor 4. Effective equipment is provided and procedures established to maintain food at proper temperature during serving.

Factor 5. Table service is provided for all who can and will eat at a table including wheelchair patients.

Factor 6. Trays provided bedfast patients rest on firm supports such as over-bed tables. Sturdy tray stands of proper height are provided patients able to be out of bed.

## Standard I

### Maintenance of Sanitary Conditions

Sanitary conditions are maintained in the storage, preparation, and distribution of food.

Factor 1. Effective procedures for cleaning all equipment and work areas are followed consistently.

Factor 2. Dishwashing procedures and techniques are well developed, understood, and carried out in compliance with the State and local health codes.

Factor 3. Written reports of inspections by State or local health authorities are on file at the facility with notation made of action taken by the facility to comply with any recommendations.

Factor 4. Waste which is not disposed of by mechanical means is kept in leak-proof nonabsorbent containers with close-fitting covers and disposed of daily in a manner that will prevent transmission of disease, a nuisance, a breeding place for flies, or a feeding place for rodents. Containers are thoroughly cleaned inside and out each time emptied.

Factor 5. Dry or staple food items are stored off the floor in a ventilated room not subject to sewage or waste-water backflow, or contamination by condensation, leakage, rodents, or vermin.

Factor 6. Handwashing facilities including hot and cold water, soap and individual towels, preferably paper towels, are provided in kitchen areas.

## APPENDIX C

Dietitians' Role in Nursing Homes (Robinson, 1967)



## APPENDIX C

## DIETITIANS' ROLE IN NURSING HOMES (ROBINSON, 1967)

APPROPRIATE RESPONSIBILITIES FOR CONSULTING DIETITIANS  
WORKING IN NURSING HOMES AND RELATED FACILITIES.\*

1. Analysis of the food intake of patients and recommendations to the administrator based on evident need for change in the menu pattern.
2. Review of the food budget with the administrator.
3. Consideration of the psycho-social needs of the patients as these affect food consumption.
4. Routine evaluation of menus planned by a food service supervisor or cook-manager. Instruction and assistance with the planning may be necessary.
5. Development of a system for planning modified diets, including adjustments for individual patients.
6. Implementation of the use of a diet manual which meets the needs of the specific facility.
7. Consideration of the frequency of meals (at least three meals with not more than a 14-hr. span between a substantial evening meal and breakfast).
8. Consideration of the availability of between-meal or bed-time snacks of nourishing quality if a three-meal plan is used. Consideration of the nutritional value (for the day) if a four- or five-meal plan is used.
9. Recommendation of a plan for recording and filing menus (to be kept at least one year), if such a plan is not already in effect.
10. Consultation with the administrator and food service supervisor or cook-manager about a satisfactory pattern for ordering food.
11. Observation of food production and service procedures.
12. Evaluation of food as to acceptability, taste, appearance, temperature, and size of servings.

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\*Dietitians will not necessarily assume all of these responsibilities in each facility, but will identify the responsibilities appropriate in each situation.

13. Consultation with food service personnel, making suggestions as to how recipe standardization may be achieved. Demonstrations and group discussions may be utilized to promote change.
14. Evaluation of sanitation and safety of food handling procedures.
15. Provision of information and assistance in establishing corrective measures in safe and sanitary practices. Instruction of food service personnel in group sessions, using discussion, visual aids, and pertinent literature.
16. Evaluation of the adequacy of staffing to provide the food and service required and to cover the department for a period of 12 hr. or longer.
17. Encouragement and assistance with the rewriting of work schedules and in determining number of employees required; making recommendations to administrator.
18. If work assignments are not posted, advising the food service supervisor or cook-manager of the need for doing so.
19. Evaluation of the adequacy and use of equipment to provide the food and service required. If additional equipment is needed, determining specific needs and informing the administrator.
20. Discussion with patients as to appetite, food habits, enjoyment of meals, and the menu pattern. Both the part-time dietitian and dietary consultant will have limited time to talk with patients. It is important, however, that this phase of responsibility be fulfilled to the extent of a better understanding of the dietary needs of patients.
21. Counseling patients and their families when special dietary needs indicate that explanations or instructions are needed.
22. Discussion with family members concerning food served to patients and food gifts brought to them.
23. Establishment of a close working relationship with the administrator so that food service will be coordinated effectively with the general management of the facility.
24. Frequent communication with other key personnel providing service in the facility to promote coordination of dietary care with total patient care.
25. Establishment of close working relationships with food service personnel.
26. Development of a practical plan for in-service training for food service personnel. The program should be "paced" to the possibilities for acceptance and understanding.
27. In-service training sessions may be less frequent and scheduling may be more difficult. This is, however, one of the most effective tools of the consultant.

28. Planning with the director of nursing for classes related to the responsibilities of nurses and nursing aides in food service.

APPENDIX D

Cover Letter



DEPARTMENT OF INSTITUTIONAL MANAGEMENT  
JUSTIN HALL

October 8, 1970

Dear Consultant:

Since the enactment of "Medicare", consulting dietitians have been in great demand to meet the conditions of participation for hospitals and extended care facilities. Guidelines and recommendations are available to help the consulting dietitian in her job. At this time no information exists on the extent of the acceptance of recommendations given by the consultant.

My study is an attempt to evaluate the management recommendations given by the consultant dietitian in nursing homes and small hospitals in Kansas. The information that you will provide us in the enclosed questionnaire will enable us to assess the management recommendations that you as a consultant make.

Please check the appropriate answer carefully. If you have any additional information or remarks you would like to add, please feel free to do so at the end of the questionnaire. Your answers should apply to the facility to which this letter is addressed; however, it is not necessary for you to identify yourself or your facility. Also enclosed for your convenience is a self-addressed stamped envelope for you to place your completed questionnaire in and drop it in the mail.

Thank you for your time and consideration in answering this questionnaire.

Sincerely,

(Mrs.) Grace M. Shugart  
Head, Department of  
Institutional Management

(Mrs.) Suzanne W. Hagwood  
Graduate Student

SWH/fr  
enc.

## APPENDIX E

### Questionnaire

## APPENDIX E

## QUESTIONNAIRE

Please check the answer that is most appropriate.

1. How many hours do you work each month?  
☐ 8 to 10 hours  
☐ 10 to 12 hours  
☐ 12 to 16 hours  
☐ 16 to 20 hours  
☐ more than 20 hours
2. What is the size of the facility?  
☐ less than 40 beds  
☐ 40 to 60 beds  
☐ 60 to 80 beds  
☐ 80 to 100 beds  
☐ more than 100 beds
3. How many employees do you have in your facility?  
☐ 1 to 4 employees  
☐ 4 to 8 employees  
☐ 8 to 10 employees  
☐ 10 to 15 employees  
☐ more than 15 employees
4. Do you have a trained (formal schooling) food service supervisor?  
☐ yes  
☐ no
5. Did you have an interview with the administrator before accepting your present position?  
☐ yes  
☐ no
6. In the interview did the administrator outline your responsibilities?  
☐ yes  
☐ no
7. Do you have a written job description?  
☐ yes (if yes, answer Question 8)  
☐ no (if no, skip Question 8)
8. Who wrote your job description?  
☐ previous consulting dietitian  
☐ you  
☐ administrator  
☐ both you and the administrator  
☐ any other \_\_\_\_\_

9. Please check the management responsibilities that are included in your job.

Menu Planning

- ☐ Routine evaluation of menus
- ☐ Analysis of food intake
- ☐ 14 hour span between evening meal and breakfast
- ☐ Availability of in-between meal snacks if using 3 meal plan
- ☐ Plan for recording and filing menus

Food Preparation

- ☐ Observation of food production and service procedures
- ☐ Evaluation of food as to acceptability, taste, appearance, temperature, and size of servings
- ☐ Suggestions on achieving recipe standardization
- ☐ Evaluation of sanitation of food handling procedures & practices
- ☐ Evaluation of safety of food handling procedures & practices
- ☐ Evaluation of the adequacy and use of equipment

Food Purchasing

- ☐ Consultation about a satisfactory pattern for ordering food

Budgeting

- ☐ Review of the food budget with the administrator

Personnel

- ☐ Evaluation of adequacy of staffing for a period of 12 hours or longer
- ☐ Encouragement and assistance with the rewriting of work schedules
- ☐ Advising food service supervisor of the need for work assignments
- ☐ Establishment of close working relationship with the food service supervisor

Training

- ☐ Conducting frequent in-service training sessions for food service personnel
- ☐ Planning with the director of nurses for classes related to responsibilities for nursing service

Interdepartmental Relationships

- ☐ Establishment of close working relationship with administrator
- ☐ Frequent communication with other key personnel providing service to promote coordination of dietary care with total patient care

10. Does the dietary department have written policies governing meal hours?
- ☐ yes
  - ☐ no
11. Does the dietary department have a written policy that governs who eats in the facility? (ex. employees, guests)
- ☐ yes
  - ☐ no



12. Does the dietary department have written purposes or objectives?  
☐ yes  
☐ no
13. Does the dietary department have written policies governing the type of meal service? (ex. dining room, tray service)  
☐ yes  
☐ no
14. Does the dietary department have an organization chart?  
☐ yes  
☐ no
15. Are the menus written one week in advance?  
☐ yes  
☐ no
16. Is a basic set of cycle menus used in planning meals?  
☐ yes (if yes, answer Question 17)  
☐ no (if no, skip Question 17)
17. What length of time do your basic set of cycle menus cover?  
☐ 2 to 3 weeks  
☐ 4 to 5 weeks  
☐ 6 weeks  
☐ more than 6 weeks
18. Does the dietary department keep record for receiving and storing foods?  
☐ yes  
☐ no
19. Does the dietary department keep an accurate inventory of foodstuffs?  
☐ yes  
☐ no
20. Does the dietary department use standardized recipes in its preparation of menu items?  
☐ all of the time  
☐ some of the time  
☐ none
21. Does the dietary department have written job descriptions for its employees?  
☐ yes  
☐ no
22. Does the dietary department have written policies covering the illness of employees?  
☐ yes  
☐ no

23. Does the dietary department have an in-service training program?  
\_\_\_\_ yes (if yes, answer Question 24)  
\_\_\_\_ no (if no, skip Question 24)
24. How often is the in-service training program conducted?  
\_\_\_\_ once a week  
\_\_\_\_ once every 2 to 3 weeks  
\_\_\_\_ once a month  
\_\_\_\_ once every 2 to 3 months
25. Are you able to make recommendations on management problems?  
\_\_\_\_ yes  
\_\_\_\_ no
26. Does the administrator consider your management recommendations?  
\_\_\_\_ all recommendations  
\_\_\_\_ some recommendations  
\_\_\_\_ very few recommendations  
\_\_\_\_ none
27. Does the administrator adopt your management recommendations?  
\_\_\_\_ all recommendations  
\_\_\_\_ some recommendations  
\_\_\_\_ very few recommendations  
\_\_\_\_ none
28. Do you submit written reports to the administrator?  
\_\_\_\_ yes  
\_\_\_\_ no
29. What type of facility is your present position in?  
\_\_\_\_ hospital  
\_\_\_\_ nursing home
30. Do you have a college degree?  
\_\_\_\_ B. S.  
\_\_\_\_ M. S.  
\_\_\_\_ other \_\_\_\_\_
31. In what field is your major?  
\_\_\_\_ home economics  
\_\_\_\_ foods and nutrition  
\_\_\_\_ institutional management and dietetics  
\_\_\_\_ other \_\_\_\_\_
32. Are you a member of the American Dietetic Association?  
\_\_\_\_ yes  
\_\_\_\_ no

REMARKS

## APPENDIX F

### Results of Questionnaire

## APPENDIX F

## RESULTS OF QUESTIONNAIRE

Please check the answer that is most appropriate.

1. How many hours do you work each month?  
26 8 to 10 hours  
5 10 to 12 hours  
8 12 to 16 hours  
4 16 to 20 hours  
21 more than 20 hours  
1--less than 4 hours      1--unanswered
2. What is the size of the facility?  
25 less than 40 beds  
18 40 to 60 beds  
7 60 to 80 beds  
13 80 to 100 beds  
2 more than 100 beds
3. How many employees do you have in your facility?  
8 1 to 4 employees  
14 4 to 8 employees  
9 8 to 10 employees  
6 10 to 15 employees  
28 more than 15 employees
4. Do you have a trained (formal schooling) food service supervisor?  
10 yes  
55 no
5. Did you have an interview with the administrator before accepting your present position?  
61 yes  
4 no
6. In the interview did the administrator outline your responsibilities?  
47 yes  
18 no
7. Do you have a written job description?  
37 yes (if yes, answer Question 8)  
27 no (if no, skip Question 8)  
1--unanswered
8. Who wrote your job description?  
5 previous consulting dietitian  
10 you

4 administrator  
13 both you and the administrator  
2 any other \_\_\_\_\_  
3--unanswered

9. Please check the management responsibilities that are included in your job.

Menu Planning

64 Routine evaluation of menus  
36 Analysis of food intake  
39 14 hour span between evening meal and breakfast  
43 Availability of in-between meal snacks if using 3 meal plan  
40 Plan for recording and filing menus

Food Preparation

62 Observation of food production and service procedures  
62 Evaluation of food as to acceptability, taste, appearance, temperature, and size of servings  
49 Suggestions on achieving recipe standardization  
59 Evaluation of sanitation of food handling procedures & practices  
57 Evaluation of safety of food handling procedures & practices  
52 Evaluation of the adequacy and use of equipment

Food Purchasing

48 Consultation about a satisfactory pattern for ordering food

Budgeting

35 Review of the food budget with the administrator

Personnel

37 Evaluation of adequacy of staffing for a period of 12 hours or longer  
41 Encouragement and assistance with the rewriting of work schedules  
40 Advising food service supervisor of the need for work assignments  
51 Establishment of close working relationship with the food service supervisor

Training

53 Conducting frequent in-service training sessions for food service personnel  
15 Planning with the director of nurses for classes related to responsibilities for nursing service

Interdepartmental Relationships

61 Establishment of close working relationship with administrator  
49 Frequent communication with other key personnel providing service to promote coordination of dietary care with total patient care

10. Does the dietary department have written policies governing meal hours?
- 56 yes  
9 no

11. Does the dietary department have a written policy that governs who eats in the facility? (ex. employees, guests)  
49 yes  
15 no  
1--unanswered
12. Does the dietary department have written purposes or objectives?  
48 yes  
17 no
13. Does the dietary department have written policies governing the type of meal service? (ex. dining room, tray service)  
35 yes  
27 no  
3--unanswered
14. Does the dietary department have an organization chart?  
44 yes  
18 no  
3--unanswered
15. Are the menus written one week in advance?  
55 yes  
4 no  
6--unanswered
16. Is a basic set of cycle menus used in planning meals?  
56 yes (if yes, answer Question 17)  
8 no (if no, skip Question 17)  
1--unanswered
17. What length of time do your basic set of cycle menus cover?  
32 2 to 3 weeks  
18 4 to 5 weeks  
4 6 weeks  
1 more than 6 weeks  
2--unanswered
18. Does the dietary department keep record for receiving and storing foods?  
41 yes  
22 no  
2--unanswered
19. Does the dietary department keep an accurate inventory of foodstuffs?  
42 yes  
21 no  
2--unanswered

20. Does the dietary department use standardized recipes in its preparation of menu items?  
15 all of the time  
44 some of the time  
5 none  
1--unanswered
21. Does the dietary department have written job descriptions for its employees?  
57 yes  
8 no
22. Does the dietary department have written policies covering the illness of employees?  
59 yes  
3 no  
3--unanswered
23. Does the dietary department have an in-service training program?  
46 yes (if yes, answer Question 24)  
19 no (if no, skip Question 24)
24. How often is the in-service training program conducted?  
2 once a week  
3 once every 2 to 3 weeks  
30 once a month  
10 once every 2 to 3 months  
1--as needed
25. Are you able to make recommendations on management problems?  
61 yes  
2 no  
2--unanswered
26. Does the administrator consider your management recommendations?  
33 all recommendations  
25 some recommendations  
3 very few recommendations  
-- none  
4--unanswered
27. Does the administrator adopt your management recommendations?  
9 all recommendations  
49 some recommendations  
3 very few recommendations  
-- none  
4--unanswered
28. Do you submit written reports to the administrator?  
45 yes  
18 no  
2--unanswered

29. What type of facility is your present position in?  
49 hospital  
16 nursing home
30. Do you have a college degree?  
56 B. S.  
9 M. S.  
other \_\_\_\_\_
31. In what field is your major?  
14 home economics  
10 foods and nutrition  
32 institutional management and dietetics  
9 other \_\_\_\_\_
32. Are you a member of the American Dietetic Association?  
43 yes  
21 no  
1--unanswered

REMARKS



MANAGEMENT RECOMMENDATIONS OF KANSAS  
CONSULTING DIETITIANS

by

Suzanne W. Hagwood

B. S., Mount Mary College, 1959

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AN ABSTRACT OF A MASTER'S REPORT

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Institutional Management

KANSAS STATE UNIVERSITY  
Manhattan, Kansas

1971

## ABSTRACT

In the past decade there have been rapidly increasing opportunities and changing responsibilities for dietitians as consultants. The effectiveness of the consultant depends on the administrator's understanding of the skills and competencies of the dietitian, especially in the field of food service management. This study was undertaken to assess the use by Kansas nursing homes and small hospitals of the management recommendations of consulting dietitians and the management practices in the dietary departments of these institutions.

A questionnaire was mailed to consultant dietitians in a selected sample of 181 nursing homes and small hospitals under 100 beds. Ninety-two questionnaires were returned and 65 were useable. The classification indicated 8.7 percent of the respondents who had returned the questionnaire were individuals without professional training who considered themselves consultant dietitians.

The strongest areas of management practices in the dietary department reported were in observation of food production and service procedures, evaluation of food, routine evaluation of the menu, and a close working relationship with the administrator. Weakest areas were in written job description of the consultant, a written policy for the type of meal service, use of standardized recipes in food preparation, and review of the food budget with the administrator.

The majority of consultants were able to make management recommendations to the administrators. However only one-half of the consultants felt the administrator considered all their recommendations. Three-fourths of the consultants indicated that only some of their management recommendations were adopted by the administrator.

The study indicated more effective management practices were utilized in the dietary departments with consultants who had trained food service supervisors employed than those other groups in the study sample.

Consulting dietitians should constantly evaluate the management practices within the dietary department in which they are employed. They should also keep abreast through continuing education of the newest techniques and methods in food service management.