ROLE OF THE CONSULTANT DIETITIAN IN NURSING HOMES: PERCEPTIONS OF DIETITIANS AND ADMINISTRATORS

by

DIANE M. SPEAR

B.S., Kansas State University, 1975

A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Dietetics, Restaurant,
and Institutional Management

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1978

Approved by:

Arlene G. Fadew
Major Professor

ACKNOWLEDGMENTS

Sincere appreciation is expressed to Dr. Allene Vaden for her guidance and professional expertise throughout this research and in preparation of this manuscript. Gratitude is also extended to Dr. Marian Spears and Dr. Kay Newell for their contributions as committee members.

Recognition and appreciation are due to the many consultant dietitians and nursing home administrators who so willingly gave their time and effort to participate in this study. Also, I would like to acknowledge the valued help and contributions of C. L. Gerwick and Associates during the initial phases of the research, and express appreciation to Clara Gerwick for her interest and guidance.

A special word of thanks is given to my husband, David, for his continual support and understanding throughout the completion of my graduate study. Also, with the assistance and encouragement of my family and friends this thesis was made possible.

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INTRODUCTION

In 1917, dietetics was defined by the founders of The American Dietetic Association (ADA) as the science of nutrition and the art of feeding people (1). Today, this definition still stands, but with new interpretations. Much literature has been published by ADA throughout the last decades in an effort to establish what dietetics is, what it has been, and what it should be. Dietitians have been employed primarily in the clinical setting with emphasis on development of technical and professional skills in the art of feeding people and manipulating diets. The profession of dietetics has grown to include a number of specialties. For example, the profession has been experiencing increasing demands to provide professional service to increasing numbers of elderly people in nursing homes and other health related facilities. Impetus has been given to these demands because of legislation concerning the care of the elderly (2).

With the advent of the Public Law 89-97, Title XVIII, commonly called Medicare, many healthcare facilities were required to recruit and utilize professional services of a qualified dietitian to insure that beneficiaries would receive quality nutritional care (3). This requirement was subsequently adopted by many states as part of licensing regulations for facilities and voluntarily by other types of residential facilities.

The professional response to meet this demand has been identified and defined by ADA as the Consultant Dietitian. As defined in the ADA position paper, a consultant dietitian is a professionally educated and qualified person who guides the group care facility in the operation of a safe

foodservice that provides nursing home residents with enjoyable meals which meet their nutrition and therapeutic needs (4).

The role of the consultant was a new concept to the dietitian. The staff functions of the consultant differed greatly from the managerial authority of the line position of the full-time dietitian in which responsibility and accountability are more clearly defined. The consultant's role is limited to that of advising and counseling, and she/he is accountable only for the technical quality of the advice provided (5, 6). The foodservice supervisor is responsible for accomplishing the basic objectives of the foodservice including the authority of decision and end results (5).

Towle (7) stated that professional consultation should be practiced in close reference to the administrator and foodservice supervisor. He further contended that the success of the consultant depends upon the support of the administrator and the cooperation of the foodservice supervisor in implementation of suggestions and recommendations.

Hagwood (8) stated that many administrators are apprehensive of the consultant's role because of a lack of understanding of the specific areas for which the dietitian is trained, especially in the field of institutional management. Other authors have agreed (9-11) and emphasized that an understanding of the consultant's role is necessary if she/he is to serve the facility effectively.

The overall objective of this research was to study the role of the dietitian in nursing homes as perceived by both the consultant and the nursing home administrator. A number of guidelines have been developed for consultant dietitians; however, there are limited data on the specific functions and activities of consultant dietitians in nursing homes and

related facilities. Search of the literature did not disclose any reports on the nursing home administrator's perceptions of the role of the consultant dietitian. More specifically the objectives of the study were:

(1) To study characteristics of dietitians consulting in nursing homes, i.e., the education and work experience of the consultant.

(2) To delineate major problem areas in nursing home facilities as defined by consultant dietitians and nursing home administrators.

(3) To analyze the responsibilities and activities of the consultant dietitian in relation to those of the foodservice supervisor in nursing homes and the frequency and importance of the consultant's activity in specific areas of operation as assessed by consultant dietitians and nursing home administrators.

(4) To study the degree of involvement of the administrator in foodservice activities.

(5) To identify administrators' perceptions of the major contributions of the consultant dietitian to the nursing home operation.

REVIEW OF LITERATURE

Role of the Consultant Dietitian

The members of The American Dietetic Association (ADA) believe that the right of every person in a group care facility is proper nutritional care and quality foodservice (4). According to ADA, the consultant to a group care facility should be a registered dietitian with a minimum of three years of experience with varied responsibilities, and should maintain competence through continuing education. Personal qualifications cited include ability to work with people, flexibility, maturity, decisiveness, patience, integrity, and professionalism.

McWhorter (12) asserted that consulting is challenging and depending upon the interpretation of the role, the work can be either gratifying or frustrating. She defined the consultant as a "salesperson" selling first herself and then her knowledge and ideas. She described the consultant as an expert without authority who functions through influence, service, and advice gained from knowledge and past experience.

A number of other authors (2, 4, 5, 13-17) have discussed the role of the consultant and generally have concurred with McWhorter. Montag (5) pointed out that a clear understanding of the consultant's role is imperative for a dietary consultant's effectiveness.

Historical Perspective

With the advent of World War I the first professional chartered organization of dietitians, The American Dietetic Association, was founded. When dietitians first began practicing the profession, their primary

concern was with feeding hospitalized soldiers and people under wartime conditions (18). The concept of the dietitian gradually changed, however, from a concern for feeding people to a greater emphasis on clinical nutrition and the science of nutrition. Thus, the dietitian of the thirties and forties practiced primarily in the hospital setting. It was also during these years that the dietitian as a consultant became a reality.

Brush (19) stated that since 1932 there has been diet counseling and consultation to nursing homes and small hospitals, especially in the western states area. In 1941, Barber, a leading dietitian in the field, 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. Her title soon became Food Consultant to the Secretary of War. In 1944 Hall (20) predicted that a dietitian specialized in administration could have an enviable position as a consultant in the post-war period and that clinical dietitians and nutritionists in public health were being sought for their consultative services.

Public Law 725, the Hill-Burton Act, passed by Congress in 1946 was designed to help states with the construction of hospitals and health centers to meet the need for more hospital beds and for community health centers. State health departments and special hospital commissions working on the remodeling and construction were encouraged to employ qualified dietitians to assist with planning (21).

According to Barber (22), in July 1948, a nutrition consultant was added to the three year old Nutrition Section of the U.S. Public Health Service to assist the state and local health departments in development of local nutrition programs, staff education programs, and adaption of methods and techniques of dietary appraisal. Jeans reported that two years later

the Food and Nutrition Board of the National Research Council was organized to work toward improvement of the nutritional status of people and of dietary management in various institutions (23). It was shown through surveys that many institutions had poor dietary regimens and were lacking the services of a dietitian or a person with dietetics training. Suitable printed materials for reference and instruction were indicated as a first step towards increasing the knowledge and improving the practices of those in charge of diets in institutions. The ADA was requested to prepare a series of articles to be used by the consultant dietitian.

In 1951 a survey of hospitals showed that 59 per cent of the facilities were located in towns of less than 5,000 people. The majority of the small hospitals could not afford trained dietitians even if they were available. This situation was being met by a new type of service, that of the consultant dietitian (22).

The American Nursing Home Association and the Council of the American Medical Association met in 1959 to develop a set of suggested guidelines for medical care in nursing homes and related facilities. One of the guidelines related to nutritional care and suggested that each nursing home should consider using consultative services in nutrition and diet therapy provided by the state health department or by other agencies or persons qualified to provide such services. The guidelines also indicated that the nursing home administration should assure that all dietary regimes ordered by the patient's physician were carried out (24).

According to Bowes (25), many nursing homes and related facilities for the aged did not employ well trained personnel for foodservice. Spears (26) stated that there was a lack of supervisors in some hospitals in Arkansas in which she functioned as a consultant dietitian. Within the

institutions she serviced, it was understood that there must be supervisory personnel, as the services she provided would be useless if there was no one to carry out her suggestions and plans. A part of her services included a class for foodservice managers dealing with special diets and problems in foodservice administration.

Piper (27) reported that in 1963 one half of all the state health agencies employed dietary consultants and nutritionists to provide consultation to group care facilities. Congress passed Public Law 89-97 in 1965 and established Medicare and Medicaid under Title XVIII and XIX of the Social Security Act of 1935 (28). The enactment of this legislation created a demand for consultative service by dietitians for persons in group care facilities. At the time the legislation was enacted, it was estimated that less than one per cent of nursing homes and health related facilities employed professional dietitians (29). Ten years later, in a study conducted by the Public Health Service of the U.S. Department of Health, Education, and Welfare (USDHEW) (28), it was found that approximately 90 per cent of the skilled nursing facilities received some consultation or supervision from a qualified dietitian. Niles (30) found in 1974 that 43 per cent of nursing homes in Kansas employed a dietitian either full- or parttime as a consultant.

Within the past few years, consultation has become an important area of practice in dietetics. The ADA by-laws, adopted in July 1977, provided for practice groups within the ADA framework. The consultant dietitians in health care facilities became the first and largest practice group to become part of a division within the ADA Council on Practice (31).

A number of authors have recognized that one of the dietitian's major roles in the future is that of a consultant (18, 32). Johnson (18) stated

that dietitians, as translators of nutritional information into effective nourishment for people, will have justified their existence when they fulfill the role of consultant. According to Stokes (32), at no other time in history have the opportunities for dietitians been so great.

Types of Consulting Services

Stokes (32) stated that dietary consulting can be the pivotal point of an innovative future which virtually abounds with opportunities never before considered: administrative consulting; nutrition counseling; developing new food delivery systems; devising effective, cost-reducing, and labor-efficiency procedures; drafting courses for foodservice supervisors; expanding journalistic contributions; becoming a truly viable member of the health care team; participating on boards of directors; and lending nutrition expertise in a variety of areas such as penal systems, schools, hospitals, nursing homes, and many other areas. Consultants provide these services under various arrangements.

Four basic types of arrangements for consulting services have been reported (33): (a) the self-employed dietary consultant, (b) group practice--a legal partnership of dietitians, (c) the package plan, and (d) the consultant for a group of homes under one management. Williams (34) asserted that the self-employed dietary consultant who may be seeking employment with a nursing home must first arrive at an agreement with the administrator of a facility. The concerns are direct responsibility, needs and goals of the foodservice department, consultant time devoted to service of those needs and goals, and payment of services.

Woodward (35) described a legal partnership as a group of dietitians who form a company under an agreed name to serve nursing homes and other

health related facilities, to furnish guidelines, offer moral support, provide supervision to dietetic consultants in their employ, and recruit such accounts for service. In 1965 a group of dietitians formed a legal partnership and took the name A'DACO. The primary goals of the company were: (a) to improve the effectiveness of the dietary consultant by giving aid, materials, and guidance to the consultant, (b) to provide the consultant with a well-paying position, (c) to provide the consultant with recognition as a member of a professional team, and (d) to provide meaningful service to a nursing home in a short time and at a reasonable cost. The group of dietitians, all fully employed, met regularly to discuss progress and problems and to give advice. An office was obtained to store all necessary materials and to provide a central meeting place. Woodward indicated that the greatest advantage to the facility is that it receives the total company service, which includes the advice and the supervision of all members of the company as well as the consultant's services; also the company guarantees continuity of service. The additional operational expenses of maintaining an office was listed as a main disadvantage to the consultant group.

Marshall (36) indicated that the third approach, the "Package Plan," was for consultant dietitians who preferred structure. Food Art Horizons used such a "package" consisting of six parts: six-week menu cycle for general and modified diets, purchasing guide for each week based on the menus, standardized quantity recipes, diet manual, meat specifications, and training guide. Marshall reported that in putting this plan into effect, the first step was to sell the idea and program to the administration of the facility. The second step was to adapt the program to meet the needs of the facility. The third step was to provide weekly supervision in such

areas as employee training, kitchen activities, and department organization. Marshall listed advantages of the "Package Plan" as economical use of time in development of basic management tools and the amount of control of foodservice activities achieved. On the other hand, some disadvantages identified that may be unique to this type of service were the high cost in purchasing the program, use of similar menus by all homes under the program, and the difficulty in altering existing procedures to fit those provided in the new program (36).

According to Oliver (37), the consultant dietitian employed by a group and providing consultation for a number of homes includes the same type of services under other types of arrangements. One of the greatest advantages is flexibility of time spent in each facility based on current needs. Other advantages include group purchasing, budgetary control, and personnel administration.

Line and Staff Functions

Montag (5) stated that the dietary consultant must clearly understand the concepts of line and staff functions in order to serve the facility effectively. Haimann and Scott (38) defined the line organization as having a direct line of authority extending from superior to subordinate. According to these authors the staff guides, advises, counsels, and serves the line personnel through specialized knowledge and expertise. Hayman and Scott indicated it is the privilege of the line personnel to accept, alter, or reject the advice given to them by the staff. Strauss and Sayles (39) concluded that line managers welcome staff activities which promise to help them achieve goals, but resist those unrelated to needs. In the 1977 position paper on recommended salaries and employment practices for members

of ADA (13), the consultant dietitian was defined as one who affects the management of human effort and facilitates resources by advice or services in nutrition care.

Since both the terms "staff" and "consultant dietitian" are defined in terms of advice and service, the role of the consultant can be described as a staff function (5). Hartman (11) compared the consultant and parttime dietitian and delineated the function of the parttime dietitian as supervisory with responsibility to direct the foodservice. Robinson (2) formulated similar distinctions between the dietary consultant and parttime dietitian; however, she also acknowledged overlap between the two.

Activities of the Consultant

The dietary consultant, according to Lane (17), works mainly with the administrator and the foodservice supervisor in developing necessary training programs and in guiding employees as they begin to use new knowledge and skills. She also recognized the consultant dietitian as a liaison between the foodservice department and the nursing department.

In the guidelines established by the USDHEW (40), consultant dietitian functions were described as teaching and training, giving specialized advice, and establishing liaison with medical and nursing staff at the professional level. According to Reel (6), the consultant's major objective is to produce desirable changes of behavior which can help insure lasting and continual progress toward organizational goals. Reel asserted that achieving this objective was made more difficult by the staff role, which limits the use of authority and compels the dietitian to accomplish objectives primarily through persuasion and acceptance. Further, she stated that responsibility and accountability for the accuracy and quality of advice and recommendations belong to the consultant dietitian.

Reel (6) also contended that the consultant can effect great improvement in a foodservice department by performing the necessary organizational and administrative procedures. Robinson (2) pointed out that although the principles of organization and management are the same, the application will differ among facilities because of individual strengths and needs of various institutions. She emphasized that the consultant must be able to recognize these strengths and needs and base advice on careful evaluation and judgment. She also indicated that the initial evaluation of the foodservice department will form the basis for the consultant's plan of service.

Lippitt and Lippitt (41) contended that the jobs of a growing number of persons encompass helping or consulting functions. They indicated that many consultants function as helpers from outside the organization, while others perform as inside or internal consultants. The authors developed a descriptive model that presents the consultant's role on a continuum from directive to nondirective. They described the more directive role as one in which the consultant assumes leadership and directs the activity. In the nondirective mode, the consultant provides data, for the client to use or not, as a guide for the client's self-initiated problem solving. In the past, the consultant dietitian's role has been in a nondirective mode, from outside the organization, as either the consultant or shared dietitian to nursing homes.

Lippitt and Lippitt (41) stated that the roles of directive and nondirective are not mutually exclusive but may manifest themselves in many ways at any stage in the particular client situation. They indicated that most consultants use multiple roles in working with a client. The

following descriptions for the multiple roles of the consultant were listed with the related level of consultant activity:

Role Description	Level of Activity
1. Advocate	Proposes guidelines, persuades, or directs in the problem solving process
2. Informational Expert	Regards, links, and provides policy or practice decisions
3. Trainer Educator	Trains client
4. Joint Problem Solver	Offers alternatives and participates in decisions
5. Alternative Identifier and Linker	Identifies alternatives and resources for clients and helps assess consequences
6. Fact Finder	Gathers data and stimulates thinking interpretives
7. Process Counselor	Observes problem solving process and raising issues
8. Objective Observer/Reflector	Raises questions for reflection

The multiple role descriptions were listed from most directive to nondirective. The authors described factors to consider in selection of the role the consultant will assume with a client as the following: (a) the nature of the contract, (b) goals to be obtained, (c) norms and standards of the client system and the consultant, (d) personal limitations and inclinations of the consultant, (e) internal or external status of the consultant, and (f) events external to the consultation process.

In a study conducted by Brenner (42), it was found that areas in the dietary department operation in which the consultants were directly involved were the areas in which the foodservice supervisors were less skilled. Montag (5) asserted that the consultant provides advice and service in the management processes of planning, organizing, coordinating,

and controlling. The consultant may propose or recommend: (a) plans or policies, such as physical layout and procurement of new equipment; (b) new or revised programs for installation, for example, purchasing procedures; (c) establishment of accounting records and budgets, (d) operational controls, and (e) in-service program for increasing the knowledge and improving the procedures in principles of therapeutic nutrition and food-service management.

Scialabba (43) contended that dietitians who practice in ambulatory care settings need to be prepared to meet frequent challenges to demonstrate competence. They must be competent, not only in the act of dietary counseling, but in fiscal planning, implementing and evaluating programs, coordinating and integrating within the health team.

In a study conducted by Smith (44), a panel of forty-two consultant dietitians and a second panel of 100 nursing home administrators predicted that the future responsibilities of the consultant dietitian over the next decade would remain basically the same as at present. These panel members purported that the functions of planning and writing menus would continue to be the number one responsibility of the consultant. Other responsibilities ranked as important by the panels related to planning, implementing, conducting classes for personnel, and evaluating staff. The panel members also forecasted that one of the major responsibilities of the consultant dietitian in the next ten years will be assessment of patients' nutritional status and development, implementation, and evaluation of nutritional care plans.

The position paper (4) on the role of the registered dietitian in consultative services to group care facilities outlined the consultant's functions to include three major categories of activities: (a) evaluating

and making recommendations regarding kitchen designs, menu preparation and implementation, budget planning, and staff competency and adequacy; (b) interpreting and/or suggesting adjustments of the physician's dietary order, initial and continued assessment, as needed, of individual residents or patients, integrating recommendations in the total care plan, nutritional counseling, and discharge planning; and (c) providing staff education, participating in appropriate facility committees and conferences, promoting good nutritional practices, and writing reports on current status of goals.

Effective Consultation

It is generally agreed that there are at least three skills that are basic to the management process (45, 46); these have applicability to the role of the consultant and effective consultation:

> Technical skill--implies an understanding of and proficiency in specific activities involving procedures and techniques.
>
> Human skills--involves leadership ability and skill in intergroup relationships. Ability to work with and through others is essential for effective consultation.
>
> Conceptual skill--involves the ability to see the organization as a whole and the interrelationships of the organization parts. A large percentage of the consultant dietitians time is spent in utilizing this skill through assistance with broad-scale goal setting, program planning, and policy decision making.

According to Lane (47), the success of dietary consultation in a nursing home depends on cooperation. She further contended that in carrying out any program of improvements, the consultant dietitian must have support of administration. In addition, the consultant must be able to depend upon the foodservice supervisor to implement suggestions and recommendations. Robinson (2) further elaborated by stating that desired results will not be obtained unless sufficient time is devoted to establishing relationships conducive to effective improvement in the foodservice.

Montag (9) asserted that if the dietary consultant is to serve the institution most effectively a clear understanding of the consultant's role by all concerned is essential. She listed the following conditions as necessary to promote effective consultation:

1. The administration must explain clearly the function of the consultant to the supervisor, including the supervisor's relation with the consultant.
2. The consultant must "sell" ideas, through motivation and self-actualization.
3. The supervisor must be informed that recommendations are based on established standards and are not criticisms of the dietitian.
4. The consultant must use technical competence to insure that new programs and procedures are both feasible and workable.
5. The consultant must create an image of help and resource to develop acceptance for ideas and points of view.
6. The foodservice supervisors must regard any programs that are developed as their own, and receive as well as assume credit for any improvements.
7. The consultant must show qualities of patience, reliability, tolerance, flexibility, and professional ethics (5).

Baker and Schaffer (48) cited six problems and points that often reduce the effectiveness of staff consultants. (a) Staff makes promises and asserts that this and only this particular approach will solve the problem. (b) The consultant proposes methods that may be theoretically correct, but also may be inappropriate to the particular situation. (c) The consultant may see only that situation which relates to her/his background and interests. (d) The person or persons receiving consultation are placed in the position of having to judge conflicting courses of action suggested by multiple staff personnel. (e) The person or persons receiving consultation were previously "sold" by another consultant not as knowledgeable and competent as necessary. (f) The consultant is a relative

newcomer to the organization and is unaware of important policies, politics, and folklore. Also, they listed several principles which must be observed by the staff person to be effective in helping managers accept and use new concepts and technologies:

1. Begin where the managers are ready to begin.
2. Design projects so as to build on the success achieved in the first project, and to key the pace to what the manager or organization can sustain.
3. Share control with the line management.
4. Share knowledge with the line management.
5. Unify the various consulting efforts in the organization.

Role of the Foodservice Supervisor

The term foodservice supervisor is a job title that has been assigned to one who supervises foodservice employees in the performance of assigned duties (49). The ADA Committee to Develop a Glossary of Terminology for the Association and Profession proposed the generic term Dietetic Assistant to promote clarity and understanding of the role of this dietetic team member (50). The generic name included foodservice supervisor among a number of job titles. Although the generic term is retained for professional use in ADA publications and communications, Foodservice Supervisor is the job title used frequently in institutions. The ADA-approved definition of the dietetic assistant (50) is:

> A person who has successfully completed a program for dietetic assistants which meets the standards established by the ADA. Under the supervision of a dietitian, of a dietetic technician, or an administrator and a consultant dietitian, and through assigned tasks, the dietetic assistant participates in providing foodservice supervision and nutritional care service.

Background on Role of Supervisor

As long ago as 1943, during World War II, The American Dietetic Association recognized the need for delegation of duties to non-professionals as the shortage of professionally qualified dietitians became more acute (51). The need for dietitians in the armed services influenced and increased the civilian need for dietitians. Even with the advent of peace in 1945 the civilian need did not diminish. To meet these demands, it soon became apparent that the available dietitians would need to concentrate their efforts in performing specialized activities. By employment of and delegating to non-professional persons, the dietitian would be relieved of the day-to-day operational functions. At this time the foodservice supervisor was foreseen as a hospital position where at least one professionally qualified dietitian might serve as the department administrator.

An ADA survey in 1962 (52) indicated that the foodservice supervisor position in hospital dietetic departments had gained firm footage. Almost 70 per cent of the hospitals with more than 100 beds reported employing one or more foodservice supervisors, whereas approximately 40 per cent of those under 100 beds employed at least one foodservice supervisor.

As the role of the foodservice supervisor grew, specialization appeared in the larger hospitals (53). Also the smaller institutions and nursing homes which for the most part were not large enough to employ the services of a full-time dietitian were employing foodservice supervisors. In such situations, it was suggested the foodservice supervisor have the assistance and advice of a dietary consultant (51, 54). In very small institutions, usually twenty-five beds or less, where the person in charge may also take part in actual food preparation, it was recommended that the

person's title should be cook-manager rather than foodservice supervisor (51, 53).

Training programs were developed for the education of foodservice supervisors and cook-managers. An ADA committee charged with exploring the possibilities of organizing a group for supervisors reported in 1960 that the constitution for the new organization had been accepted and the group was named The Hospital, Institution, and Educational Food Service Society (HIEFSS). The first HIEFSS meeting was held at the forty-third ADA Annual Meeting in 1960 (55).

Educational Programs

In a study conducted by Anderson (56), it was concluded that a need existed for the education of cook-managers of nursing homes. Analysis of job responsibilities compared with educational preparation showed a definite lack of preparation in specialized knowledge required for the magnitude of the position.

Publication of outlines for classroom instruction and supervised experience was the first effort of ADA with respect to education for the foodservice supervisor. The next noted accomplishments were development of an extensive bibliography and performance rating scale (54). Lane (57) reported that the first training program was established in the adult vocational education school system of Cleveland, Ohio. A correspondence course for training foodservice supervisors was developed by ADA in 1959 (58). It involved the preparation of lessons which were sent to the course director for grading and evaluation, following guidance and counsel by the student's selected preceptor who was an ADA member. In the nursing homes, the consultant dietitian qualified to serve in the capacity of preceptor (57).

Another correspondence course was developed at Pennsylvania State University and was provided through the extension service (51, 57). Other programs available included programs at junior colleges and vocational-technical public schools (57). Van Horne (59) reviewed and listed a number of additional programs.

To fulfill Medicare requirements, many nursing home administrators have established the position of foodservice supervisor in the foodservice department and have enrolled the employee in an ADA approved course at the state or local level or through correspondence. Smith (60) reported in 1971 that 7 per cent of the foodservice managers of large nursing homes and 18 per cent of those in small nursing homes participating in the study conducted in West Tennessee had received training in the foodservice field. In the national survey conducted by USDHEW (28) it was found that approximately 40 per cent of the facilities surveyed had only a full time qualified dietetic service supervisor.

ADA has established standards and procedures for approving dietetic assistant programs (61). Guidelines have been prepared for use in planning and developing approved programs (62). ADA approval helps to assure basic national performance standards for the entry-level practitioner and promotes career development and mobility.

Lane (57) reported that one of the chief difficulties of dietitians consulting in nursing homes is the absence of adequate supervision in the foodservice department. According to Lane, the key to an efficiently operated and coordinated foodservice is an able, well-trained foodservice supervisor.

Activities of the Foodservice Supervisor

Schiller and Vivian (63), in 1974, reported lack of time as a primary deterrent to ideal role performance of the dietitian. The ADA position paper on the dietetic technician and dietetic assistant (59) claimed that effective utilization of the dietetic technician and the dietetic assistant would permit the dietitian to fulfill professional functions and to develop innovative services. Thus, the foodservice supervisor in nursing homes and small institutions was considered to have general responsibility for the operation of the foodservice and for reporting to the administrator (51).

According to Montag (5), the foodservice supervisor is responsible for accomplishing the basic objectives of the foodservice department, having the authority for final decisions and end results. Whereas, the consultant dietitian's role is that of advising, counseling, and assisting the foodservice supervisor. In the pure line and staff relationship, the consultant carries no authoritative power. Several authors (2, 64) have contrasted the role of the consultant and the supervisor. Robinson (2) also interpreted the consultant's role as having no direct management responsibilities while the foodservice supervisor or cook-manager assumes the actual management of the foodservice operation. The responsibilities appropriate to the position of foodservice supervisors were originally developed by ADA in 1954 (65) and over the past decades revisions have been made (50, 53).

Nursing Home Administration

The early role of long term care facilities was to provide custodial care. McQuillan (66) stated that the present-day role goes well beyond this to include continuing care for those recovering from surgical procedures or medical problems, assisting the patient in achieving maximum

physical and emotional health, and assisting the elderly in achieving an active participation in life.

Rakich et al. (67) reported that long-term care facilities in the U.S. are largely sole proprietorships with the owner also serving as administrator. Others are owned by partnerships or by a non-profit corporation or are part of a chain. Only about 19 per cent of the facilities are operated on a non-profit basis, thus producing the term, nursing home industry. Schachter (68) indicated that in recent years this industry has undergone a tremendous growth rate that has been paralleled by an even greater increase of governmental funds spent for institutional care. Mitchel (69) contended that the introduction of Medicare and the upgrading of standards helped to change the generally poor image of the nursing home to a much more positive one. Similarly, the nursing home administrators have been forced to upgrade preparation for their roles because of the broader interpretations of long-term care as a result of the new nursing home administration licensure requirements.

According to Mitchel (69), the nursing home administrator is the catalyst for the development and implementation of all services and plays a major role in provision of high-quality care. By planning and day-to-day management, the nursing home administrator determines the level of care (70). The nursing home administrator's primary role is to get the people representing various disciplines to carry out what they have been hired to do in the most efficient manner possible (69). In order to direct his staff effectively, the administrator must establish clearly the goals and objectives of the facility.

As stated in the USDHEW report (28) on the long-term care facility improvement study, the administrator is fully responsible for the

day-to-day operation of the nursing home and is accountable to the governing body alone. The governing body should appoint an administrator who is currently licensed by the state and qualified by education and experience to manage the facility effectively. The report also charged that the administrator has the responsibility for effectively coordinating staff efforts to assure the delivery of high quality patient care. The findings of the study revealed that 96.7 per cent of the facilities (6,372) had designated administrators, however 29.2 per cent of the administrators had not been so designated in writing. Findings related to policies indicated that in 93.2 per cent of the facilities rules and regulations pertaining to patient health care were established, but in 19.7 per cent, the rules and regulations were not enforced by the administrators. Recommendations were made that further study determine the body of knowledge and preparation needed by administrators of nursing homes. The report also implied that state nursing home licensure programs are licensing individuals who are ineffective administrators and recommended that review of these licensure procedures be undertaken. Yokie (71) reported that in July 1975, The College of Nursing Home Administrators received a USDHEW grant to develop and provide a series of educational units for training in the field of long term care administration.

Consultation in Relation to Administration

Montag (9) stressed the need for good working relationships between the consultant, the foodservice supervisor, and the administrator, and emphasized that a complete understanding by the administrator of the consultant's role was imperative if the consultant was to serve the institution effectively. According to Clark and Knickrehm (10), knowledge of the

administrator's perceptions of the dietitian's role can help the dietitian improve her performance. Findings from their study revealed close correlation between administrator's and dietitian's perceptions of managerial skills and personal characteristics of successful dietitians. Towle (7) indicated that the consultant works primarily with the administrator of the nursing home and the foodservice supervisor in providing information, developing training programs, and in guiding employees in developing knowledge and skills. The success of consulting dietitians in the nursing homes depends upon the support of the administrator and the cooperation of the foodservice supervisor in the implementation of suggestions and recommendations.

Kurtz (72) and Robinson (2) implied that effective communication between the administrator and the dietitian must be maintained if a service responsive to the objectives of both is to be achieved. In preemployment interviews, Montag (9) stated that both parties should determine mutual objectives and agree on conditions of employment. These conditions generally include extent of the services provided, the time required, rate of pay, and method of payment. She further stated that the function of the consultant should be interpreted clearly to the foodservice supervisor by the administrator. Montag also contended that acceptance by the supervisor is dependent on the consultant having full support of the administrator.

Jernigan (73) developed the following list of responsibilities of the administrator to the consultant dietitian of nursing homes:

1. To discuss with the dietitian the department needs and area of improvement.
2. To define the number of hours to be worked.
3. To specify the rate of pay including additional expenses if any.

4. To designate the foodservice supervisor or other full-time employee as the person to be trained by the dietitian and to be responsible for carrying out programs initiated by the dietitian.

5. To orient the dietitian to the problems of the facility.

6. To introduce the consultant dietitian to the nursing home staff, with an explanation of position and responsibilities.

7. To set aside specific time for consultation with the dietitian at least once a month.

8. To allow the dietitian time to become acquainted with patients, nursing staff, and dietary employees before attempting to make any major changes in procedures.

Health Care Legislation

To help meet the health care needs of the elderly and the poor, the U.S. Congress passed Public Law 89-97 in 1965, and established Medicare and Medicaid under Title XVIII and XIX of the Social Security Act (28). Coverage of care rendered by a certified nursing home was one of the benefits. Certification was obtained by demonstrating compliance with federal regulations. Since the mid-sixties, the regulations have evolved from ensuring safety to a greater focus on the need for achieving optimum quality care, as well as technical assistance to states in support of efforts to upgrade nursing homes. According to Schachter (68), the only hope for continued federal support of extended care facilities lies in the industry's realization that compliance with the federal standards is mandatory.

In 1966, the USDHEW Social Security Administration published the Conditions of Participation for Extended Care Facilities (74). Smith (75) indicated that recognition of the importance of dietary services in meeting the total needs of the patient was evidenced by these standards.

In 1972, development of unified standards and regulations governing skilled nursing facilities under Titles XVIII and XIX were approved by the Congress (28). In January of 1974 these regulations were published and interpretive guidelines for professional and consumer groups as well as instructional guidelines and forms for surveyors were developed. In reference to dietetic services the standard on staffing stated (76):

> Overall supervisory responsibility for the dietetic service is assigned to a full-time qualified dietetic service supervisor. If the dietetic service supervisor is not a qualified dietitian, he functions with frequent, regularly scheduled consultation from a person so qualified.

Also published in January 1974 were the regulations governing intermediate care facilities creating in response to congressional legislation a new level of care to be provided under the Medicaid program (77). Professional resources to meet staffing and consultant requirements were cited as scarce and unavailable in many areas; therefore consultants were eliminated in a number of areas including meal services. A number of the state regulatory agencies, however, have deemed it mandatory that intermediate care facilities receive the services of a qualified dietitian. For example, the Kansas Department of Health and Environment 1977 regulations for the licensure and operation of an intermediate care home (78) state that overall planning and supervision of the dietetic service department of an intermediate care facility shall be under the direction of a dietetic services supervisor who shall be a qualified dietitian or a trained food-service supervisor who has consultation with a qualified dietitian.

According to Robinson (2) enactment of federal and state legislation along with an increase in the number and size of hospitals, nursing homes, and related facilities has forced expansion of professional dietary services. Smith (75) contended that selected standards and factors within

the standards and regulations have been designed to provide maximum benefit to the patient from a dietary point of view.

METHODOLOGY

Design of the Study

The sample was selected from consultant dietitians in twelve states of the North Central region (Figure 1) as defined by USDHEW (79). The study was limited to dietitians consulting in nursing homes and the administrators of each dietitian's nursing home accounts. Phase I of the study involved development of the research instruments and identification of the consultant dietitians for the survey phase; Phase II was the actual collection of data to fulfill objectives of the study.

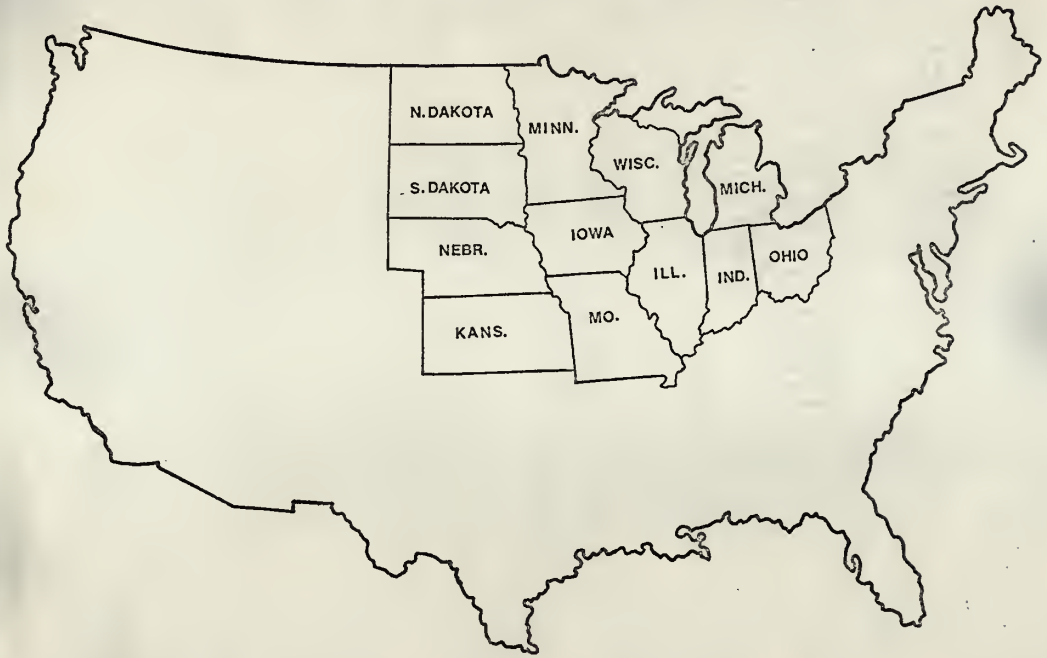
Semi-structured interviews and a pretest were conducted with several consultant dietitians and nursing home administrators to facilitate the planning of the research. In the actual study, administrators and the consultant dietitians were asked to complete similar questionnaires concerning the role of the consultant dietitian in long-term care facilities.

Phase I: Selection of Sample and Development of Research Instruments

Selection of Sample

A computer printout listing consultant dietitians by state was obtained from The American Dietetic Association (ADA). All consultants (N = 589) on the ADA listing in the twelve states were surveyed to determine: (a) consultants employed by nursing homes; (b) the number of nursing home accounts each consultant served; and (c) the consultants' willingness to participate in the study.

Figure 1. USDHEW North Central Region


N. DAKOTA
MINN.
WISC.
MICH.
S. DAKOTA
IOWA
NEBR.
ILL.
IND.
OHIO
KANS.
MO.

In the preliminary interviews in the design of the research, findings indicated that descriptions of the consultant's role should be studied in relation to particular nursing homes. Differences among institutions affected the function and activities of the consultant in a particular situation. Therefore, it was important to determine the number of nursing home accounts each consultant served for design of Phase II. Therefore, in Phase I, each consultant received a memorandum outlining the purpose of the study and a self-addressed, stamped postcard to return. A copy of the postcard and memorandum are included in Appendix A.

Of the 346 dietitians responding (58.7 per cent), 252 were included in Phase II. Only a few were not willing to participate. The majority of those not selected for Phase II were not presently consulting in nursing homes and therefore, did not meet the constraints of the study.

Development of the Instruments

The appropriate instrument selected for collecting data on role perceptions of consultant dietitians and administrators was a questionnaire. As indicated, in development of the instrument, an interview survey was conducted among nine selected consultants and four nursing home administrators in various areas of the state of Kansas. The interview schedule (Appendix B) consisted of a series of open ended questions that considered responsibilities of the foodservice supervisor versus those of the consultant, perceptions of the consultant's roles in the foodservice operation, and the involvement of the administrator in the foodservice operation.

A portable recorder was used for the semi-structured interviews to facilitate accuracy in recording data and in analysis. After an explanation of the sponsorship and purpose of the study, the person being

interviewed was given an abbreviated outline of questions to be used as a guide during the semi-structured interview (Appendix B). General questions were asked, then related items not mentioned in the response were suggested by the interviewer.

Using the information obtained from the semi-structured interviews, two questionnaires, one for the consultant dietitian and one for the administrator, were developed for use in Phase II of the study. The preliminary questionnaires were evaluated by a group of ten consultant dietitians and selected nursing home administrators whom the consultants believed would provide valuable input in the pretesting of the instrument. Each consultant and administrator received a copy of the appropriate cover letter and questionnaire and an evaluation form for recording suggestions for revision. A memorandum was attached acknowledging appreciation for their willingness to participate in the pilot study and a brief instruction on completing the evaluation form. Copies of the cover letter and questionnaires were returned along with the evaluation forms giving comments and suggestions concerning the cover letter and questionnaire (Appendix C).

The questionnaires were revised using information from the evaluation sheets; however no revisions were needed on the cover letters. Only minor revisions on the questionnaires were needed, mainly in format and spacing. Also a response category was added to the scales for evaluating foodservice-related activities indicating the activity was not performed in the facility.

Final Research Instruments

The consultant questionnaire was printed on yellow paper and the administrator questionnaire on blue to distinguish the two forms. The

administrator questionnaire was photographically reduced to appear shortened and condensed, and to permit a four-page folded format. The consultant questionnaire was printed in an eight-page booklet form. The letterhead stationery of the Department of Dietetics, Restaurant and Institutional Management, Kansas State University, was used for the cover letters, and the letterhead form was used for the front page of the questionnaire to identify the study with sponsoring organization.

Consultant Questionnaire. The consultant questionnaire (Appendix D) had four sections. Section I provided some overall information about the home; Section II, data on activities of the consultant dietitian, foodservice supervisor, and administrator in the nursing home foodservices; Section III, an evaluation of the performance of the supervisor, and the last section, biographical-demographical information on the consultant dietitians.

More specifically the first section of the research instrument was designed to provide: (a) background information on the nursing home, including type of facility and number of beds; (b) information on employment on the consultant dietitian, including length of time the facility had employed a consultant; hours per month spent at the facility; hours per month spent away from the facility; and specific activities performed away from the facility; and (c) information on the present major problem areas in the foodservice department. Ten possible problem areas were listed; a three-point rating scale was used for evaluating each area. The three ratings were: not really a problem, somewhat a problem, and major problem area.

In Section II, a list of areas of responsibilities with categories of activities was adapted from a study conducted by Brenner (42). These nine categories were:

Menu Planning
Modified Diets
Food Purchasing
Food Preparation
Food Service
Organization and Management
Sanitation
Records and Reports
Education and Training

There were from two to seven activities in each of the nine categories. Three scales were used in rating each activity. Scale A identified activities of the consultant dietitian and the foodservice supervisor; Scale B was for a rating of frequency of activity by the consultant; and Scale C provided data on degree of involvement of administrators in the foodservice activities. These three scales were as follows:

Scale A. Activities of dietitian and foodservice supervisor (FSS)

Activity performed by:

1. Consultant dietitian only
2. Consultant dietitian with assistance of supervisor (75:25)
3. Joint responsibility (50:50)
4. Foodservice supervisor with assistance of consultant dietitian (75:25)
5. Foodservice supervisor only
6. Neither FSS or consultant

Scale B. Frequency of activity by dietitian

1. Performed almost every visit to facility (or at home prior to each visit)
2. Performed every 2 or 3 visits
3. Performed only occasionally
4. Not performed by dietitian

Scale C. Degree of involvement of administrator in foodservice activities

1. Not involved in activity
2. Only periodic involvement
3. Frequent involvement

4. Takes complete responsibility
5. Activity not performed in facility

Section III of the instrument was designed to provide information on the foodservice supervisor: (a) length of time employed by the facility; (b) education and training; and (c) characteristic traits and abilities. A four-point rating scale was used for evaluation of the foodservice supervisor's performance.

Seven biographical items comprised Section IV of the questionnaire. These questions were asked to obtain information related to the education and work experience of the consultant.

Administrator Questionnaire. The administrator questionnaire (Appendix E) was composed of two sections. Section I of this questionnaire contained the same list of areas of responsibilities with categories of activities that was used in the consultant's questionnaire. Again, three scales were employed in rating each activity; Scales A and C were identical to those on the other questionnaire. Scale B provided an evaluation of the importance the administrator attached to the consultant's activities. The three ratings were: not really important, somewhat important, and very important.

Section II of the questionnaire covered three major areas, each using Likert-type rating scales. As in the dietitian's questionnaire, the administrators were asked (a) to rate the foodservice supervisor and (b) to evaluate problem areas in the foodservice department. The third section contained a list of possible areas in which the consultant made a contribution. Each area was rated using a three-point scale to describe degree of change brought about by the dietitian; these ratings were: little, if any change; some change; significant change.

Phase II: Collection of Research Data

Distribution of the Instruments

The 252 dietitians identified in Phase I of the study received a set of two questionnaires for each nursing home for which she/he served as a consultant. A total of 791 sets of questionnaires were distributed. Corresponding questionnaires were stamped with an identical unique number to facilitate follow-up of nonrespondents and to permit matching of data from the consultant and the administrator for a particular home.

Cover letters for each questionnaire included a brief description of the study, and an appeal to encourage the respondent to complete and return the questionnaire, and a statement assuring respondents of anonymity (Appendix F). Instructions for completing and returning the instruments also were included. The consultant dietitians were asked to deliver or mail the questionnaires to the administrators in order to encourage their response.

Questionnaires were mailed from and returned to the Department of Dietetics, Restaurant and Institutional Management, Kansas State University. A self-addressed, stamped envelope was included with each questionnaire (the consultant's and administrator's) to encourage response, and an additional pre-stamped envelope was provided for the consultant dietitian to mail the questionnaire to the administrator if necessary.

Follow-up Mailings

Because of the design of the study, four types of follow-up were needed: (a) to dietitians and administrators at the same home from whom there was no response; (b) to consultants who failed to respond for one or more homes, although letters were received from administrators of the

homes; (c) to administrators of homes who had not responded although dietitians had; and (d) to consultants for whom only partial responses were received. Follow-up letters (letter a) were sent to the 104 nonrespondent dietitians reminding them of the first mailing and encouraging them to review its contents and to participate in the final phase of the study. Follow-up letters sent to consultant dietitians (letter b) and administrators (letter c) for which only one of a pair of questionnaires was received emphasized the importance of obtaining both questionnaires in order to utilize the data from the facility. An additional questionnaire and a return envelope were enclosed.

Following the preceding mailings, an additional follow-up letter (letter d) was mailed to consultant dietitians for whom partial response was obtained listing names of homes for which information had been received. A form was provided to be completed and returned indicating whether the additional homes for which questionnaires had not been received were still among the consultant's accounts. Copies of the letters are included in Appendix G.

Returns

Sixteen dietitians did not participate in Phase II because they were no longer serving as consultants at the time the materials were distributed. Sixty-two per cent of the questionnaires sent to dietitians were returned and 48 per cent of the administrator questionnaires were returned. In the initial mailing, corresponding data were received on 27 per cent of the nursing homes. After the follow-up mailing, corresponding data were received on 297 homes (41 per cent).

Data Analyses

Data from the returned instruments were paired (consultant questionnaire and administrator questionnaire for each nursing home facility) and coded for computer analysis. Data analysis was concerned primarily with comparisons between consultant and administrator responses. Also, data were analyzed separately for each of the groups.

Frequency distributions were compiled for all data on the consultant and administrator questionnaires. In addition, means and standard deviations for consultant reports of hours per month, hours per month away from the facility on related activities, and number of visitations to the facility per month were computed.

The t-test for related samples (80, 81) was computed to compare consultant and administrator mean ratings of problem areas in nursing home foodservice. Also degree of agreement between responses from both groups for each nursing home was determined by computing the percentage of matched pairs of administrators and consultants who were in complete agreement on ratings; i.e. responses were identical.

In addition to the frequency distributions, relative degree of agreement was determined for administrators and consultants on Scales A and C (A. Activities of dietitian and foodservice supervisor and C. Degree of involvement of administrator in foodservice activities). Since Scale B differed on the two forms, responses were analyzed separately for each group. Frequency distributions were compiled from consultant's reports of frequency of activity (Scale B). Mean scores were computed from administrator's ratings of importance of the consultant dietitian's activities (Scale B).

The t-test for related samples was used to compare consultants and administrators mean ratings on performance of the foodservice supervisor. Degree of agreement between paired responses also was determined.

Means and standard deviations were computed for administrator ratings of the consultant's contributions (Section II. 3, Administrator Questionnaire, Appendix E). The administrator mean ratings of change effectiveness of the consultant dietitian also were related to the performance of the foodservice supervisor. For this analysis the performance criteria for the foodservice supervisor were grouped into the following four dimensions: (a) dependability--items a and j; (b) interpersonal skills--items b, c, and h; (c) flexibility--item d; and (d) technical skills--items e, f, g, and i (Section III, Consultant Questionnaire; Section II. 1, Administrator Questionnaire). Foodservice supervisor performance scores were computed for each dimension by summing the ratings of the consultant and administrator. The mean scores for the total group were used to divide the supervisors into two groups on each dimension, a high performance group and a low performance group. Scores equal to or below the mean were defined as low performance; scores greater than the mean, high performance. Administrators from homes with low performance supervisors constituted one group and those from homes with high performance supervisors, a second group for comparison of change effectiveness ratings of consultants. The t-test for two independent samples (80, 81) was computed to compare the administrators' ratings.

One-way analysis of variance (80, 81) was used to study the relationships of the consultant's change effectiveness and the consultant's length of employment at the facility and experience in consulting and the number of consultation visits per month.

RESULTS AND DISCUSSION

General Information

Descriptive data about the consultant dietitians participating in the study are shown in Table 1. The majority of consultants (75 per cent of the 133 dietitians participating) had been members of ADA for over ten years, and 66.2 per cent of the consultants had been employed in the dietetic profession for over ten years. Nearly half (48.5) of the dietitians had been employed as consultants for six to ten years; another 27.3 per cent had consulted for two to five years; and 9.8 per cent, eleven or more years, indicating that the consultant is generally characterized as a dietitian with a number of years of experience who has chosen to consult on a long-term, perhaps permanent basis. This information also suggested that for certain reasons some dietitians may temporarily leave the working profession at one time or another, however retaining their membership, and later return to the professional practice, perhaps as a consultant dietitian. This was indicated by the longer tenure in ADA than in professional employment.

Information gathered concerning the education and training of the consultant dietitians indicated that the majority of the consultants became a member of ADA through an internship program (almost 85 per cent). Only one of the dietitians participating in the study had received training through a coordinated undergraduate program. The remainder gained professional qualification through the variety of other routes available. The internship route to ADA membership was one of the few open to those dietitians

Table 1: Characteristics of study sample of consultant dietitians in nursing homes

biographical information	N	%
years member of ADA		
1 year or less	-	-
2-5 years	11	8.3
6-10 years	22	16.5
11 years or more	100	75.2
years in profession		
less than 5 years	6	4.5
5-10 years	39	29.3
11-25 years	74	55.6
more than 25 years	14	10.5
years as consultant		
1 year or less	19	14.4
2-5 years	36	27.3
6-10 years	64	48.5
11 years or more	13	9.8
present position		
consultant dietitian	128	97.7
part-time dietitian	2	1.5
full-time dietitian	-	-
shared dietitian	1	.8
membership in ADA		
coordinated undergraduate program	1	.8
internship	109	84.5
traineeship	4	3.1
work experience or preplanned experience	8	6.2
other--advanced degree	7	5.4
highest degree		
bachelor's	101	76.5
master's	30	22.7
Ph.D.	1	.8

Table 1: (cont.)

biographical information	N	%
major field for bachelor's		
dietetics, institutional management, or foods and nutrition	123	93.2
home economics education	7	5.3
other	2	1.5
major field for master's		
dietetics, institutional management, or foods and nutrition	26	76.5[1]
home economics education	2	5.9
education, other than home economics	2	5.9
other	4	11.8

[1]% based on number of consultants with master's degrees (N = 30).

with membership of more than six years. Studies indicate that the entry-level dietitian most often accepts positions as clinical dietitians in hospital settings (82, 83). Approximately 93 per cent (N = 123) of the consultants had earned bachelor's degrees in dietetics, institutional management, or foods and nutrition; whereas 22.7 per cent of the consultants had earned master's degrees.

Table 2 gives general information about the size of the homes and the length of time the facility has had a consultant dietitian. Almost 50 per cent of the homes were 50 to 99 beds; only a small percentage were small homes, i.e., under 50 beds. The majority of the homes had employed a consultant for a period of time; over 75 per cent had employed a consultant for three or more years. Also, over half of the homes had employed the present consultant for three or more years, reflecting a definite trend of stability among the consultants and their nursing home accounts.

The consultants reported that 64 per cent of the foodservice supervisors had been employed in the nursing home three years or more, in addition almost 20 per cent of these supervisors had been with the facility for nine or more years. Fifteen per cent had been employed for less than one year. It was also reported that approximately 72 per cent of the foodservice supervisors had received training through a correspondence course or a vocational technical training course. In comparison to the findings of the USDHEW survey of 1975 (28) in which 40 per cent of the nursing home facilities employed qualified dietetic service supervisors, this study suggests there has been a significant increase in the number of trained supervisors since the time of that survey. This large increase in trained foodservice supervisors or dietetic service supervisors is probably due in part to the 1974 federal standards for certification and participation for

Table 2: Characteristics of nursing homes

	N	%
type of facility		
proprietary	188	66.4
voluntary	39	13.8
public	56	19.8
number of beds in the facility		
less than 25	5	1.7
25 to 49	40	13.7
50 to 74	86	29.4
75 to 99	55	18.8
100 to 199	85	29.0
200 or more	22	7.5
length of time the facility has employed a consultant dietitian		
less than 1 year	20	6.8
1-2 years	51	17.5
3-4 years	72	24.7
5-8 years	95	32.5
9 years or more	54	18.5
length of time present consultant has been employed by the facility		
less than 1 year	44	14.9
1-2 years	95	32.2
3-4 years	75	25.4
5-8 years	64	21.7
9 years or more	17	5.8
length of time the foodservice supervisor has been employed by the facility		
less than 1 year	43	15.0
1-2 years	60	20.9
3-4 years	66	23.0
5-8 years	64	22.3
9 years or more	54	18.8
training completed by foodservice supervisor		
correspondence course	85	34.0
vocational technical training course	94	37.6
other	69	27.6

skilled nursing facilities (76) as well as by various state regulations covering both skilled and intermediate care facilities which require the foodservice department to be under the direction of a trained foodservice supervisor.

Problem Areas in Nursing Home Foodservice

Consultants and administrators were asked to rate each of a list of possible problem areas on a three-point scale; (1) not really a problem, (2) somewhat a problem, and (3) major problem area (Table 3). Significant differences were found in the ratings of the two groups on five of the problem areas: modified diets, quantity food production, interdepartmental communication, sanitation, and food quality. In all instances the consultants rated these five operational areas as more of a problem than did the administrators.

The areas listed most frequently as problems by both dietitians and administrators are presented in Tables 19 and 20 (Appendix H). These tables present the percentages of administrators and dietitians indicating the various areas that were problems in their view. The administrators listed the following most frequently as problem areas in foodservice: (a) personnel-selection, training, and attitude, (b) cost of department operation, which is not an unexpected reaction on the part of the administrator, and (c) facilities--adequacy of storage and equipment. Problem areas indicated least frequently were: food production methods, menus, and quality of food. Overall, the consultants had a greater degree of concern in all areas evaluated than did the administrators, except for the area of cost of department operation. The administrator's mean score as illustrated in Table 3 was slightly greater than that of the consultants. This

Table 3: Comparison of consultant and administrator ratings of problem areas in nursing home foodservice[1]

problem area[2]	N	consultant's mean rating[3]	administrator's mean rating	t value[4]
personnel	291	1.74 ± 0.71	1.67 ± 0.67	1.50
modified diets	294	1.71 ± 0.68	1.43 ± 0.58	6.59***
facilities	293	1.59 ± 0.72	1.52 ± 0.67	1.73
quantity food production	292	1.50 ± 0.61	1.29 ± 0.49	4.90***
cost of department operation	290	1.45 ± 0.62	1.53 ± 0.63	1.72
interdepartmental communication	292	1.42 ± 0.59	1.32 ± 0.53	2.75**
sanitation	292	1.41 ± 0.58	1.32 ± 0.52	2.59**
food purchasing	290	1.41 ± 0.60	1.37 ± 0.55	1.00
menu variety, etc.	293	1.33 ± 0.51	1.29 ± 0.48	1.06
food quality	294	1.29 ± 0.52	1.11 ± 0.31	5.42***

[1]Scale: 1 = not really a problem; 2 = somewhat a problem; 3 = major problem area.

[2]Statements ordered from most to least.

[3]Mean and standard deviation.

[4]t-test for two related samples.

* $P \leq .05$
** $P \leq .01$
*** $P \leq .001$

seems to indicate differences related to professional expertise and interests.

Table 4 shows the degree to which the consultants and administrators agreed on the problem areas of a particular nursing home facility. More than 50 per cent of the consultants and administrators were in complete agreement on all problem areas listed. Almost 72 per cent of the consultants and administrators agreed on the degree to which quality food was a problem; whereas 53 per cent were in agreement that both accuracy of modified diets and cost of department operation were not "really a problem," "somewhat a problem," or "major problem."

Activities of the Consultant Dietitian

Amount of time the consultant spent at the nursing home facility and the time spent away from the facility were two aspects of the role and functioning that were examined (Table 5). The most common pattern for the consultants was to make either one, two, or three visits per month to a facility and to spend from three to eight hours per month. The average time spent at a facility was 11.8 hours. One-third of the consultant dietitians indicated they spent no time on work away from the facility; however, half of the consultants spend from one to four hours per month, or an average of 2.5 hours, working on such activities as in-service training, menu planning, policies and procedures and job descriptions, and records and reports. These consultation activities performed away from the facility are listed in Table 6.

Table 4: Agreement of administrators and consultants on problem areas in the foodservice department

problem areas	% agreement[1]
menu--variety, combinations, use	60.4
modified diets--accuracy	53.1
food purchasing--cost, time, specifications, location	60.7
facilities--adequate storage equipment	58.0
quality food	71.4
quantity food production techniques	54.1
sanitation	67.1
personnel--selection, training, attitude	54.0
cost of department operation	53.1
communication between departments and/or with administration	65.1

[1]N = 297 paired responses (from an administrator and consultant for each nursing home).
% agreement = relative number of administrators and consultants whose responses agree.

Table 5: Dietetic consultation time for nursing home

			%
hours per month at facility		3-4	16.2
		5-8	43.5
		9-12	14.2
		13-20	15.6
		over 20	10.5
	mean	11.8 hrs.	
number of visitations to facility per month		once	37.5
		2-3	36.1
		4-8	24.9
		9 or more	1.3
	mean	2.6 times	
hours per month away from facility on related activities		none	33.1
		1-4	53.7
		5-8	9.1
		8 or more	4.1
	mean	2.5 hrs.	

N = 297

Table 6: Consultation activities performed away from facility

activity	N	%
menu planning	132	44.4
planning inservice education	194	65.3
preparing records and reports	105	35.4
writing policies, job descriptions, etc.	108	36.4
other	42	14.1

N = 297

Activities of the Consultants and Foodservice Supervisor (Scale A)

Consultant Ratings. Responsibilities of the consultant dietitian in relation to the foodservice supervisor were measured by asking the consultant to indicate who performed the various activities in the foodservice department. Table 7 enumerates the activities listed most frequently as independent and joint responsibilities of the consultant dietitian and foodservice supervisor as perceived by the consultant in relation to each nursing home. For instance, nearly 57 per cent of the consultants indicated that they wrote modified diets independent of the foodservice supervisor. Also one-third of the consultants planned the menus for their nursing home accounts. Independent responsibilities (performed by the consultant alone) tended to be in the areas of planning and writing menus, in-service training, nutritional assessment, and discussing diet with the physician. Most activities, however, were joint responsibilities of the consultant and supervisor except for very specific operational tasks, which were performed most often by the foodservice supervisors independent of the consultant dietitian. Personnel employment activities and development and maintenance of records and reports were tasks that were frequently not the responsibility of either the consultant or foodservice supervisor.

Administrator Ratings. Table 8 shows the reports of the administrators regarding their perceptions of the activities performed by the consultant dietitian and foodservice supervisor. They indicated that most activities were shared by the consultant and supervisor; however the consultant's tasks that the administrators listed most frequently as those performed independent of the foodservice supervisor were in the areas of writing modified diets, assessing nutritional status of residents,

Table 7: Activities of dietitian and foodservice supervisor in nursing home foodservice as reported by consultant dietitians

activity	activity performed by: cons.[1] only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
menu planning						
plans and writes menus	33.7	15.2	10.8	29.3	7.4	3.7
make menu changes	5.1	13.9	13.9	42.2	24.1	0.7
modified diets						
writes modified diets	56.9	7.1	7.1	22.9	3.7	2.4
adjusts modified diets	26.2	20.4	7.8	33.3	11.2	1.0
visits residents	13.5	14.5	38.9	29.7	3.0	0.3
assesses nutritional status of residents	45.9	21.6	12.8	15.2	0.3	4.1
confers with residents regarding diet	18.5	18.9	31.3	26.6	3.7	1.0
discusses diets with physicians	54.4	8.8	3.4	5.1	2.7	25.5
food purchasing						
determines items and amounts to purchase	1.0	0.7	1.7	26.7	64.7	5.1
places orders	0.7	0.3	0.3	3.4	85.4	9.9
confers with salesmen	0.7	---	1.0	9.6	78.4	10.3

N varies from 287 to 297.

[1] cons. = consultant.

Table 7: (cont.)

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
inspects the quantity and quality of deliveries	0.7	---	0.7	12.5	83.1	3.1
writes specifications	9.1	5.6	4.2	22.0	31.4	27.9
food preparation						
determines amounts to prepare	1.3	2.4	7.1	24.9	61.3	3.0
standardizes recipes	12.2	11.1	14.9	37.2	22.0	2.7
tests menu items for taste and appearance	1.4	3.4	22.0	50.0	22.6	0.7
assigns work to employees	---	1.0	2.0	6.4	85.8	---
food service						
supervises service and distribution of meals	1.4	2.7	8.4	36.1	49.7	1.7
checks portion control	2.0	3.4	14.2	50.5	28.8	1.0
checks plate waste	2.0	2.0	12.9	46.1	34.6	2.4
organization and management						
develops department policies and procedures	13.1	29.0	20.2	22.6	6.4	8.8
prepares job descriptions	11.4	25.3	20.2	24.6	12.5	6.1
initially interviews department personnel	1.4	---	1.0	3.4	60.5	33.7

Table 7: (cont.)

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
hires department personnel	0.7	---	0.3	3.8	59.4	35.8
evaluates department personnel	2.0	1.0	3.4	15.7	60.1	17.7
conducts exit interviews with department personnel	1.0	0.3	1.4	3.1	52.2	41.9
communicates with other departments	1.0	5.8	47.6	35.3	7.5	2.7
sanitation						
establishes sanitation standards	10.4	19.5	31.6	27.9	8.4	2.0
checks dishwashing temperatures	5.4	5.8	24.5	38.8	24.5	1.0
checks refrigerator temperatures	6.4	4.4	24.9	39.1	24.9	0.3
establishes cleaning schedules and procedures	5.4	10.8	14.2	37.6	30.8	1.0
assigns cleaning tasks	0.3	1.0	3.7	8.5	82.7	3.7
records and reports						
develops the following forms:						
census records	17.2	5.4	5.7	10.1	26.0	35.5
summary of food cost	10.9	2.0	4.1	7.8	24.2	50.9
inventories	5.4	2.0	3.4	7.1	54.1	27.9
budgets	3.4	4.1	6.8	7.1	21.4	57.1

Table 7: (cont.)

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
maintains the following forms:						
census records	1.7	0.7	2.4	4.7	62.4	28.1
summary of food cost	3.8	1.0	2.4	3.4	43.2	46.2
inventories	0.3	0.3	1.4	3.1	74.6	20.3
budgets	1.4	1.4	6.1	5.1	30.6	55.4
education and training						
conducts inservice training for foodservice employees	52.9	24.9	11.8	9.4	0.3	0.7
conducts inservice for other employees	68.1	9.8	3.7	5.1	0.3	12.9
orients new employees	0.3	1.7	1.0	13.6	80.0	3.4

Table 8: Nursing home administrators' perceptions of activities performed by consultant dietitians and foodservice supervisors

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
menu planning						
plans and writes menus	25.5	26.2	10.1	29.0	7.3	1.7
makes menu changes	4.2	22.0	14.0	38.1	21.3	.3
modified diets						
writes modified diets	48.8	18.7	7.8	18.0	6.0	.7
adjusts modified diets	21.6	29.7	13.8	26.1	8.8	---
visits residents	8.1	14.0	34.7	30.9	11.2	2.1
assesses nutritional status of residents	28.2	25.4	23.0	16.4	3.5	3.5
confers with residents regarding diet	12.1	17.1	28.5	30.2	10.7	1.4
discusses diets with physicians	33.6	12.9	8.2	10.7	4.6	30.0
food purchasing						
determines items and amounts to purchase	2.8	4.8	4.1	27.6	56.6	4.1
places orders	---	2.4	1.0	5.2	83.7	7.6
confers with salesmen	1.0	.3	2.8	10.0	77.2	8.6

N varies from 266 to 290.

Table 8: (cont.)

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
inspects the quantity and quality of deliveries	---	1.7	3.5	12.1	80.6	2.1
writes specifications	8.5	12.5	11.0	21.0	33.5	13.5
food preparation						
determines amounts to prepare	3.4	9.3	9.3	27.2	49.0	1.7
standardizes recipes	10.0	20.0	15.5	30.3	22.8	1.4
tests menu items for taste and appearance	2.1	8.6	18.9	33.7	35.4	1.4
assigns work to employees	1.4	1.7	2.1	11.4	78.6	4.8
food service						
supervises service and distribution of meals	3.1	4.5	4.8	26.9	60.0	.7
checks portion control	.7	10.7	11.4	36.9	39.7	.7
checks plate waste	1.0	4.8	11.8	30.4	50.9	1.0
organization and management						
develops department policies and procedures	6.4	24.1	25.9	26.2	7.8	9.6
prepares job descriptions	7.0	19.3	18.9	26.0	12.6	16.1
initially interviews department personnel	1.1	1.1	3.9	6.0	64.4	23.6

Table 8: (cont.)

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
hires department personnel	.7	1.4	1.1	5.6	60.2	31.0
evaluates department personnel	1.7	1.4	3.8	17.1	65.9	10.1
conducts exit interviews with department personnel	1.1	1.8	1.8	5.4	56.7	33.2
communicates with other departments	.4	3.6	31.7	37.8	24.1	2.5
sanitation						
establishes sanitation standards	10.1	17.4	29.5	26.0	11.8	5.2
checks dishwashing temperatures	4.5	7.0	15.0	29.4	41.6	2.4
checks refrigerator temperatures	3.5	5.9	16.6	30.4	41.5	2.1
establishes cleaning schedules and procedures	1.7	4.8	12.5	31.1	45.3	4.5
assigns cleaning tasks	.3	2.4	3.1	11.5	77.8	4.9
records and reports						
develops the following forms:						
census records	4.7	6.6	7.7	10.9	38.3	31.8
summary of food cost	1.8	5.2	10.7	17.3	30.6	34.3
inventories	.4	3.6	6.9	12.7	61.2	15.2
budgets	1.1	4.5	12.3	17.8	26.8	37.5

Table 8: (cont.)

activity	activity performed by: cons. only	cons. and FSS (75:25)	jointly (50:50)	FSS and cons. (25:75)	FSS only	neither
	%	%	%	%	%	%
maintains the following forms:						
census records	2.2	2.2	5.9	8.5	53.9	27.3
summary of food cost	1.9	3.4	6.4	14.6	40.4	33.3
inventories	.4	1.1	4.9	9.7	69.4	14.6
budgets	1.1	1.5	7.5	15.4	34.2	40.2
education and training						
conducts inservice training for foodservice employees	37.9	26.6	19.5	12.8	2.1	1.1
conducts inservice for other employees	43.2	14.0	12.9	8.1	3.7	18.1
orients new employees	1.1	3.2	8.5	16.0	68.7	2.5

discussing diets with physicians, and conducting in-service training. It was interesting that the percentage of administrators perceiving these responsibilities as being independent activities of the consultants was less than that of the consultants, indicating some difficulties on the part of the administrator in understanding the role and the functions of the consultant. Apparently the administrators were not completely aware of those activities for which the consultant assumed the total responsibility.

Agreement of Consultants and Administrators. The relative number of consultants and administrators representing individual facilities who agreed on responses to Scale A are shown in Table 9. The greatest degree of agreement between both the consultants and administrators was in the operational tasks most frequently scored as activities performed by the foodservice supervisor independent of the consultant dietitian. The activities both agreed on the least ($\leq$ 40 per cent) were making menu changes, adjusting modified diets, assessing nutritional status of residents, writing specifications, standardizing recipes, developing department policies, procedures, and job descriptions, communication with other departments, and establishing sanitation standards. This again emphasizes the possibility that administrators were not completely aware of the consultant's role in relation to that of the foodservice supervisor in performance of specific activities, especially those areas of responsibility in which the consultant assumed a greater amount or complete responsibility.

Frequency of Consultant Activities (Scale B)

The activities listed by the consultants as most frequently performed on every visit to the nursing home were resident visitation and diet

Table 9: Agreement of administrators and consultants on responses to Scale A. Activities of dietitian and foodservice supervisor

activities	% agreement[1]
menu planning	
plans and writes menus	50.0
makes menu changes	39.8
modified diets	
writes modified diets	59.0
adjusts modified diets	37.5
visits residents	43.0
assesses nutritional status of residents	36.4
confers with residents regarding diet	40.1
discusses diets with physicians	47.1
food purchasing	
determines items and amounts to purchase	60.6
places orders	84.2
confers with salesmen	77.4
inspects the quantity and quality of deliveries	76.6
writes specifications	37.9
food preparation	
determines amounts to prepare	46.0
standardizes recipes	35.1
tests menu items for taste and appearance	40.1
assigns work to employees	76.7
food service	
supervises service and distribution of meals	46.5
checks portion control	41.8
checks plate waste	47.9
organization and management	
develops department policies and procedures	35.8
prepares job descriptions	33.3
initially interviews department personnel	69.8
hires department personnel	74.2
evaluates department personnel	58.5
conducts exit interviews with department personnel	64.4
communicates with other departments	37.5

[1] N = 297 paired responses (from an administrator and consultant for each nursing home).
% agreement = relative number of administrators and consultants whose responses agreed.

Table 9: (cont.)

activities	% agreement
sanitation	
establishes sanitation standards	34.0
checks dishwashing temperatures	40.6
checks refrigerator temperatures	42.2
establishes cleaning schedules and procedures	44.3
assigns cleaning tasks	74.2
records and reports	
develops the following forms:	
census records	42.0
summary of food cost	47.0
inventories	51.5
budgets	49.8
maintains the following forms:	
census records	62.2
summary of food cost	53.2
inventories	66.3
budgets	52.7
education and training	
conducts inservice training for foodservice employees	52.5
conducts inservice for other employees	44.4
orients new employees	65.6

consultation, nutritional assessment, communication with other departments, and checking foodservice and sanitation procedures (Table 10). Activities indicated as not performed by the dietitian were specific operational tasks, such as purchasing, personnel administration, and maintenance of certain records and reports. These findings indicate the activities of high priority among a majority of the dietitians during a consultation visit to each nursing home account. The consultants reported on Scale A (Table 7) that many of these activities were performed either jointly (50:50) by the consultant and foodservice supervisor or by the foodservice supervisor with assistance from the consultant (75:25).

Several of the key activities of the consultant were performed only occasionally, except for in-service classes for foodservice employees which were presented every two to three visits to the facility. As indicated earlier nearly 50 per cent of the nursing homes had employed the present consultant dietitian for three to eight years. This may be an indication that some of the activities rated as performed only on occasion by the consultant may be related to the length of time the facility has employed the consultant. Perhaps less time was needed for various activities because of greater organization that may have resulted from a long-term consultation relationship.

Administrative Assessment of Importance of Consultant Activities (Scale B)

The consultant's activities that the administrator perceived as very important (Table 11) tended to be in the areas of menu planning, modified diets, organization and management, and education and training. For example, the consultant's in-service training within the department received a mean importance score of 2.81 on a three-point scale indicating

Table 10: Frequency of activities in nursing home foodservice as reported by consultant dietitians

activities	frequency of activity: every visit	every 2 or 3 visits	only occasionally	not performed
	%	%	%	%
menu planning				
plans and writes menus	17.5	18.2	53.8	10.6
makes menu changes	21.2	21.5	43.7	13.7
modified diets				
writes modified diets	23.8	24.8	46.6	4.8
adjusts modified diets	30.6	22.8	43.9	2.7
visits residents	71.9	16.6	10.5	1.0
assesses nutritional status of residents	50.3	29.9	16.7	2.7
confers with residents regarding diet	59.4	21.5	17.7	1.0
discusses diets with physicians	7.9	7.2	59.8	24.7
food purchasing				
determines items and amounts to purchase	4.1	6.5	23.2	65.9
places orders	3.1	0.7	3.1	92.1
confers with salesmen	1.7	1.7	24.0	71.6
inspects the quantity and quality of deliveries	3.1	4.1	21.6	70.4
writes specifications	1.4	3.1	41.5	52.6

N varies from 282 to 297.

Table 10: (cont.)

activities	frequency of activity: every visit	every 2 or 3 visits	only occasionally	not performed
	%	%	%	%
food preparation				
determines amounts to prepare	4.2	7.0	35.5	53.0
standardizes recipes	9.0	13.4	59.0	18.6
tests menu items for taste and appearance	49.8	12.5	28.0	9.7
assigns work to employees	2.5	2.5	7.8	86.6
food service				
supervises service and distribution of meals	37.6	9.4	18.1	34.5
checks portion control	49.0	13.2	26.0	11.8
checks plate waste	46.7	12.9	26.5	13.6
organization and management				
develops department policies and procedures	5.2	13.1	68.5	13.1
prepares job descriptions	1.7	3.8	78.5	15.9
initially interviews department personnel	0.7	0.3	8.0	90.2
hires department personnel	0.7	4.5	94.1	0.7
evaluates department personnel	2.1	2.8	31.6	63.2
conducts exit interviews with department personnel	2.1	3.5	92.9	1.4
communicates with other departments	72.3	14.2	9.2	4.3

Table 10: (cont.)

activities	frequency of activity: every visit	every 2 or 3 visits	only occasionally	not performed
	%	%	%	%
sanitation				
establishes sanitation standards	31.0	25.5	38.6	4.8
checks dishwashing temperatures	49.8	18.8	21.6	9.8
checks refrigerator temperatures	48.4	20.8	22.1	8.7
establishes cleaning schedules and procedures	7.6	9.3	59.8	23.4
assigns cleaning tasks	2.8	1.4	11.4	83.7
records and reports				
develops the following forms:				
census records	4.2	3.1	33.6	58.8
summary of food cost	2.4	3.1	25.3	68.2
inventories	1.0	2.4	21.9	74.3
budgets	0.7	1.0	22.5	75.1
maintains the following forms:				
census records	3.5	3.8	6.9	85.1
summary of food cost	1.7	4.5	11.4	81.7
inventories	0.3	2.1	11.8	85.4
budgets	4.5	10.7	83.4	0.3

Table 10: (cont.)

activities	frequency of activity: every visit	every 2 or 3 visits	only occasionally	not performed
	%	%	%	%
education and training				
conducts inservice training for foodservice employees	37.7	47.6	13.7	0.7
conducts inservice for other employees	5.2	9.0	74.8	11.0
orients new employees	0.7	2.1	16.6	79.9

Table 11: Mean importance scores of administrators' ratings of consultants' activities[1]

item number	activity[2]	mean importance score[3]
activities rated very important (mean 2.40 to 3.0)		
9.1	inservice training for foodservice employees	2.81 ± .50
2.1	writes modified diets	2.77 ± .57
2.4	assesses nutritional status of residents	2.74 ± .58
1.1	plans and writes menus	2.71 ± .61
2.2	adjusts modified diets	2.68 ± .58
2.5	confers with residents regarding diet	2.54 ± .74
7.1	establishes sanitation standards	2.53 ± .71
6.1	develops department policies and procedures	2.49 ± .74
2.3	visits residents	2.45 ± .71
9.2	conducts inservice for other employees	2.44 ± .80
6.7	communicates with other departments	2.43 ± .84
1.2	makes menu changes	2.41 ± .72
activities rated as somewhat important (mean 1.70 to 2.39)		
2.6	discusses diets with physicians	2.38 ± .87
4.2	standardizes recipes	2.35 ± .73
6.2	prepares job descriptions	2.28 ± .82
5.2	checks portion control	2.20 ± .75
4.3	tests menu items for taste and appearance	2.11 ± .72
7.2	checks dishwashing temperatures	2.10 ± .79
7.3	checks refrigerator temperatures	2.09 ± .81
5.3	checks plate waste	2.03 ± .78
3.5	writes specifications	2.00 ± .92
7.4	establishes cleaning schedules and procedures	1.10 ± .80
4.1	determines amounts to prepare	1.97 ± .82
5.1	supervises service and distribution of meals served	1.91 ± .75
8.2a	develops summary of food cost form	1.87 ± .86
3.1	determines items and amounts to purchase	1.85 ± .79
8.4a	develops forms for budget	1.84 ± .88

[1] N varies from 264 to 287.

[2] Activities ordered most to least important.

[3] Mean and standard deviation; scale: 1 = not really important; 2 = somewhat important; 3 = very important.

Table 11: (cont.)

item number	activity	mean importance score
9.3	orients new employees	1.75 ± .79
8.4b	maintains budget forms	1.70 ± .91
activities rated as not important (mean 1.30 to 1.69)		
8.2b	maintains food costs forms	1.69 ± .81
6.5	evaluates department personnel	1.68 ± .86
8.3a	develops inventory forms	1.65 ± .84
8.1a	develops census records	1.64 ± .83
8.3b	maintains inventory forms	1.56 ± .76
3.4	inspects the quantity and quality of deliveries	1.56 ± .79
7.5	assigns cleaning tasks	1.47 ± .72
4.4	assigns work to employees	1.44 ± .73
6.3	initially interviews department personnel	1.42 ± .77
8.1b	maintains census records	1.41 ± .70
3.3	confers with salesmen	1.41 ± .76
3.2	places orders	1.38 ± .78
6.6	conducts exit interviews with department personnel	1.37 ± .74
6.4	hires department personnel	1.32 ± .66

this was a very important activity in the view of the administrators. The activities perceived as less important (mean < 1.70) were in the areas of food purchasing, maintaining certain reports and records, and personnel management. Percentage responses of administrator's ratings of importance of consultant dietitian's activities are listed in Table 21 (Appendix H). It was interesting to note that the consultant's activities listed as very important by the administrators coincided with those activities which the consultants indicated were their total or major responsibilities (Table 7).

Administrative Involvement in Nursing Home Foodservice Operations (Scale C)

Administrator Reports

The activities in which at least 25 per cent of the administrators indicated they took complete responsibility were in the areas of organization and management and records and reports (Table 12). Areas of limited administrative involvement were: menu planning, modified diets, food preparation, and service of food. These findings were not surprising; it was expected that the financial management and personnel employment areas would be aspects of particular concern to the administrators; whereas it also was anticipated the nutrition care and food production activities would be delegated to the foodservice supervisor and/or dietitian. It was expected, however, that the administrators might be more involved in purchasing than was reported.

Consultant Perceptions

The consultant dietitians perceived the administrators as having a high degree of involvement in the areas of personnel administration and employment, and records and reports, especially budget records (Table 13).

Table 12: Administrative involvement in foodservice activities as reported by nursing home administrators

activity	degree of involvement				
	not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
menu planning					
plans and writes menus	54.4	31.4	11.3	1.1	1.8
makes menu changes	55.5	34.3	8.8	1.1	.4
modified diets					
writes modified diets	85.6	10.4	2.2	.7	1.1
adjusts modified diets	85.7	11.4	1.8	.7	.4
visits residents	23.0	28.7	46.8	1.1	.4
assesses nutritional status of residents	52.3	33.6	12.3	1.4	.4
confers with residents regarding diet	37.1	39.9	20.9	.4	1.8
discusses diets with physicians	63.2	24.5	6.9	2.9	1.4
food purchasing					
determines items and amounts to purchase	26.7	34.7	29.8	8.4	.4
places orders	45.8	31.5	11.9	10.1	.7
confers with salesmen	30.0	43.8	15.5	10.2	.4

N varies from 272 to 288.

Table 12: (cont.)

activity	degree of involvement				
	not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
inspects the quantity and quality of deliveries	36.6	41.5	16.5	5.3	---
writes specifications	46.7	28.1	15.7	6.2	3.3
food preparation					
determines amounts to prepare	72.0	21.3	6.0	.7	---
standardizes recipes	84.3	12.1	2.5	.7	.4
tests menu items for taste and appearance	40.1	31.0	28.5	.4	---
assigns work to employees	53.7	26.5	14.1	5.7	---
food service					
supervises service and distribution of meals	50.7	35.9	12.0	1.4	---
checks portion control	42.5	41.4	15.4	.7	---
checks plate waste	32.6	44.6	22.5	.4	---
organization and management					
develops department policies and procedures	9.4	23.4	51.0	15.7	.3
prepares job descriptions	14.1	25.0	38.7	20.8	1.1
initially interviews department personnel	22.6	24.7	26.4	26.4	---
hires department personnel	22.0	22.4	23.4	31.8	.3
evaluates department personnel	21.8	30.5	29.5	16.1	1.8

Table 12: (cont.)

activity	degree of involvement: not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
conducts exit interviews with department personnel	23.2	24.3	23.2	26.1	2.1
communicates with other departments	6.2	18.8	61.6	13.4	---
sanitation					
establishes sanitation standards	15.8	29.2	44.0	10.9	---
checks dishwashing temperatures	27.9	40.6	26.9	4.2	---
checks refrigerator temperatures	28.8	40.0	27.7	3.5	---
establishes cleaning schedules and procedures	38.3	34.4	20.6	6.7	---
assigns cleaning tasks	56.3	24.6	12.3	6.0	.7
records and reports					
develops the following forms:					
census records	26.5	19.4	26.5	26.2	1.4
summary of food cost	10.4	13.6	38.4	35.1	2.5
inventories	21.9	24.1	35.3	17.6	1.1
budgets	4.3	7.8	39.5	45.2	2.8

Table 12: (cont.)

activity	degree of involvement				
	not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
maintains the following forms:					
census records	35.8	14.2	22.6	26.6	.7
summary of food cost	13.4	14.5	35.1	35.5	1.4
inventories	23.7	22.7	31.7	21.2	.7
budgets	5.4	9.4	34.4	47.1	3.3
education and training					
conducts inservice training for foodservice employees	43.2	39.9	15.4	1.5	---
conducts inservice for other employees	35.7	34.6	23.9	5.5	.4
orients new employees	44.9	30.4	20.7	4.0	---

Table 13: Degree of involvement of nursing home administrators in foodservice activities as reported by consultant dietitians

activity	degree of administrative involvement				
	not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
menu planning					
plans and writes menus	79.2	14.6	3.8	1.4	1.0
makes menu changes	71.8	21.3	6.6	0.3	---
modified diets					
writes modified diets	93.8	4.5	1.0	0.7	---
adjusts modified diets	93.4	5.9	0.7	---	---
visits residents	40.2	26.2	32.5	1.0	---
assesses nutritional status of residents	74.9	14.6	9.1	0.7	0.7
confers with residents regarding diet	57.2	32.6	10.2	---	---
discusses diets with physicians	73.5	17.8	5.2	2.8	0.7
food purchasing					
determine items and amounts to purchase	48.1	30.1	14.5	6.9	0.3
places orders	61.8	19.8	9.0	8.7	0.7
confers with salesmen	48.1	31.1	11.4	8.7	0.7

N varies from 280 to 297.

Table 13: (cont.)

activity	degree of administrative involvement: not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
inspects the quantity and quality of deliveries	67.3	20.8	8.1	3.9	---
writes specifications	63.2	16.8	6.7	3.9	9.1
food preparation					
determines amounts to prepare	87.9	8.9	2.5	0.7	---
standardizes recipes	95.8	2.5	0.7	0.7	0.4
tests menu items for taste and appearance	47.5	32.6	18.8	0.7	0.4
assigns work to employees	65.6	22.3	7.8	4.3	---
food service					
supervises service and distribution of meals	66.4	24.4	8.8	0.4	---
checks portion control	65.4	23.7	10.6	0.4	---
checks plate waste	57.2	33.6	8.8	0.4	---
organization and management					
develops department policies and procedures	20.0	42.8	27.7	8.4	1.1
prepares job descriptions	48.1	31.4	15.2	4.9	0.4
initially interviews department personnel	34.0	15.8	18.6	31.6	---
hires department personnel	36.1	11.6	17.2	35.1	---

Table 13: (cont.)

activity	degree of administrative involvement: not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
evaluates department personnel	32.4	24.2	22.8	17.8	2.8
conducts exit interviews with department personnel	28.7	15.1	13.3	36.2	6.5
communicates with other departments	11.4	21.4	60.1	6.8	0.4
sanitation					
establishes sanitation standards	41.0	36.4	20.8	0.7	1.1
checks dishwashing temperatures	61.1	28.9	9.3	0.7	---
checks refrigerator temperatures	65.2	25.9	8.2	0.7	---
establishes cleaning schedules and procedures	71.0	19.4	8.5	1.1	---
assigns cleaning tasks	75.6	14.1	7.4	2.8	---
records and reports					
develops the following forms:					
census records	38.9	13.9	15.7	26.4	5.0
summary of food cost	22.4	14.6	18.9	39.9	4.3
inventories	32.4	23.8	13.9	23.5	6.4
budgets	8.9	8.9	23.5	53.0	5.7

Table 13: (cont.)

activity	degree of administrative involvement				
	not involved	periodic	frequent	complete	not performed at facility
	%	%	%	%	%
maintains the following forms:					
census records	46.4	15.0	9.6	27.1	1.8
summary of food cost	27.0	13.1	17.4	40.8	1.8
inventories	42.1	20.4	13.6	20.7	3.2
budgets	14.8	8.5	19.4	54.4	2.8
education and training					
conducts inservice training for foodservice employees	65.5	29.2	4.2	0.7	0.4
conducts inservice for other employees	52.0	31.0	14.2	2.5	0.4
orients new employees	51.8	30.1	13.5	4.6	---

The activities the consultants indicated as areas of limited involvement tended to be those areas in which the consultants had assumed active responsibility and in the areas of which the foodservice supervisor had a large degree of responsibility such as food purchasing, food preparation, and service of food.

Agreement of Administrators and Consultants

Consultants and administrators from the same homes agreed most frequently on degree of administrative involvement related to those areas which were the consultants and foodservice supervisors complete or major responsibility (Table 14). In other words, those areas of responsibilities were reported to be areas of limited administrative involvement. It was interesting to note that about 50 per cent of the administrator and consultant responses were in complete agreement on degree of involvement of administrators in foodservice activities.

Effectiveness of Foodservice Supervisor

Table 15 shows the comparison of consultant and administrator ratings of foodservice supervisor performance on a scale from one to four. Significant differences were found between ratings of the two groups on two performance criteria: "work assignment reliability" and "adjust modified diets." The administrators rated the foodservice supervisor higher than did the dietitians in both of these areas. Both groups tended to rate the foodservice supervisors as average or above average in most areas. Frequency responses of the consultants and administrators are presented in Tables 22 and 23 (Appendix H). As shown in Table 16, 40 per cent or more of the administrators and consultant dietitians agreed on performance ratings of the foodservice supervisor in each nursing home.

Table 14: Agreement of administrators and consultants on responses to Scale C. Degree of involvement of administrator in foodservice activities

activities	% agreement[1]
menu planning	
plans and writes menus	58.2
makes menu changes	64.2
modified diets	
writes modified diets	84.4
adjusts modified diets	85.3
visits residents	39.9
assesses nutritional status of residents	49.8
confers with residents regarding diet	49.3
discusses diets with physicians	62.7
food purchasing	
determines items and amounts to purchase	51.3
places orders	59.6
confers with salesmen	52.0
inspects the quantity and quality of deliveries	49.1
writes specifications	45.1
food preparation	
determines amounts to prepare	72.3
standardizes recipes	82.0
tests menu items for taste and appearance	42.4
assigns work to employees	60.4
food service	
supervises service and distribution of meals	50.4
checks portion control	49.8
checks plate waste	46.5
organization and management	
develops department policies and procedures	36.5
prepares job descriptions	31.4
initially interviews department personnel	50.4
hires department personnel	54.0
evaluates department personnel	46.1
conducts exit interviews with department personnel	44.9
communicates with other departments	49.1

[1] N = 297 responses (from an administrator and consultant for each nursing home).
% agreement = relative number of administrators and consultants whose responses agreed.

Table 14: (cont.)

activities	% agreement
sanitation	
establishes sanitation standards	39.3
checks dishwashing temperatures	40.2
checks refrigerator temperatures	40.4
establishes cleaning schedules and procedures	43.3
assigns cleaning tasks	59.6
records and reports	
develops the following forms:	
census records	38.3
summary of food cost	43.4
inventories	37.4
budgets	47.8
maintains the following forms:	
census records	44.4
summary of food cost	42.6
inventories	42.4
budgets	47.4
education and training	
conducts inservice training for foodservice employees	50.4
conducts inservice for other employees	42.7
orients new employees	46.6

Table 15: Comparison of consultant and administrator ratings of foodservice supervisor performance[1]

performance criteria	N	consultant's mean rating[2]	administrator's mean rating	t value[3]
work assignment reliability	288	2.91 ± .85	3.02 ± .77	2.07*
assign work to others	290	2.61 ± .90	2.61 ± .85	0.0
get along with others	290	2.80 ± .89	2.83 ± .87	0.62
accept new ideas	289	2.82 ± .93	2.83 ± .92	0.18
adjust modified diets	287	2.43 ± .89	2.69 ± .83	4.82***
food purchasing	288	2.86 ± .81	2.93 ± .80	1.28
amounts to prepare	289	2.89 ± .80	2.98 ± .77	1.87
interdepartmental relationship	287	2.75 ± .92	2.82 ± .84	1.21
accurate records	268	2.56 ± .96	2.64 ± .92	1.32
follow-through on recommendations	289	2.81 ± .95	2.88 ± .89	1.16

[1]Scale: 1 = below average; 2 = average; 3 = above average; 4 = outstanding.

[2]Mean and standard deviation.

[3]t-test for two related samples

* $P \leq .05$
*** $P \leq .001$

Table 16: Agreement of administrators and consultants on performance of foodservice supervisor

performance area	% agreement[1]
reliability in carrying out work assignments	44.4
ability to assign work to others	46.6
ability to get along with others	45.5
willingness to accept new ideas	48.4
ability to adjust modified diets to meet individual needs	40.8
can determine items, amounts, and quantities to be purchased	42.7
can determine amounts to prepare	45.7
maintains a good working relationship with other departments	46.3
maintains accurate census records; menus as served; food cost; records of modified diets	45.9
follow through on recommendations of consultant dietitian	44.6

[1]N = 297 paired responses (from an administrator and consultant for each nursing home).
% agreement = relative number of administrators and consultants whose responses agreed.

Implementation of Change by the Consultant

Table 17 enumerates the administrators ratings of the areas of the foodservice in which the consultants had brought about change. Areas in which the administrators perceived little or no change were: (a) facilities, (b) cost of department, (c) food purchasing, and (d) personnel. In the area of facilities, the consultant generally has limited opportunity to contribute. In addition, cost of the department is an area that is a

Table 17: Administrator's ratings of consultant's contributions[1]

area of contribution[2]	mean rating[3]
modified diets--accuracy	2.53 ± .58
menu--variety, combinations, use	2.33 ± .70
sanitation	2.05 ± .72
communication between department and/or administration	1.97 ± .74
quantity food production techniques	1.91 ± .73
quality food	1.85 ± .71
personnel--selection, training, attitude	1.68 ± .68
food purchasing--cost, time, specifications, location	1.68 ± .68
cost of department operation	1.61 ± .67
facilities--adequate storage, equipment	1.37 ± .58

N varies from 289 to 290.

[1]Scale: 1 = has brought about little, if any change; 2 = has brought about some change; 3 = has brought about significant change.

[2]Ordered from most to least.

[3]Mean and standard deviation.

continuing concern of the administrators. With the continual increases in food prices, this finding is not surprising. In some instances, menu changes made by consultants necessitated for nutritional reasons may cause food costs to increase. In the area of personnel, the consultant may have little opportunity for input in employment decisions. The primary impact of the consultant would be in personnel training. In comparing these findings to the ratings of problem areas, administrators also rated

facilities, cost of department, and personnel most frequently as major problem areas. Food production methods and quality food, which appeared as areas of limited change, were not considered problem areas in the view of most of the administrators. This might be an indication that the areas administrators perceived as low problem areas are areas in which she/he is least concerned about the consultant bringing about change. The ratings indicate that the administrators viewed changes in menus and modified diets as the most important contributions of the consultants. Data indicate that some notable change was effected in sanitation and communication between the foodservice department and other departments. Table 24 (Appendix H) lists administrator's percentage responses to the items related to contributions of consultant dietitians.

To study the consultant's effectiveness in relation to the performance of the foodservice supervisor, the ten performance criteria for rating the supervisor were categorized into four performance areas and scores were computed. The only criterion which was related to the dietitian's change efforts was that of technical skills of the supervisor (Table 18). In those homes where the supervisors were rated as low performers, the contributions were rated more highly than in those homes with supervisors rated as high performers.

The contributions of the consultant also were studied in relation to the consultant's length of employment at the facility and experience in consulting and the number of consultation visits per month. No significant differences were found. It was conjectured, therefore, that the dietitian's effectiveness was related to situational variables in various facilities.

Table 18: Dietitians change effectiveness in relation to technical performance of foodservice supervisor

dietitian's contributions to changes in operation	nursing homes with low performance FSS[1] (N=163)	nursing homes with high performance FSS (N=128)	t value
	mean s.d.	mean s.d.	
menu--variety, combinations, use	2.41 ± .68[2]	2.23 ± .70	2.29*
modified diets--accuracy	2.57 ± .57	2.48 ± .59	1.30
food purchasing--cost, time, specifications, location	1.73 ± .65	1.62 ± .70	1.31
facilities--adequate storage, equipment	1.36 ± .60	1.39 ± .55	.47
quality of food	1.89 ± .68	1.81 ± .75	.88
quantity food production techniques	1.98 ± .71	1.83 ± .76	1.71
sanitation	2.16 ± .68	1.92 ± .07	2.78**
personnel--selection, training, attitude	1.71 ± .67	1.65 ± .71	.79
cost of department operation	1.63 ± .70	1.60 ± .65	.34
communication between department and/or with administrator	2.02 ± .73	1.91 ± .75	1.36

[1] Low performance = scores equal to or below mean on administrative and consultant performance rating of FSS.
High performance = scores greater than mean.

[2] Administrative ratings of change contribution of consultant dietitian; scale = 1 has brought about little, if any change, 2 has brought about some change, 3 has brought about significant change.

* $P \leq .05$
** $P \leq .01$

SUMMARY AND CONCLUSIONS

The emergence of the dietitian as a consultant in the health care field has introduced a new concept of role function, limited to that of advising and counseling. Because the consultant works closely with both the administrator and foodservice supervisor, a clear understanding of the consultant's role is necessary for effective consultation. The primary objective of this research was to study the role of the dietitian in nursing homes as perceived by the consultant dietitian and the nursing home administrator.

The sample was selected from consultant dietitians in twelve states of the North Central region of the United States. The study was limited to dietitians consulting in nursing homes and the administrators of each dietitian's nursing home accounts. Phase I of the study involved development of the research instruments and identification of the consultant dietitians for the survey phase; Phase II was the actual collection of data to fulfill objectives of the study.

Semi-structured interviews and a pretest were conducted with several consultant dietitians and nursing home administrators to facilitate the planning of the research. In the actual study, administrators and the consultant dietitians were asked to complete corresponding questionnaires concerning the role of the consultant dietitian in long-term care facilities.

The consultant questionnaire had four sections: (a) Section I--overall information about the facility; (b) Section II--data on activities of the consultant dietitian, foodservice supervisor, and administrator in the

nursing home foodservices; (c) Section III--evaluation of the performance of the foodservice supervisor; and (d) Section IV--biographical-demographical information on the consultant dietitians. The first section included a list of ten possible problem areas to be evaluated using a three-point rating scale. Areas of responsibility with nine categories of activities were listed in the second section of the questionnaire. Three scales were used in rating each activity. Scale A identified activities of the consultant dietitian and the foodservice supervisor; Scale B was for a rating of frequency of activity by the consultant; and Scale C provided data on degree of involvement of administrators in the foodservice activities.

The administrator questionnaire was composed of two sections. Section I contained the same list of areas of responsibilities with categories of activities that was used in the consultant's questionnaire. Again, three scales were employed in rating each activity; Scales A and C were identical to those on the consultant questionnaire. Scale B provided an evaluation of the importance the administrator attached to the consultant's activities. Section II contained three major areas using Likert-type rating scales. As in the dietitian's questionnaire, the administrators were asked (a) to rate the foodservice supervisor and (b) to evaluate problem areas in the foodservice department. The third section contained a list of possible areas in which the consultant made a contribution to effecting change.

The 252 dietitians identified in Phase I of the study received a set of two questionnaires for each nursing home served. A total of 791 sets of questionnaires were distributed. Sixty-two per cent of the questionnaires sent to dietitians and 48 per cent of the administrator questionnaires were returned. In the initial mailing, corresponding data were

received on 27 per cent of the nursing homes. After the follow-up mailing, corresponding data were received on 41 per cent of the homes, or 297.

General information obtained from dietitians participating in the study indicated that the consultant is generally characterized as having a number of years of experience in the profession of dietetics. Data also suggested that these dietitians have chosen to consult on a long-term basis. The majority of the homes (over 75 per cent) had employed a consultant for a period of time (for three or more years). Over half of the homes had employed their present consultant for three or more years, reflecting a definite trend of stability among the consultants and their nursing home accounts.

Consultants and administrators were asked to rate each of a list of possible problem areas in nursing home foodservice. The administrators listed the following most frequently as problem areas in foodservice: (a) personnel-selection, training, and attitude, (b) cost of department operation, and (c) facilities including adequacy of storage and equipment. Problem areas indicated least frequently were: food production methods, menus, and quality of food. The consultants had a greater degree of concern in all areas evaluated than did the administrators, except for the area of cost of department operation. This seems to indicate differences related to professional expertise and interests. More than 50 per cent of the consultants and administrators were in complete agreement on all problem areas listed.

The most common pattern for the consultants was to make either one, two, or three visits per month to a facility and to spend from three to twelve hours per month. The majority spent from one to four hours per month away from the facility on related activities.

Responsibilities of the consultant dietitian in relation to the foodservice supervisor were assessed by asking the consultant and the administrator to indicate who performed the various activities in the foodservice department. Findings revealed the consultant's independent responsibilities tended to be in the areas of planning and writing menus, in-service training, nutritional assessment, and discussing diet with the physician. Most activities were joint responsibilities of the consultant and the supervisor except for very specific operational tasks, which were performed most often by the foodservice supervisors. The administrators' perceptions of the consultant's responsibilities differed somewhat from the reports of the consultant dietitians, indicating some difficulties on the part of the administrator in understanding the role and the functions of the consultant.

The activities listed most frequently by the consultants as activities performed on every visit to the nursing home were resident visitation and diet consultation, nutritional assessment, communication with other departments, and checking foodservice and sanitation procedures. Several key activities were reported as performed only occasionally, except for in-service classes for foodservice employees. Perhaps less time was needed because of greater organization possible with the long-term consultation relationship that was characteristic.

The activities that the administrator perceived as very important tended to be in the areas of menu planning, modified diets, organization and management, and education and training. The activities perceived as less important were in the areas of food purchasing, maintaining certain reports and records, and personnel management. The consultant's activities listed as very important by the administrators coincided with those

activities which the consultants indicated were their major responsibilities.

The activities in which at least 25 per cent of the administrators indicated they took complete responsibility were in the areas of organization and management and records and reports. Areas of limited involvement were: menu planning, modified diets, food preparation, and service of food. The consultants had accurate perceptions of administrative involvement. They viewed the administrators as having a high degree of involvement in the areas of personnel administration and employment and records and reports, especially budget records. Consultants and administrators agreed most frequently on degree of administrative involvement related to those areas which were the consultants and/or supervisors complete or major responsibility; in other words, those reported to be areas of limited administrative involvement.

Comparison of consultant and administrator ratings of foodservice supervisor performance indicated that both groups tended to rate the supervisor as average or above average in most areas. Forty per cent or more of the administrators and consultants agreed on performance ratings of the foodservice supervisor in each nursing home.

Areas in which the administrators perceived that little or no change had been brought about by the consultants were: (a) facilities, (b) cost of department, (c) food purchasing, and (d) personnel. The ratings indicate that the administrators viewed changes in menus and modified diets as the most important contributions of the consultants.

In comparing the consultant's effectiveness in relation to the performance of the foodservice supervisor, the criterion which was related to the dietitian's change efforts was that of the supervisor's technical

skills. In those homes where the supervisors were rated as low performers, the consultant's contributions were rated more highly. Perhaps the supervisor who is less skilled in the technical areas has a greater need and perhaps a higher degree of receptivity to the consultant's recommendations. Also, there may be a greater need in the nursing home for changes in the operational standards and procedures.

No significant differences were found in the comparison of the consultant's contributions in relation to length of employment at the facility, experience in consulting, and number of consultation visits per month. Apparently situational variables were the greatest influences on the consultant's effectiveness.

The activities performed by the consultant dietitian were appropriate in view of the recommendations in the literature. Authorities in the field have identified the consultant's role as an advisor to the foodservice supervisor and administrator. Data from the study revealed that most activities performed were joint responsibilities of the consultant and the supervisor, except for the highly technical or professional skills that may be beyond the scope of supervisory abilities.

For the most part, the administrators viewed the role of the consultant in an appropriate light. The data reflected that most administrators valued the dietitian's functions in the professional areas, such as nutritional assessment, menu planning, and modified diets. Also, with few exceptions the administrators apparently tended not to become immersed in foodservice activities themselves. Their reported involvement in employment and other personnel processes and in record keeping and reports seemed appropriate functions. It was surprising that their degree of involvement in purchasing was somewhat limited in most homes.

The differences in the responses of the consultants and administrators, as measured by degree of agreement, suggested that greater efforts may need to be made by consultants to communicate their role and functions to the nursing home administrator, however. Data concerning the consultant contributions indicated the difficulty faced in effecting change within organizations. It was conjectured that the dietitian's effectiveness is situational in relation to characteristic strengths and weaknesses of specific facilities.

The results of this research suggest the need for additional studies on the functions of the consultant and on nursing home foodservice. These might include: (a) the effectiveness of the consultant dietitian as a change agent; (b) the quality of nutritional care offered by the foodservice department; (c) the effectiveness of the nursing home foodservice in meeting the individual needs of residents; (d) the extent of nursing home administrators' knowledge of foodservice activities; (e) further evaluation of the foodservice supervisor's function; (f) identification of competencies for the consultant dietitian and foodservice supervisor; and (g) identification of nutrition and foodservice-related competencies needed by nursing home administrators.

REFERENCES

(1) Foster, J.T.: A hospital administrator's view of the shared responsibility. J. Am. Dietet. A. 67:539, 1975.

(2) Robinson, W.F.: Dietitians' role in nursing homes and related facilities. J. Am. Dietet. A. 51:130, 1967.

(3) Wilson, F.A. and Neuhauser, D.: Health Services in the United States. Cambridge, Mass.: Ballinger Publication Co., 1974.

(4) Position paper on the role of the registered dietitian in consultative services to group care facilities. J. Am. Dietet. A. 67:579, 1975.

(5) Montag, G.M.: The role of the dietary consultant. J. Am. Dietet. A. 51:138, 1967.

(6) Reel, L.C.: Consultant dietitians effect change by working with the administrator and the foodservice supervisor. J. Am. Dietet. A. 66:45, 1975.

(7) Towle, D.A.: The consultation process. Univ. of North Carolina: School of Public Health and the School of Social Work, 195D.

(8) Hagwood, S.: Management recommendations of Kansas consulting dietitians. Unpublished master's report, Kansas State Univ., 1971.

(9) Montag, G.M.: Preliminary steps to effective dietary consultation. Hospitals 43:13D (July 16), 1969.

(1D) Clark, H.E. and Knickrehm, M.E.: How do administrators and administrative dietitians perceive the chief dietitian? J. Am. Dietet. A. 61:647, 1972.

(11) Hartman, J.: What you can expect of dietary consultant. Modern Hosp. 1D6:138 (Feb.), 1966.

(12) McWhorter, B.: The role of the consultant dietitian. In The part time and consultant dietitian. Univ. of Kansas School of Medicine, 1966.

(13) Position paper on recommended salaries and employment practices for members of The American Dietetic Association. J. Am. Dietet. A. 71:644, 1977.

(14) Ferguson, C.K.: Concerning the nature of the human systems and the consultant's role. J. of Applied Behavioral S. 4:179, 1968.

(15) Daub, E.F.: The consultant dietitian. Hosp. and Nursing Home Food Mgt. 4:10 (Jan.), 1968.

(16) Hille, H.M.: Examining the role of the dietary consultant. Hospitals 35:75 (Sept. 1), 1961.

(17) Lane, M.M.: The consultant dietitian. Nursing Homes 14:19 (Dec.), 1965.

(18) Johnson, D.: The dietitian--a translator of nutritional information. J. Am. Dietet. A. 64:608, 1974.

(19) Brush, M.K.: A new kind of patient service. Nutr. News 28:14, 1965.

(20) Hall, G.S.: The future of the dietitian. J. Am. Dietet. A. 20:587, 1944.

(21) Jones, M.C.: Dietary consultation--a service for small institutions. J. Am. Dietet. A. 26:650, 1950.

(22) Barber, M.I.: History of The American Dietetic Association. Philadelphia: J.B. Lippincott Co., 1959.

(23) Jeans, P.C.: Dietary consultation--a service for small institutions. J. Am. Dietet. A. 26:649, 1950.

(24) Guides for nursing homes. J. Am. Dietet. A. 35:1269, 1959.

(25) Bowes, A.P.: Nutrition services in state department of health. Am. J. Clin. Nutr. 9:638, 1961.

(26) Spears, M.C.: Consultant or shared dietitian? J. Am. Dietet. A. 38:357, 1961.

(27) Piper, G.M.: Planning new community nutrition series. J. Am. Dietet. A. 44:161, 1964.

(28) Long term care improvement study. USDHEW Publication No. 017-001-00397-2, 1975.

(29) Cashman, J.: Nutritionist, dietitians, and Medicare: An overview of Medicare. J. Am. Dietet. A. 50:21, 1967.

(30) Niles, C.: Factors influencing foodservice costs in adult care homes. Unpublished master's thesis, Kansas State Univ., 1974.

(31) Larson, L.S.: Greetings for the new year--1978. Consultant Dietitian in Health Care Facilities, An ADA Practice Group Newsletter 3:1 (Jan.), 1978.

(32) Stokes, J.F.: Dietary consulting: Future field of the present. Consultant Dietitian Special Interest Group Newsletter 2:12 (July), 1977.

(33) Four approaches to dietary consultation for nursing homes. Hospitals 41:92 (March 1), 1967.

(34) Williams, C.R.: The self-employed dietary consultant. Hospitals 41:92 (March 1), 1967.

(35) Woodward, N.: Group practice--a legal partnership of dietitians. Hospitals 41:93 (March 1), 1967.

(36) Marshall, B.H. The 'package plan.' Hospitals 41:93 (March 1), 1967.

(37) Oliver, J.: Dietary consultation for a group of homes under one management. Hospitals 41:93 (March 1), 1967.

(38) Haimann, T. and Scott, W.G.: Management in the Modern Organization. 2nd ed. Boston: Houghton Mifflin Co., 1974.

(39) Strauss, G. and Sayles, L.R.: Personnel, the Human Problems of Management. 3rd ed. Englewood Cliffs, N.J.: Prentice-Hall Inc., 1972.

(40) A Guide to Nutrition and Food Service for Nursing Homes and Homes for the Aged. USDHEW Publication No. (HRA) 76-3141, 1975.

(41) Lippitt, G. and Lippitt, R.: The Consultation Process in Action. La Jolla, Calif.: University Associates, Inc., 1978.

(42) Brenner, M.E.: An analysis of consulting dietitians in nursing homes and health related facilities. Unpublished master's thesis, Cornell Univ., 1971.

(43) Scialabba, M.A.: Functions of dietetic personnel in ambulatory care. J. Am. Dietet. A. 67:545, 1975.

(44) Smith, E.R.: Forecasting educational and training requirements and responsibilities for consulting dietitians to nursing homes. Unpublished master's thesis, The Univ. of Tennessee, 1975.

(45) Katz, R.L.: Skills of an effective administrator. Harv. Bus. Rev. 52:90 (Sept.-Oct.), 1974.

(46) Hersey, P. and Blanchard, K.: Management of Organizational Behavior. New Jersey: Prentice Hall, 1969.

(47) Lane, M.: Dietary consultant: What we have learned from the Medicare requirements. Nursing Homes 18:17 (Jan.), 1969.

(48) Baker, J.K. and Schaffer, R.H.: Making staff consulting more effective. Harv. Bus. Rev. 47:62 (Jan.-Feb.), 1969.

(49) The name, dietetic assistant to be retained. J. Am. Dietet. A. 69:125, 1976.

(50) Committee to develop a glossary on terminology for the association and profession: Titles, definitions, and responsibilities for the profession of dietetics. J. Am. Dietet. A. 64:661, 1974.

(51) The food service supervisor. J. Am. Dietet. A. 46(3):183, 1965.

(52) Food service in hospitals: An A.D.A. survey. J. Am. Dietet. A. 44:255, 1964.

(53) Duties and responsibilities in the department of dietetics. J. Am. Dietet. A. 46(3):179, 1965.

(54) Lane, M.M.: Food service supervisors in nursing homes. Nursing Homes 19:26 (Sept.), 1970.

(55) Ross, M.L.: The hospital, institution, and educational food service society. ADA Annual Reports and Proceedings, 1959-60. Chicago: Am. Dietet. A.

(56) Anderson, C.K.: Analysis of in-service education needed by cook-managers in nursing homes. Unpublished master's thesis, Univ. of Washington, 1969.

(57) Lane, M.M.: Supervisor training. Nursing Homes 17:27 (June), 1968.

(58) Wood, M.J., Perry, E., Poley, L.C., and Thomas, G.I.: Training auxiliary workers. J. Am. Dietet. A. 29:688, 1953.

(59) Van Horne, M.B.: Review of the 1950-60 decade. J. Am. Dietet. A. 37:242, 1960.

(60) Smith, B.H.: Food service personnel training and employment needs of nursing homes in West Tennessee. Unpublished master's thesis, Univ. of Tennessee, 1971.

(61) Position paper on the dietetic technician and the dietetic assistant. J. Am. Dietet. A. 67:246, 1975.

(62) Essentials of an acceptable program of dietetic assistant education. Rev., Chicago: Am. Dietet. A., 1974.

(63) Schiller, M.R. and Vivian, V.M.: Role of the clinical dietitian. J. Am. Dietet. A. 65:287, 1974.

(64) The Dietary Consultant in Health Care Facilities. Calif. Dietetic Assn., 1970.

(65) Duties and responsibilities. J. Am. Dietet. A. 30:692, 1954.

(66) McQuillan, F.L.: Fundamentals of Nursing Home Administration. Philadelphia; W.B. Saunders Co., 1974.

(67) Rakich, J.S., Beaufort, L.B., and O'Donnavan, T.R.: Managing Health Care Organizations. Philadelphia, W.B. Saunders Co., 1977.

(68) Schachter, A.: The nursing home industry: An overview. In Schneeweiss, S.M. and Davis, S.W.: Nursing Home Administration. Baltimore: University Park Press, 1974.

(69) Mitchel, M.: The administrator as coordinator of healthcare services. In Schneeweiss, S.M. and Davis, S.W.: Nursing Home Administration. Baltimore: University Park Press, 1974.

(70) An administrative opportunity and challenge. Nursing Homes 24:14 (Feb.), 1975.

(71) Yokie, A.J.: The nursing home administration--his professional growth and development. Nursing Homes 24:17 (May), 1975.

(72) Kurtz, C.: What do dietitians ask of administrators? Modern Hosp. 105:158 (Nov.), 1965.

(73) Jernigan, A.K.: What a part-time dietary consultant can do. Hospitals 40:146 (Oct. 16), 1966.

(74) Social Security Administration, U.S. Dept. of Health, Educ. and Welfare: Conditions of Participation for Extended Care Facilities. Washington, D.C.: U.S. Govt. Prtg. Offc., Publ. HIM-3, 1966.

(75) Smith, C.E.: Standards for dietary services in extended care facilities. Hospitals 40:101 (June 1), 1966.

(76) USDHEW: Skilled nursing facilities. Standards for certification and participation in Medicare and Medicaid programs. Federal Register 39(12):2238 (Jan. 17), 1974.

(77) USDHEW: Medical assistance program. Intermediate care facility services. Federal Register 39(12):2220 (Jan. 17), 1974.

(78) Regulations for the Licensure and Operation of an Adult Care Home. Topeka: Kansas Dept. of Health and Environment, 1977.

(79) Directory of Nursing Home Facilities, North Central Volume, USDHEW Publication No. 76-20002, 1975.

(80) Roscoe, J.T.: Fundamental Research Statistics for the Behavioral Sciences. 2nd ed. Dallas: Holt, Rinehart and Winston, Inc., 1975.

(81) Nie, H.H., Hull, C.H., Jenkins, J.G., Steinbrinner, K., and Bent, D.H.: Statistical Package for the Social Sciences. 2nd ed. New York: McGraw-Hill Book Co., 1976.

(82) Morales, R.: Development of the methodology for analysis of competencies in an area of dietetic practice. Unpublished Ph.D. dissertation, Kansas State Univ., 1978.

(83) Loyd, M. and Vaden, A.G.: Practitioners identify competencies for entry-level generalist dietitians. J. Am. Dietet. A. 71:510, 1977.

APPENDIXES

APPENDIX A

Phase I Correspondence to Consultants

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

Date: May 7, 1976

To: Consulting Dietitians in the
Midwestern States

From: Diane M. Spear, R.D.
Graduate Student

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

At Kansas State University we are currently engaged in a project to study the role of the consulting dietitian in nursing homes. This first phase, Phase I, of the study is concerned with identifying consultants who are currently working with nursing homes and with determining the number of nursing home accounts these consultants may have.

Phase II of the study will involve completion of questionnaires provided to the respondents of Phase I who are willing to provide information concerning their consulting responsibilities.

We need your help in order for the project to be successful. Would you be willing to participate in the survey? There have been increasing demands for dietitians to provide professional services to nursing homes and long term care facilities. However, relatively limited data are available on the specific functions and activities of consulting dietitians--your thinking and opinions will be most valuable to this research.

Enclosed is a self-addressed postcard on which questions are asked regarding your willingness to take part in Phase II. Will you complete this short form and return it to me today? Thank you.

Are you currently working as a consulting dietitian? Yes ____ No ____

Do you consult in nursing homes? Yes ____ No ____

If yes, how many nursing home accounts do you have? _____

Are you willing to participate in Phase II of this study? Yes ____ No ____

Name _____

Address _____

APPENDIX B

Interview Schedules

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

SURVEY OF NURSING HOME
DIETARY DEPARTMENTS

Interview with nursing home consultant dietitian

Interview Guide
(for consultant dietitian)

1. What are your major responsibilities and the major responsibilities of the foodservice supervisor in the nursing home(s) with which you consult?

2. How much time do you spend in your nursing home(s) per week and/or per month? How much time do you spend concerning the nursing home(s) away from the facility per week and/or per month?

3. What activities that you perform consume the most amount of your time? the least amount of your time?

4. What are the areas in which you are responsible for making the major decisions in the operation of the departments of the nursing homes in which you consult?

5. Are there any aspects of the dietary department of your nursing home(s) for which you assume full responsibility?

6. What role does the administrator generally play in relation to the foodservice operation in nursing homes in which you consult?

7. What do you feel are the major problems found in nursing home dietary departments?

8. Generally, in what ways do you feel nursing home dietary departments can be improved?

9. What is your opinion concerning training programs for nursing home dietary employees? Would formal training be more beneficial for nursing home supervisory personnel?

10. What topics do you think should be included in training sessions for nursing home foodservice supervisors?

11. How would you evaluate the effectiveness of the supervisors in the home(s) in which you consult?

12. How would you evaluate your relationship with the foodservice supervisor(s)?

13. What kinds of changes do you often find need to recommend? How successful do your change efforts tend to be?

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

SURVEY OF NURSING HOME
DIETARY DEPARTMENTS

Interview with nursing home consultant dietitian

Interview Guide
(to be used by interviewer)

1. What are your major responsibilities and the major responsibilities of the foodservice supervisor in the nursing home(s) you consult?

___ Menu planning?
___ Writing special diets?
___ Purchasing food?
___ Supervision of food preparation?
___ Supervision of food service to patients?
___ Preparation of food (actual cooking, etc.)?
___ Visiting patients?
___ Explaining diets to patients?
___ Hiring personnel?
___ Training personnel (in-service training and new employees)?
___ Preparing work schedule for personnel?
___ Keeping records of foodservice department expenditures?

2. How much time do you spend in your nursing home(s) per week and/or per month? How much time do you spend concerning the nursing home(s) away from the facility per week and/or per month?

3. What activities that you perform consume the most amount of your time? the least amount of your time?

___ Menu planning?
___ Therapeutics?
___ Food purchasing?
___ Food preparation?
___ Food service?
___ Sanitation?
___ Equipment and layout?
___ Department administration?
___ Records and reports?
___ Education and training?

4. What are the major areas in which you are responsible for making the major decisions in the operation of the dietary department?

___ Menu planning?
___ Thereapeutics?
___ Food purchasing?
___ Food preparation?
___ Food service?
___ Sanitation?
___ Equipment and Layout?
___ Department administration?
___ Records and reports?
___ Education and training?

5. Are there any aspects of the dietary department of your nursing home(s) for which you assume full responsibility?

___ Nutritional adequacy of diets?
___ Personnel management?
___ Financial management?
___ Other?

6. What role does the administrator of the nursing home play in relation to the foodservice operation?

___ Interviews and hires dietary personnel?
___ Writes job descriptions?
___ Develops department policies?
___ Develops department procedures?
___ Instigates recommendations of consultant dietitian?
___ Develops department budget?

7. What do you feel are the major problems found in nursing home dietary departments?

___ Menu - variety, combinations?
___ Food purchasing - quality, cost, quantity?
___ Facilities - adequate storage, equipment?
___ Leftovers?
___ Special diets?
___ Sanitation?
___ Quantity food production techniques?
___ Cooperation between foodservice and nursing personnel?
___ Cost of operating the department?
___ Patient complaints - food, service, service times?

8. In what ways do you feel nursing home dietary departments can be improved?

9. What is your opinion concerning training programs for your dietary employees? Would formal training be more beneficial for your supervisory personnel?

10. What topics do you think should be included in training sessions for nursing home foodservice supervisors?

    ___ Basic nutrition?
    ___ Menu planning?
    ___ Modified diets?
    ___ Food preparation procedures?
    ___ Cost control?
    ___ Food purchasing?
    ___ Sanitation, safety, hygiene?
    ___ Supervision, personnel relations?
    ___ Other?

11. How would you evaluate the effectiveness of the supervisors in the home(s) in which you consult?

12. How would you evaluate your relationship with the foodservice supervisor(s)?

13. What kinds of changes do you often find need to recommend? How successful do your change efforts tend to be?

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

SURVEY OF NURSING HOME
DIETARY DEPARTMENTS

Interview with nursing home administrators

Interview Guide
(for administrator)

1. What are the major responsibilities of the consultant dietitian and the major responsibilities of the foodservice supervisor in your nursing home?

2. What do you feel are the major problems in your nursing home dietary department?

3. What is your role in relation to the operation of your nursing home foodservice?

4. What are the areas in which you are responsible for making the major decisions in the operation of the dietary department?

5. Are there any aspects of the dietary department of your nursing home for which you assume full responsibility?

6. How much time is spent per week and/or per month with your nursing home by the consultant dietitian? Is this time adequate?

7. In what ways do you feel your foodservice department might be improved?

8. What is your opinion concerning training programs for your dietary employees? Would formal training be more beneficial for your supervisory personnel?

9. What topics do you think should be included in training sessions for nursing home foodservice supervisors?

10. How would you evaluate the effectiveness of your foodservice supervisor? consultant dietitian?

11. How would you evaluate their relationship?

12. What changes has the consultant suggested in the last year? Were these changes made? How successful were they?

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

SURVEY OF NURSING HOME
DIETARY DEPARTMENTS

Interview with nursing home administrator

Interview Guide
(to be used by interviewer)

1. What are the major responsibilities of the consultant dietitian and the major responsibilities of the foodservice supervisor in your nursing home?

___ Menu planning?
___ Writing special diets?
___ Purchasing food?
___ Supervision of food preparation?
___ Supervision of food service to patients?
___ Preparation of food (actual cooking, etc.)?
___ Visiting patients?
___ Explaining diets to patients?
___ Hiring personnel?
___ Training personnel (in-service training and new employees)?
___ Preparing work schedule for personnel?
___ Keeping records of foodservice department expenditures?

2. What do you feel are the major problems in your nursing home dietary department?

___ Menu - variety, combinations?
___ Food purchasing - quality, cost, quantity?
___ Facilities - adequate storage, equipment?
___ Leftovers?
___ Special diets?
___ Sanitation?
___ Quantity food production techniques?
___ Personnel - complaints, waste time, sickness?
___ Cooperation between foodservice and nursing personnel?
___ Cost of operating the department?
___ Patient complaints - food, service, service times?

3. What is your role in relation to the operation of your nursing home foodservice?

___ Interviews and hires dietary personnel?
___ Writes job descriptions?
___ Develops department policies?
___ Develops department procedures?
___ Instigates recommendations of consultant dietitian?
___ Develops department budget?

4. What are the areas in which you are responsible for making the major decisions in the operation of the dietary department?

___ Department administration?
___ Records and reports?
___ Education and training?
___ Equipment and layout?
___ Food service?
___ Food production?
___ Food purchasing?
___ Sanitation?

5. Are there any aspects of the dietary department of your nursing home for which you assume full responsibility?

___ Personnel management?
___ Financial management?
___ Other?

6. How much time is spent per week and/or per month with your nursing home by the consultant dietitian? Is this time adequate?

7. In what ways do you feel your foodservice department might be improved?

8. What is your opinion concerning training programs for your dietary employees? Would formal training be more beneficial for your supervisory personnel?

9. What topics do you think should be included in training sessions for nursing home foodservice supervisors?

___ Basic nutrition?
___ Menu planning?
___ Modified diets?
___ Food preparation procedures?
___ Cost control?
___ Food purchasing?
___ Sanitation, safety, hygiene?
___ Supervision, personnel relations?
___ Others

10. How would you evaluate the effectiveness of your foodservice supervisor? Consultant dietitian?

11. How would you evaluate their relationship?

12. What changes has the consultant suggested in the last year? Were these changes made? How successful were they?

APPENDIX C

Correspondence for Pretest of Instruments

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

July 26, 1976

TO:

FROM: Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

We appreciate your willingness to help in the pilot study as part of a research project here at K-State on the role of the consultant dietitian in nursing homes. We are sking that four of your associates read the cover letter, complete the enclosed questionnaire for two of the homes, and evaluate them both using the form provided. We, also, would like for you to enlist the help of eight nursing home administrators to evaluate the questionnaire. Envelopes are enclosed for mailing these questionnaires. For the pilot study, the administrators do not have to be from the same homes as those represented by the dietitians. Please feel free to make any of your own suggestions you believe will improve the study. Thank you.

Department of Dietetics, Restaurant
and Institutional Management
Justin Hall
Manhattan, Kansas 66506
Phone: 913 532-5521-2

July 26, 1976

TO: Administrators and Dietitians in Pilot Study

FROM: Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

We appreciate your willingness to help in the pilot study which is part of a research project here at K-State on the role of the consultant dietitian in nursing homes.

We want your honest reactions and criticisms to help us finalize the questionnaire prior to distribution to the 260 dietitians who have agreed to participate in the actual study. Each of these 260 dietitians will be asked to enlist the participation of nursing home administrators with whom they work.

Attached is a copy of the preliminary questionnaire, a form to evaluate the questionnaire, and the cover letter that will be sent to participants in the actual study. After reading the cover letter and completing the questionnaire, please evaluate them both. Feel free to make any suggestions you believe will improve the study. Thank you.

Department of Dietetics, Restaurant
and Institutional Management
Kansas State University

Evaluation of the Study

1. The questionnaire was difficult to answer.

   _____ yes
   _____ no

   Comments:

2. What suggestions to you have for revising the questionnaire?

   _____ leave questionnaire as it is
   _____ suggestions (specify)

3. What additions would you suggest?

   _____ none
   _____ as listed below

4. What would you omit on the questionnaire:

   _____ nothing
   _____ as indicated below

APPENDIX D

Final Research Instrument, Consultant Form

KANSAS STATE UNIVERSITY

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

STUDY OF THE ROLE OF THE CONSULTANT DIETITIAN IN LONG-TERM CARE FACILITIES

(Form to be completed by Consultant Dietitian)

Please complete all questions in relation to the facility named below and return in the stamped envelope provided as soon as possible.

Thank you!

Diane M. Spear, R.D.
Allene G. Vaden, Ph.D., R.D.

* Name of Nursing Home _____
Address _____
City and State _____

* Facility will not be identified in report of study.
Name of facility is requested for followup purposes only.

Section I.

1. Type of facility:

   _____ 1. Proprietary
   _____ 2. Voluntary
   _____ 3. Public

2. Number of beds in the facility:

   _____ 1. Less than 25
   _____ 2. 25 to 49
   _____ 3. 50 to 74
   _____ 4. 75 to 99
   _____ 5. 100 to 199
   _____ 6. 200 or more

3. Average daily census: _____

4. Average number of modified diets per meal: _____

5. Length of time the facility has employed a consultant dietitian:

   _____ 1. Less than 1 year
   _____ 2. 1-2 years
   _____ 3. 3-4 years
   _____ 4. 5-8 years
   _____ 5. 9 years or more

6. Length of time you have been employed by the facility:

   _____ 1. Less than 1 year
   _____ 2. 1-2 years
   _____ 3. 3-4 years
   _____ 4. 5-8 years
   _____ 5. 9 years or more

7. a. Hours per month spent at this facility: _____

   b. Number of times you visit facility each month: _____

8. Amount and kind of work for this facility done away from the facility:

   a. Hours per month away from facility: _____

   b. Activities performed away from facility (check as many as applicable):

      _____ 1. Menu planning
      _____ 2. In-service education and training
      _____ 3. Records and reports
      _____ 4. Organization and management (policies, job descriptions, etc.)
      _____ 5. Other, please specify

      _____

9. Presently, what are the major problem areas in the foodservice department?

   Please rate each of these possible problem areas on the following scale:

   1. Not really a problem
   2. Somewhat a problem
   3. Major problem area

   _____ 1. Menu - variety, combinations, use
   _____ 2. Modified diets - accuracy
   _____ 3. Food purchasing - cost, time, specifications, location
   _____ 4. Facilities - adequate storage, equipment
   _____ 5. Quality food
   _____ 6. Quantity food production techniques
   _____ 7. Sanitation
   _____ 8. Personnel - selection, training, attitude
   _____ 9. Cost of department operation
   _____ 10. Communication between departments and/or with administration

Section II.

What are your major responsibilities in this nursing home facility and what are the major responsibilities of the foodservice supervisor (FSS) in charge of the foodservice? To what degree is the administrator involved in the activities of the foodservice? Please read the following lists of responsibilities and carefully rate each activity on each of the three scales below:

Scale A. Activities of dietitian and foodservice supervisor (FSS)

Activity performed by:

1. Consultant dietitian only
2. Consultant dietitian with assistance of supervisor (7S:2S)
3. Joint responsibility (5O:5O)
4. Foodservice supervisor with assistance of consultant dietitian (7S:2S)
5. Foodservice supervisor only
6. Neither FSS or consultant

Rate each activity on each scale.

Scale B. Frequency of activity by dietitian

1. Performed almost every visit to facility (or at home prior to each visit)
2. Performed every 2 or 3 visits
3. Performed only occasionally
4. Not performed by dietitian

Scale C. Degree of involvement of administrator in foodservice activities

1. Not involved in activity
2. Only periodic involvement
3. Frequent involvement
4. Takes complete responsibility
5. Activity not performed in facility

Scale A. Activities of dietitian and FSS	Scale B. Frequency of activity	Scale C. Administrator involvement
1. Menu Planning		
1. Plans and writes menus	____	____
2. Makes menu changes	____	____
2. Modified Diets		
1. Writes modified diets	____	____
2. Adjusts modified diets	____	____
3. Visits residents	____	____
4. Assesses nutritional status of residents	____	____
5. Confers with residents regarding diet	____	____
6. Discusses diets with physicians	____	____
3. Food Purchasing		
1. Determines items and amounts to purchase	____	____
2. Places orders	____	____
3. Confers with salesmen	____	____
4. Inspects the quantity and quality of deliveries	____	____
5. Writes specifications	____	____

Scale A. Activities of dietitian and FSS	Scale B. Frequency of activity	Scale C. Administrator involvement	
			4. Food Preparation
____	____	____	1. Determines amounts to prepare
____	____	____	2. Standardizes recipes
			3. Tests menu items for taste and appearance
____	____	____	4. Assigns work to employees
____	____	____	
			5. Food Service
____	____	____	1. Supervises service and distribution of meals
____	____	____	2. Checks portion control
____	____	____	3. Checks plate waste
			6. Organization and Management
____	____	____	1. Develops department policies and procedures
____	____	____	2. Prepares job descriptions
			3. Initially interviews department personnel
____	____	____	4. Hires department personnel
____	____	____	5. Evaluates department personnel
____	____	____	6. Conducts exit interviews with department personnel
____	____	____	7. Communicates with other departments
____	____	____	
			7. Sanitation
____	____	____	1. Establishes sanitation standards
____	____	____	2. Checks dishwashing temperatures
____	____	____	3. Checks refrigerator temperatures
			4. Establishes cleaning schedules and procedures
____	____	____	5. Assigns cleaning tasks
____	____	____	
			8. Records and Reports
			Develops the following forms:
____	____	____	1. Census records
____	____	____	2. Summary of food cost
____	____	____	3. Inventories
____	____	____	4. Budgets
			Maintains the following forms:
____	____	____	1. Census records
____	____	____	2. Summary of food cost
____	____	____	3. Inventories
____	____	____	4. Budgets
			9. Education and Training
____	____	____	1. Conducts in-service training for foodservice employees
____	____	____	2. Conducts in-service for other employees
____	____	____	3. Orients new employees

Section III.

1. How long has the foodservice supervisor been with this facility?

   ____ 1. Less than 1 year
   ____ 2. 1-2 years
   ____ 3. 3-4 years
   ____ 4. 5-8 years
   ____ 5. 9 years or more

2. Has the food service supervisor received any training?

   ____ 1. Correspondence course
   ____ 2. Vocational technical training course
   ____ 3. Other, please specify

   _____

3. Please rate the foodservice supervisor using the following scale:

   1. Below average
   2. Average
   3. Above average
   4. Outstanding

   ____ a. Reliability in carrying out work assignments

   ____ b. Ability to assign work to others

   ____ c. Ability to get along with others

   ____ d. Willingness to accept new ideas

   ____ e. Ability to adjust modified diets to meet individual needs

   ____ f. Can determine items, amounts, and quantities to be purchased

   ____ g. Can determine amounts to prepare

   ____ h. Maintains a good working relationship with other departments

   ____ i. Maintains accurate census records; menus as served; food cost; records of modified diets

   ____ j. Follows through on recommendations of consultant dietitian

Section IV.

1. How many years have you been a member of The American Dietetic Association (ADA)?

   ____ 1. 1 year or less
   ____ 2. 2-5 years
   ____ 3. 6-10 years
   ____ 4. 11 years or more

2. Total number of years you have been employed in the profession.

   ____ 1. Less than 5 years
   ____ 2. 5-10 years
   ____ 3. 11-25 years
   ____ 4. More than 25 years

3. Total number of years you have been working as a consultant dietitian.

   ____ 1. 1 year or less
   ____ 2. 2-3 years
   ____ 3. 4-5 years
   ____ 4. 6-10 years
   ____ 5. More than 10 years

4. Please check the classification that best describes your present position:

   ____ 1. Consultant dietitian
   ____ 2. Part-time dietitian
   ____ 3. Full-time dietitian
   ____ 4. Shared dietitian
   ____ 5. Other, please specify

   _____

5. How did you become a member of ADA?

   ____ 1. Coordinated undergraduate program
   ____ 2. Internship
   ____ 3. Traineeship
   ____ 4. Work experience or preplanned experience
   ____ 5. Advanced degree

6. What is your most advanced degree?

   ____ 1. Bachelor's
   ____ 2. Master's
   ____ 3. Ph.D.

7. What was your major field of study for each degree?

   a. Major field for Bachelor's:

      ____ 1. Dietetics, institutional management, or foods and nutrition
      ____ 2. Home economics education
      ____ 3. Education, other than home economics
      ____ 4. Other, please specify

      _____

   b. Major field for Master's:

      ____ 1. Dietetics, institutional management, or foods and nutrition
      ____ 2. Home economics education
      ____ 3. Education, other than home economics
      ____ 4. Other, please specify

      _____

APPENDIX E

Final Research Instrument, Administrator Form

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

STUDY OF THE ROLE OF THE CONSULTANT DIETITIAN

(Form to be completed by Nursing Home Administrator)

Please complete all questions and return in the envelope provided as soon as possible. Thanks!

Section I.

What are the major responsibilities of the dietitian in this nursing home facility and what are the major responsibilities of the foodservice supervisor in charge of the foodservice? As the administrator, to what degree are you involved in the activities of the foodservice? Please read the following lists of responsibilities and carefully rate each activity on each of the three scales below:

Scale A. Activities of dietitian and foodservice supervisor (FSS)

Activity performed by:

1. Consultant dietitian only
2. Consultant dietitian with assistance of foodservice supervisor (7S:2S)
3. Joint responsibility (5O:5O)
4. Foodservice supervisor with assistance of consultant dietitian (7S:2S)
5. Foodservice supervisor only
6. Neither FSS or consultant

Scale B. Importance of consultant's activity in this area of operation

1. Not really important
2. Somewhat important
3. Very important

Scale C. Degree of involvement of administrator in foodservice activities

1. Not involved in activity
2. Only periodic involvement
3. Frequent involvement
4. Take complete responsibility
5. Activity not performed in facility

Rate each activity on each scale.

Scale A. Activities of dietitian and FSS	Scale B. Importance of consultant's activity	Scale C. Administrator involvement	
_____	_____	_____	1. Menu Planning
_____	_____	_____	1. Plans and writes menus
			2. Makes menu changes
_____	_____	_____	2. Modified Diets
_____	_____	_____	1. Writes modified diets
_____	_____	_____	2. Adjusts modified diets
			3. Visits residents
_____	_____	_____	4. Assesses nutritional status of residents
_____	_____	_____	5. Confers with residents regarding diet
_____	_____	_____	6. Discusses diets with physicians

Scale A. Activities of dietitian and foodservice supervisor (FSS)

Activity performed by:

1. Consultant dietitian only
2. Consultant dietitian with assistance of foodservice supervisor (75:25)
3. Joint responsibility (50:50)
4. Foodservice supervisor with assistance of consultant dietitian (75:25)
5. Foodservice supervisor only
6. Neither FSS or consultant

Scale B. Importance of consultant's activity in this area of operation

1. Not really important
2. Somewhat important
3. Very important

Scale C. Oegree of involvement of administrator in foodservice activities

1. Not involved in activity
2. Only periodic involvement
3. Frequent involvement
4. Take complete responsibility
5. Activity not performed in facility

Scale A. Activities of dietitian and FSS	Scale B. Importance of consultant's activity	Scale C. Administrator involvement	
			3. Food Purchasing
____	____	____	1. Determines items and amounts to purchase
____	____	____	2. Places orders
____	____	____	3. Confers with salesmen
____	____	____	4. Inspects the quantity and quality of deliveries
____	____	____	5. Writes specifications
			4. Food Preparation
____	____	____	1. Determines amounts to prepare
____	____	____	2. Standardizes recipes
____	____	____	3. Tests menu items for taste and appearance
____	____	____	4. Assigns work to employees
			5. Food Service
____	____	____	1. Supervises service and distribution of meals
____	____	____	2. Checks portion control
____	____	____	3. Checks plate waste
			6. Organization and Management
____	____	____	1. Oevelops department policies and procedures
____	____	____	2. Prepares job descriptions
____	____	____	3. Initially interviews department personnel
____	____	____	4. Hires department personnel
____	____	____	5. Evaluates department personnel
____	____	____	6. Conducts exit interviews with department personnel
____	____	____	7. Communicates with other departments
			7. Sanitation
____	____	____	1. Establishes sanitation standards
____	____	____	2. Checks dishwashing temperatures
____	____	____	3. Checks refrigerator temperatures
____	____	____	4. Establishes cleaning schedules and procedures
____	____	____	5. Assigns cleaning tasks

Scale A. Activities of dietitian and FSS	Scale B. Importance of consultant's activity	Scale C. Administrator involvement	
			8. Records and Reports
			Develops the following forms:
____	____	____	1. Census records
____	____	____	2. Summary of food cost
____	____	____	3. Inventories
____	____	____	4. Budgets
			Maintains the following forms:
____	____	____	1. Census records
____	____	____	2. Summary of food cost
____	____	____	3. Inventories
____	____	____	4. Budgets
			9. Education and Training
____	____	____	1. Conducts in-service training for foodservice employees
			2. Conducts in-service for other employees
____	____	____	3. Orients new employees
____	____	____	

Section II.

1. Please rate the foodservice supervisor using the following scale:

   1. Below average
   2. Average
   3. Above average
   4. Outstanding

____ a. Reliability in carrying out work assignments

____ b. Ability to assign work to others

____ c. Ability to get along with others

____ d. Willingness to accept new ideas

____ e. Ability to adjust modified diets to meet individual needs

____ f. Can determine items, amounts, and quantities to be purchased

____ g. Can determine amounts to prepare

____ h. Maintains a good working relationship with other departments

____ i. Maintains accurate census records; menus as served; food cost; records of modified diets

____ j. Follow through on recommendations of consultant dietitian

2. Presently what are the major problem areas in the foodservice department?

Please rate each of these possible problem areas on the following scale:

1. Not really a problem
2. Somewhat a problem
3. Major problem area

_____ 1. Menu - variety, combinations, use

_____ 2. Modified diets - accuracy

_____ 3. Food purchasing - cost, time, specifications, location

_____ 4. Facilities - adequate storage, equipment

_____ 5. Quality of food

_____ 6. Quantity food production techniques

_____ 7. Sanitation

_____ 8. Personnel - selection, training, attitude

_____ 9. Cost of department operation

_____10. Communication between departments and/or with administrator

3. Please indicate the consultant's contributions in each of the areas listed below using the following scale:

1. Has brought about little, if any, change
2. Has brought about some change
3. Has brought about significant change

_____ 1. Menu - variety, combinations, use

_____ 2. Modified diets - accuracy

_____ 3. Food purchasing - cost, time, specifications, location

_____ 4. Facilities - adequate storage, equipment

_____ 5. Quality of food

_____ 6. Quantity food production techniques

_____ 7. Sanitation

_____ 8. Personnel - selection, training, attitude

_____ 9. Cost of department operation

_____10. Communication between department and/or with administrator

* Name of Nursing Home _____

Address _____

City and State _____

* Facility will not be identified in report of study.
Name of facility is requested for followup purposes only.

APPENDIX F

Correspondence for Initial Distribution of Instruments

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

November 5, 1976

Dear Consultant Dietitian:

We appreciate your willingness to participate in Phase II of the study being conducted here at Kansas State University concerning the role of the consultant dietitian in nursing homes.

The study is being conducted in twelve midwestern states and involves 260 consultant dietitians and the administrators from each of their nursing home accounts. Enclosed are questionnaires with self-addressed, stamped return envelopes, one set of two questionnaires for each nursing home for which you are the consultant. You should complete the yellow questionnaire in each set for each of your nursing home accounts. Please ask the administrator to complete the blue questionnaire.

Because of our concern for an adequate response from the administrators, we would like you to deliver the questionnaires and information to the administrators, hopefully to encourage their interest and response. However, we have included envelopes for you to mail the questionnaire to the administrator if this is more convenient. Please encourage them to respond.

The data obtained in this study will be kept completely confidential and used only for the purpose of this study. Nursing homes will not be identified individually; all data will be reported in aggregate form and in summaries only.

For the project to be successful, we need your help! We are especially interested in your thinking regarding the role of the consultant dietitian, as there is limited data available on the specific functions and activities of the consultant and that of the foodservice supervisor in nursing homes. Will you complete the enclosed questionnaire(s) and deliver or mail the corresponding questionnaire to your nursing home administrators as soon as possible? Thank you.

Sincerely,

Diane M. Spear

Diane M. Spear, R.D.
Graduate Student

Research team:

Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

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

November 5, 1976

Dear Nursing Home Administrator:

At Kansas State University we are currently engaged in a project to study the role of the consultant dietitian in nursing homes. The first phase of the study was concerned with identifying consultants who were currently working with nursing homes and who were willing to participate in our research. The second phase of the study is being conducted throughout twelve states in the North Central region of the Midwest and involves 260 consultant dietitians in nursing homes and the administrators from each of their nursing home accounts.

We need your help for the project to be successful. There have been increasing demands for dietitians to provide professional services to nursing homes and extended care facilities. However, limited data are available on the specific functions and activities of consultant dietitians--your thinking and opinions will be most valuable to this research.

Enclosed is a questionnaire and self-addressed, stamped envelope. The data obtained in this study will be kept completely confidential and used only for the purpose of this study. Nursing homes will not be identified individually; all data will be reported in aggregate form and in summaries only. Will you complete this form and send it to me today? Thank you.

Sincerely,

Diane M. Spear

Diane M. Spear, R.D.
Graduate Student

Research team:

Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

APPENDIX G

Correspondence for Follow-up Mailings

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

Letter A

January 18, 1977

Dear Consultant Dietitian:

In November you should have received a packet containing questionnaires as part of the study being conducted here at Kansas State University concerning the role of the consultant dietitian in nursing homes. We appreciated the interest you expressed in the project last spring. In reviewing the questionnaires that have been returned, I found that your response had not been received.

Because of our concern for an adequate response, we are asking that you review the contents of the packet, complete the enclosed questionnaire(s), and deliver or mail the corresponding questionnaire to your nursing home administrators as soon as possible.

In the event that you are not presently consulting in nursing homes, we would like to have that information.

We need your help for the project to be successful. Thank you.

Sincerely,

Diane M. Spear, R.D.
Graduate Student

Research team:

Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

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

Letter B

January 18, 1977

Dear Consultant Dietitian:

In November you received a packet containing questionnaires as part of a study being conducted here at Kansas State University concerning the role of the consultant dietitian in nursing homes. As you may recall, the packet contained one set of two questionnaires for each nursing home for which you serve as a consultant, one for the administrator of that home and the other to be completed by you.

We appreciate your assistance with the study! However, in reviewing the questionnaires that have been returned, I have found that I received a response from the administrator of your home(s) but have not received the corresponding questionnaire to be completed by you. In order to utilize the data received it is imperative that we obtain your completed questionnaire as well. Enclosed are the questionnaire(s) and self-addressed, stamped return envelope(s) with the nursing home(s) identified for which there was incomplete data. Will you please complete the form(s) and return to me today? Thank you.

Sincerely,

Diane M. Spear, R.D.
Graduate Student

Research team:

Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

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

Letter C

January 18, 1977

Dear Nursing Home Administrator:

At Kansas State University we are currently engaged in a project to study the role of the consultant dietitian in nursing homes. The first phase of the study was concerned with identifying consultants who were currently working with nursing homes and who were willing to participate in our research. The second phase of the study is being conducted throughout twelve states in the North Central region of the Midwest and involved 260 consultant dietitians in nursing homes and the administrators from each of their nursing home accounts.

In reviewing the questionnaires that have been returned, I have found that I received a response only from the dietitian consulting in your nursing home. Since the consultant may not have had the opportunity to request your participation in this study, I am enclosing a questionnaire and self-addressed, stamped envelope. In order to utilize the data already received, it is imperative that we obtain your completed response as well as that of the dietitian.

There have been increasing demands for dietitians to provide professional services to nursing homes and extended care facilities. However, limited data are available on the specific functions and activities of consultant dietitians--your thinking and opinions will be most valuable to this research.

The data obtained in this study will be kept completely confidential and used only for the purpose of this study. Nursing homes will not be identified individually; all data will be reported in summaries only. Will you complete this form and return to me today? Thank you.

Sincerely,

Diane M. Spear, R.D.
Graduate Student

Research team:

Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

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

Letter D

January 25, 1977

Dear Consultant Dietitian:

We appreciate your participation in the study we are conducting concerning the role of the consultant in nursing homes. Our records from Phase I of the study indicate you are employed by _____ homes; however, we have received either partial or complete data from only _____ homes. Last week we sent follow-up mailings to dietitians or direct to administrators if either the consultant or administrator form had not been received. The homes for which we have received information are listed below:

name(s) of home	consultant questionnaire received	administrator questionnaire received

If you are presently consulting with the additional homes, we would appreciate getting information from those homes as well.

You should have received adequate forms in the November, 1976, mailing for these homes. We would appreciate it if you would complete the forms and mail them to us as soon as possible.

In the event you are not working with other homes, we would like to have that information also. Please complete the form below and return in the enclosed envelope.

Sincerely,

Diane M. Spear, R.D.
Graduate Student

Research team:

Diane M. Spear, R.D.
Graduate Student

Allene G. Vaden, Ph.D., R.D.
Assistant Professor of
Institutional Management

Name _____

Are you still consulting at _____ nursing homes?

_____ yes, all of them

_____ no, only the ones listed in the letter are my accounts

_____ I am consulting at only _____ accounts (indicate number) at the present time.

APPENDIX H

Supplemental Tables, Tables 19-24

Table 19: Consultant dietitians' ratings of problem areas in nursing home foodservice

problem area	not really a problem	somewhat a problem	major problem area
	%	%	%
menu--variety, combinations, use	68.8	28.8	2.4
modified diets--accuracy	40.9	46.3	12.8
food purchasing--cost, time, specifications, location	64.7	29.5	5.8
facilities--adequate storage, equipment	54.9	31.5	13.6
quality food	74.3	22.6	3.0
quantity food production techniques	55.1	39.1	5.8
sanitation	63.6	31.6	4.8
personnel--selection, training, attitude	42.0	42.7	15.4
cost of department operation	61.8	31.7	6.5
communication between departments and/or with administration	62.6	32.0	5.4

N varies from 292 to 297.

Table 20: Administrators' ratings of problem areas in nursing home foodservice

problem area	not really a problem	somewhat a problem	major problem area
	%	%	%
menu--variety, combinations, use	72.2	26.4	1.4
modified diets--accuracy	62.0	33.2	4.7
food purchasing--cost, time, specifications, location	66.4	30.2	3.4
facilities, adequate storage, equipment	58.3	31.9	9.8
quality of food	89.5	10.5	-
quantity food production techniques	71.5	27.1	1.4
sanitation	70.8	26.8	2.4
personnel--selection, training attitude	43.7	45.4	10.8
cost of department operation	54.4	37.8	7.8
communication between department and/or with administrator	70.8	26.1	3.1

N varies from 285 to 295.

Table 21: Nursing home administrators' ratings of importance of consultant dietitians' activities

activity	not really important	somewhat important	very important
	%	%	%
menu planning			
plans and writes menus	7.0	16.4	76.2
makes menu changes	12.2	36.7	50.3
modified diets			
writes modified diets	6.3	11.2	81.8
adjusts modified diets	4.9	22.7	71.3
visits residents	11.9	31.8	55.6
assesses nutritional status of residents	6.0	15.2	77.7
confers with residents regarding diet	9.3	31.7	57.3
discusses diets with physicians	19.6	26.4	52.9
food purchasing			
determines items and amounts to purchase	38.5	40.9	18.5
places orders	75.1	15.4	7.0
confers with salesmen	71.4	19.4	7.4
inspects the quantity and quality of deliveries	59.8	26.7	12.1
writes specifications	37.1	29.9	30.9
food preparation			
determines amounts to prepare	32.2	40.2	26.6
standardizes recipes	14.1	37.0	48.2
tests menu items for taste and appearance	20.7	47.7	31.2
assigns work to employees	68.7	21.0	8.9
food service			
supervises service and distribution of meals	32.5	44.4	22.7
checks portion control	18.8	43.4	37.5
checks plate waste	28.8	40.0	31.2

N varies from 264 to 285.

Table 21: (cont.)

activity	not really important	somewhat important	very important
	%	%	%
organization and management			
develops department policies and procedures	14.4	22.5	62.7
prepares job descriptions	23.3	25.8	50.5
initially interviews department personnel	72.3	16.0	10.3
hires department personnel	77.8	13.6	7.9
evaluates department personnel	52.3	30.6	16.0
conducts exit interviews with department personnel	74.9	16.0	7.6
communicates with other departments	15.4	25.7	54.5
sanitation			
establishes sanitation standards	12.2	22.6	64.8
checks dishwashing temperatures	27.3	37.1	35.7
checks refrigerator temperatures	26.8	36.9	35.5
establishes cleaning schedules and procedures	31.7	38.0	29.9
assigns cleaning tasks	64.1	25.6	9.3
records and reports			
develops the following forms:			
census records	56.1	26.4	16.0
summary of food cost	41.8	31.7	25.4
inventories	55.2	26.1	17.5
budgets	44.4	30.1	23.7
maintains the following forms:			
census records	69.7	20.5	8.7
summary of food cost	51.3	29.4	18.1
inventories	59.6	26.0	13.2
budgets	54.7	24.2	18.5
education and training			
conducts inservice training for foodservice employees	4.7	10.0	85.3
conducts inservice for other employees	17.1	22.9	59.6
orients new employees	46.4	33.6	19.3

Table 22: Consultant dietitians' ratings of performance of nursing home foodservice supervisors

performance area	ratings			
	below average	average	above average	out-standing
	%	%	%	%
reliability in carrying out work assignments	3.8	28.8	39.7	27.7
ability to assign work to others	10.5	36.1	35.7	17.7
ability to get along with others	6.8	31.3	37.8	24.1
willingness to accept new ideas	8.9	27.0	37.5	26.6
ability to adjust modified diets to meet individual needs	14.7	41.3	31.4	12.6
can determine items, amounts, and quantities to be purchased	3.4	32.1	41.6	22.5
can determine amounts to prepare	2.4	31.6	41.8	24.1
maintains a good working relationship with other departments	7.2	35.6	32.2	25.0
maintains accurate census records; menus as served; food cost; records of modified diets	12.9	38.1	30.2	18.3
follow-through on recommendations of consultant dietitian	8.5	30.0	33.4	28.0

N varies from 278 to 297.

Table 23: Administrators' ratings of performance of nursing home food-service supervisor

performance area	ratings			
	below average	average	above average	out-standing
	%	%	%	%
reliability in carrying out work assignments	1.7	23.6	46.2	28.4
ability to assign work to others	7.8	39.9	36.2	16.0
ability to get along with others	4.4	33.4	36.5	25.6
willingness to accept new ideas	7.8	29.0	35.8	27.3
ability to adjust modified diets to meet individual needs	5.8	36.8	39.5	17.9
can determine items, amounts, and quantities to be purchased	3.1	26.5	45.4	25.1
can determine amounts to prepare	1.0	27.7	43.8	27.4
maintains a good working relationship with other departments	4.5	32.3	39.2	24.1
maintains accurate census records; menus as served; food cost; records of modified diets	11.9	34.0	36.5	17.9
follow-through on recommendations of consultant dietitian	6.5	26.6	40.3	26.6

N varies from 285 to 293.

Table 24: Administrators' ratings of contributions of consultant dietitians

operational area	change implemented by dietitian		
	little, if any	some	signifi-cant
	%	%	%
menu--variety, combinations, use	13.1	40.7	46.2
modified diets--accuracy	4.2	39.0	56.8
food purchasing--cost, time, specifications, location	43.8	44.4	11.8
facilities--adequate storage, equipment	67.8	27.3	4.9
quality of food	33.7	47.4	18.9
quantity food production techniques	31.6	45.8	22.6
sanitation	23.3	48.1	28.6
personnel--selection, training, attitude	44.3	43.3	12.5
cost of department operation	49.3	40.0	10.7
communication between departments and/or with administrator	28.8	45.1	26.0

N varies from 285 to 290.

ROLE OF THE CONSULTANT DIETITIAN IN NURSING HOMES: PERCEPTIONS OF DIETITIANS AND ADMINISTRATORS

by

DIANE M. SPEAR

B.S., Kansas State University, 1975

AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

Department of Dietetics, Restaurant,
and Institutional Management

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1978

ABSTRACT

The dietetic profession has been experiencing expanding demands to provide professional service to nursing homes and health-related facilities because of the increasing number of elderly people and recent legislation concerning their care. Professional roles of dietitians have been changing to meet the needs of these community institutions. The dietitian usually serves in a consulting capacity in these facilities. The consultant's role is limited to that of advising and counseling, and the consultant is accountable only for the technical quality of the advice provided and does not have operational responsibilities.

Data are limited on the specific functions and activities of consultant dietitians in nursing homes and health-related facilities, however. This research was designed to study and compare the roles of the consultant dietitian and the foodservice supervisor in nursing homes.

The sample was selected from consultant dietitians within twelve states in the north central region of the United States. The study was limited to dietitians consulting in nursing homes and the administrators of each dietitian's nursing home accounts. Phase I of the study involved identification of consultant dietitians; Phase II was the actual collection of data to fulfill objectives of the study.

Data were available from consultants and administrators in 297 nursing homes. The majority had employed a consultant for a period of time; almost 60 per cent had employed a consultant for three to eight years. Nearly half (47.1 per cent) of the homes had employed the present

consultant for three to eight years, reflecting a definite trend of stability among consultants and their nursing home accounts.

The administrators listed the following most frequently as problem areas in foodservice: (a) personnel--selection, training, and attitude; (b) cost of department operation, which is not an unexpected reaction on the part of the administrator; and (c) facilities--adequacy of storage and equipment. The consultant had a greater degree of concern in all problem areas evaluated than did the administrators, except for the area of cost of department operation.

The most common pattern for the consultants was to make either one, two, or three visits per month to a facility and to spend three to twelve hours per month. Independent responsibilities performed by the consultant tended to be in the areas of planning and writing menus, in-service training, nutritional assessment, and discussing diet with the physician. Most activities were joint responsibilities of the consultant and supervisor except for very specific operational tasks which were performed most often by the foodservice supervisors independent of the consultant dietitian. The activities listed by the consultants as most frequently performed on every visit to the nursing home were resident visitation and diet consultation, nutritional assessment, communication with other departments, and checking foodservice and sanitation procedures.

The consultant's activities perceived as very important by the administrators were in the areas of menu planning, modified diets, organization and management, and education and training. The activities perceived as less important were food purchasing, food preparation, and maintaining certain reports as well as employment activities.

The activities in which 25 per cent or more of the administrators took complete responsibility were in the areas of organization and management and records and reports. Areas of limited administrative involvement were: menu planning, modified diets, food preparation, and food service. Areas in which administrators indicated the consultant had brought about most significant change were: (a) modified diets, (b) menus, (c) sanitation, and (d) communication between the foodservice department and other departments and with the administrator.