POLICIES AND PROCEDURES IN KANSAS HOSPITALS RELATED TO SELECTIVE AND CYCLE MENUS

by

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INTRODUCTION

The menu is a primary management tool in the hospital foodservice system for achieving the objective of quality food for patient satisfaction. Selective and cycle menus are widely used in hospitals throughout the United States. Hospital size is a major determinant in the use of these two types of menu approaches, particularly selective menus. The objective of this project was to study menu practices in 25-200 bed short-term general hospitals in Kansas. Of particular interest to the study was the extent of use of selective and cycle menus and the related operational policies and procedures.

Policies and procedures are important control elements in the management of foodservice systems. Written policies and procedures provide a reference and a basis for managerial decisions concerning menu practices, as well as other operational phases of foodservice.

Successful menu planning takes a great amount of time in order to provide patient satisfaction, to better utilize the time and effort of the menu planner, to improve recipes and production techniques, to utilize labor efficiently, and to achieve cost control. Cycle menus promote advanced, thorough planning of menus. The cycle menu as defined for this report is a set of carefully planned, tested menus that are used in rotation for a certain number of weeks during a given season of the year (1). The American Hospital Association statistics indicate the average patient stay in Kansas short-term hospitals is 8.2 days (2). Through use of a cycle menu of three to six weeks in length, the possibility of repeating a menu within the average patient's stay in the hospital is slight.

Selective menus are defined for this report as meals for hospital patients, wherein the patient can pre-select his choice of food prior to the meal being served (3). The number of selections available varies from hospital to hospital. As long as there are two or more selections on the menu there is selectivity. Consideration of patients likes and dislikes through the use of selective menus will increase patient satisfaction, will tend to decrease plate waste, and has been found to be a valuable teaching aid.

Literature reviewed relevant to the study included the following topics: policies and procedures, menu considerations in the hospital system, advantages and limitations of cycle and selective menu approaches.

REVIEW OF LITERATURE

Policies and Procedures

Policies and Procedures as Guidelines for Organizational Behavior

Management of a hospital dietary department is the efficient and effective utilization of resources to accomplish predetermined goals. According to Wilford (4), an organization must have an established philosophy, purpose, or mission within which a goal achievement process is developed. This statement of purpose establishes bases for which the organization exists and provides the framework for establishment of goals.

Policies and procedures establish the boundaries within which the institution will operate and convey the philosophy of the institution (5). Glans et al. (6) stated that the goals and objectives of a business are implemented by its policies and practices. Policies convey the ideas, attitudes, and philosophies, whereas procedures are the methods which are used to accomplish these policies (6).

Policy also has been defined by Kast and Rosenzweig (7) as a general plan of action that guides the members of the organization in the conduct of its operation. McFarland (8) indicated that policies usually take the form of statements telling members of an organization how they should act in specific frequently occurring situations that affect a substantial number of people in the group. Lazzaro (9) believes that policies, put in writing and properly communicated through an organization, create a means for uniformity and coordination and of getting things done through people in an economical and consistent manner. Definite, clear cut policies, in writing and distributed to all concerned, will avoid misunderstanding, waste, friction,

and lost motion. Lazzaro (9) adds that policies must be understood and have the respect of everyone in the organization.

Procedures are detailed step-by-step descriptions of the way in which policies are accomplished (10). According to Shapiro (11), procedures also fix responsibility on specific job incumbents for a specific action. Program objectives and policy statements thus become operational realities. Procedures reinforce oral instructions, provide assistance in orienting and training employees, and when written into manuals, are readily available for future reference, thus less subject to misinterpretation (10).

The Policy and Procedure Manual

A policy and procedure manual, or a compilation of written policy and procedure statements, can be an effective tool of management in accomplishing predetermined goals (12). Carlisle (5) stated that a written manual encourages teamwork; promotes clarity, consistency, and continuity of performance; establishes standards against which actual performance can be measured; and promotes delegation of authority. Written policy and procedure manuals save supervisory man-hours spent in answering repetitive questions and serve as a source document for inspection by approval agencies. Shapiro (11) asserted that the development and modification of an effective operational policy and procedure manual must be a continuous process if it is to meet changing conditions, needs, and problems.

Ten basic benefits of a policy and procedure manual have been identified (9):

1. Flow of management information - A complete flow of information requires that data be communicated up and down the line of the organization. Manuals provide a means for communication down the line, but another means must be sought for communication upward.

2. On-the-job reference guide - Experience has demonstrated that management personnel have the need for frequent reference to written policies and procedures in the normal course of administrative operations.

3. Indoctrination - Indoctrination cannot be accomplished by giving the new employee a manual but it can be used as supplementary material.

4. Supervisory and executive training.

5. Clarification of organizational structure and responsibilities.

6. Uniformity in interpretation and administration of policies.

7. Coordination of activities among departments.

8. Elimination of unnecessary duplication.

9. Constant review and improvement of policies and procedures - Supervisory personnel should be encouraged to make recommendations for change in policy and procedure if their experience indicates that current instructions contained in the manual are impracticable.

10. Internal auditing of policies, procedures, and controls - Auditing is more effective and is accomplished more expeditiously when manuals are available to guide those doing the work.

Organization of the policy and procedure manual and the way in which it is presented are important in the effectiveness of the manual. All policies and procedures should be presented in a similar manner so they can be easily identified and understood. An index or outline of the contents of each section of the manual often is included for the purpose of allowing readers to find material quickly (13, 14). Color coding each major category of the manual is another method (15). The faster a person can find the desired information, the more frequently he will use the manual (13).

Policies and Procedures in the Hospital Dietary Department

Policy and procedure manuals are required to meet standards for certain health programs. Federal regulations affecting hospitals (16) and

hospital accreditation standards (17) require written policies and procedures for hospitals and other health care institutions. The dietary policy and procedure manual should be a part of the hospital manual. Subpart J of the Social Security Administration regulation of Federal Health Insurance for the Aged (20 C.F.R. 405) states that there must be written policies and procedures for food storage, preparation, and service, developed by a qualified dietitian (preferably meeting the qualification standards of The American Dietetic Association) (16). Standard III of Standards for Accreditation of Hospitals states that there shall be written policies and procedures governing all dietetic activities (17).

Every hospital dietary department is unique in its operation, and the policy and procedure manual should be designed for the institution using it. The policies developed depend on the size of the hospital, the philosophy of the administration and dietary department, and the staff functions, while procedures are influenced by departmental organization (18).

The policies and procedures of the dietary department should be developed in the following categories (10, 15, 17, 19):

1. Purpose of the department - a statement concerning the nutritional and medical diet needs of patients and meals or refreshments for personnel, for guests and for social or special occasions.

2. Organization - a chart or description stating the responsibilities and lines of authority for all dietary personnel and the relationship of the dietary department head (or consultant) to the administrator and other department heads.

3. Budget - definition of areas of responsibility and allocation for personnel, food, and non-food supplies.

4. Menu - the type of menu (cycle, selective, nonselective); number of routine meals and snacks or nourishments served; pattern for the regular menu; and responsibility for menu writing, revisions, and for filing menus.

5. Modified diets - specification of diet manual used; schedule and methods of consultation with physicians and nursing staff; responsibility for planning, preparing, and checking diets before serving; patient visitation and instruction; the policy and procedure for diet orders by physicians; and notification to the dietary department of diet and nourishment orders.

6. Meal and nourishment services - systems and personnel responsible for patient tray service, for guest tray service, for cafeteria service, and for inbetween meal nourishment or snack service; time schedule for meals and snacks or nourishments; and distribution of ice water to the patient's bedside.

7. Purchasing and storage - the requirements and responsibilities for specifications; bases upon which suppliers are selected; policies for ordering and receiving food and non-food dietary supplies; minimum standard for inventory; and the system of storing and issuing supplies.

8. Dietary operating costs - the system of reports and records and reporting responsibilities.

9. Preparation of food - allocation of responsibility for supervision; utilization of standardized recipes; lists of items to be routinely prepared in addition to planned menu items to allow for substitutions; and policies for preparation of special occasion items.

10. Housekeeping and sanitation - supervision and methods of warewashing (tableware, utensils); periodic and emergency maintenance of equipment; employee health examinations; safety and sanitation programs; personal grooming and uniforms; and delineation of responsibilities between the housekeeping department and the dietary department concerning laundry service, floor and equipment care, and trash disposal.

11. Inservice education - responsibility for education programs; the frequency and time allocation for employee training; and the responsibility and educational programs for other hospital personnel.

12. Personnel management - job descriptions and work schedules for the dietitians, foodservice supervisors, cooks and other foodservice personnel and policies concerning the hiring, firing, and orientation of employees.

Menu Planning

General Considerations

Production and service of high-quality foods to meet the nutritional requirements of patients, within a budgetary allowance, is the basis for successful operation of a dietary department (20). When developing a hospital meal pattern, the first step specified by Fowler, West, and Shugart (20), is to plan a regular or normal diet that will supply all food essentials necessary for good nutrition. This pattern then becomes the foundation for most modified diets and is the core of all meal planning.

Certain basic considerations must be studied in order to ensure successful menu planning. Among the basic considerations are the nutritional needs of the clientele; the food habits of the group of patients as influenced by their racial, regional, and religious customs; and the number of people to be served. The menu planner should be aware of the conditions under which food is to be prepared and served, such as the equipment available, the arrangement of the kitchen and serving areas, and the style of service; the personnel, their schedules, abilities, and skills; the amount of money provided in the budget; and the proper ratio of high and low cost food items. Certain outside influences must be taken into consideration also, such as the season of the year, the climate, and the availability of foods. In order to yield quality foods the menu planner should consider pleasing combinations of food with a variety in texture, color, flavor, form or shape, consistency, temperature, satiety value, and the method of preparation (21, 22, 23). Schutz, Rucker, and Hunter (24) reported that patients are hesitant to select foods with unfamiliar names; therefore, descriptive food titles should be used on printed menus.

Cycle Menus

Successful menu writing takes considerable amount of professional time. Cycle menus have been found to be a time saving tool because menus are rotated and used over again instead of writing a new set of menus each week (1, 25). The American Hospital Association (1) recommends that the dietitian, in order to establish a cycle menu system, must first determine the length of the cycle to be used.

During the initial service of the menu cycle, or test period, notes should be kept concerning the acceptability of the menu items and suggestions for changes. Market orders should be carefully planned and checked and acceptable recipes should be standardized and filed (1).

The length of the menu cycle varies from hospital to hospital, usually 3 or 4 weeks are used (21). A two to three week period is suitable for most small hospitals (26). Seasonal variations in available foods can be included by writing several sets of cycle menus; for example, spring, summer, fall, and winter cycles (20).

Advantages can be cited for use of cycle menus. Hubbard, Sharp, and Grant (27) estimated that 8 to 12 hours were required to write a one-week menu plan. After the initial planning of the cycle menu, menu planning time was reduced to 3 to 4 hours each, which included time for menu conferences and the completion of desired changes. The dietitians spent 5 to 6 hours each week writing modified menus, while only 2 to 3 hours a week were required to write modified menus from the cycle menu. These authors (27) concluded that about half to two-thirds of the dietitian's time previously spent on menu writing was now available for other duties.

Standardization of procedures is simplified with the use of cycle menus. The menu specifies the recipes to be used, which in turn, indicates

production methods needed and serving procedures required (27). A recipe is considered standardized when it has been tried in a given situation and has repeatedly produced good results (21). Ortolano and Rainey (28) reported that the quality of individual products increased appreciably because the cooks became accustomed to working with the same menu items and they tried to improve the items each time they were prepared.

The cycle menu can offer more acceptable menu combinations. If a menu item is found to be unacceptable to the patients, replacements can be made (27). Hubbard, Sharp, and Grant (27) stated that common menu writing errors of poor combinations of color, flavor, and texture can be eliminated through repeated review of the menu before it is reused.

The American Hospital Association (1) states that cycle menus promote improved purchase records and food cost control. They also indicated that cycle menus promote better organization of personnel time and work schedules.

The use of cycle menus presents some disadvantages. Repeated menus may become monotonous to patients and cafeteria customers (27). Vaden (29) found that in small hospitals not employing a dietitian, menus were monotonous and inadequately planned.

Since average patient stay in Kansas short-term hospitals is 8.2 days (2), a two to four week cycle should be adequate to prevent monotony. New recipe items can be added to the cafeteria service to help alleviate monotony for hospital personnel. Cycle menus could be more costly if changes were not made to incorporate seasonal foods (27). West, Wood, and Harger (21) stated that if the disadvantages could be resolved the cycle menu can become an effective management tool for the dietary department.

Selective Menus

The selective menu plan provides the patient a choice of food (30). When in the hospital, a patient's independence is taken from him; he must follow the rules of the doctor, nursing staff, and the hospital. The patient is given some freedom of choice by exercising the right to choose the foods he wants to eat (3). The selection from a menu creates a sense of individual importance in each patient (31). Cabot (32) contended that patients probably will eat more with greater enjoyment because they express their food likes and dislikes.

Cost of using selective menus is a topic of disagreement among hospitals. Flynn (33) believes that food costs are somewhat higher with selective menus. Cabot (32) described some hidden costs with selective menus; for example, the paper, typing, and printing of the menus. The distribution, collection, and tallying of the menus are added time consuming tasks. The service time may be longer because the choices must be read by the servers and each tray must be checked to ensure that the proper foods are on each tray (32).

Costs do not necessarily have to increase with use of selective menus. Swenson (34) noted that the result of less plate waste may bring about a reduction in cost with the use of selective menus. Rosenow (35) contended that the increase in cost was due to general rise in prices rather than to the effect of selective menus. The degree of patient satisfaction and fewer complaints with use of selective menus tend to offset any additional cost (1).

Many hospitals that converted to selective menus have found reduced plate waste (1). Elman (36) contends that because patients are permitted to make their own selection of foods, they are no longer served foods they

dislike, thus food wastage is reduced. Douce (30) found that the major cause for plate waste with selective menus was that the patient, at the time of meal service, was no longer able to eat all that he had selected. She suggested that if the dietary department had adequate information regarding the condition of each patient much waste could be eliminated.

Nutritional adequacy of the patient's diet is of upmost importance to the dietary department. Selective menus do not necessarily ensure adequate nutrition for all patients, even though the menus are planned carefully (1). Wakefield and Potgieter (37) found that patient's diets generally are adequate, or very nearly so in all nutrients, whether they are self-selected or non-self-selected. Ortolano and Rainey (38) suggested that selective menus, completed by the patients, should be scanned to check for nutritional adequacy. Assistance should be given to patients who desire help in selecting a nutritionally adequate diet. When problems and questions arise that dietary personnel cannot handle, these problems and questions should be referred to the dietitian (38).

The selective menu provides an effective teaching aid, not only for patients on modified diets, but also for teaching basic nutrition and proper eating habits to all patients (28). Robinson (31) noted that items on a selective menu create an interest in food for some patients who otherwise might not be interested in eating. Because the selective menu encourages more patient contact with the dietary department, the nursing staff is partially relieved of receiving dietary complaints without the authority to act. Use of selective menus and the concomitant increase in patient contact help to establish a better rapport with the nursing service (31).

Written policies and procedures and use of cycle and selective menus have been identified as desirable management practices in the hospital dietary department. Within the context of the present study, the menu policies, procedures, and practices of 25-200 bed short-term general hospitals in Kansas were studied.

METHODOLOGY

A questionnaire (Appendix A) was mailed to foodservice directors of 114 25-200 bed hospitals in Kansas to obtain data concerning menu practices, policies, and procedures. The names and addresses of the selected group were obtained from a current listing published by the American Hospital Association (2). The initial mailing and one follow-up yielded a 94.7 per cent response. Of the 108 questionnaires returned, 104 were used in data analysis (details are included in Appendix B). Copies of correspondence that accompanied the instrument are included in Appendix C.

The thirty-item questionnaire requested general information about the hospital and the dietary department, foodservice policies and procedures, and specific information about the use of cycle and selective menus and related operational practices. Before mailing, the questionnaire and correspondence were reviewed by three Kansas State University faculty, two from Department of Institutional Management and one from the College of Education.

The cover letter included a brief discussion of the scope of the study, a statement of anonymity of individual responses, instructions concerning completion of the questionnaire, and a statement encouraging response. A self-addressed stamped envelope was included to facilitate response. The study sample was coded by number to identify the returned responses for purposes of follow-up. A letter and another copy of the questionnaire were mailed one month after the initial mailing to solicit replies from nonrespondents.

Responses were coded and data punched on computer cards for electronic data processing. Descriptive statistics were computed for all items. The chi square test of independence was computed to study responses to

several items. Two demographic breakdowns were used for this analysis, hospital size and type of person in charge of the dietary department.

RESULTS AND DISCUSSION

General Information

The 104 respondent hospitals were grouped into three categories based on size or number of hospital beds: 25- to 50-beds, 51- to 100-beds, and over 100-beds. Distribution of the study sample among these categories was 42.3 per cent, 38.5 per cent, and 19.2 per cent, respectively.

Direction of the dietary or foodservice department varied among the hospitals. A member of The American Dietetic Association (ADA dietitian) was in charge of thirty-three (31.7 per cent) of the hospitals; and a graduate home economist or foodservice director in nineteen (18.3 per cent) hospitals. The foodservice directors were distinguished from the foodservice supervisors based on educational background. Persons were classified as directors if they indicated completion of a college degree. Foodservice supervisors directed thirty-five (33.7 per cent) dietary departments and cook-managers, seventeen (16.3 per cent).

Direction of the dietary department was studied also by size of hospital (Table 1). A significant difference among hospitals was noted, with smaller hospitals employing fewer professional dietitians and conversely, more cook-managers. None of the large hospitals (101-200 beds) employed a cook-manager as the person in charge of the dietary department. These hospitals were directed by persons with primarily supervisory responsibilities.

The person in charge of the dietary department was employed on a full-time basis in 83.3 per cent of the hospitals, while in 16.7 per cent this person was employed on a part-time basis. A dietitian was employed in a

consulting capacity in 92.1 per cent of the hospitals where an ADA dietitian was not in charge. Seven hospitals did not employ a dietitian in any capacity. Ninety hospitals employed one dietitian, six employed two, and one hospital, three dietitians.

Table 1: Hospital size and dietary department direction

size of hospital	number of hospitals	ADA Dietitian (N = 33)	Home Economist/ Foodservice Director (N = 19)	Foodservice Supervisor (N = 35)	Cook-Manager (N = 17)
		%	%	%	%
25-50 beds	44	25.0	13.6	31.8	29.5
51-100 beds	40	32.5	15.0	42.5	10.0
101-200 beds	20	45.0	35.0	20.0	0.0

Chi square = 16.59; significant at $P < 0.01$.

The number of personnel employed in the dietary department tended to increase somewhat proportionately to hospital size (Table 2). The mean

Table 2: Personnel employed in the dietary department

size of hospital	number of hospitals	full-time mean number of employees[1]	part-time mean number of employees[1]
25-50 beds	44	5.5 ± 3.5	3.6 ± 2.5
51-100 beds	40	10.1 ± 4.8	6.0 ± 4.0
101-150 beds	12	16.4 ± 8.0	8.2 ± 9.4
151-200 beds	8	28.5 ± 10.0	17.3 ± 14.0

[1]Mean and standard deviation.

number of dietary employees in the smaller hospitals (25-50 beds) was 5.5; whereas the mean number was 28.5 in the larger hospitals (151-200 beds).

Policies and Procedures

Complete policy manuals were reported in 68.6 per cent of the hospitals. Some policies were written in 28.4 per cent; no policies were written in 2.9 per cent of the hospitals. Two of the respondents, who indicated there were no written policies and procedures in their hospital, commented that a manual was being developed.

No significant differences were found in percentage of written policies and procedures when data were studied by hospital size; however, the larger hospitals tended to have more complete policy and procedure manuals (Table 3). Also shown in Table 3 is the analysis of data in relation to person in charge of foodservice. Type of direction of the hospital foodservice was unrelated to the completeness of the policy and procedure manual. Perhaps there was some difference among the respondents concerning the definition of a complete manual.

Written policies and procedures in selected operational areas were studied. Table 4 presents percentages of hospitals with written policies and procedures in these areas.

Diet orders by physicians was a common policy found in the dietary department policy and procedure manual. Distribution and return of menus from patients was the operational area for which the smallest number of respondents reported no written policy. However, the need for a written policy statement in this area would be dependent on the use of a printed selective menu.

Table 3: Percentage of written institutional policies and procedures by size of hospital and direction of foodservice

breakdown of data	number of hospitals	complete policy manual	some policies written	none written	chi square[1]
		%	%	%	
size of hospital					
25-50 beds	44	65.9	34.1	0.0	
51-100 beds	40	65.0	27.5	7.5	
101-200 beds	18	83.3	16.7	0.0	6.73
person in charge of foodservice					
ADA dietitian	32	56.3	40.6	3.1	
Home Economist/ Foodservice Director	18	77.8	22.2	0.0	
Foodservice Supervisor	35	80.0	17.1	2.9	
Cook-Manager	17	58.8	35.3	5.9	6.63

N = 102

[1]Chi square values are nonsignificant.

Eighty per cent of the large hospitals (101-200 beds) had written policies and procedures in all operational areas studied. Significant differences in percentages of hospitals with written policies and procedures, according to the bed size, were found in three areas: house menu patterns, distribution and return of menus from patients, and late trays.

The existence of written policies and procedures in the selected operational areas was studied also in relation to the person in charge. A significant difference was found in number of hospitals with policy statements concerning diet orders by physicians, house menu patterns, foodservice hours, the distribution and return of trays, and late trays. Hospitals with a cook-manager in charge had fewer written policies and procedures in all but one of the operational areas studied.

Table 4: Percentages of hospitals with written policies and procedures in selected operational areas

policy	total (N=104)	size of hospital			chi square	person in charge of foodservice				chi square
		25-50 beds (N=44)	51-100 beds (N=40)	101-200 beds (N=20)		ADA dietitian (N=33)	home ec/ FS Director (N=19)	FS Super. (N=35)	Cook-mngr. (N=17)	
	%	%	%	%		%	%	%	%	
diet orders by physicians	87.5	84.1	85.0	100.0	3.55	84.8	100.0	94.3	64.7	12.48**
diet instructions	75.0	68.2	72.5	95.0	5.49	81.8	89.5	71.4	52.9	7.59
house menu patterns	72.1	54.5	80.0	95.0	13.20**	87.9	89.5	65.7	35.3	19.10**
approved modified diet pattern	76.9	75.0	77.5	80.0	0.21	81.8	78.9	74.3	70.6	1.01
distribution and return of menus from patients	32.7	20.5	27.5	70.0	16.14**	39.4	36.8	34.3	11.8	4.25
guest meals	63.5	59.1	57.5	85.0	4.98	72.7	63.2	54.3	64.7	2.50
snacks and inbetween feedings	59.6	56.8	52.5	80.0	4.44	72.7	63.2	57.1	35.3	6.72
foodservice hours	73.1	63.6	75.0	90.0	4.98	81.8	84.2	74.3	41.2	11.30*
distribution and return of trays	66.3	61.4	62.5	85.0	3.87	81.8	63.2	68.6	35.3	11.04*
late trays	65.4	47.7	70.0	95.0	14.19**	81.8	68.4	68.6	23.5	17.33**

*Significant at $P < 0.05$.

**Significant at $P < 0.01$.

Menu Policies, Procedures, and Practices

Menu Planning

Menu planning was done by the dietitian in 49.0 per cent of the hospitals. In 22.2 per cent of the hospitals two persons were involved in planning menus. In most of these hospitals the dietitian planned the menu in cooperation with the foodservice director, supervisor, or chief cook. Foodservice supervisors were responsible for menu planning in 14.4 per cent of the hospitals. In the remaining hospitals the menus were developed by the foodservice director, chief cook, or in one report, by personnel in headquarters office of a foodservice contractor.

Respondents were asked to rank their main concerns when planning menus for the dietary department (Table 5). Patient satisfaction was a significantly greater concern to the menu planners than other concerns ranked (Appendix D). Cost of food ranked second among concerns when developing menus. Mean ranks for cost of labor, skill of employees, and time available for preparation were similar. Of least concern to the menu planners was amount of storage, available equipment, and type of service.

Cycle Menus

Cycle menus were used in 88.5 per cent of the hospitals in the study. There was a significant relationship between hospital size and the use of cycle menus (Table 6). All respondents employed in large hospitals (101-200 beds) reported use of cycle menus. Usage rate was 92.5 per cent in 51-100 bed hospitals and 79.5 per cent in small hospitals (25-50 beds). There was no significant relationship between the type of direction of the dietary department and the use of cycle menus (Table 6).

Table 5: Rank order of concerns of dietary department menu planner

main concerns of menu planner	rank[1] 1	2	3	4	5	6	7	8	mean[2]
	%	%	%	%	%	%	%	%	
cost of food	17.0	41.5	2.1	12.8	7.4	6.4	8.5	4.3	3.27 ± 2.12
cost of labor	0.0	6.4	30.9	13.8	16.0	4.3	16.0	12.8	4.80 ± 1.94
amount of storage and/or refrigerator space	1.1	5.3	13.8	13.8	16.0	13.8	12.8	23.4	5.48 ± 1.98
patient satisfaction	79.8	6.4	7.4	2.1	1.1	3.2	0.0	0.0	1.48 ± 1.14
equipment available	0.0	7.4	11.7	17.0	16.0	13.8	21.3	12.8	5.32 ± 1.84
skill of employees	2.1	18.1	10.6	14.9	12.8	17.0	13.8	10.6	4.78 ± 2.05
type of service	1.1	4.3	9.6	8.5	10.6	21.3	14.9	29.8	5.96 ± 1.91
time available for preparation	2.1	10.6	12.8	17.0	19.1	20.2	11.7	6.4	4.80 ± 1.79

N = 94

[1]Ranked 1, most concern to 8, least concern.

[2]Mean and standard deviation.

Table 6: Percentage of hospitals using cycle menus by size of hospital and direction of foodservice

breakdown of data	number of hospitals	use cycle menus	do not use cycle menus	chi square
		%	%	
size of hospital				
25-50 beds	44	79.5	20.5	
51-100 beds	40	92.5	7.5	
101-200 beds	20	100.0	0.0	6.67*
person in charge of foodservice				
ADA Dietitian	33	93.9	6.1	
Home Economist/ Foodservice Director	19	89.5	10.5	
Foodservice Supervisor	35	82.9	17.1	
Cook-Manager	17	88.2	11.8	2.07

N = 104

*Significant at $P < 0.05$.

Of the ninety-two respondents to the question concerning length of cycle menu, a two to three week cycle was used by 51.1 per cent; a four to five week by 35.9 per cent; a six week cycle by 5.4 per cent; and a cycle longer than six weeks by 7.6 per cent. One cycle menu was repeated all year in 22.7 per cent (N = 88) of the hospitals. A two cycle, summer/winter combination, was used in 31.8 per cent and a four cycle plan (summer, fall, winter, spring) in 36.4 per cent. In 9.1 per cent of the hospitals, combinations other than the ones suggested were used.

Justifications for use of cycle menus were ranked by the respondents (Table 7). Mean ranks for time and effort of the menu planner, better organization of time and work schedules of employees, and improvement of food

cost control and purchase records were not significantly different (Appendix D). Greater opportunity to improve and standardize recipes was of significantly less concern.

Table 7: Rank order of reasons for using cycle menus

reasons	rank[1]				mean[2]
	1	2	3	4	
	%	%	%	%	
saves time and effort for the menu planner	33.3	21.8	20.5	24.4	2.36 ± 1.18
greater opportunity to standardize recipes	11.5	21.8	32.1	34.6	2.90 ± 1.01
better organization	33.3	26.9	16.7	23.1	2.30 ± 1.16
improvement of food cost control	24.4	28.2	29.5	17.9	2.41 ± 1.05

N = 78

[1]Ranked 1, most significant reason to 4, least significant reason.

[2]Mean and standard deviation.

In design of this study the assumption was made that a greater percentage of recipes are standardized in hospitals using cycle menus. All recipes were reportedly standardized in 26.8 per cent of the dietary departments studied. Approximately 75 per cent of the recipes were standardized in 32.0 per cent; and 50 per cent or less were standardized in 41.2 per cent of the hospitals. Although the chi square value was not significant, data indicate hospitals using cycle menus tended to have a greater percentage of standardized recipes (Table 8).

Table 8: Comparison of cycle menu usage and degree of recipe standardization

	number of hospitals	per cent of recipes standardized				
		100 per cent	75 per cent	50 per cent	25 per cent	chi square[1]
		%	%	%	%	
cycle menus used	85	28.2	34.1	24.7	12.9	
cycle menus not used	12	16.7	16.7	25.0	41.7	6.79

[1]Chi square value is nonsignificant.

Selective Menus

Selective menus are used in 44.4 per cent of the hospitals (N = 99). Larger hospitals (101-200 beds) reported significantly higher usage than smaller hospitals (Table 9). Data concerning use of selective menus in relation to type of direction of the hospital foodservice also is presented in Table 9. The chi square value was highly significant for this analysis. The percentage of usage was only 12.5 in hospitals with a cook-manager in charge of the foodservice; whereas the percentage was 60.6 in hospitals with an ADA dietitian. These findings were not surprising in view of the fact that more of the smaller hospital dietary departments were directed by cook-managers.

The predominate reason given for not using selective menus was that the hospital was too small (50.8 per cent). Only 5.1 per cent of the hospitals stated they had too few employees to warrant use of a selective menu. Although expense and paper work were disadvantages of selective menus cited in the literature (32, 33), these were of little concern to the respondents of this study as reasons for not using selective menus. Only one

Table 9: Percentage of hospitals using selective menus

breakdown of data	number of hospitals	use selective menus	do not use selective menus	chi square
		%	%	
size of hospital				
25-50 beds	40	25.0	75.0	
51-100 beds	39	43.6	56.4	
101-200 beds	19	84.2	15.8	18.34***
person in charge of foodservice				
ADA Dietitian	33	60.6	39.4	
Home Economist/ Foodservice Director	16	56.3	43.8	
Foodservice Supervisor	33	36.4	63.6	
Cook-Manager	16	12.5	87.5	11.90**

N = 98

**Significant at P < 0.01

***Significant at P < 0.001

respondent selected each of the following reasons: too expensive, too much paper work, and limited storage space. Responses other than those listed on the questionnaire were limited facilities, patients happy with present system, foodservice supervisor unfamiliar with this approach, and previous use of selective menus without success (e.g., low patient response, patients incapable of completing menus, and many write-in items).

Selectivity in a menu may mean that a hospital offers a choice of the beverage or dessert or it may mean that the hospital offers a wide range of selection. Table 10 summarizes data concerning type of selection offered in reporting hospitals. Beverage choices were offered most often (95.3 per cent). Breakfast, lunch, and dinner entrees, desserts, and vegetable other

than potatoes were offered in 80 per cent or more of the hospitals using selective menus. When asked how many choices were given for the lunch-dinner entree item, all respondents indicated two or three selections were provided.

Table 10: Percentage of hospitals providing various types of menu item selection

type of menu item	selection offered	
	yes	no
	%	%
breakfast entree	90.7	9.3
breakfast breads	79.1	20.9
lunch entree	81.4	18.6
dinner entree	86.0	14.0
potato or substitute	69.8	30.2
other vegetable	81.4	18.6
salads	67.4	32.6
desserts	86.0	14.0
beverage	95.3	4.7

N = 43

Patients on regular diets were offered selection by all hospitals using selective menus (Table 11). Selection was offered least often to patients on fat restricted diets (57.5 per cent).

The distribution and return of selective menus can be important to the dietary department in predicting the production of food. Hospitals reported various rates of return of completed selected menus: 66.7 per cent reported 76-100 per cent return; 16.7 per cent had a 51-75 per cent return; 9.5 per cent had a 26-50 per cent return; and 7.1 per cent reported 25 per cent or less return. Table 12 presents data concerning distribution and return of menus. Placement of menu on the breakfast tray was the most

Table 11: Percentage of hospitals offering selections for various diet categories

type of diet	selection offered	
	yes	no
	%	%
regular (house) diet	100.0	0.0
soft diet	85.0	15.0
bland, low residue, low fiber	62.5	37.5
low sodium diet	62.5	37.5
calorie restricted diet	62.5	37.5
fat restricted diet	42.5	57.5

N = 40

Table 12: Method of distribution and return of selective menus

method	distribution (N = 43)	return (N = 42)
	%	%
menus placed on breakfast tray	44.2	21.4
by dietary personnel	16.3	35.7
by dietitian	2.3	2.4
by nursing staff	9.3	11.9
by auxillary personnel	2.3	9.5
combination of above methods	25.6	19.0

popular method of distribution. However, a combination of methods was used in 27.6 per cent of the hospitals. Dietary personnel were responsible for return of the menus in the greatest percentage of the hospitals.

Accurate forecasts of demand for various menu items are an important factor in control of food production and food cost. A large percentage (82.6 per cent) of the respondents indicated they could predict the food choices of patients most of the time; 4.3 per cent stated they could always predict patient food choices; and 13.0 per cent could rarely predict patient food choices. Completed selective menus were tallied by hand in 86.7 per cent of the hospitals offering selective menus. Other hospitals used a tabulating machine or estimated the menu items chosen by patients.

The chief reason for using selective menus was that fewer complaints were voiced by patients (Table 13). The mean rank was significantly different than for other reasons ranked (Appendix D). There was no significant difference in mean ranks for less plate waste and more contact with patients. Although some authorities (28, 38) have indicated that selective menus can be an effective teaching aid, this reason for using selective menus was ranked low by respondents of this study. Too many food items at each meal was given as the greatest disadvantage for use of selective menus by a majority of hospitals using this system (Table 14). Added storage was of least concern to these hospitals.

Patient Reaction

Regardless of the practices a foodservice has developed, they are designed primarily with the patient in mind. Patient satisfaction is the preeminent objective of the hospital foodservice. Patient reactions are

Table 13: Rank order of reasons for use of selective menus

reason	number of hospitals	rank[1] 1	2	3	4	mean[2]
		%	%	%	%	
fewer complaints	48	60.4	12.5	14.6	12.5	1.79 ± 1.11
easy teaching aid	47	2.1	25.5	21.3	51.1	3.21 ± 0.91
less plate waste	48	18.8	35.4	22.9	22.9	2.50 ± 1.05
more contact with patients	48	22.9	27.1	37.5	12.5	2.40 ± 0.98

[1]Ranked 1, most significant reason to 4, least significant reason.
[2]Mean and standard deviation.

Table 14: Disadvantages in using selective menus[1]

reason	disadvantage	not a disadvantage
too expensive	30.8	69.2
too much paper work	35.9	64.1
added employees are needed	30.8	69.2
added storage is needed	23.1	76.9
too many prepared food items at each meal	53.8	46.2
other	7.7	92.3

N = 39
[1]Disadvantages cited by hospitals using a selective menu.

elicited by various means and are received through a number of feedback channels.

In this study, 90.9 per cent of the respondents reported that patient reaction to food and foodservice was recorded through visits by dietary personnel. Many received comments through nursing service staff (69.1 per cent) or comments on menus (56.4 per cent). Patient questionnaires were utilized in 34.5 per cent of the hospitals. One hospital employed a representative to visit with patients about foodservice. Others indicated the administrator, hospital questionnaire as distinguished from a foodservice questionnaire, and notes and letters from patients were sources of information.

A special pediatric menu is a patient service offered by some hospitals. Of ninety-one respondents to the question concerning service of a special menu to children, thirty-three (36.3 per cent) reported this practice.

SUMMARY

The purpose of this project was to study the extent of use of cycle and selective menus and the related operational policies, procedures, and practices in 25-200 bed short-term general hospitals in Kansas. A questionnaire was mailed to the person in charge of the dietary department in 114 hospitals. Of the 108 questionnaires returned (94.7 per cent), 104 were used in data analysis.

The study indicated that smaller hospitals employ fewer professional dietitians and conversely more cook-managers to direct the dietary department. The larger hospitals (101-200 beds) were directed by persons with primarily supervisory responsibilities.

The 101-200 bed hospitals had more complete policy and procedure manuals than small hospitals (100 beds or less). Eighty per cent of these hospitals had written policies and procedures in all specific operational areas studied. Significant differences in percentages of hospitals with written policies and procedures, according to the bed size, were found in three areas: house menu patterns, distribution and return of menus from patients, and late trays. A greater percentage of hospitals had written policies on diet orders by physicians, house menu patterns, late trays, foodservice hours, and distribution and return of trays when an ADA dietitian was in charge of the dietary department than when a cook-manager was in charge.

Patient satisfaction was the primary concern of the respondents in planning menus. Cost of food ranked second among concerns when developing menus. Cycle menus were used by all large hospitals (101-200 beds); whereas the percentage of small hospitals (25-50 beds) using cycle menus was 79.5

per cent. Use of selective menus was also greater in large hospitals (101-200 beds) than in small. The use of selective menus was reported more frequently when the dietary department was under the direction of an ADA dietitian rather than a cook-manager. The chief reason for using selective menus was that fewer complaints were voiced by patients. The predominate reason for not using selective menus was that the hospital was too small.

Study of the type of menu item selections indicated that a beverage choice was offered most often. Choice of breakfast, lunch, and dinner entrees, desserts, and vegetable other than potatoes were offered in 80 per cent or more of the hospitals using selective menus. Placement of the printed menu on the breakfast tray was the most popular method of distribution. Dietary personnel were responsible for return of the menus in the greatest percentage of the hospitals.

Regardless of the practices a foodservice has developed, they are designed primarily with the patient in mind. Patient satisfaction is the preeminent objective of the hospital foodservice. Patient reactions were elicited by various means and were received through a number of feedback channels by hospitals in this study. Respondents in 90.9 per cent of the hospitals reported patient reaction to food and foodservice was recorded through visits by dietary personnel.

IMPLICATIONS OF THE STUDY

Several implications can be drawn from this study. First, it is felt the short, concise nature of the questionnaire contributed to the high rate of return (82.7 per cent, initial mailing; 94.7 per cent, total return). Also, foodservice directors in the hospitals studied evidently are interested in contributing to the knowledge base of the dietetics field.

Results of the study seem to indicate there is an apparent need for training of cook-managers, at least in the areas of menu planning and development of policies and procedures. In small hospitals there is less likelihood that a professional dietitian will be in charge because of lack of availability and/or resources. Dietitians in the hospitals studied appear to be aware of their responsibilities for planning and organizing in their areas of control.

Policy and procedure manuals that are complete and readable aid in efficient management of an organization. An accurate manual provides guidelines which function in the decision making process of a dietary department. Further study of hospital foodservice policy and procedure manuals could yield valuable information concerning format, completeness, and more data concerning areas for improvement. Organizational materials on policies and procedures could be developed for use as a guide for small hospitals.

Further research is needed in the area of cycle and selective menus as an effective management tool. More in-depth research into the reasons small hospitals are not using cycle and selective menus should be done as a basis for development of training information. Additional assessment of menu practices could extend the usefulness of the present study; e.g., evaluation

of menu format, nutrient composition, and of variety and combinations of foods on menus.

In those hospitals using selective menus, patient contact by dietary personnel was frequent. The dietary directors seemed more concerned with patient need and satisfaction than with waste of supplies. Comparative evaluations are needed of patient reactions to food and foodservice among hospitals using and not using selective menus, and the effect of dietary contact on patient satisfaction.

ACKNOWLEDGEMENTS

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Lastly, appreciation is expressed to those who participated and provided the information for this study.

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APPENDIXES

APPENDIX A

Questionnaire

Kansas State University
Department of Institutional Management
Manhattan, Kansas 66506

SURVEY OF MENU PRACTICES IN KANSAS HOSPITALS

Please check the most appropriate answer.

1. Indicate the size of the hospital.
   ____ less than 50 beds
   ____ 51 to 100 beds
   ____ 101 to 150 beds
   ____ 151 to 200 beds

2. The dietary department employs how many full time employees? ____

3. The dietary department employs how many part time employees? ____

4. Who is in charge of the dietary department?
   ____ A.D.A. dietitian
   ____ Home Economist
   ____ Food Service Supervisor
   ____ Cook-manager
   ____ other _____

5. The person placed in charge of the dietary department is employed on what basis?
   ____ full time
   ____ part time

6. If not in charge, is a dietitian employed as a consultant?
   ____ yes
   ____ no

7. Does the institution have written policies and procedures for the operation of the foodservice?
   ____ yes, a complete policy manual exists
   ____ some policies are written
   ____ no

8. Indicate which areas are covered by written institutional policies and procedures.
   ____ diet orders by physicians
   ____ diet instructions
   ____ house menu patterns
   ____ approved modified diet patterns
   ____ distribution and return of menus from patients
   ____ guest meals
   ____ snacks and inbetween feedings

____ foodservice hours
____ distribution and return of trays
____ late trays

9. Who plans the menus?
____ dietitian
____ foodservice director
____ foodservice supervisor
____ chief cook
____ other _____

10. How many dietitians are employed? ____

11. Are cycle menus used?
____ yes
____ no

If your answer is no, skip to question 15.
If yes, continue on to question 12.

12. If yes, what is the length of the menu cycle?
____ 2 to 3 weeks
____ 4 to 5 weeks
____ 6 weeks
____ more than 6 weeks

13. How many sets of menu cycles are used?
____ one cycle year round
____ two cycles; summer and winter
____ four cycles; spring, summer, fall, winter
____ other, please specify _____

14. Which of the following would you consider the most significant reason for using cycle menus? *Rank in order of significance* (1 - most significant to 4 - least significant).
a. ____ saves time and effort for the menu planner
b. ____ greater opportunity to improve and standardize recipes
c. ____ better organization of time and work schedules of employees
d. ____ improvement of food cost control and purchase records

15. Please indicate the degree to which recipes are standardized.
____ all recipes are standardized
____ about 75% are standardized
____ about 50% are standardized
____ about 25% are standardized

16. Are selective menus used for some or all patient diets?
____ yes
____ no

If your answer is no, answer question 17 and then skip to question 29.
If yes, skip question 17 and continue on with question 18.

17. If selective menus are not used, which of the following would most appropriately express your reason for not using them?
____ too expensive
____ too much paper work
____ too few employees
____ limited storage space for the added inventory items needed in selective menus
____ hospital is too small to warrant selection
____ other, please specify _____

18. Check the group or groups in which menu selections are available.
a. ____ breakfast entree
b. ____ breakfast breads
c. ____ lunch entree
d. ____ dinner entree
e. ____ potato or substitute
f. ____ other vegetable
g. ____ salads
h. ____ desserts
i. ____ beverage

19. How many choices are given for the lunch-dinner entree item?
____ 2 or 3 choices
____ 4 or 5 choices
____ 6 or more choices

20. For which diets are selective menus used?
____ regular (house) diet
____ soft diet
____ bland, low residue, low fiber diet
____ low sodium diet
____ calorie restricted diet
____ fat restricted diet

21. How are the menus distributed to the patients?
____ menus are placed on the breakfast tray
____ by the dietary personnel
____ by the dietitian
____ by the nursing staff
____ by the auxillary personnel
____ other, please specify _____

22. How are the menus returned to the dietary department?
____ on the breakfast tray
____ by the dietary personnel
____ by the dietitian
____ by the nursing staff
____ by the auxillary personnel
____ other _____

23. What percentage of completed menus are usually returned to the dietary department?
____ under 25%
____ 26 to 50%
____ 51 to 75%
____ 76 to 100%

24. How are the menu items tabulated?
____ menus are hand tallied
____ menus are tallied using a tabulating machine
____ estimates are used
____ other _____

25. Can patient choices of food be anticipated to any degree of accuracy?
____ always
____ most of the time
____ rarely

26. How are patients' reactions to food and foodservice evaluated?
____ patient comments passed on by nursing staff
____ patient comments passed on by medical staff
____ visits to patients by dietary personnel
____ comments on menus
____ patient questionnaires
____ other _____

27. Which of the following would you consider the most significant reason for using selective menus? Rank in order of significance (1 - most significant to 4 - least significant).
a. ____ fewer complaints from patients
b. ____ easy teaching aid
c. ____ less plate waste
d. ____ more contact with patients

28. Which of the following would you consider the greatest disadvantage in using selective menus?
____ too expensive
____ too much paper work
____ added employees are needed
____ added storage is needed
____ too many prepared food items at each meal
____ other _____

29. Are special menus used for pediatric patients?
____ yes
____ no

30. What is your main concern in planning menus for the dietary department? Rank in order of most concern - 1 to least concern - 8.
a. ____ cost of food
b. ____ cost of labor

c. ____ amount of storage and/or refrigerator space
d. ____ patient satisfaction
e. ____ equipment available
f. ____ skill of employees
g. ____ type of service
h. ____ time available for preparation

APPENDIX B

Responses to the Questionnaire

Responses to the questionnaire

	questionnaires mailed					
	initial mailing		follow-up mailing[1]		total response	
	number	per cent	number	per cent	number	per cent
questionnaires mailed	114		22		114	100.0
responses	92	82.7	16	14.0	108	94.7
questionnaires unusable[2]					4	3.5
questionnaires analyzed					104	91.2

[1]Mailed one month after initial mailing.

[2]*Questionnaires ruled "unusable":*
One questionnaire was partially completed.
Three questionnaires were received after data analysis was completed.

APPENDIX C

Correspondence

Department of Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521

INITIAL CORRESPONDENCE

April 4, 1973

Dear Foodservice Director:

At Kansas State University, we are conducting a study concerning menu practices in Kansas hospitals. The purpose is to study the extent of use of selective and cycle menus and to gain other information about menu planning and procedures. The enclosed questionnaire was designed to provide this information.

Your answers will be most valuable to this study. Please mark the answers most nearly corresponding to policies and practices in your institution. If you have any additional information or remarks, please feel free to express them at the end of the questionnaire.

It is not necessary for you to identify yourself or your hospital. We have asked a number of questions which will provide information for classification and analysis of data. An identification number has been used to aid us in followup; however, you or your hospital will not be linked individually with your responses.

When you have completed the questionnaire, please place it in the enclosed envelope and drop in the mail. Thank you for your cooperation and time in answering the questionnaire.

Sincerely,

Allene Vaden, Ph.D., R.D.
Assistant Professor

Paula Biggs (Mrs.)
Graduate Student

PB/fj

Department of Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521

FOLLOW-UP CORRESPONDENCE

May 1, 1973

Dear Foodservice Director:

We need your help! Last month we wrote a letter to you asking for your assistance in a study we are conducting at Kansas State University concerning menu practices in Kansas hospitals. Since you may not have received the letter, let me briefly restate its contents. The purpose of the project is to gain knowledge concerning the extent of use of selective and cycle menus and to gain other information about menu planning and procedures.

Your answers will be most valuable to this study. Please mark the answers most nearly corresponding to policies and practices in your institution. If you have any additional information or remarks, please feel free to express them at the end of the questionnaire.

It is not necessary for you to identify yourself or your hospital. We have asked a number of questions which will provide information for classification and analysis of data. An identification number has been used to aid us in followup; however, you or your hospital will not be linked individually with your responses.

We appreciate your time and consideration in filling out this questionnaire. The greater percentage of return, the more accurate our compilation of information will be. We would be grateful if you could complete the questionnaire and return in the enclosed, stamped envelope by May 11. Thank you.

Sincerely,

(Mrs.) Allene Vaden, Ph.D., R.D.
Assistant Professor

(Mrs.) Paula Biggs
Graduate Student

PB/fj

APPENDIX D

Results of t-tests for analysis of differences in mean ranks for questions 14, 27, and 30

Results of t-tests for analysis of differences in mean ranks for questions 14, 27, and 30

Question 14: Which of the following would you consider the most significant reason for using cycle menus? Rank in order of significance (1 - most significant to 4 - least significant).

a. saves time and effort for the menu planner
b. greater opportunity to improve and standardize recipes
c. better organization of time and work schedules of employees
d. improvement of food cost control and purchase records

reason	mean	standard deviation	t-value	degrees of freedom	probability
a. saves time and effort	2.36	1.18			
b. improves recipes	2.90	1.01	2.71	77	0.008
a. saves time and effort	2.36	1.18			
c. better organization	2.29	1.16	0.29	77	0.775
a. saves time and effort	2.36	1.18			
d. improve food costs	2.41	1.05	0.25	77	0.807
b. improve recipes	2.90	1.01			
c. better organization	2.29	1.16	2.95	77	0.004
b. improve recipes	2.90	1.01			
d. improve food costs	2.41	1.05	2.60	77	0.011
c. better organization	2.29	1.16			
d. improve food costs	2.41	1.05	0.58	77	0.561

Question 27: Which of the following would you consider the most significant reason for using selective menus? Rank in order of significance (1 - most significant to 4 - least significant).

a. fewer complaints from patients
b. easy teaching aid
c. less plate waste
d. more contact with patients

Appendix D -- Continued

reason	mean	standard deviation	t-value	degrees of freedom	probability
a. fewer complaints	1.81	1.12			
b. easy teaching aid	3.21	0.91	5.65	46	0.000
a. fewer complaints	1.80	1.11			
c. less plate waste	2.50	1.05	2.79	47	0.008
a. fewer complaints	1.81	1.12			
d. more contact with patients	2.43	0.97	2.45	46	0.018
b. easy teaching aid	3.21	0.91			
c. less plate waste	2.47	1.04	3.26	46	0.002
b. easy teaching aid	3.21	0.91			
d. more contact with patients	2.43	0.97	4.00	46	0.000
c. less plate waste	2.47	1.04			
d. more contact with patients	2.43	0.97	0.17	46	0.863

Question 30: What is your main concern in planning menus for the dietary department? Rank in order of most concern - 1 to least concern - 8.

a. cost of food
b. cost of labor
c. amount of storage and/or refrigerator space
d. patient satisfaction
e. equipment available
f. skill of employees
g. type of service
h. time available for preparation

a. cost of food	3.27	2.12			
b. cost of labor	4.80	1.94	7.62	93	0.000
a. cost of food	3.27	2.12			
c. amount of storage space	5.48	1.98	6.62	93	0.000
a. cost of food	3.27	2.12			
d. patient satisfaction	1.48	1.14	6.56	93	0.000

Appendix D -- Continued

reason	mean	standard deviation	t-value	degrees of freedom	probability
a. cost of food	3.27	2.12			
e. equipment available	5.32	1.84	6.10	93	0.000
a. cost of food	3.27	2.12			
f. skill of employees	4.78	2.05	4.16	93	0.000
a. cost of food	3.27	2.12			
g. type of service	5.96	1.91	8.29	93	0.000
a. cost of food	3.27	2.12			
h. time available for preparation	4.80	1.79	4.86	93	0.000
b. cost of labor	4.80	1.94			
c. amount of storage space	5.48	1.98	2.10	93	0.038
b. cost of labor	4.80	1.94			
d. patient satisfaction	1.48	1.14	13.58	93	0.000
b. cost of labor	4.80	1.94			
e. equipment available	5.32	1.84	1.55	93	0.124
b. cost of labor	4.80	1.94			
f. skill of employees	4.78	2.05	0.06	93	0.949
b. cost of labor	4.80	1.94			
g. type of service	5.96	1.91	3.74	93	0.000
b. cost of labor	4.80	1.94			
h. time available for preparation	4.80	1.79	0.00	93	1.000
c. amount of storage space	5.48	1.98			
d. patient satisfaction	1.48	1.14	17.21	93	0.000
c. amount of storage space	5.48	1.98			
e. equipment available	5.32	1.84	0.62	93	0.538
c. amount of storage space	5.48	1.98			
f. skill of employees	4.78	2.05	2.14	93	0.035
c. amount of storage space	5.48	1.98			
g. type of service	5.96	1.91	1.48	93	0.143

Appendix D -- Continued

reason	mean	standard deviation	t-value	degrees of freedom	probability
c. amount of storage space	5.48	1.98			
h. time available for preparation	4.80	1.79	2.39	93	0.019
d. patient satisfaction	1.48	1.14			
e. equipment available	5.32	1.84	16.99	93	0.000
d. patient satisfaction	1.48	1.14			
f. skill of employees	4.78	2.05	13.53	93	0.000
d. patient satisfaction	1.48	1.14			
g. type of service	5.96	1.91	18.93	93	0.000
d. patient satisfaction	1.48	1.14			
h. time available for preparation	4.80	1.79	14.49	93	0.000
e. equipment available	5.32	1.84			
f. skill of employees	4.78	2.05	1.95	93	0.055
e. equipment available	5.32	1.84			
g. type of service	5.96	1.91	2.12	93	0.037
e. equipment available	5.32	1.84			
h. time available for preparation	4.80	1.79	1.84	93	0.069
f. skill of employees	4.78	2.05			
g. type of service	5.96	1.91	4.40	93	0.000
f. skill of employees	4.78	2.05			
h. time available for preparation	4.80	1.79	0.07	93	0.943
g. type of service	5.96	1.91			
h. time available for preparation	4.80	1.79	4.47	93	0.000

POLICIES AND PROCEDURES IN KANSAS HOSPITALS RELATED TO SELECTIVE AND CYCLE MENUS

by

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B. S., Kansas State University, 1969

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ABSTRACT

The purpose of this project was to study the extent of use of cycle and selective menus and the related operational policies, procedures, and practices in 25-200 bed short-term general hospitals in Kansas. A questionnaire was mailed to the person in charge of the dietary department in 114 hospitals. Of the 108 questionnaires returned (94.7%), 104 were used in data analysis.

The study indicated that smaller hospitals employ fewer professional dietitians and conversely more cook-managers to direct the dietary department. The larger hospitals (101-200 beds) were directed by persons with primarily supervisory responsibilities.

The 101-200 bed hospitals had more complete policy and procedure manuals. Eighty per cent of these hospitals had written policies and procedures in all specific operational areas studied. Significant differences in percentages of hospitals with written policies and procedures, according to bed size, were found in three areas: house menu patterns, distribution and return of menus from patients, and late trays. A greater percentage of hospitals had written policies on diet orders by physicians, house menu patterns, late trays, foodservice hours, and distribution and return of trays when an ADA dietitian was in charge of the dietary department than when a cook-manager was in charge.

Patient satisfaction was the primary concern of the respondents in planning menus. Cost of food ranked second among concerns when developing menus. Cycle menus were used by all large hospitals (101-200 beds); whereas the percentage of small hospitals (25-50 beds) using cycle menus was 79.5 per cent. Use of selective menus was also greater in large hospitals

(101-200 beds) than in small. The use of selective menus was reported more frequently when the dietary department was under the direction of an ADA dietitian rather than a cook-manager. The chief reason for using selective menus was that fewer complaints were voiced by patients. The predominate reason for not using selective menus was that the hospital was too small.

Study of the type of menu item selections indicated that a beverage choice was offered most often. Choices of breakfast, lunch, and dinner entrees, desserts, and vegetable other than potatoes were offered in 80 per cent or more of the hospitals using selective menus. Placement of the printed menu on the breakfast tray was the most popular method of distribution. Dietary personnel were responsible for return of the menus in the greatest percentage of the hospitals.