EVALUATION OF DIETARY DEPARTMENTS IN HOSPITALS OF FIFTY-BED OR LESS CAPACITY

A THESIS

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CHAPTER I

I N T R O D U C T I O N

Hospitals of 50-bed or less capacity do not usually retain the services of a full-time dietitian, but instead utilize the services of the dietary consultant, shared or part-time dietitian. The dietitian who serves in this capacity must work very closely with the hospital administrator and food service supervisor in identifying and solving problems that exist in the dietary department.

In that food service is frequently an area of negative criticism and discontent exemplified by patients, it warrants investigation. Objective evaluations by hospital administrators and dietary consultants in hospitals of 50-bed or less capacity should prove to be a useful tool for dietary consultants in planning future programs.

There is also the question as to whether or not the dietary consultant can successfully perform and carry out the designated duties and responsibilities as outlined by the American Dietetic Association and Medicare during the minimum eight-hour day per month visitation. Evaluations by hospital administrators and dietary consultants, identifying problem

areas in the dietary department should give some index, relative to the number of hours necessary to carry out the duties and responsibilities essential to the accomplishment and maintenance of high standards of service to patients.

REVIEW OF LITERATURE

Hospital Food Service

Food service in a hospital, as pointed out by the American Hospital Association (8), must please many people if it is to be successful. From the physician's point of view, the food service is an important factor in a patient's treatment, whether instructions are given for a modified diet or for a regular diet. To the patient, each meal is an important event. The familiar experience of eating can help ease the discomfort of unfamiliar surroundings. To personnel, the food service represents a convenience, a time for relaxation, and often a means of reducing job tensions. In some instances, food may be a part of the exmployee's salary. How the employee feels about the food served may influence attitudes toward the job, the supervisor and the institution. The public, too, which includes visitors, visiting medical men, and salesmen, looks critically at the food served in the hospital. Even though visitors may not be permitted to use the food services, and even though guest trays may not be allowed, visitors need only be present when meals are served

to form an opinion of the quality of the food served or of the food service staff. Hospital administrators have come to look upon food service as one of the services most vulnerable to criticism. Opinions of the hospital food service may affect the standing of the institution in the community. Thus, the food service can result in good or poor public relations (8).

Greenaway (24) stated that the food service product is on trial every day at every meal. Reaction to it is immediate and sometimes devastating. In order to produce a satisfactory food service, objectives and organization are necessary. Greenaway further stated that since the product of the food service is susceptible to the emotional likes and dislikes of people with built-in habits dating from childhood, it is one of the most difficult marketing problems encountered in any field. Kurtz (30) reported that no administrator could be so naive as to expect every person in the institution to be satisfied with the food service all the time.

Administrator-Dietitian Relationships

Wellin (49), in a paper presented at the 40th Annual meeting of the American Dietetic Association, stated that the administrator regards the dietitian as a happy hostess for a large eating establishment and feels that the aim of

contacts made with the "customers" is to boost morale and encourage pleasant and happy thoughts about the hospital. Krehl (29) reported that all too often, the dietitian has been relegated to a position "near the kitchen" where it is thought that the menus are planned. Some individuals even think that the dietitian "cooks the meal." The food service is the prime focus for criticisms by patients, house staff, and others associated with the hospital food enterprise.

Unfortunately, hospital administrators and physicians, as noted by Graning (23), are currently conditioned to thinking that the dietitian is useful in matters such as modified diets. Even the degree of sophistication is limited to bland, liquid and low sodium diets.

Kurtz (30) emphasized that the dietitian functions best when it is understood what is expected and the individual is provided adequate opportunity for professional growth. Kurtz presented factors necessary for good administrator-dietitian relationships:

1) A frank discussion on the part of administrator and dietitian at the time of the employment interview is basic to a good relationship between the two, but such interviews are the exception rather than the rule.

2) As leader of the administrative team, the administrator has to discover ways of motivating the dietitian to the highest level of professional performance of which she is capable.

3) The dietitian should have a definite and clear-cut idea of the lines of authority as represented by the organization chart of the institution. It is of prime importance for her to understand to whom she is responsible.

4) As a member of the administrative team involved directly with patient care, the dietitian should report directly to the administration.

5) The administrator and the dietitian should seek an understanding of the philosophy of feeding.

6) There must be mutual confidence between both members of the team. The administrator must be able to trust the dietitian's judgement regarding matters which should come to his attention. The dietitian expects and needs the assurance of the administrator that problems and possible solutions presented for consideration will receive due attention at the appropriate time.

7) An atmosphere of comfortable communication must be worked out by the administrator-dietitian team. Each should understand and appreciate the working habits of the other, for this is one of the determinants in arranging for the best communication processes.

Jernigan (26) stated that communication, which grows in a climate of trust and confidence, is a management skill of vital importance, one of the most exacting skills of management, and one of the most neglected.

In a study of five hospitals by Newton (35), data revealed that administrators seem to think there is good communication with dietitians, but dietitians on the

contrary, do not share this opinion. Instead, the dietitians were of the opinion that administrators know little and care less about the objectives and activities of the dietitian. Schwartz (42) pointed out that the sense of trust between administrator and dietitian is the indispensible factor in a good working relationship.

Marshall (33) listed five basic steps that administrators should consider in establishing a successful dietary program with the dietary consultant. The administrator:

1) Defines the food service objectives and the part the dietitian is expected to play in achieving these objectives.

2) Selects a dietitian who has suitable qualifications to perform the work satisfactorily.

3) Gives enthusiastic and positive cooperation to the dietitian. If the kitchen staff has not had professional supervision, it may reject the advice and authority of the consultant. The administrator must set the atmosphere for cooperation and back up the procedures introduced by the dietitian.

4) Is willing to follow the dietitian's professional decisions regarding nutrition and diet therapy, as well as in the areas of food production, purchasing and service.

5) Pays the consultant promptly.

The following responsibilities of the dietitian to the administrator have been clearly defined by the American Dietetic Association (5):

The professionaly qualified dietitian:

1) Is loyal to the administrator as director of the institution.

2) Informs the administrator on administrative developments pertinent to the department of dietetics.

3) Reports routinely, both in writing and in conference, to the administrator concerning present situations in the department, pertinent observations, and future plans.

4) Directs effective management of the department of dietetics through planning, organizing, coordinating, budgeting, controlling, and evaluating.

5) Cooperates in the development of policies for: the purchasing of food, equipment, and services; personnel and salary ranges; catering; and other activities of concern to the department.

6) Develops and keeps current the organization chart of the department showing responsibilities and authority of all personnel.

7) Develops and keeps current job analyses and descriptions for all positions.

8) Serves nutritionally adequate and palatable food under the strictest standards of sanitation and within the budget allocated for the department of dietetics.

9) Obtains, compiles, and collects information pertinent to the operation of the department of dietetics. Prepares meaningful reports, with explanations and implications for the future.

10) Evaluates periodically the departmental functions in relation to present and future goals.

11) Informs all persons concerned of matters pertinent to or of interest to them. Establishes and uses effective communication.

Impact of Medicare

The Associate Administrator of Virginia Mason Hospital, Austin Rose (40), in a presentation to the Institute on Dietary Department Administration on February 23, 1966 reported that the hospital industry, the fifth largest in the nation and the most complex of organizations, was about to experience a mammoth change--Medicare. As a sampling of these changes, Austin reviewed three impacts which would materialize from Medicare:

1) Manpower shortage. Hospitals, as time goes by, would experience severe manpower shortages. Physicians, nurses, and dietitians would be in short supply, and universities and nursing schools appeared unable at the time to make up the shortage. This would require federal or state participation in order to subsidize and develop educational programs at a more rapid pace.

2) Facilities shortage. There are a number of areas in the nation where hospitals are already functioning at peak capacity. It must be determined how the demand for additional beds will affect educational programs and how soon hospitals will be able to supply the added facilities to fill the need and at what cost.

3) The right to quality medicine. A considerable challenge exists for all to maintain traditional standards in the face of many changes.

Cashman (17), Chief of Medical Care Administration, stated that Medicare is "the law of the land." With the basis of support that Medicare provides, all of the health professions will have significant opportunities to pursue and promote as standard procedure the goals and aspirations of the various disciplines. Whenever and wherever medical care is given, the quality and appropriateness of that care must be in prime consideration. The development and enactment of Medicare legislation has provided the individual communities and the entire health community the opportunity to review the present scope and range of health care. Needs and resources have been re-evaluated, successful patterns of care identified, and areas of insufficiency defined. Because of Medicare, this process of review can be continued and pursued to the benefit of all the participants.

Cashman (17) further stated that members of the American Dietetic Association must meet the new and exciting challenge of the profession. As a professional group, dietitians must be prepared to supply the rapidly growing demand for nutritional services. Leadership in setting and maintaining standards for nutrition in the Medicare Program must come

from dietitians. Speaking the language of physicians, administrators and patients is important in exercising leadership.

Birk, Piper and Smith (12) shared the opinion of Cashman (17) relative to opportunities and challenges that the Medicare program has presented for the dietetic profession. Birk and Others (12) noted that prior to the Medicare Act, it was doubtful that any hospital of 50-bed or less capacity employed the services of a dietitian.

As the result of the Medicare Act, the Social Security Administration (43) has outlined the standards for hospital dietary departments on organization, facilities, diets, and conferences. The hospital must have an organized dietary department directed by qualified personnel. A hospital which has a contract with an outside food management company may be found to meet this condition of participation if the company has a therapeutic dietitian on a full-time, part-time or consultant basis. Smith and Piper (44) pointed out that dietitians figure prominently in the "Conditions of Participation--Dietary Departments," and that the dietetic profession is committed to support the defined responsibilities of the dietary department which will contribute to improvement in the field of medical care.

Evaluation of the Dietary Department

In 1956, a report by a special committee of the American Dietetic Association (1) presented in checklist form, the first formalized standards for evaluating the effectiveness of the dietary service in a hospital entitled: "Tool for Evaluating the Hospital Department of Dietetics." At the same time, work in developing standards was continued. In 1963, a second committee of the American Dietetic Association (6) published a report under the title, "Standards for Effective Administration of the Hospital Department of Dietetics." Since the latter report reflected more current thinking, the joint committee of the American Hospital Association and the American Dietetic Association (1) recommended that the original checksheet be updated for use in conjunction with the newer report, incorporating enlarged knowledge and a broadened philosophy. The checksheet retains the title, "Checksheet for Evaluating a Hospital Department of Dietetics." This checksheet permits an appraisal of existing conditions and provides an opportunity to interpret where and how changes can improve individual and departmental efficiency. The form may be used by hospital administrators or directors of dietetics. In either case, the tool should reflect the efficiency of the department as well as that of those areas which require attention. This form is not intended to serve as the only

tool in evaluation, but is to be used in conjunction with other existing materials and standards.

Goulet (22), a hospital administrator, suggested a pattern for evaluating the dietary department in relation to advancing technology and as a segment of the whole hospital. Six areas discussed were:

1) The definition of the departmental goals:
2) The management organization, including the relationship of the dietary department to the administrator, medical staff, nursing, accounting, purchasing, maintenance and housekeeping;
3) The patient and staff food service system;
4) Space requirements;
5) Staffing patterns and personnel policies; and
6) Food purchasing.

Ross (39), in evaluating dietary department management, summarized seven characteristics most prevalent in the make-up of a successful dietary department head:

1) Honesty;
2) Identification with institutional objectives;
3) Technical knowledge and competence;
4) Communication ability;
5) Judgement and intelligence;
6) Emotional balance; and
7) Leadership style.

The results of an in-depth evaluation of hospital food service as reported by Blumenthal (13) revealed that departmental objectives, plan of organization, delineation of responsibilities, policies and procedures, budget reports and job descriptions are not formalized in writing in many hospitals. Visnyer (48) suggested that from time to time, it is wise to take a critical look at a food service operation as it might be reviewed and evaluated by a stranger.

The role of the dietary consultant.--The problems of a dietary consultant in a small hospital as described by Kelly (28) are similar to those of a dietitian in a large hospital, except for the fact that the problems in the small hospital are more personalized, more tradition bound, and more local in nature. As a resource person, an advisor, a suggestion maker and a sounding board, the job utilizes all formal and informal education and a considerable amount of common sense.

Hartman (25) emphasized that the dietary consultant, qualified to advise, evaluate, teach and train, can help the hospital upgrade professional food service standards. Montag (34) pointed out that since the term staff and dietary consultant is defined in terms of advice and service, the role of the dietary consultant can be described as a staff function. The dietary consultant is limited to an advisory and service capacity and carries no authorative

power. Montag (34) and Daub (19) have outlined activities that a dietary consultant might consider:

The consultant:

1) May provide advice and service in the process of management, in the techniques and methods of planning, organization, coordination, and control.

2) Can be very helpful in spelling out such management activities as lines of authority and areas of responsibility.

3) May give opinions of proposed plans or policies, such as layout of physical facility or procurement of new equipment.

4) Is of great value in developing new programs for installation if requested; for example, reviewing and setting up purchasing procedures or employee work schedules.

5) May help to establish accounting records and budgets which are yardsticks for performance.

6) May determine the need for and the formulation of such controls for the food service supervisor as inventory or portion control.

7) May be called on to undertake an active in-service training program; for example, instructing dietary personnel and patients in principles of modified diets.

To reach departmental goals, Robinson (38) recommended that the dietary consultant provide at least four hours of service in the facility each week. The time required, however, will vary with the size of the facility, number and complexity of therapeutic diets, and competence of the food service

personnel, particularly the person responsible for food service management.

The Louisiana Dietetic Association (32), at the request of the Department of Hospitals, developed a form entitled: "Report of the Consulting Dietitian's Visit." The form was developed as proof of the existence of the dietary consultant's visit. Toward the end, or immediately following the consultation visit, the dietary consultant should take a few moments to record her thoughts concerning the visit.

The role of the food service supervisor.--The food service supervisor, dietary supervisor or cook-manager figures prominently in small hospitals of 50-bed capacity or less. The American Dietetic Association (3) recommended that, in small institutions, usually 25-beds or less, in which the person in charge of food service is also responsible for actual food preparation, the title be that of "cook-manager" rather than food service supervisor. Whenever a food service supervisor or cook-manager is responsible for the dietary operation of the food service department, additional duties are usually assumed by virtue of the responsibilities of the position.

Van Horne (47) stated that as long ago as 1951, the need for training food service supervisors to assist the

dietitian in routine administrative duties inspired the development of courses of study and supervised experiences for workers employed in food service departments. As the concept of the food service supervisor evolved, it became apparent that the manager of food service in small hospitals without the full-time services of a professional dietitian could also benefit greatly by this type of training. Whereas experience in food service is of great benefit in preparing workers for supervisory positions, the complex knowledge derived from many fields such as record-keeping, personnel management, sanitation, nutrition, quality food preparation, and menu-planning make it necessary that experience be supplemented by formal planned instruction.

Van Horne (47) further stated that as the number of graduates of the various training programs increased during the 1950's, the position of the food service supervisor became identified as a special job category with a common educational background. To meet the need for continued education and better communications between individuals in this new category, a national society, the Hospital, Institutional and Educational Food Service Society (HIEFSS) was founded in 1960. A person who is eligible to become a member of the society is a food service supervisor who, by training and experience, is qualified to supervise and instruct workers

in a food service department. Membership in HIEFSS calls for various optimal training courses, all of which include classroom instruction in nutrition and modified diets; menu-planning, purchasing and other aspects of administration; principles of food preparation and service; housekeeping and sanitation; and supervisory skills.

Many brochures, guides and books have been published, including the American Hospital Association's Training the Food Service Supervisor (10) and Diet and Menu Guide for Hospitals (8). These publications are planned to aid food service employees and supervisors.

Getty and Hollenworth (21) pointed out that the food service supervisor in a small hospital, without a full-time dietitian, is an effective liaison between the dietitian and the administrator, the dietary department and staff, and the hospital and the community. Daub (18) stated that the dietary consultant works under the guidance of the administrator who should designate a food service supervisor or cook-manager as the person to be trained and responsible for carrying out the program suggested by the dietary consultant and approved by the administrator.

Spears (45), upon being asked to serve in the capacity of dietary consultant for three Arkansas hospitals, insisted

there be a dietary supervisor before taking corrective measures in any of the hospitals. This meant that the administrators had to promote the best employee to that position.

The following suggested list of duties and responsibilities of the food service supervisor have been outlined by the American Dietetic Association (3):

General responsibilities:

1) Consulting with the dietitian regarding operating problems, patient food service, and therapeutic diets.

2) Orienting, training, supervising, and evaluating new personnel.

3) Training, supervising, and evaluating other personnel.

4) Instructing employees in use, care, and maintenance of equipment.

5) Preparing work and time schedules for food service employees.

6) Supervising sanitation and housekeeping procedures.

7) Maintaining safety standards.

Responsibilities in the Area of Administration:

1) Assisting in ordering food supplies.

2) Receiving deliveries and checking receipts against specifications and orders.

3) Maintaining or improving standards of food preparation and service.

4) Supervising activities of work areas, including cafeterias, dining rooms, and the dishwashing room.

5) Assisting in the standardization of recipes and supervising their use.

Responsibilities in the Area of Patient Food Service:

1) Writing modified menus according to patterns established by the dietitian or the dietary consultant.

2) Supervising serving units or central tray service.

3) Contacting patients daily who are receiving routine diets and/or selective menus.

As the result of data collected by Tillotson and Styer (46) a "Performance Evaluation Form for Food Service Employees" has been designed and covers 11 major requirements for successful performance of a food service worker. This form may be used by the dietitian or food service supervisor. The requirements are:

1) Shows initiative and a spirit of cooperation;

2) Shows interest in work;

3) Follows directions;

4) Maintains high food service standards;

5) Maintains sanitary standards and cares for equipment;

6) Pays attention to details;

7) Communicates with others;

8) Is sensitive to needs of others;

9) Is dependable and reliable;

10) Maintains high standards for personal appearance and conduct;

11) Uses judgement in applying safety rules.

Staffing in the dietary department.--Rothenbuhler and Bartscht (41) found that hospital administrators and department heads often compare staffs for similar size hospitals (in terms of beds) and discover significant differences. Often the staff in the hospital departments are established on the basis of the staffs that exist in other hospitals of similar bed size. Because bed size or number of patients in a hospital is only one factor which affects staff needs, these are inappropriate and inaccurate methods for either comparing or determining staff needs.

As part of a survey of dietary labor in Iowa hospitals, findings by Jolin and McKinley (27) showed that hospitals serving less than 60 meals served 8.6 meals per full-time employee equivalent. Statistical data gathered by the Hospital Administrative Services, a project of the Hospital Research and Educational Trust, sponsored by American Hospital Association (7), in 1963 revealed that the median number of meals prepared per dietary man-hour was 2.9 (2.1 to 3.9) for 78 hospitals having 49 beds and under. Labor minutes per meal were 20.7. Boenker (14), in a study of dietary staffing

in Texas, found that in hospitals of 50-bed capacity or less, the mean number of beds per employee was 6.5 with a range of 5 to 10.

Lofquist and Others (31) showed, as a result of an investigation into dietary departments in small hospitals located in Minnesota, that the average total labor minutes expended per meal served was 16.9 minutes, with no significant relationship between the bed capacity of the hospital and labor minutes per meal.

Ostenso and Donaldson (37), in an investigation of hospital dietary labor resources of 10 Wisconsin hospitals, found that many factors affect the utilization of labor time including the degree of food control exercised from receiving of raw food to arrival of meals at the bedside of the patient; system of food distribution; system of dishwashing; use of selective or non-selective menus; amount and quality of cafeteria service and physical layout. Daub (20) pointed out that there are many variables in food service and it is difficult to establish a standard for staffing other than one on a sliding rule. It could take either from 14 to 17 or from 15 to 20 man-minutes per meal, and this is a standard to work toward.

STATEMENT OF THE PROBLEM

The overall purpose of the study was to obtain an evaluation of dietary departments by hospital administrators and dietary consultants in American Hospital Association-registered and Medicare-approved hospitals of 50-bed or less capacity in Louisiana. Hospitals in Louisiana of 50-bed or less capacity were chosen, not only because Louisiana is the resident state of the author, but also because it is very possible that some of the hospitals may provide clinical experience for students in the field of foods and nutrition. The Task Force for the Seventies of the American Dietetic Association has recommended that clinical experience become a prerequisite for the undergraduate in order to better prepare the student for the dietetic internship program (4).

The specific purposes of the study were to:

1) Identify problems in the dietary departments as viewed by hospital administrators and dietary consultants;

2) Investigate the opinion of dietary consultants as to the adequacy of the time alloted to the duties and responsibilities of the dietary department as outlined by the American Dietetic Association; and

3) Establish a guideline to staffing needs in hospitals of 50-bed or less capacity by determining the average total labor minutes per meal served.

DEFINITION OF TERMS USED

Registered hospital: One which fulfills the requirements as set forth by the American Hospital Association (9).

Dietary consultant: Advises and assists public and private establishments, such as child care centers, hospitals, nursing homes, and schools, on food service management and nutritional problems in group feeding. Plans, organizes, and conducts such activities as in-service training courses, conferences, and institutes for food service managers, food handlers, and other workers. Develops and evaluates informational materials. Studies food service practices and facilities, and makes recommendations for improvement. Confers with architects and equipment personnel in planning for building or remodeling food service units (16).

CHAPTER II

PROCEDURE

The investigator selected 50 American Hospital Association-registered hospitals in Louisiana of 50-bed or less capacity to take part in the study. Names and addresses of the hospital administrators were obtained from the "Listing of Hospitals, United States," published in Hospitals, Journal of the American Hospital Association, August 1, 1969 (9).

A letter explaining the purpose of the study was sent to the administrators asking for a personal interview pertaining to the dietary department. A stamped, self-addressed post card was enclosed, which was to be checked "Yes" if a personal interview could be arranged, or "No" if a personal interview could not be arranged.

Twenty-eight "Yes" responses were received from the administrators, but only 27 qualified for the study because one hospital had increased in capacity to 150 beds since the August 1, 1969 American Hospital Association publication. Of the remaining hospitals, 14 did not respond, five checked "No," and three had ceased operation.

The investigator was interested in surveying at least 30 hospitals; therefore, it became necessary to solicit the cooperation of hospital administrators who had not returned the post card. In order to obtain additional affirmative responses, four administrators were contacted. One of the hospital administrators explained that such an interview could not be permitted unless it was approved by the Louisiana Hospital Association, and on this basis, refused.

Appointments for the personal interview were made by telephone. Upon visiting the hospitals, several had increased in size since the August 1, 1969 American Hospital Association publication, but did not exceed 50 beds. Interviews with the administrators required from 20 to 30 minutes, and an additional 10 to 20 minutes were given to a tour of the dietary department. In several instances, the food service supervisor was asked to explain various aspects of the food service department and answer any questions that may have arisen.

Two instruments, developed by the investigator, based on survey forms used in similar studies, were used to collect the data. The survey form for administrators, entitled: "Evaluation of Hospital Dietary Departments by Hospital Administrators" was divided into four general categories. These categories were: general information concerning the

dietary department, dietary personnel, the physical facility, and the service of food. A copy of the letter and instrument follows.

March 12, 1970

Dear

In order to fulfill the requirements for the Master of Science degree in Institutional Administration at Texas Woman's University, Denton, Texas, it is necessary that I complete a research project. The results of the research will be used in the teaching of student dietitians.

To collect the data, I am interested in asking hospital administrators in registered hospitals of 50-bed capacity or less in Louisiana to evaluate their dietary departments. May it be emphasized that neither you, nor your hospital will be identified in any way.

Enclosed you will find a card on which you may check "Yes" or "No." If the answer is "Yes," you will be contacted by telephone as to the specific date and time of the interview. Please return this card at your earliest convenience.

Your cooperation in participating in this evaluation will be deeply appreciated.

Respectively yours,

Verdi Robinson Pass
(Mrs. William L. Pass)

(Post Card to Be Returned to Author)

Yes_____. You may make an appointment for a personal interview relative to your research.

No_____. You may not make an appointment For a personal interview relative to your research.

_____
(Signature of Administrator)

EVALUATION OF HOSPITAL DIETARY DEPARTMENT BY HOSPITAL ADMINISTRATOR

Hospital Administrator only _____

Medical Director _____

Owner _____

Number of beds _____

Type of hospital _____

General Information Concerning the Dietary Department

1. Is a budget allocated to the dietary department? Yes____ No____

2. Does the dietary department have a policy and procedure manual? Yes____ No____

3. Is a diet manual available for dietary personnel? Yes____ No____

   Medical and nursing staff? Yes____ No____

Personnel

4. Do you employ the services of a Registered dietitian? Yes____ No____

   Foods and nutrition major? Yes____ No____

   Home Economist Yes____ No____

   If the answer is "No," is it due to Inavailability? Yes____ No____

   Noninterest? Yes____ No____

   Lack of funds? Yes____ No____

   Other reasons? (explain)_____

5. How often does the dietitian visit your facility?

   Number of days per week, or _____

   Number of days per month _____

6. Are regular conferences held with the dietitian concerning the dietary department? Yes____ No____

   If there is no dietitian, are regular conferences held with the individual directly responsible for the dietary department? Yes____ No____

7. How many full-time personnel are employed in the dietary department? _____

   How many hours do they work per day? _____

   How many hours do they work per week? _____

8. How many part-time workers are employed in the dietary department? _____

   How many hours do they work per day? _____

   How many hours do they work per week? _____

9. Are split shifts used? Yes____ No____

10. Who is directly responsible for the dietary department?_____

11. Is there a functioning personnel training program for dietary employees? Yes____ No____

12. Define areas, if any, in which employees are especially

    Strong_____

    Weak_____

13. Are physical examinations routinely given employees? Yes____ No____

    If given, how often? _____

14. In what areas, if any, would you like to have more direction, assistance and/or recommendations from the dietitian?_____

The Physical Facility

15. Is the dietary department, presently, adequately equipped to meet

a. Food service needs? Yes____ No____

b. Receiving and storing? Yes____ No____

c. Preparation? Yes____ No____

d. Serving? Yes____ No____

e. Dishwashing? Yes____ No____

f. Garbage and trash disposal? Yes____ No____

16. Is space adequately allocated to meet dietary needs? Yes____ No____

17. Is equipment systematically replaced? Yes____ No____

18. Are sanitation techniques satisfactorily observed and carried out? Yes____ No____

19. Is the dietary department regularly inspected by the local or state sanitarian? Yes____ No____

20. Are there any major pieces of equipment in the department that are not being used? Yes____ No____

21. Is there a desk available or a place for the dietary consultant or food service supervisor to do necessary paper work? Yes____ No____

Is there a place for records and files concerning the dietary department? Yes____ No____

Food Service

22. Who plans the menus? _____

23. Are menus selective? _____

Or, non-selective? _____

24. Are cycle menus used? Yes____ No____

If yes, how long is the cycle? _____

25. Are standardized recipes used? Yes____ No____

26. Who does the purchasing? _____

27. Are written specifications used? Yes____ No____

28. To what extent are convenience foods used? _____

29. Is food purchased from

Retailers? Yes____ No____

Wholesalers? Yes____ No____

Both? Yes____ No____

30. Approximately what percentage of the diets are modified? _____

31. Are patients visited regarding their food habits before diet preparation or as soon as possible after admission? Yes____ No____

32. Who serves trays to patients?

Dietary personnel Yes____ No____

Nursing service Yes____ No____

Other (specify) _____

33. How are trays transported to patients?

Open cart	Yes____ No____
Unheated, closed cart	Yes____ No____
Combination of heated and refrigerated cart	Yes____ No____
Other (specify)	_____

34. Are meals served to employees? Yes____ No____

If so, approximately how many per day? _____

Are visitors served? Yes____ No____

If so, approximately how many per day? _____

35. What are some common

Patient complaints?

Praises or commendations?

36. What, in your opinion is the general attitude of the following groups toward the food service?

	Favorable	Indifferent	Unfavorable
Patients	_____	_____	_____
Nursing service	_____	_____	_____
Medical staff	_____	_____	_____

37. What is your general attitude toward the food service? (Please elaborate)

Satisfactory

Unsatisfactory

38. How do you think the dietary department could be improved?

After the data had been collected from the 30 hospital administrators, the investigator became interested in including dietitians, who consult in Louisiana hospitals of 50-bed or less capacity, in the study. It was believed that participation by the dietary consultants would result in a study that would be more meaningful. A letter explaining the purpose of the study and a survey form on which to report the data were mailed to the dietary consultants.

The Public Health Nutritionist of the Department of Hospitals for the State of Louisiana supplied the names of 18 dietary consultants employed by 20 American Hospital Association-registered hospitals, but could only furnish a partial list of addresses. The investigator contacted the Secretary of the Louisiana Dietetic Association in an attempt to obtain the remaining addresses, but was informed that because of a policy of the association, the addresses could not be revealed. However, the Secretary stated that if the survey forms were mailed to the association's headquarters, with stamped envelopes, the envelopes could be addressed and mailed to the dietary consultants.

The instrument, entitled: "Evaluation of the Hospital Dietary Department by Dietary Consultants" was used to collect the data. This instrument was divided into four general

categories very similar to the instrument used in collecting the data from administrators. These categories were: general information concerning the dietary department, dietary personnel, the physical facility, and the service of food. A copy of the letter and the instrument follows.

May 30, 1970

Dear

I am most interested in soliciting your cooperation and participation in a research project involving dietitians serving as consultants in American Hospital Association-registered hospitals of 50-bed or less capacity in Louisiana.

The data collected will become part of a thesis used to complete the requirements for the Master of Science degree in Institutional Administration at Texas Woman's University in Denton, Texas. May it be emphasized that neither you, nor the hospital retaining your services will be identified.

Enclosed, you will find a survey form entitled "Evaluation of the Hospital Dietary Department by Dietary Consultants," and a stamped, self-addressed envelope in which to return the data. Your cooperation in participating in this research project will be deeply appreciated. Your name was given to me by the Public Health Nutritionist for the Louisiana State Department of Hospitals.

May I hear from you at your very earliest convenience?

Sincerely yours,

Verdi Robinson Pass
(Mrs. William Lee Pass)

EVALUATION OF HOSPITAL DIETARY DEPARTMENT BY DIETARY CONSULTANTS

Kind of Hospital:

Community_____ Private_____ Other_____

General_____ Specialized_____

Number of beds_____

General Information Concerning Dietary

1. Is a budget allocated to the dietary department? Yes____ No____

2. Does the dietary department have a policy and procedure manual? Yes____ No____

3. Is a diet manual available for

   Dietary personnel? Yes____ No____

   Medical staff and nursing service? Yes____ No____

Personnel

4. How often you visit the hospital?

   Number of days per week _____

   hours per week _____

   OR

   Number of days per month _____

   hours per month _____

5. Do you hold regular conferences with the administrator concerning the dietary department? Yes____ No____

6. How many full-time personnel are employed in the dietary department? _____

   How many hours do they work per day? _____

   How many hours do they work per week? _____

7. How many part-time personnel are employed in the dietary department? _____

   How many hours do they work per day? _____

   How many hours do they work per week? _____

8. Are split shifts used? Yes____ No____

9. Do you feel that the number of personnel employed is adequate to prepare and serve the meals in this hospital dietary department? Yes____ No____

   If your answer is "No," please explain on back of sheet.

   Do you feel that the dietary department is overstaffed? Yes____ No____

10. Who is directly responsible for the dietary department?

    Food supervisor Yes____ No____

    Cook manager Yes____ No____

    Other (specify) _____

11. Is there a functioning in-service training program? Yes____ No____

12. Define areas, if any, in which the employees are especially

    Strong _____

    Weak _____

    (If additional space is needed, please use back of sheet.)

13. How often are physical examinations given to dietary employees?_____

14. Do you feel that sufficient time is given you, as a dietary consultant, to successfully carry out your duties and responsibilities as outlined by the American Dietetic Association and Medicare to render high standards of patient service? Yes____ No____

    If your answer is "No," please explain on back of sheet.

The Physical Facility

15. At present is the dietary department adequately equipped to meet

    a. Food service needs Yes____ No____

    b. Receiving and storing Yes____ No____

    c. Preparation Yes____ No____

    d. Serving Yes____ No____

    e. Dishwashing Yes____ No____

    f. Garbage and trash disposal Yes____ No____

16. Is space adequate for food preparation and service? Yes____ No____

17. Is equipment systematically replaced? Yes____ No____

18. How often is the dietary department inspected by the local or state sanitarian? _____

19. Are there any major pieces of equipment in the dietary department that are not being used? Yes____ No____

    If "Yes," please list them.

    _____ _____

    _____ _____

20. Do you think that sanitation techniques are satisfactorily carried out? Yes____ No____

21. Is a desk or office available to do paper work in or near the department? Yes____ No____

Is a place provided for records and files concerning the department? Yes____ No____

Food Service

22. Who plans the menus? _____

23. Are menus

Selective? Yes____ No____

Non-selective Yes____ No____

24. Are cycle menus used? Yes____ No____

How long is the cycle? _____

25. Are standardized recipes used? Yes____ No____

26. Who does the purchasing? _____

27. Are written specifications used? Yes____ No____

28. To what extent are convenience foods used? _____

29. Is food purchased from

Wholesalers? Yes____ No____

Retailers? Yes____ No____

Both? Yes____ No____

30. What time are the following meals served?

Breakfast?_____ Evening meal_____

31. What is the average census per day for patients? _____

32. Approximately what percentage of the diets are modified? _____

33. Are patients visited regarding their food habits when you are not there? Yes____ No____

34. Who serves trays to patients?

Dietary Yes____ No____

Nursing service Yes____ No____

Other (specify) _____

35. How are trays transported?

Open cart Yes____ No____

Unheated closed cart Yes____ No____

Combination heated and refrigerated cart Yes____ No____

Other (specify) _____

36. Are meals served to employees? Yes____ No____

If so, approximately what is the average number served per day? _____

Average number of visitors? _____

Average number of staff meals? _____

37. What are some common patient complaints concerning

Food _____

Service _____

Personnel _____

38. What, in your opinion, is the general attitude of the following groups toward the food service?

	Favorable	Indifferent	Unfavorable
Patients	_____	_____	_____
Nursing service	_____	_____	_____
Medical staff	_____	_____	_____
The Administrator	_____	_____	_____

39. What is your professional evaluation concerning the adequacy of food service in this hospital?

Excellent_____ Satisfactory_____ Needs improvement_____

If improvement is needed, please list the areas.

CHAPTER III

ANALYSIS OF DATA

The overall purpose of the study was to determine from hospital administrators in American Hospital Association-registered hospitals of 50-bed capacity or less, located in Louisiana, various policies and procedures that would aid in evaluating dietary departments. Of the 50 administrators contacted, 30 agreed to participate in the study. Survey forms were mailed to 18 dietary consultants employed in 20 American Hospital Association-registered hospitals of 50-bed capacity or less, located in Louisiana. The survey forms were completed by 11 dietary consultants, but only nine of these were unable replies. One of the dietitians consulted in nursing homes rather than in a hospital; and the other dietitian was employed full-time in a 150-bed hospital. Data obtained from the administrators and the dietary consultants will be wherever possible, analyzed simultaneously.

Each survey form was divided into four general categories: general information concerning the dietary department, dietary personnel, the physical facility and the service of the food. The information will be discussed in the above order.

GENERAL INFORMATION

The first part of the survey form requested information concerning the type of hospital and the bed capacity. Data from hospital administrators and dietary consultants revealed that 74.4 per cent of the hospitals were community hospitals, 23.0 per cent were privately owned and one was a city hospital. A total of 39 hospitals were included in this study. The number and percentage of each type hospital included in the study follow:

Hospitals	Administrators Number	Dietary Consultants Number	Per cent
Community	24	55	74.4
Private	6	3	23.0
City	0	1	2.6
Total	30	9	100.0

According to the hospital administrators, 28 hospitals were general hospitals and two were specialized hospitals. All nine of the dietary consultants categorized the hospitals in which they were employed as general. Of the total number of hospitals included in the study, 94.9 per cent were

general and 5.1 per cent were specialized. The distribution follows:

Hospitals	Administrators Number	Dietary Consultants Number	Per cent
General	28	9	94.9
Specialized	2	0	5.1
Total	30	9	100.0

One hospital administrator was also the owner and the medical director; 29 were hospital administrators only. Two of the administrators were female. Of the two hospitals that were administered by females, one was a 50-bed specialized hospital and the other was a 46-bed general hospital. Twenty-three of the 30 hospitals reported by administrators were Medicare-affiliated.

The hospital bed size ranged in capacity from one, having 10 beds, to three having 50 beds. For the purpose of data analysis, the hospitals were categorized as follows:

Bed Capacity (Range)	Administrators Number	Dietary Consultants Number	Per cent
<30	8	5	33.3
30-39	12	1	33.3
40-50	10	3	33.3
Total	30	9	99.9

According to reports by the administrators, eight hospitals were less than 30 beds, 12 were between 30 and 39 beds and 10 were within the 40 to 50-bed range. When the bed capacity of hospitals reported by dietary consultants were combined with those for which the administrators furnished data, the number of hospitals in each category was idential, 13 hospitals in each group. The mean bed capacity according to information furnished by both administrators and dietary consultants was 34.2

Included in the survey form was a question concerning the allocation of a budget to the dietary department. Administrators revealed that seven of the 30 hospitals had budgets, whereas only one out of nine consultants reported that the dietary department operated on a budget. Only one in five of the total group of hospitals surveyed were reported to have a budget for the dietary department. Hospitals with budgets for the dietary department are shown below:

Bed Capacity (Range)	Administrators Number	Dietary Consultants Number	Per cent
<30	3	1	10.3
30-39	1	0	2.6
40-50	3	0	7.7
Total	7	1	20.7

Several administrators explained that the hospital was too small to plan budgets for the dietary department. Of the hospitals reporting budgets, one-half were institutions with less than a 30-bed capacity, three were hospitals with between 40 and 50 beds and one was a hospital with between 30 and 39 beds. One administrator stated that the dietary department had "sort of a budget."

No budgets were prepared specifically for the dietary department in 92 per cent of the hospitals surveyed by Lofquist and others (31). The only food cost record kept in 52 per cent of the hospitals was the total amount of money spent each month for food. In an "In-depth Evaluation of a Food Service Department" by Blumenthal (13), 65 per cent of the hospitals under 200 beds had operating budgets.

The survey form requested information as to whether or not policy and procedure manuals were available for dietary employees and the medical and nursing staff. Twenty-six administrators reported having policy and procedure manuals in the dietary department; 28 provided diet manuals for dietary personnel and in 24 hospitals, diet manuals were available for the medical and nursing staff. Responses from dietary consultants showed that seven hospitals had policy and procedure manuals. Diet manuals were available for dietary employees in all of this group of hospitals and available for

the medical and nursing staff in seven of the nine hospitals for which information was reported by consultants. In one of the two hospitals lacking a diet manual for the medical and nursing staff, the dietary consultant noted that one was being prepared. The combined responses revealed that 84.8 per cent of the hospitals had policy and procedure manuals 97.4 per cent had diet manuals for dietary personnel and that 31 or 79.7 per cent of the hospitals reported the availability of a dietary manual.

Balsley (11) pointed out that manuals were used, not only by the dietary, medical and nursing staff, but were also made available to the social worker. In an evaluation of the dietary departments by Blumenthal (13), 59 per cent had policy and procedure manuals. Boles (15) pointed out that a policy and procedure manual is a management tool that offers increased efficiency and better organization. By having policies and procedures in writing, departmental employees and the administration can use the manual as a ready reference to determine appropriate action for most situations.

PERSONNEL

Administrators were asked if the hospital retained the services of a dietary consultant. The responses concerning

dietary consultants and the number of hours employed per month by the hospitals follow:

Hours Per Month Per Consultant	Bed Capacity <30 Number	30-39 Number	40-50 Number	Total
8	4	0	2	6
16	2	1	0	3
32	1	5	4	10
64	0	1	0	1
Full-time	1	1	2	4
As needed	0	0	1	1
Total	8	8	9	25

A total of 25 of the 30 hospitals or 83.3 per cent of the group reported by administrators employed the services of a dietary consultant. One male dietitian was included in this group. The hospital that employed the male dietitian was a new 25-bed facility. The number of hours employed per month ranged from 8 to 64 hours. Only four of the consultants in the 25 hospitals employing consultants were full-time employees. The largest number of consultants, 10 individuals, visited the facility 32 hours per month. Three consultants were employed 16 hours per month and one consultant visited 64 hours per month. One consultant in a specialized hospital was reported to visit the hospital when needed by the dietary department. A total of three individuals employed as dietary consultants in the hospitals reported by administrators were home economists.

The nine dietary consultants providing information for the study reported working 8 to 48 hours per month. Four consultants worked eight hours per month, three were employed 8 to 16 hours per month and two individuals indicated working 24 to 48 hours per month. Two individuals were full-time consultants, one in a hospital of less than 30 beds and one in a hospital of between 30 and 39 beds. One home economist, employed in a hospital of between the 30 and 39-bed capacity, visited 32 hours per month. Of the five hospitals that did not employ dietary consultants, one administrator expressed interest in the services of one; the consultants had resigned and had not been replaced in two hospitals; and one administrator stated that the hospital would benefit from the services of a dietary consultant, but the hospital could not afford the expense of this service. The fifth hospital utilized the services of the wife of one of the staff doctors who was reported to "serve the needs of the hospital."

Of the seven hospitals that were not Medicare-affiliated, three had dietary consultants; one employed a full-time dietitian and one had a full-time home economist. Eight dietitians replied in the affirmative to the question as to whether or not adequate time was allowed to successfully perform the duties and responsibilities as outlined by the American Dietetic Association and Medicare. One consultant did not respond to this item.

An American Dietetic Association Survey (2) revealed that budgetary limitations of small hospitals usually restrict the employment of a full-time professionally qualified dietitian. By making use of the services of a dietary consultant, part-time or shared dietitian, smaller hospitals may effectively utilize the services of a dietitian and still maintain operating budgets. A survey conducted by the American Dietetic Association showed that 12.9 per cent of the hospitals under 50-bed capacity had dietitians directing the food service. In this survey, the administrator frequently designated himself as "in charge." The study by Lofquist and others (31) revealed that 22 per cent of 152 hospitals surveyed employed dietitians. The most frequent reason given for not employing a dietitian in hospitals of 30-bed or less capacity was that the hospital could not afford the cost of this service.

Communication between the administrator and the dietary consultant is very important. All the hospital administrators employing dietitians reported having regularly scheduled conferences with the dietary consultant and/or the individual directly responsible for the dietary department. All of the consultants responded in the affirmative to the question concerning regularly scheduled conferences.

In order to determine the labor minutes per meal, it was necessary to determine from both the administrators and

the consultants the number of full time and part-time employees. In the present study as in previous studies (14, 27, 41), there was no apparent relationship between bed size, number of meals served, and the number of personnel employed. The number of full-time and part-time employees as given by the administrators and consultants follow:

Bed Capacity (Range)	Full-time Number	Part-time Number	Total Number
<30 (N=12)*	53	14	67
30-39 (N=13)	74	11	85
40-50 (N=13)	106	4	110
Total (N=38)	233	29	262

*Data given for one hospital was inadequate to calculate.

The total number of employees in hospitals of less than 30 beds was 67 employees, 53 full-time and 14 part-time employees. The range was from two full-time employees in a 10 bed hospital to 10 full-time and four part-time employees in a 26-bed hospital. In hospitals between 30 and 39 beds, there was a total of 85 employees, 74 full-time and 11 part-time employees, with a range of two full-time and two part-time dietary employees in a 30-bed hospital to eight full-time employees and one part-time employee in a 36-bed hospital. Hospitals in the 40 to 50 bed category were rported to employ

a total of 110 dietary personnel, 106 full-time and four part-time employees. The number of dietary employees ranged from four full-time employees and one part-time employee in a 50-bed hospital to 14 full-time employees in a 50-bed hospital. There was a total of 262 dietary employees, 233 full-time and 29 part-time in all the hospitals included in the survey.

Administrators indicated that hours worked by full-time employees varied from 8 to 10 per day and 40 to 50 hours per week. Part-time employees were reported to work from 2 to 8 hours per day and from 8 to 32 hours per week. Twenty per cent of the hospitals reported by administrators used split shifts. Two administrators reported that split shifts would eventually be discontinued. Consultants stated that four of the nine hospitals included in the survey used split shifts. Part-time employees were reported by consultants to work from 4 to 8 hours per day and 8 to 36 hours per week.

The investigator was interested in determining the man-hours per meal, the bed capacity per meal, and the total labor minutes per meal served. Due to the inadequacy of information submitted by one consultant, one of the hospitals was not included in the calculations. The distribution of man-hours

per hospital per week as reported by administrators, consultants and the combined group are as follows:

Bed Capacity (Range)	Administrators Number	Dietary Consultants* Number	All Hospitals Number
<30 (N=12)*	222	122	172.0
30-39 (N=13)	254	200	227.0
40-50 (N=13)	320	368	334.0
Overall Average	298	227	262.5

*Data from one consultant was not included.

According to administrators, the average number of man-hours worked per week by dietary employees in 30 hospitals was 298. The average number varied from 222 in hospitals of less than 30 beds to 320 in hospitals of between 40 and 50 beds. The average number of man-hours worked per week by employees of eight hospitals reported by dietary consultants was 227 man-hours for this group. This average number of man-hours ranged from 122 hours in hospitals with less than 30 beds to an average of 368 hours per week in hospitals of between 40 and 50 beds. The average number of man-hours for the total group of 38 hospitals was 262.5 man-hours. The overall average number of man-hours per day for all 39 of the hospitals investigated was 38.5. The bed capacity per

full-time dietary employee equivalent for 38 of the hospitals was also determined, as shown below:

Bed Capacity (Range)	Administrators Average Number	Dietary Consultants Average Number	All Hospitals Average Number
<30 (N=12)	5.3	5.8	5.5
30-39 (N=13)	5.8	7.0	6.4
40-50 (N=13)	6.4	6.3	6.3
Overall Average	5.8	6.3	6.0

Administrators revealed that the overall bed capacity per dietary employee for the 30 hospitals was 5.8, with a range of 5.3 beds per dietary employee in hospitals under 30 beds to 6.4 beds per dietary employee in hospitals in the 40 to 50 bed capacity. In eight hospitals reported by dietary consultants, the average number of beds per dietary employee ranged from 5.8 for hospitals under 30 beds to 6.3 for hospitals reporting between 40 and 50 beds. The overall average for the 38 hospitals for which these data were available was 6.0 beds per dietary employee.

Labor minutes per meal were investigated. Responses from administrators and dietary consultants have been analyzed.

Bed Capacity (Range)	Administrators Average Number	Dietary Consultants Average Number	All Hospitals Average Number
<30 (N=12)	22.4	17.8	20.1
30-39 (N=13)	18.4	18.2	18.3
40-50 (N=13)	17.0	14.6	15.8
Overall Average	19.3	16.8	18.1

Responses given by administrators showed that the average time in labor minutes per meal served by the dietary department ranged from 17 minutes in hospitals with 40 to 50 beds to 22.4 minutes in hospitals with less than 30 beds. The average number of labor minutes per meal served, according to the reports by administrators, was 19.3 In the hospitals reported by dietary consultants, the number of labor minutes per meal ranged from 14.6 minutes in hospitals with 40 to 50 beds to 18.2 minutes in hospitals having between 30 and 39 beds. The overall average for the 38 hospitals for which these data were available was 18.1 labor minutes per meal served. The number of meals per labor hour were 3.3.

The Hospital Administrative Services, a project of the Hospital Research and Educational Trust, sponsored by the

American Hospital Association (7) revealed that the median average of meals prepared per dietary man-hour for hospitals under 49 beds were 2.9, with a range of 2.1 to 3.9. The median labor minutes per meal served was 20.7 for hospitals under 49 beds. The total of 78 hospitals included in this 1963 survey were of 49-bed capacity or less.

Determining staffing needs according to bed capacity could be misleading when employee, visitor and staff meals are served. One administrator reported that staffing is a major problem in that particular hospital because "one day, the hospital is full of patients and the next day, there are no patients at all." There was a concensus among dietary consultants that the staff was adequate to prepare and serve meals and that the dietary department was not overstaffed.

Two administrators reported having dietitians, both full-time as the person responsible for the dietary department. All three of the home economists included in the study were given full responsibility for the dietary department. An outline of data given by both administrators and consultants is shown in Table I. Sixteen administrators and six consultants or 54.4 per cent of the total group stated that the food service supervisor was responsible for the dietary department. Other individuals responsible for the dietary department were: in one hospital a dietary supervisor; one

TABLE I

INDIVIDUALS RESPONSIBLE FOR THE FOOD SERVICE DEPARTMENT IN HOSPITALS OF 50-BED OR LESS CAPACITY AS REPORTED BY HOSPITAL ADMINISTRATORS AND DIETARY CONSULTANTS

Individual	Administrators	Dietary Consultant*	Total	
			Number	Per cent
Dietitian	2	-	2	5.1
Home economist	3	-	3	7.7
Food service supervisor	16	6	22	56.4
Dietary supervisor	1	-	1	2.5
Kitchen supervisor	1	-	1	2.5
Cook manager	1	1	2	5.1
Administrator	4	-	4	10.2
Registered nurse	1	1	2	5.1
Executive housekeeper	1	-	1	2.5
Total	30	8	38	97.1

*One dietary consultant did not respond to the item.

hospital, a kitchen supervisor, and in two hospitals, a cook manager. In four hospitals, the administrator reported himself as the individual in charge of the dietary department. An executive housekeeper and a registered nurse were responsible for the dietary department in two hospitals. One consultant did not respond to this question.

Training programs in the dietary departments were investigated. Eighteen administrators and four dietary consultants answered in the affirmative when asked if training programs were offered for dietary personnel. Eleven administrators and four dietary consultants reported having no training program; one administrator replied, "Somewhat," and one consultant failed to respond to the question. A total of 22 or 56.4 per cent of the hospitals in the survey provided training programs for dietary employees.

Ninety per cent of the hospitals surveyed by Jolin and McKinley (27) reported providing training for dietary employees. It is only through a well planned training program that dietary employees can become more efficient in performing the duties required by the food service organization.

Administrators and dietary consultants were asked to define areas in which the employees were especially weak or especially strong. The areas reported are listed in Table II.

TABLE II

AREAS INDICATING STRENGTHS AND WEAKNESSES OF DIETARY EMPLOYEES IN 39 HOSPITALS OF 50-BED OR LESS CAPACITY AS REPORTED BY HOSPITAL ADMINISTRATORS AND DIETARY CONSULTANTS

Areas	Administrators	Dietary Consultants	Total
	Number	Number	Number
Areas of Strengths			
Food preparation techniques	0	6	6
Accurate production	0	1	1
No response	0	2	2
Areas of Weaknesses			
Lack of understanding of special diets	3	2	5
Ability to communicate	1	0	1
Care of equipment	1	0	1
Patient-employee relationship	1	0	1
Work simplification	1	2	3
Utilization of left-overs	0	1	1
Sanitation	0	1	1
No response	0	3	3

Only the dietary consultants reported areas of strength. Six consultants indicated food preparation techniques and one listed accurate production as special strengths of the dietary department. Among the weaknesses of employees most frequently mentioned was the lack of understanding of special diets by dietary personnel. Three administrators and two consultants emphasized the need for dietary employees to develop a better understanding of special diets. Work simplification was given as an area of weakness by one administrator and two dietary consultants. Sanitation and the utilization of left-overs were two weaknesses pointed out by consultants and three administrators indicated inability to communicate, the care of equipment and patient-employee relationships as weaknesses. Three dietary consultants did not list weaknesses. Twenty-three administrators reported satisfaction with the performance of the dietary employees.

Hospital administrators and consultants reported that physical examinations were given the dietary employees once each year in 27 hospitals, twice each year in 8 hospitals, and 2 to 4 times each year in one hospital. One administrator stated that no physical examinations were being given to the dietary employees at the time of the investigator's visit, but that eventually employees would be given physical examinations. One consultant stated that physical examinations were

given only at the time of employment of dietary personnel, after which, only x-rays were required. One dietitian did not respond to this question.

Even though 64 per cent of the administrators expressed satisfaction with the performance of the dietary consultant, three individuals pointed out areas in which more assistance was needed by the consultant. Two administrators were interested in having the consultant outline a budget for the food service department. Two administrators were desirous of the dietary consultant taking a more active role in patient teaching. Three other areas, each named by one administrator were: menu planning with less repetition of foods, the compilation of a policy and procedure manual and employee teaching. The administrator interested in the dietary consultant doing a better job of employee teaching explained that the dietitian did not have a working knowledge of food service management and that teaching would be much more effective if the consultant would show the employee what to do as well as explain what was to be done. One administrator stated inability to comment on the performance of the dietitian because of the employment of the dietitian just one month prior to the visit of the investigator.

THE PHYSICAL FACILITY

The most proficient personnel will not be able to attain the goals and objectives of the dietary department if the physical facility is not adequate or functional. The number of administrators and dietary consultants answering in the affirmative to the adequacy of the food service facility in 38 of the 39 hospitals investigated is shown in Table III. The area most adequately equipped was food preparation, according to 71.8 per cent of the administrators and consultants. The garbage and trash disposal areas were reported as adequate in 64.1 per cent of the hospitals; 59 per cent of the hospitals had adequate serving and dishwashing areas; and 54.4 per cent were reported to have adequate receiving and storage areas. Less than one-half, or 48.7 per cent of the total hospitals investigated, were reported to have space adequate for food preparation and service.

Ten administrators and five dietary consultants or 38.4 per cent indicated that equipment was systematically replaced. Twenty-three administrators and six dietary consultants (74.4 per cent of the total hospitals represented in the study) reported that there was no equipment in the dietary department not being used. Equipment reportedly not being used by the remaining 25.6 per cent of the hospitals were two potato peelers, two steamers, two steam-jacketed

TABLE III

ADEQUACY OF THE PHYSICAL FACILITY IN 38 HOSPITALS OF 50-BED OR LESS CAPACITY AS REPORTED BY HOSPITAL ADMINISTRATORS AND DIETARY CONSULTANTS*

Food Service Area	Bed Capacity			Total	
	<30 Number	30-39 Number	40-50 Number	Number	Per cent
Receiving and storage	9	5	8	22	56.4
Food Preparation	10	8	10	28	71.8
Serving	9	6	8	23	59.0
Dishwashing	9	5	9	23	59.0
Garbage and trash disposal	9	6	10	25	64.1
Adequate space	6	5	8	19	48.7

*One dietary consultant did not respond to question

kettles and a juicer, grinder, hot top, slicer, gram scale, coffee urn, large floor-model mixer and two large ovens. The reason given for non-use of the equipment by the consultants was that the equipment was too large for production needs.

One of the questions in the survey pertained to the availability of office space for the dietitian and/or individual in charge of the dietary department. In 11 dietary departments, the administrators indicated that offices were available for paperwork. In seven hospitals, other administrative offices were used by the dietary personnel. Twelve food service departments had desks, one of which was placed in the storeroom. Twenty-two food service departments were reported to have files available for use. Eight dietary consultants stated that a desk or office was available to do paperwork. One consultant reported that office or desk space was not available.

Hospital administrators and dietary consultants were asked about the performance of sanitation techniques. All of the administrators and seven of the consultants or 94.9 per cent of all the hospitals participating in the survey stated that sanitation techniques were satisfactorily performed, even under adverse circumstances. Two dietitians indicated there was room for improvement. Twenty-nine of

of the 30 administrators reported that the local or state sanitarian visited the facility once each month and one administrator stated that the food service facility was visited 1 to 3 times per year by the sanitarian.

FOOD SERVICE

The last part of the survey forms dealt with the food service provided by the 39 participating hospitals. When asked who planned the menus, 61.5 per cent of the administrators and dietary consultants reported that the menus were planned by the dietary consultant, however, 23.0 per cent of the respondents stated that the menus were planned by the food service supervisor. In 10.2 per cent of the hospitals, the menus were planned by a consultant-supervisor team. In the two remaining hospitals, menus were reported to be planned by a cook-manager in one hospital and by a registered nurse in the other. An inquiry was made into the use of selective or non-selective menus. Nine dietary consultants and 29 administrators, 97.4 per cent of the institutions, reported the use of non-selective menus. The one hospital that used selective menus was a specialized hospital. Several administrators mentioned the desire for selective menus, but indicated that this might result in an increase in food and labor costs.

In hospitals surveyed by Lofquist and others (31), dietitians and home economists planned only 25 per cent of the

menus. Selective menus were used in only 10 per cent of the hospitals investigated by Lofquist and co-workers (31).

Administrators and consultants reported the use or non-use of cycle menus, and if used, the length of the cycle. Thirty-one or 79.7 per cent of the hospitals reported use of a cycle menu. The length of the cycle varied from one week in three hospitals to 12 weeks in two hospitals. The four-week cycle was used more frequently than any of the other cycles mentioned. In 10.2 per cent of the hospitals, menus were planned one at a time and in four other hospitals, the administrator was unaware of the length of the menu cycle.

Cycle menus, ranging from 2 to 7 weeks were in use in only 18 of the 152 hospitals surveyed by Lofquist and co-workers (31). Jolin and McKinley (27) reported that 29 per cent of the hospitals studied used cycle menus which were for four weeks or less. Selective menus were used for patients on general diets in 34 per cent of the hospitals included in the study. In 19 per cent of the participating hospitals, menus were planned less than one week in advance.

The use of standardized recipes aid in portion and cost control. Standardized recipes were reported in use in 48.7 per cent of the 39 hospitals included in this survey. Of the remaining hospitals, 41.0 per cent did not use standardized

recipes and 7.7 per cent stated that standardized recipes were used to some extent. One consultant indicated that the dietary department was in the process of standardizing recipes.

In the study by Blumenthal (13), 89 per cent of the hospitals under 200 beds reported using standardized recipes. Standardized recipe files assist in work planning and food purchasing. Written purchasing policies were reported in use in 42 per cent of the hospitals studied by Blumenthal (13).

In 53.8 per cent of the hospitals participating in the present study, the food was purchased by the food supervisors. Two dietary or kitchen supervisors did the purchasing of food in 5.1 per cent of the hospitals. Dietitians and home economists were responsible for the purchasing in 23.0 per cent of the hospitals and the hospital administrator in 7.7 per cent. An executive housekeeper, two registered nurses, an administrator-cook-manager team, and a consultant-supervisor team purchased foods in the remaining hospitals.

The specification of foods to be purchased provides an index to the quality and quantity desired. Only nine hospital administrators and one dietary consultant reported using specifications for purchasing. One of the administrators stated that there were specifications, but doubted if such a tool

were actually used; whereas, two consultants reported that specifications were used to a certain extent.

When asked about the use of convenience foods in the dietary department, hospital administrators and dietary consultants responded as follows:

Amount of Convenience Foods Used	Hospital Administrators Number	Dietary Consultants Number	Total Number
None	3	2	7
Very little	18	3	21
Vegetables only	2	1	3
Desserts only	2	1	3
25 per cent	0	1	1
50 per cent	2	1	3
80 per cent	1	0	1
Total	30	9	39

Convenience foods were reportedly used to a very small extent by 53.8 per cent of the hospitals; whereas, 17.9 per cent of the hospitals stated that no convenience foods were used. Three of the hospitals used convenience foods in the form of vegetables and desserts only. One hospital reported that 80 per cent of the foods purchased were convenience items. The hospital reported to use the highest proportion of convenience foods also reported 21.5 labor minutes per meal. It is inconceivable that a 26-bed hospital utilizing

80.0 per cent convenience foods would use 21.5 labor minutes per meal. Either the dietary department was overstaffed or the hospital administrator may have misunderstood the meaning of "convenience" as applied to food items.

Foods were reported to be purchased from both wholesalers and retailers by 56.4 per cent of the hospitals included in the study; 30.7 per cent indicated purchasing from wholesalers only and the remaining 12.8 per cent of the hospitals were said to purchase foods from retailers only. The study by Lofquist and others (31) revealed that in hospitals of less than 30 beds, foods were purchased from retail markets. In the present study, all administrators purchasing from retailers mentioned that it would be more economical if foods were purchased from wholesalers. However, purchases were made from local retail merchants in order to satisfy local interests and maintain good public relations in the community.

Based on data received from administrators and consultants, the use of modified diets varied from practically none in two of the specialized hospitals to 90 per cent in two other hospitals of 25 and 35 bed capacity. Data submitted

by hospital administrators and dietary consultants are shown below:

Use of Modified Diets (Percentage of total)	Administrators	Dietary Consultants	Total
	Number	Number	Number
Practically none	2	0	2
10-20	3	0	3
21-30	9	1	10
31-40	3	4	7
41-50	6	3	9
51-60	1	0	1
61-70	1	0	1
71-80	1	0	1
81-90	2	1	3
Not known	2	0	2
Total	30	9	39

Responses to the question concerning the use of modified diets revealed that in 10 hospitals modified diets accounted for 21 to 30 per cent of the total diets served; 41 to 50 per cent of the total in nine hospitals; and between 31 and 40 per cent of the total diets in seven hospitals. The overall mean for the reported used of modified diets was approximately 36 per cent of the total diets served.

The Minnesota survey by Lofquist and others (31) showed that in hospitals employing dietitians, the percentage of modified diets was slightly higher. In the present study, the

the investigator found no apparent relationship between the employment or non-employment of a dietitian and the percentage of modified diets prescribed. The study conducted by Jolin and McKinley (27) revealed that the average number of modified diets represented 24 per cent of the total diets served.

Twenty-two administrators and seven dietary consultants (or 74.4 per cent of the 39 hospitals) reported that patients were visited concerning food preferences; two administrators stated that the patients were visited when there was a feeding problem. One administrator stated that only patients placed on special diets were visited and one dietary consultant reported the periodic visiting of the patients. Three administrators and one consultant indicated that patients were not visited. One administrator did not respond to the question.

In the study by Blumenthal (13), 75 per cent of the hospitals reported that patients were not visited by the food service personnel. Blumenthal emphasized that direct communication with patients is virtually the only way that personal likes and dislikes can be determined and without such conferences, the food service cannot be planned to meet the taste of individual patients.

In 61.5 per cent of the hospitals investigated in the present study, the trays were served to patients by the nursing

service. In 33.3 per cent of the hospitals, the dietary personnel served the trays to the patients. Both dietary personnel and nursing service were reported by one administrator to serve the trays to the patients. In one specialized hospital, dietary employees were designated to serve the breakfast trays and the patients ate dinner and supper in the dining room. In about 80 per cent of the hospitals investigated by Lofquist and others (31), supervision of tray service was the responsibility of the nursing staff.

The food was transported to patients by use of the combination heated and refrigerated cart in 43.5 per cent of the hospitals taking part in this survey. Only 7.7 per cent of the hospitals were reported to use the open cart with the heated pellet system. One administrator stated that the pellet system was used with a closed cart to transport the food. Food was reported to be transported in an unheated, closed cart by 7.7 per cent of the hospitals and by an open cart in 30.7 per cent of the hospitals. Trays were said to be transported individually, by hand, in two hospitals.

Administrators and consultants stated that meals were served to dietary employees in all the hospitals surveyed. Staff meals were reported to be served in 79.7 per cent of the hospitals and visitor meals were reported to be served

in 64.1 per cent of the 39 hospitals included in the study. The average number of meals served per day per hospital may be seen below:

Group Served	Bed Capacity			All Hospitals
	<30 Meals	30-39 Meals	40-50 Meals	Meals
Patients	58	88	111	86
Employees	5	30	24	20
Staff and visitors	23	18	22	20
Total	86	136	159	126

According to administrators and consultants, the average number of meals served per day for the 39 hospitals was 126 meals. The overall number of meals per day average for all hospitals included in the study ranged from 24 meals for a 10-bed hospital to 180 meals for a 50-bed hospital. Data from the 39 hospitals revealed that the average number of patient meals per day was 86; the average number of employee meals and staff and visitor meals was 20 per day for each of these two groups.

Practically all of the administrators reported that the patients had very few complaints concerning the food or the service of the food. In two hospitals, complaints were reported to come from patients on special diets. In eight

hospitals, the administrators stated that comments from patients were very complementary. Complaints of patients were listed by eight dietary consultants and included the following: cold food, cold coffee, tough meat, food dislikes such as salmon and liver, absence of salt on salt-free diets, cold foods were not cold enough, supper scheduled too early and the desire to select one's own diet.

Administrators and dietary consultants were asked to express personal opinions about the attitudes of patients, the nursing personnel and the medical staff toward the food service. Responses were summarized in Table IV. All 30 of the administrators and the nine dietary consultants indicated that the attitudes of the medical staff appeared favorable. The percentage of the administrators and dietary consultants rating the attitudes of the patients as favorable was 92.3 per cent, with only 7.7 per cent rating the patient's attitudes as unfavorable. The attitudes of the nursing staff toward the food service was rated as favorable by 89.7 per cent of the administrators and consultants and as indifferent by 10.3 per cent.

The administrators and dietary consultants were asked to give an overall rating of the dietary department. The ratings are shown in Table V. Twenty-five administrators rated the dietary department as satisfactory, four rated it

TABLE IV

ATTITUDES OF PATIENTS, NURSING PERSONNEL AND THE MEDICAL STAFF TOWARD THE FOOD SERVICE IN HOSPITALS OF 50-BED OR LESS CAPACITY AS RATED BY HOSPITAL ADMINISTRATORS AND DIETARY CONSULTANTS

Attitudes	Patients		Nursing Personnel		Medical Staff	
	Number	Per cent	Number	Per cent	Number	Per cent
Favorable	36	92.3	35	89.7	39	100.0
Indifferent	0	0.0	4	10.3	0	0.0
Unfavorable	3	7.7	0	0.0	0	0.0
Total	39	100.0	39	100.0	39	100.0

TABLE V

ATTITUDES OF HOSPITAL ADMINISTRATORS AND DIETARY CONSULTANTS TOWARD THE FOOD SERVICE IN HOSPITALS OF 50-BED OR LESS CAPACITY AS RATED BY HOSPITAL ADMINISTRATORS AND DIETARY CONSULTANTS

Attitudes	Ratings of Administrators		Ratings of Dietary Consultants	
			Attitude of Administrator	Personal Rating
	Number	Per cent	Number	Number
Favorable	0	0.0	9	0
Excellent	0	0.0	0	4
Very satisfactory	4	13.3	0	0
Satisfactory	25	83.4	0	4
Needs improvement	1	3.3	0	1
Total	30	100.0	9	9

very satisfactory and one explained that it needed improvement. All nine dietary consultants reported that the attitudes of the administrators appeared to be favorable toward the food service. Four dietary consultants rated the food service as excellent, four rated it satisfactory and one pointed out that improvement was necessary.

When administrators were asked how the food service could be improved, five reported that no suggestions for improvement could be made at the present time. Twelve administrators reported that more space was necessary and 10 stated that additional and more efficient equipment would improve the food service. Three administrators expressed a desire for patients to be able to select the diet and three other administrators indicated interest in having the dietary consultant set up a budget. Three administrators expressed the need for employees to develop a better understanding of the preparation of modified diets. In two hospitals, the administrator pointed out that physical examinations for the dietary employees were of prime importance. Areas as named by only one administrator were: relocation of the dietary department, charting, a dietary training program, better communications between dietary and nursing personnel, utilization of disposables for the evening meal in order to help alleviate the labor problem, improved menu planning by the dietary

consultant and more efficient supervision in the dietary department. One other administrator expressed the need for the dietary consultant to develop a working knowledge of food service management.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The overall purpose of the present study was to obtain an evaluation of dietary departments from hospital administrators and dietary consultants in American Hospital Association-registered hospitals of 50-bed or less capacity in Louisiana. The specific purposes of the survey were to:

1) Identify problems in the dietary department as viewed by hospital administrators and dietary consultants;

2) Investigate the opinions of dietary consultants as to the adequacy of the time alloted to the duties and responsibilities of the dietary department as outlined by the American Dietetic Association, and

3) Establish criteria to serve as guidelines to staffing needs in hospitals of 50-bed or less capacity by determining the labor minutes per meal.

Two survey forms, "Evaluation of Dietary Department by Hospital Administrator" and "Evaluation of Dietary Department

by Dietary Consultant" were used to collect the data. Each survey form was divided into four general categories: general information concerning the dietary department, personnel, the physical facility, and the service of food.

Personal interviews were conducted with 30 hospital administrators and survey forms were mailed to 18 dietary consultants of which nine usable replies were received. Data furnished by administrators and consultants were, wherever possible, combined for the purposes of data analysis.

General information concerning the dietary department was requested. All of the hospitals investigated were registered by the American Hospital Association. According to administrator, 23 hospitals were Medicare-affiliated. Of the 39 hospitals investigated, 74.4 per cent were community hospitals, 23.0 per cent were private and one was a city hospital. Thirty-seven hospitals or 94.9 per cent were classified as general and two hospitals were specialized. The mean bed capacity for all the hospitals reporting was 34.2

Hospitals with budgets represented only 20.7 per cent of the hospitals, or one in five. There were policy and procedure manuals available for dietary personnel in 84.8 per cent of the hospitals; 97.4 per cent of the hospitals had diet manuals for the dietary personnel; and 79.7 per cent of

the hospitals had diet manuals available for the medical and nursing staff.

In response to the question of whether or not a dietary consultant was employed by the hospital, 25 administrators reported retaining the services of a consultant. The hours of visitation ranged from eight per month to full-time employment. Dietary consultants indicated that sufficient time was alloted to successfully perform the duties and responsibilities in the dietary department as outlined by Medicare and the American Dietetic Association.

The average number of man-hours per day per hospital for dietary personnel, according to 30 administrators and eight dietary consultants, was 38.5. The number of meals served per man-hour was 3.3, and the average bed capacity per dietary employee for 38 hospitals reporting usable data for this item was 6.0 beds. The average number of labor minutes per meal served was 18.1 minutes.

In 22 of the 39 hospitals, or 56.4 per cent, administrators and consultants reported that the food service supervisor was responsible for the dietary department. Administrators were reported to be responsible for the food service department in 10.2 per cent of the hospitals; home economist were responsible in 7.7 per cent; and dietitians

were responsible for the food service department in 5.1 per cent of the hospitals. Cook managers were responsible for the food service department in two hospitals. The individuals responsible for the food service departments in the four remaining hospitals were a kitchen supervisor, a dietary supervisor, a registered nurse and an executive housekeeper.

The existence of a training program in the dietary department was investigated. Administrators and consultants indicated that 56.4 per cent of the hospitals had a functioning training program in the dietary department.

Areas of possible strengths and weaknesses of the employees were investigated. Six consultants listed food preparation techniques and one consultant named accuracy of food production as areas in which employees were especially strong. The area of weakness mentioned most frequently by both administrators and consultants was a lack of understanding of special diets by dietary employees.

Physical examinations were required in 38 hospitals. In one of the hospitals in which physical examinations were required, the consultant reported that physical examinations were given upon employment, after which, only routine x-rays were required.

Sixty-four per cent of the administrators reported satisfaction with the performance of the consultant. Areas in which the administrators expressed needing more assistance from the dietary consultant were: personnel teaching, visiting the patient, planning of budgets, compilation of policy and procedure manuals, and better menu planning. One administrator emphasized the need for the consultant to develop a working knowledge of food service management.

The adequacy of the physical facility was investigated. According to administrators and consultants, the most adequately equipped area was the food preparation area, named by 71.8 per cent of all hospital administrators reporting. Less than one-half, or 48.7 per cent of the hospitals were reportd to have adequate space. Equipment was said to be systematically replaced in only 38.4 per cent of the 38 hospitals reporting. At least one item of equipment was reported not in use in 25.6 per cent of the hospitals. Equipment not in use included two each of potato peelers, steamers, steam-jacketed kettles and large ovens.

An inquiry was made into the availability of office space for the dietary consultant and/or supervisor. All of the administrators and seven of the eight consultants reporting revealed that an office or a desk was available for paperwork to be done.

Sanitation techniques were investigated. Most of the participants, 94.9 per cent, were reported to be satisfied with the employee's performance, even under adverse circumstances. Two individuals explained that there was a need for improvement in sanitation techniques. The local or state sanitarian was reported to visit the facility once each month, and 1 to 3 times per year in the other facility.

Factors relating to the service of food were investigated. Menus were reported to be planned by the dietary consultant in 61.5 per cent of all the hospitals, by the food service supervisor in 23.0 per cent, by a consultant-supervisor team, a cook-manager or a registered nurse in the remaining hospitals.

Selective menus were reportedly used by 97.4 per cent of the institutions. Cycle menus, with an average cycle length of four weeks, were reported to be used in 79.7 per cent of all the hospitals surveyed. Standardized recipes, according to responses of those participating in the study, were used in 48.7 per cent of the hospitals. In 53.8 per cent of the hospitals food was purchased by supervisor of the dietary department. In the remaining hospitals, food was purchased by consultants, administrators, a registered nurse, a consultant-supervisor team or an administrator-supervisor team. Only nine administrators and one consultant reported

using specifications for food purchases. Convenience foods were reported to be used by only a few hospitals. Modified diets represented an average of 36 per cent of the total diets served, according to data furnished by the participants.

In 61.5 per cent of the hospitals investigated, the trays were served to patients by nursing personnel. In the remaining hospitals, trays were served by the dietary personnel. The combination heated and refrigerated cart was used in transporting trays to patients in 43.5 per cent of the hospitals investigated. The open cart was reported to be used in 30.7 per cent; in 7.7 per cent, the open cart with pellet system; and in the remaining hospitals, trays were transported by unheated closed cart or by hand.

Meals were reportedly served to employees in all the hospitals surveyed; staff meals were served in 79.7 per cent and visitor meals were served in 64.1 per cent of the hospitals. The average number of meals served per day for all hospitals included in the study was 126.

Administrators and consultants listed very few complaints by patients. Complaints listed included cold food and coffee, tough meat, absence of salt on salt-free diets and the desire to select one's own diet.

Administrators were asked to rate the attitudes of the patients, medical staff and nursing personnel toward the food service. The attitudes of patients were rated as favorable by 92.3 per cent of the participants in the study; and as unfavorable by 7.7 per cent. The attitudes of the nursing personnel were rated as favorable by 89.7 per cent and as indifferent by 10.3 per cent of the participants. All of the administrators and consultants rated the attitudes of the medical staff as favorable. The nine consultants participating in the study rated the administrators' attitudes as favorable.

When commenting on their own attitudes, 25 administrators expressed satisfaction with the food service, four rated the dietary department as functioning very satisfactorily and one administrator stated that it needed improvement. Four dietary consultants rated the dietary department as excellent, four rated it satisfactory and one stated that it needed improvement.

Areas of improvement and/or suggestions pointed out by the participants included more space and better equipment, selective menus, a better understanding of special diets by dietary employees, more teaching of patients, planning budgets and the necessity for the consultant to develop a working knowledge of food service management.

The survey was developed to investigate the presence or absence of various factors pertinent to high standards of food service based on previous research. Even though a food service department may exist on a daily basis, without effective policies and procedures improvement and progress cannot be determined. In future studies, a larger sample of dietary consultants and the participation of patients might increase the validity of the data.

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