

ABSTRACT

A Study for the Establishment of Higher Foodservice Standards in Health-Care Facilities

by

Shira L. Bush

1. Area of Investigation

The relative need of higher standards in health-care foodservice facilities. Individual opinions of foodservice directors.

2. Materials and Methods Used

Existing text, trade publications, interviews with industry leaders, conferences with esteemed professors and the author's own experience were used for research and evaluation.

An important method used to evaluate the need for higher standards was a descriptive survey and the analysis thereof.

3. Major Findings

A. The survey showed, with a 42 percent response, that the overwhelming majority of the respondents have problems within their department.

- B. It is presumed that these problems are caused by a lack of standards and/or a failure to meet existing standards.

4. Results and Conclusions

- A. The objectives of the majority of health-care facilities is to provide the best possible care at lowest possible price. The objectives of the foodservice department is to provide the best possible food at the most reasonable cost.
- B. Continuous education of foodservice directors in all facets of the industry are necessary so that each foodservice director has the capacity to establish and maintain, and in some cases surpass his or her own standards.
- C. Where no standards exist minimum requirements should be set to satisfy the objectives and goals of both the facility and foodservice department.

A STUDY FOR THE ESTABLISHMENT OF
HIGHER FOODSERVICE STANDARDS
IN HEALTH-CARE FACILITIES

by

Shira L. Bush

A thesis submitted in partial fulfillment of the
requirements for the degree of
MASTER OF SCIENCE

in

School of Hospitality Management

at

Florida International University

Committee in charge:

Professor Donald Greenaway Chairperson

Professor Mickey Warner

August 1983

To Professors Greenaway and Warner:

This thesis, having been approved in respect to form and mechanical execution, is referred to you for judgment upon its substantial merit.

Dean Anthony G. Marshall
School of Hospitality Management

The thesis of Shira L. Bush is approved.

Professor

Major Professor

Date of Examination: August 5, 1953

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INTRODUCTION

The Statement of the Problem

The purpose of this study is to develop and establish standards for food service departments of health-care facilities in the South Florida area.

The Hypothesis

The hypothesis for this study is that there is a need for the establishment of higher standards in the food service departments of health-care facilities in the South Florida area.

The Delimitations

This study will not address itself to the nutritional and dietetic services provided by hospitals in the South Florida area.

This study will offer methods to raise the standards of the food service departments of hospitals in the South Florida area.

The Assumptions

The first assumption. The first assumption is that people will continue to become ill, and there will always be those in hospitals, who will be in need of food service.

The second assumption. The second assumption is that there is a need and desire to improve the standards of food service and food service quality in the hospitals in the South Florida area.

The Importance of the Study

In the absence of substantial material on the subject, this study of the standards and the possibility of raising those standards in the health-care food service departments of the South Florida area are self-evident.

The importance of this study can be very obvious if one has been a patient of any hospital in the South Florida area. Although some hospital dietary departments are well staffed and well conducted, there is a great deal of room for improvement.

Many times the author has heard the expression, "There goes a real pro." As the industry approaches the beginning of a new age in the health-care food service, it is important the management look closely at what it means to be a professional--both for ourselves, our employees, and our colleagues. For it is in the health-care food service industry that the opportunity exists for professionals at every job level.

It is important that the industry recognizes all those who qualify. It is important that management create a climate for individuals to realize their potential abilities. That goes for the food service director, supervisors, chefs, cooks, dietitians, and all food service workers. Likewise, it is important that the researcher meet high professional standards.

Achieving professional excellence in health-care food-service is predicated on academia but also rests heavily

upon the individual's grasp of the large body of knowledge relating to the field, the ability to approach his work at a high level of creativity rather than in a routine manner, and the presence of a code of ethics to govern his performance. It is in meeting these challenges that distinguishes the professional from the amateur.

As in other fields the body of knowledge pertaining to the health-care food service industry has increased in geometric proportions. The author can recognize the professional as the one who makes the point of keeping abreast of the myriad of new products, equipment, and techniques being developed.

Most people will agree that of the professional criteria mentioned above, the need for development and adherence to a code of ethics for the food service industry is the mark of the professional which is perhaps most frequently found lacking. The researcher would suggest that a set of quality standards is even more sorely lacking and has a higher priority.

This is evidenced by the many food service management companies that are offering training programs for potential management personnel entering the health-care field. Predictions have indicated future expansion of food service management companies into the food service industry.

The fact that no accepted set of standards exists in the South Florida area is further evidence of the importance of this study.

PART I

The health facility that cares for the ill... must realize that a good food program is essential for adequate care and the facility must give food proper emphasis in its care program. A failure to do this may negate all other efforts to provide needed care. All the values food can give--nutritional, psychological and social--must be utilized to a maximum degree. 1.

A Historical Overview

The feeding of hospital patients has always posed and still poses special problems not encountered in other institutional feeding situations. Many of these problems arise from the fact that the patient did not come to a hospital in order to dine. The patient's appetite and attitude is often altered as a consequence of their illness. In addition, many patients are restricted to diets that have been modified in many different ways. Consequently, special effort and special standards should be established to improve the acceptability of hospital food and food service.

Little or no attempt was made in early times to provide therapeutic diets. Menus in an eighteenth-century hospital in this country included mush and molasses for breakfast on Monday, Wednesday, and Friday, varied by mush

¹Lendal H. Kotschevar, Ph.D., Foodservice for the Extended Care Facility, (Boston, Massachusetts: Cahners Books, 1973), p. 3-4.

and molasses for supper on Monday, Wednesday, Thursday, and Saturday. Oxtail soup and black bread appeared on occasion. 2

In the year 1804, milk, butter, pork, soup, and hay were produced on this hospital's grounds and consumed therein. The matron, among her accomplishments, made rose water for which the sum of \$53 was received. Numerous cows, calves, and pigs were sold. Patients paid the hospital for their funeral charges. . On the debit side we find the sum of \$350 paid for nine months' salary to Francis and Hannah Higgins as steward and matron. It required 1,280 pounds of candles at a cost of \$182 to furnish light, and \$40 rent was paid to pasture the cows. A year's tobacco cost \$2.89. For a hospital population of 419 hospital cases for the year, 838 gallons of molasses, 254 gallons of brandy and spirits, 269 gallons of wine, and 24½ barrels of beef were consumed, among items listed under liquors. 3

During the Crimean War, a beginning was finally made toward the establishment of dietetics as one of the services of a hospital. Through the efforts of Florence Nightingale, a diet kitchen was set up in 1855 to provide clean, nourishing food for wounded soldiers:

The ill-cooked hunks of meat, vilely served at irregular intervals, which had hitherto been the only diet for the sick men were replaced by punctual meals, well-prepared and appetizing, while strengthening extra foods--soups and wines, and jellies ("preposterous luxuries," snarled Dr. Hall)--were distributed to those who needed them. One thing, however, she could not effect. The separation of the bones from the meat was no part of official cookery: the rule was that the food must be divided into equal portions, and if some of the portions were all bone--well, every man must take his chance. The rule, perhaps, was not a very good one; but there it was. "It would require a new Regulation of the Service," she was told, "to bone the meat." 4

²Bessie West, et al., Foodservice in Institutions, (New York: Wiley & Sons, Inc., 1977), p. 17.

³Ibid.

⁴Ibid.

In the following 50 years, progress and changes in hospital foodservices include the introduction of centralized tray service, mechanical dishwashing, the use of a separate kitchen for special diet preparation and then the elimination of such a room with the advent of frozen foods and their use in the menus, and the greater control in all areas of operation.

In addition, the segregation of staff and workers into separate dining rooms at mealtime has given way in most hospitals to the more economical plan of a common dining room. Also, pay-cafeteria for staff and employees was introduced during this period.

Standards - An Overview

Hospital foodservice departments may take either a centralized or a decentralized form. Under the centralized form, food is prepared and placed on each patient's designated tray in the production area. Ward personnel just transport and deliver it. This arrangement gives dietary personnel more control over the food and financial aspects. It usually results in monetary savings and fewer errors. In decentralized operations, bulk food is sent in heated carts to the ward or floor where it is served in portions and distributed to each patient by a nurse or dietary aide.

Food preparation in hospitals was generally divided into house or general foods and therapeutic foods. Special diet kitchens, in some situations are staffed by different

workers who prepare the therapeutic diets, while the food for ambulatory patients, patients eating regular diets, and staff members is prepared in a separate area. A combination of these areas has since taken place in most hospitals, and some have instituted central-commissary-type operations. In these the food is prepared in one place for a number of hospitals. After it is delivered, final preparation, heating, and serving are done at the particular hospital. Some institutions have switched to convenience food trays for all patients, on both regular and special diets: frozen or chilled items are delivered to a particular ward or room to be heated by microwave or reconstituting equipment and served to each patient. Disposable dishes and utensils are often used with this form of service.

The projected development of the health campus, in which all forms of medical care are centralized, suggests further changes in food production organizations. It seems to call for even greater use of central-commissary-type personnel equipment, and cost-control procedures.⁵

Today, with the growth of the microwave and other types of ovens, the decentralized system encourages a standard of laziness and at best, tepid food. Thus, the stigma of "phooey food" is reinforced simply because the patients' trays are assembled in a central kitchen while the food is still in the chilled state.

⁵William J. Morgan, Jr. Supervision and Management of Quality Food Preparation, (Berkeley: McCutchan, 1974), p. 22.

The feeding of hospitalized patients poses special problems not encountered in other institutional feeding situations. Many of these arise from the fact that patients' appetites and moods are often altered as a consequence of their illness. Also they experience lowered levels of physical activity and the administration of medications. In addition, many patients are restricted to diets that have been modified by the removal of condiments or to diets low in calories, cholesterol and so forth. Consequently, special efforts should be made to improve the acceptability of hospital food and foodservice to ensure that the food served to the patient is eaten.⁶

Standardization of recipes is very important. Standardization assures the patient and the hospital of the same palatable product each time it is served. Also, it assures the foodservice director that his food cost will remain stable (allowance for inflation must be made). This condition is mandatory in calculating yield and cost for a greater degree of accuracy.

In today's world, there is virtually no major field or blue chip company not already tied to computer technology. Computers are writing diets, menus, controlling inventory, purchasing slabs of beef and cans of tomatoes, recording sales and meals-per-man-hour and so forth. By a foodservice director just punching a few keys on his/her desktop CRT (cathode ray tube) terminal, the necessary information can be called up out of the computer's memory files. Standards are necessary even for these magical metal machines.

Hospital patients' overall attitude toward their food

⁶Owen Maller et al., "Consumer Opinions of Hospital Food and Foodservice," Journal of the ADA, 76, March 1980, p. 236.

in the hospital will vary with the ways in which the food is prepared and delivered. The problem arises when a person is admitted to a hospital, possibly for the first time, receiving a balanced diet. The problem is more acute when one or more of the patient's favorite foods is removed from his prescribed hospital diet. For example, salt is a common item restricted in some hospital diets, and to this change comes immediate cries of tasteless food. The same thing happens when a patient is restricted from the use of either sweets or oils, as occurs in a low fat diet.⁷

It is desirable to establish previously mentioned standards it is necessary to return to the basics of management.

For the purposes of this study, we shall cite the five principles as planning, organizing, directing, staffing, controlling.

Planning is deciding in advance what to do, how to do it, when to do it, and who is to do it. Planning bridges the gap from where we are to where we want to go.

Organizing puts structure into the plan by which the foodservice director will establish the standards that are necessary within his department.

Directing is assigning specific resources to accomplish specific tasks as required. Directing is running the organization on a day-to-day basis.

⁷Interview with Herbert S. Lowe, Executive Chef, retired, Miami, Florida, March 18, 1983.

Staffing is filling the roles within an organization so that the objectives of that organization may be professionally achieved.

Controlling is the measurement and correction of the performance of activities of subordinates in order to ensure that the organization's objectives and plans are being accomplished.

The cost of food combined with the cost of labor make up a vast majority of the dietary budget. This goes without saying. It is necessary that controllable standards be established in purchasing and in receiving of both food and non-food products. Procedures in purchasing and receiving must be standardized so that a foodservice director may get his monies worth, eliminate pilferage and assure himself of fresh, unspoiled and quality food products.

Most hospital administrators have undertaken the concept of marketing to improve the image and reputation of their hospitals as well as marketing to patients and to physicians.

In the context of the health care system, the marketing concept pinpoints managements' responsibility to determine the wants, needs, and values of a target market or markets and to shape the institutional system so that it can respond to these. Thus, contrary to the erroneous conceptions of many, marketing in its true sense does not seek to create a demand for particular services and products. Rather, marketing entails the modification and/or redefinition of a service-providing institution to meet the demands of (respond

to) its target markets.

As a subsystem of the total hospital-system, the food-service department must apply modern business standards, in order to achieve efficiency and thus contribute to the overall quality of the services.

In addition to the previously mentioned standards, the raising of minimum requirements in other phases of the department's operation are mandatory. Among these phases are delivery systems, menus, recruiting and personnel management, budgetary, food production and standards of supervision, safety and sanitation.

These subjects shall be expanded upon further into this study.

Standards--The Patient's View

Food is finally getting the important role it should have had long ago.

The fact of the matter is that no patient enters a hospital for the purpose of dining. It behooves dietary departments to provide a pleasurable dining experience. To this end the means of coping with this need must be developed. However, these means must be more than just means to an undefined end.

If the hospital patient is generally pleased with his food, his outlook will improve. Conversely, the patient who is unhappy with the food will also tend to be unhappy with the hospital stay and thereby--nothing will cause him to be satisfied. The latter situation of the patient eating less

can therefore impede his recovery.

The importance of the food we eat for good health and physical fitness is no longer questioned.⁸ Today nutrition is finally beginning to be recognized as an important factor in the treatment and convalescence from almost every disease.⁹

Today more and more foodservice departments are catering, whenever possible, to the patients' gastronomical whims. Several hospitals are now producing "gourmet" menus with such entrees as filet mignon, veal condon bleu, stuffed flounder, and African lobster tails. These entrees carry with them an extra charge, which patients are gladly paying to avoid "hospital food," that carries a negative connotation.

Hospital food the world over can be described in most cases with one word. That word is "phooey." Everyone in every hospital blames the personnel of every dietary department for unenjoyable food, but perhaps there is a better way to reverse this stigma. If one spends any time at all in any hospital cafeteria, one will hear the constant griping of doctors, nurses, technicians, orderlies, and clerical employees. This is how the stigma of hospital food was created. When employees are dissatisfied with their lunches or their dinners, they let everyone know; thus even the patients, whether they have eaten or not, dislike the food.

⁸Dorothy L. Callahan, ed. Focus on Nutrition (Massachusetts: Department of Education, 1970), p. 3.

⁹W.H. Sebrell, Jr. American Journal of Clinical Nutrition, XV no. 11, 1064.

This problem can be overcome by making the professional and ancillary personnel of every hospital aware of the problems and the difficulties endured by the dietary department.

The "Outpatient" Client

To survive, a hospital needs patients. Patients were always considered people who were in the hospital. For the first time in history, hospitals are now competing for patients. That competition has been the impetus for many hospitals to establish clinics in the community as well as step up the outpatient services in the hospital. Increasing their competitive edge, hospitals are offering more ancillary services and because of that more people are walking into the hospital. It is to those people who walk in and out that the foodservice director must address himself.

But there is an important difference between these people and the patients and staff of the hospital. The people who walk in can easily walk out when it is time to eat. For the first time, the hospital foodservice director does not have a totally captive audience.

So what can the hospital foodservice director do?

The first thing is to begin considering his/her operation as a restaurant rather than only a hospital dietary department. Today's foodservice director must live by a new credo: The only one who knows that the cafeteria is an institutional foodservice is the foodservice director.

Many foodservice directors rarely leave the kitchen. If they do they venture out into the cafeteria with great trepidation. This is wrong. The foodservice director should walk through the cafeteria regularly as a customer, noticing those things that a customer notices.

The foodservice director must arrange standards than can be directed toward both in- and out-patients. The following questions should be asked as they apply to either market:

Is the entranceway attractive? Is the cafeteria cheerful? It's time for giving serious thought to what your cafeteria looks like.

Are the menu boards easily visible yet eye-appealing? The black-and-white menu board is not always the best answer.

What does the food look like? Would you eat it? A good test is to take a tray and move down the line. If you don't like the way a dish looks, note it and change it.

Are the food selections appropriate? For instance, maybe it is time to stop serving only canned fruit and try more fresh fruit. Gelatin cubes piled in a dish may sell better if they have some pizzazz. It is important that the food does not look like cafeteria chow.

What do your employees look like? Are their uniforms neat and colorful? A sloppy uniform can adversely affect the customer's impression of the food.

Do your employees suffer from "department store syndrome?" The salespeople in many department stores have an attitude that "this would be a great place to work if there weren't

any customers." Do your employees give a similar impression?

Standards--Management

The five basic principles of management as defined earlier are necessary standards in every successful business.

The purpose of every plan is to facilitate the achievement of organizational purposes, missions, and objectives. Plans alone cannot make an organization successful; action is required. Plans are necessary for establishing what kind of organization structure will exist, which helps us know what kind of people we need and when we will need them, which affects the kind of leadership we need and the direction we will take, which will tell us how most effectively to lead and direct people in order to assure success of our plans by furnishing standards of control.

In order for people to work effectively towards accomplishing objectives, a structure of roles must be designed and maintained. This is the area of knowledge involved in the managerial principle of organizing.¹⁰

There is a fundamental logic to organizing: (1) establishment of organizational objectives; (2) formulation of derivative objectives, policies and plans; (3) identification and classification of activities necessary to accomplish these; (4) grouping these activities according to human and material resources available and the best way of using them;

¹⁰ Interview with Herbert S. Lowe, Executive Chef retired, Miami, Florida, March 4, 1983.

(5) delegating to one person in each group the authority necessary to carry out the activities; (6) trying these groupings together through authority relationships and information systems.

Directing is concerned with the interpersonal relations of managers and subordinates. Communication is the means by which directing is primarily achieved.

A level of communication must be set so that standards may never necessitate personal interpretation.

The foodservice director will determine for himself and/or herself what relationship he/she will have with the staff. Theory X, Theory Y, and/or Theory Z might be employed, although many veterans of the kitchen will recommend the Teddy Roosevelt maxim.

The managerial function of staffing involves recruitment, selection, placement, appraisal and development of people to fill the roles in the organization's structure. Therefore, staffing is related to organizing. That is, it sets up the intentional structures of roles and positions.

The staffing of organizational roles includes knowledge and approaches not usually recognized by departmental heads who often think of organizing as setting up the structure of roles but give little attention to filling those roles. Making staffing a separate function allows even greater emphasis to be given to the human element in satisfying these roles. Departmental heads often overlook the fact that staffing is their responsibility--not that of the personnel

department.

The managerial function of controlling is the measurement and correction of the performance of activities of subordinates in order to ensure the accomplishment of organizational objectives.

Two major prerequisites must exist before any food-service director can devise or maintain a system of controls. It is obvious that before a control technique can be used, or a system devised, controls predicated on plans, and the more integrated plans are, the more effective controls can be. There is no way that foodservice directors can determine whether their department is accomplishing what is desired and expected unless they first know what is expected.

The second prerequisite is the knowledge of where in the department the responsibility for deviating from plans lies. We must also know when and who is responsible for taking action to make corrections. This second prerequisite of control is the existence of organizational structure. As is the case in planning, the clear, more complete and more integrated this structure is, the more effective control action can be.

The basic control process, wherever it is found and whatever it controls, involves three steps: (1) establishing standards; (2) measuring performance against these standards; (3) correcting deviations from standards and plans.

Standards are by definition simply criteria of performance. In a hospital/commissary foodservice facility

standards by necessity, must be much more. There are selected points in an entire planning program where measures of performance are made so as to give foodservice directors signals as to how things are going without their having to watch every step in the execution of plans.

Standards are of many kinds, as stated herein. Among the best are verifiable goals, missions or objectives, whether stated in quantitative or qualitative terms, regularly set in well operated systems.

If standards are appropriately drawn and if means are available for determining what subordinates are doing, appraisal of actual or expected performance is fairly easy. The foodservice director must be knowledgeable enough to develop accurate standards, even where activities are difficult and hard to measure.

As new techniques are developed to measure, without a reasonable degree of objectivity, the quality of managing will rise.

If standards are drawn to reflect organizational structure and if performance is measured, the correction of negative deviations is expedited. The foodservice director then should know exactly where in his department the corrective measures must be applied.

The cause of negative deviations will often determine whether control measures are possible. Although an incorrect standard may cause deviations, if the standard is correct, plans may fail because of uncertainty, lack of knowledge,

lack of experience, or lack of judgment. One would not believe that a foodservice director would maintain his position if he were guilty of all four points.

Each foodservice director must realize that good management can function in the area of foodservice. The essence of management is that the management themselves must reach an agreement with themselves.

Management must realize that there is a constant wheel of action which is rotating around their department. This wheel carries the feedback of subordinates and middle management back to the policy and decision-makers. If this wheel stops the organization loses productivity and the motivation of its employees is lost. The organization will become stagnant, fail to achieve its objectives and fall by the wayside. In a health-care foodservice facility this must not be allowed to happen.

PART II

STANDARDS

To bring about a mutual understanding and appreciation between management and employees on the goals of the organization and how to achieve them, communication is necessary. Communication involves sending out, receiving and understanding signals representing ideas. The same idea as the one the sender had in mind should occur to the receiver when he receives the signal. It takes skill to do this. Words do not mean the same thing to everyone and other communication signals may also get different responses from different individuals. The spoken word and the written word are the most important ways of communicating.

One of the best ways to achieve good communication is through good listening. Listening is active work; it cannot be a passive, automatic response. A good foodservice director gives his full attention to the person talking, concentrating on what he hears. He knows he can think two or three times faster than the person he is listening to can talk, but the good listener keeps his mind focused on what is being said. He may use the extra time, as he waits for speech to catch up with his thoughts, for evaluating or being sure he is understanding what he hears. He becomes involved; if he does not understand, he asks questions. ¹¹

¹¹Lendal H. Kotschevar, PhD., Foodservice for the Extended Care Facility, (Boston: Cahners Books, 1973), p. 26.

Listening should be done objectively and not with prejudice, moodiness or attitudes that change the meaning of what is being said. Employees stop talking to a boss that can't listen. Soon such an individual may find himself isolated from his employees because they've given up trying to tell him anything.

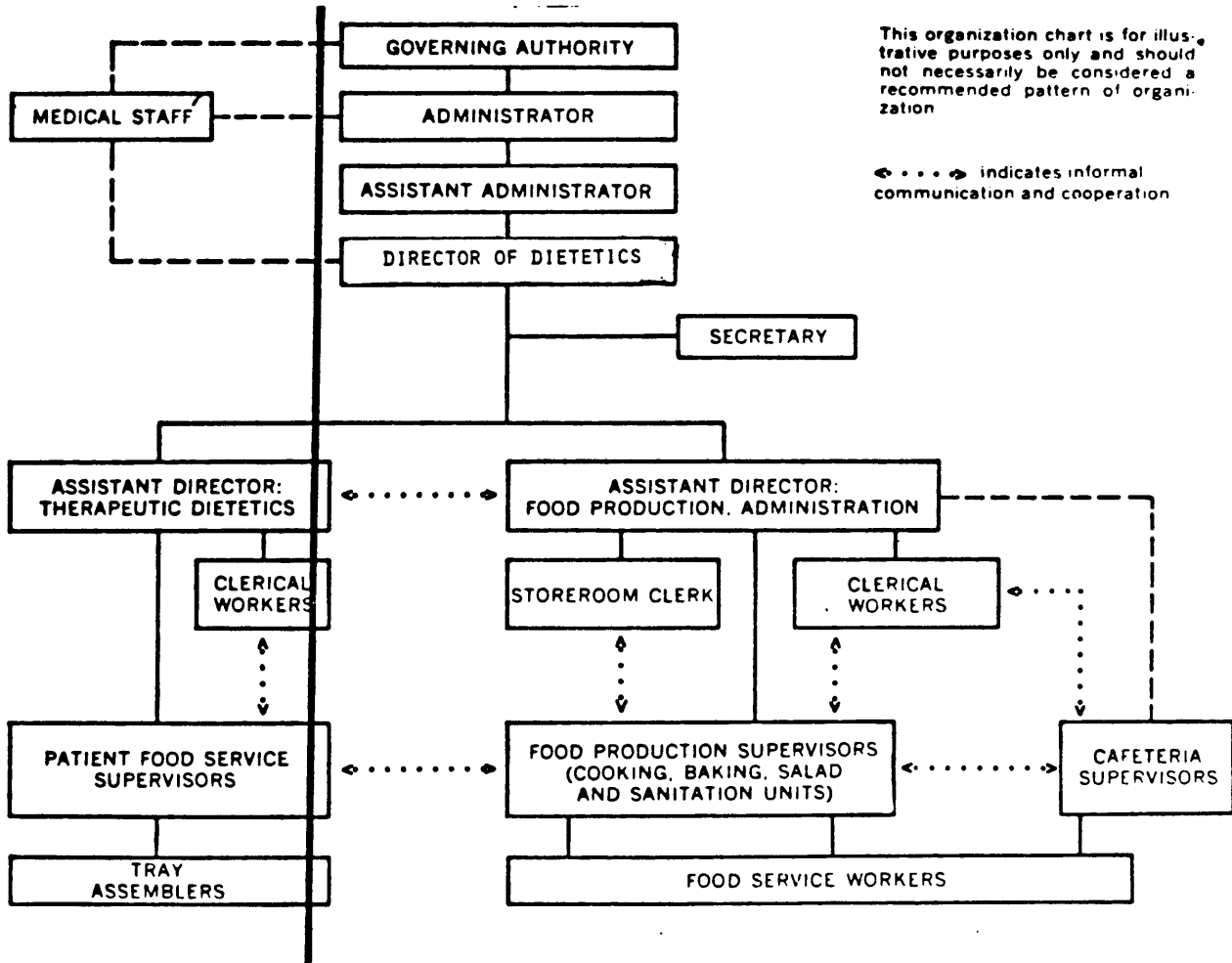
It also takes preparation to be effective when telling something to another person. Use plain, simple words; speak slowly and use voice inflections and gestures that lend emphasis and clarity to what is being said. Do not use generalities when you can be specific. Do not talk down to listeners nor show anger or dislike. Make sure the listener has understood. Do not try to be adamant in situations where there may be a difference of opinion. Choose words carefully. Although the speaker may not be aware of it, some words can sound inflammatory or bluntly contradictory even though the speaker may not have this intent.

Communication requires that one keep informed and take time to read and study written materials relating to organizational matters. Reading, like talking, should be done with full attention. Training can improve reading speed, comprehension and understanding. ¹²

The duties and responsibilities of the food service department head will vary with the size of the facility and with the training and education of the individual. The

¹²Ibid., p. 27

CHART A
 Organizational Chart
 Hospital - Over 100 Beds¹³



¹³Foodservice Manual for Healthcare Institutions, American Hospital Association, Chicago, Illinois, 1966, p. 3.

following description define the qualifications and duties of the department head as depicted in the Chart "A".

The foodservice director is a member of the institutions management team and is responsible to a designated administrator. Duties and responsibilities for this position include the following:

1. Develops long-range and short-range goals and objectives for the department.
2. Develops policies and procedures to attain the stated goals and objectives.
3. Prepares and manages the department budget.
4. Controls department resources through appropriate planning, utilization, evaluation, and data analysis.
5. Develops quality standards for nutritional care, food, and service and evaluates systems to determine department effectiveness.
6. Coordinates clinical and administrative functions to ensure high-quality nutritional care.
7. Administrates personnel policies in accordance with those established for the institution and the department.
8. Develops educational and employee motivational programs.
9. Plans and coordinates all department activities.
10. Plans and implements food service systems, including department layout, patient and nonpatient food delivery systems, and equipment requirements.
11. Maintains effective communication with department personnel, other departments, administration, and the public.
12. Represents various committees of the health care institution, such as the patient reaction/satisfaction committee, nutrition committee, total parenteral nutrition committee, patient education committee, infection control committee, purchasing

standardization committee, internal and external disaster committee, safety committee, shared services/purchasing committee, sanitation committee, cost containment committee, and quality assurance committee.

13. Participates in continuing education activities, such as reading current food service and nutrition journals, and participates in local, state, and/or national education programs.
14. Interprets current information for appropriate application to the food service department.
15. Diligently appraises the quality and cost of food service to patients and non-patients. 14

Application of these principles of management, as well as communication and motivation, are essential for a well conducted foodservice department.

The effective foodservice director recognizes that he or she has at hand a large body of information derived from a variety of disciplines, including sociology, economics, psychology, political science, anthropology, and mathematics. The effective foodservice director also knows that it is part of the job to assimilate this enormous body of knowledge. But because the manager is a practitioner, on an academician who might be interested in knowledge for its own sake, the foodservice director must develop the tools to translate theory into practice. 15

Foodservice director jobs exist because decisions have to be made. Even though much of the work in a food service

¹⁴ Ibid., p.13

¹⁵ Rita M. Numeroff, Practice of Management for Healthcare Professionals. (New York: 1982). p. 3

operation can be organized into routine tasks, there are still day-to-day situational changes that require decisions. Problems develop and need solutions that affect all of the resources of the food service operation. Choosing a course of action to solve a particular problem is an accurate definition of managerial decision making.

When asked how they make decisions, most foodservice directors are likely to reply that they do not really know. Therefore, many foodservice directors enter the job with little instruction or consciousness about a task that constitutes a major part of their job. The process for making good decisions can be learned; largely it involves becoming conscious of some of the things that have been done unconsciously all along.

The foodservice directors responsibilities are synonymous to those of the hospital administrator. Whereby the administrator has the responsibility of motivating his subordinates, so must the foodservice director motivate the members of his department. To this researchers knowledge standards of motivation exist only in textbooks; somehow, in real life, these standards became lost in the scramble for success.

A foodservice director should allow employees to participate as much as possible in making decisions affecting their work. There are four primary levels at which they take part. From the highest level to the lowest, they are:

1. Actually making the decision;
2. Providing recommendation to those who will;
3. Learning from the decision-maker the possible alternatives being considered; and
4. Learning about the decision made.

Many of the decisions made affecting an employee's work will involve the lowest levels of participation by the worker himself. However, if he can participate at higher levels, he is likely to be positively motivated.

Measure the performance of individual employees and/or groups of employees. Performance measurement, together with knowledge of results and recognition, operate to stimulate motivation. Without a job-oriented way to measure performance, there is no sound basis for the other two elements. The system should weigh each factor involved in job performance in accordance with its importance to departmental or company goals. A system which provides less than this may well motivate employees in a wrong direction.

Let the employee know how well he is doing. It is difficult to instill in an individual a desire to maintain good performance or to improve performance if he is in the dark about his past and current performance. Typically, an individual will continue to improve his performance as long as he is kept aware of his progress, but his interest and performance will deteriorate when he no longer is informed.

Recognize superior performance. As mentioned earlier,

recognition assumes a system whereby performance is adequately measured. Recognition given on the basis of a performance measurement system that does not emphasize the critical and important aspects of the job, or one that is generally considered to be unfair, may cause dissatisfaction instead of providing positive motivation.

The most effective ways to recognize many individuals are merit salary increases, promotions and increased responsibility. Their effectiveness, however, depends on the likelihood of receiving them. If remote, their motivational value is probably small. Thus, it may be desirable to supplement these established forms of recognition by a system that regularly provides awards or other recognition to individuals or work groups for superior achievement.¹⁶

Establish communication channels between top management and employees to supplement formal organizational channels. Since the goal of a motivation program is to gain wider acceptance of hospital objectives and create a greater desire to achieve them, the program should provide information about what they are and how the employee can help to attain them. This type of downward communication can be handled through a company newspaper, in-person talks, tours by top management, and closed-circuit television.

Another aspect of communication involves the upward flow of ideas and feelings from employees to top management.

¹⁶Ernest H. Ward, "Elements of An Employee Motivation Program", Personnel Journal, March 1964, p. 178-181.

Formal channels are not always adequate for this. Employee motivation may be improved by providing special channels for such special purposes as employee suggestion systems and the attitude measurement program discussed above.

Although publicity is closely related to communication, it is sufficiently different to be listed as a separate element.

Publicize foodservice department and employee achievements, as well as various aspects of the motivation program to employees. Motivation to work toward hospital goals is influenced by the employees' image of the hospital which is affected, in turn, by publicity. For example, reading about an accomplishment of the hospital from a newspaper article can enhance motivation.

Publicity directly aimed at employee motivation can also be beneficial. Internal reminders such as posters, badges, banners, features in the Hospital House Organ, and pamphlets can help the motivation program by creating a greater awareness of hospital and departmental objectives.

Establish a work-assignment system that insures that the employee's capabilities match the skills required by his work. Little can be done to increase an employee's desire to do better at a job if he has found it to be frustratingly difficult. On the other hand, a challenging job within his capability may itself be motivating in terms of the sense of achievement that comes with a job well done.

An attempt to match the employee and his work optimally requires a continuing study of the abilities required for each job, and measurement of the potential abilities of those being considered for it. Along with this program, research is required to assure that the analysis and measurement techniques used are the most valid available. Many hospitals have used personnel information files and a computer to develop programs specifically for this purpose; in many instances, results have been rewarding. ¹⁷

Each supervisor in the foodservice department should be educated in the factors and practices that enhance employee motivation. Since the supervisor plays an important role in most motivational elements he/she is the key to the success of the overall program. If the supervisor is ignorant of or disregards or neglects factors important to employee motivation, he/she can counteract all the positive elements in the program.

One approach is to systematically train members of the supervisory team about what is and is not important to employee motivation. This will enable the program to eliminate the negative and accentuate the positive influence of supervision.

¹⁷ Ibid., p. 178-181

Standards - The Budget

Fiscal responsibility and accountability are a significant part of the management function in health care facilities. Because all departments are faced with providing high-quality care while controlling rising costs, a sound system of financial planning and control is essential for the operation of an efficient and effective food service department.

Such a system requires written statements of the department mission and objectives, with orderly procedures for attaining them. Furthermore, a system of records and reports is needed for timely documentation, evaluation, and control of the departmental activities and costs. Although there are many techniques for keeping records, it is essential that procedures be standardized sufficiently to permit comparison of actual departmental costs with the operating budget, both within the institution and with other institutions. As difficult economic conditions prevail, the challenge of containing costs while providing expected services will require directors to place top priority on the financial management function.

The major purpose of a well-prepared operating budget is to guide management decisions about departmental activities. Therefore, a detailed plan of work and spending projections must be outlined and broken down into monthly schedules. Data needed to complete these schedules include the following:

- Forecasted patient days and outpatient clinic visits
- Forecasted patient meals and nonpatient meal equivalents (units of service)
- Total wage, salary, and fringe benefit expense for food service department employees
- Total patient and nonpatient food expense, broken out into major food purchase categories
- Total cost of supplies
- Total of all other direct and/or allocated expenses

In order for these data to be meaningful and useful in measuring department performance, unit-of-service costs have to be calculated. These unit-of-service costs include the labor, food, supply, and any other costs per patient meal and nonpatient meal equivalent.

As the budget is prepared, projected costs should be adjusted to reflect predicted inflationary pressures on labor, food, supply, and other expenses. During the actual budget period, projections also may need to be revised if economic conditions fluctuate from forecasted performance. This does not reduce its value as a basis for control, rather it indicates that management is aware of operational performance and business trends.

The problem appears to be that most hospitals and/or their administrators do not consult with foodservice directors when constructing the hospital budget for the coming year. The first task is to list each step in the budget process, highlighting those that either are imposed by others or for some reason are inflexible. The budget process in-

cludes the following steps:

- Prepare statistical assumptions, including, but not limited to, patient days by service, changes in building gross square feet, introduction of new services and projected dates, number of procedures for the major departments (laboratory, radiology, and so on), and number of outpatient visits.
- Prepare economic forecasts that include salary inflation factors; fringe-benefit inflation factors; inflation factors for supplies and other nonsalary items detailed by major expense item and by department; new developments that may affect the hospital, such as additional physicians joining the staff, physicians leaving the staff, additions to other hospitals in the service area, or major clinics under construction; proposed legislation or government regulations, if they are expected to pass or be implemented; and any other factor that might affect the hospital's income or expense during the budget period.
- Distribute budget packages to department heads. These packages will include assumptions, forms, schedules, and historical data for each department. It is best to distribute the packages at a department head meeting and to have at least one hour of formal instruction in budget techniques and accounting constraints.
- Give technical assistance to department heads as they prepare the first drafts of their budget requests. Prepare budget goals and policies for the period. These will constitute an outline of the financial plan. They may include a targeted net gain or loss, a marketing strategy, third party payer strategy, or any other item that has a bearing upon the hospital's finances.
- Obtain approval of budget assumptions, goals, and policies. Depending upon the hospital, this may mean governing board approval, approval by a committee of the governing board, administrative approval, or operating budget committee approval.
- Hold departmental budget hearings. Those present should include the controller, the administrator or assistant administrator, and the department head. It is also a good idea to attempt to have a board member present during each budget hearing. This makes the

department heads feel they have been heard and at the same time provides board members with an excellent opportunity to learn the intricacies of day-to-day hospital operating problems.

- Prepare typed summaries of each budget hearing. This documents promises and statements made between administration and department heads. These summaries will be referred to throughout the year as budget variances are investigated. If the typed summaries include personal observations and impressions of the controller, they should be shared only with administration. If these summaries are rather formal and include only factual information, a copy of each summary can be given to the appropriate department head. The format and distribution of budget hearing summaries will depend upon the preferences of the controller and the administrator.
- Summarize the individual department budgets into a first draft of the master budget. After reviewing this for reasonableness, the controller's department summarizes the total budget into a format to be presented to the board or a committee of the board. This presentation will be enhanced by graphs, descriptive narrative, and comparative historical data.

Each hospital must examine its own budget process, as must each department head. Naturally, this also includes the foodservice director and the foodservice department.

The first document in the hospital's budget process is the budget calendar. This lists the dates of each segment of the budget process, tells who is responsible for the segment, and provides a brief narrative to explain the purpose of the segment and to show how it fits into the total budget process.

The purpose of the budget calendar is to make a plan for the completion of the budget in time to meet outside constraints and to set deadlines.

The major purpose of the budget assumptions is to

share as much information as possible with all departments. That way the entire hospital will be planning on the same track. A group cohesiveness is created, and the budget variances throughout the year will be easier to explain.

Budget assumptions should also be used as a tool to initiate cost-containment measures and to announce any new policy that directly affects expenses in either a positive or negative manner. Assumptions set the tone of the budget. The hospital may want to increase expenses in order to increase the quality of care or patient convenience. On the other hand, the hospital may want to reduce significantly the rate of increase in costs per patient day. The important point is that through budget assumptions the hospital has a choice and can directly influence the result.

Prior to making any assumptions the hospital administrator should, as a matter of standard procedure, consult with all department heads.

Fringe Benefits

Mandated benefits as a percentage of salary expense normally increase slightly each year because of scheduled increases in Social Security, workmen's compensation, or unemployment compensation. Hospital-controlled fringe benefits--such as hospitalization, life insurance, retirement, and paid days off (holidays, vacations, sick-leave days) -- do not change as a percentage of salary unless the hospital makes a significant change in its policy.

Therefore, if salary expense increases ten percent, mandated benefits will increase slightly more than ten percent, and hospital controlled benefits will increase approximately ten percent.

Most hospitals budget fringe benefits as a percentage of salary expense. Although many hospitals budget fringe benefits in a lump sum, there is a growing trend toward budgeting, as well as recording, fringe benefits by department. Department analysis is improved when fringe benefits are departmentalized because there is a better matching of revenues with expenses by period.

Fringe benefits as a percentage of salary should be one of the hospital's assumptions. ¹⁸

In the past several years, many comprehensive budget philosophies have been lauded. This section briefly examines three of these comprehensive philosophies. They are management by objectives, zero-based budgeting, and program budgeting.

As department heads prepare their budget requests, they also prepare a draft of several objectives that they hope to accomplish during the budget period.

It is important for the director to remember that activities are not objectives. Objectives are output-oriented and serve as a performance measurement for the

¹⁸ Donald F. Beck, Basic Hospital Financial Management. (Rockville: 1980) p. 89

department. An objective identifies something the department will accomplish to improve its performance; establishes a specific time, such as the month or quarter, by which the department plans to accomplish this; and is capable of being measured.

The proposed objectives must be negotiated under the managers supervision. In this negotiation process, money and other resources needed to support the objectives are discussed. If an objective is not affordable, it is either rejected or postponed until another budget period. In the negotiation process, the reasonableness of each proposed objective must also be discussed. Some proposed objectives will be too easy, and the supervisor will have to negotiate objectives that are not so easily attainable. Other proposed objectives will be unattainable, and the supervisor will need to reduce them down to a more realistic level.

Once administration and the department head have agreed on a set of objectives, the objectives become something like a management contract. The department's commitment is to achieve the agreed-upon goals and objectives. Administration's commitment is to blend these objectives into the goals and objectives of the hospital, to provide the resources needed to meet the objectives, and to support them in every possible way.

After management by objectives is functioning between administration and department heads, the hospital should initiate this tool between department heads and first-line

supervisors and employees. Experience has shown that management by objectives works best when achievement of the negotiated goals directly affects the employees' annual merit pay increases. ¹⁹

Management by objectives can only work if the hospital administration is willing to accept feedback from the foodservice director as well as all other department heads.

The first task needed to implement zero-based budgeting is to define goals and objectives first for the hospital, then for identifiable functions, such as nursing services, ancillary services, administrative support and of course the foodservice department. The objectives for the identifiable major functions will define the service level for each of these activities. A service level is a broad qualitative objective; for example:

- bills for inpatient service will be mailed no later than nine days after discharge
- central supply lost-charge slips will equal about two percent of gross revenue for a particular department
- the pharmacy will dispense medication with a unit-dose system and will have an admixture program for intervenous solutions
- the laboratory will do 90 percent of the diagnostic tests in-house and refer 10 percent to an outside laboratory.

¹⁹Ibid., p. 91

Some examples of the identifiable objectives in a foodservice department are:

- setting reasonable limits for over and under production
- using a par inventory system (buying up to a certain number)
- limiting budgets for special functions

The basic budget document used in zero-based budgeting is called a decision package. The department head prepares a decision package for each current or proposed function or activity that has been defined. The decision package identifies the resources and personnel needed to perform that activity at the minimum level needed, the current level if this is an existing function, and other appropriate levels. In the decision package these levels are related to expected benefits. ²⁰

Although this budget approach can provide a degree of integration between operating plans and financial plans that is seldom achieved in most hospitals, it will not work and should not be tried in every institution. It is an approach that requires a commitment from the chief executive officer. This executive must be not only interested in zero-based budgeting but must be personally supportive. This budget approach takes a lot of effort and is very difficult and time-consuming to implement.

²⁰Ibid., p. 92

It should also be cautioned that the accomplishments of zero-based budgeting are difficult to measure in specific monetary terms. Much of the benefits takes place at the level of the decision packages as department heads evaluate and redirect their resources to achieve better goal congruence.

Program budgeting is a unique technique for evaluating the hospital's budget as well as analyzing variances. Although program budgeting is most often associated with an incremental approach to departmental budgeting, with some modifications it can also be used effectively in conjunction with zero-based budgeting, management by objectives, and other budget philosophies.

To initiate program budgeting, the hospital must first define its programs or major classifications of revenue and expense. A list of budget or decision programs for a hospital could include inpatient care outpatient care, ancillary services, general services, plant services, administrative, and general. Within each of these programs the hospital could have subprograms.

Although program budgeting can be used by any hospital, it works best in an institution that has carefully defined annual goals and objectives. If these goals and objectives have been identified for several years into the future, the administrator can identify programs by the year in which the hospital will place a major budget emphasis. By evaluating the hospital's present strengths and weaknesses by year, a plan can be formulated to correct these over time. Program

budgeting is a superior way to manage goal congruence because it is geared to top management thinking.²¹

Any hospital can take advantage of any of the above mentioned budgeting methods. It is of the utmost importance, regardless of which method is chosen, that the hospital administration consult with the foodservice director prior to the planning of any capital expenditures or the reduction of daily budgetary necessities.

Standard - The Computer

In an article appearing in Food Management Magazine, Angelo Gagliano, Foodservice Director at Sloan-Kettering Memorial Cancer Center, stated that "The computer provides a data bank so the location and menu for each patient can be recorded and updated regularly. Food can be prepared as close to tray assembly as possible. With the aid of the light-coded system, employees can easily dish food onto trays which are placed in delivery carts. Once completed, the carts are transported through dumb-waiters to patients' floors where a dietary hostess is awaiting their arrival.²² The South Florida hospital industry would do well to model their standards after Gagliano's system.

Gagliano admits that his is a "second generation system" adapted from the system installed at Miami's Baptist Hospital.

In a personal interview, Dell Placides, Foodservice

²¹Ibid, p. 94

²²"Angelo Gagliano, Silver Plate-Hospital," Food Management, May 1977, p. 41.

Director of Baptist Hospital in Miami, Florida emphasized, "Today's management must make a move towards more progressive management, it must insist upon increased accountability and rely upon more sophisticated controls."

Dell Placides, Foodservice Director of Miami's Baptist Hospital, is of the opinion that food production will change and increase as today's technicians make advances in research and development. "Automation and specialized equipment will lead to greater productivity and efficiency in the future."

Placides was especially emphatic about the sophistication of computer systems.²³

Analysts have suggested that computerization may result in employees becoming less loyal to their organizations and more bored with their jobs. Therefore, this research hopes to provide a vehicle for the setting of standards high enough to combat employees' boredom.

There is virtually no major field or blue chip company not already tied to computer technology. Little by little, it is moving into institutional foodservice. [Computers are writing diets, menus, controlling inventory, purchasing slabs of beef and cans of tomatoes, recording sales and meals-per man-hour and so forth. By a foodservice director or dietitian just punching a few keys on their desktop CRT (cathode ray tub) terminal the necessary information can be called up out of computer storage devices (tapes and disks which

²³ Interview with Dell Placides, Foodservice Director, Baptist Hospital, Miami, Florida, February 25, 1983.

retain the data--the computer's "memory"]]. And, yes, right there in the wink of an eye is the data displayed on the terminal screen in bar charts or graphs or two- three- and five-year projections, all painted out in bright reds, greens, oranges and blues for easy viewing.

Computers have become so fast that they have cut time down into nanoseconds; that is, one-billionth of a second. Now the computer itself is really nothing more than a large, intricate assembly of electrical switches that turn either "on" or "off" so as to either transmit or block the current. The key to the computer wizardry, is based on (1) the software and (2) the switches. The power is there. The problem is to use it efficiently.

Just as computers can take over the tedious tasks in a foodservice operation, there is also some tedious work involved in getting on to computers. Hospitals especially must prepare long and diligently to get menus standardized and on paper before they can put them into the computer.

Building a data base is a very detailed painstaking and time consuming task. In some industries that time is shortened through purchasing a standard data base (software) but there is no one standard that will cover, an entire dietary department. Nor would a single group of standardized group of recipes for an individual hospital.²⁴

²⁴Karolyn Schuster, "The Choice," Food Management, August 1981, p. 73.

The inevitability of computers in foodservice is now apparent. The potential for cost savings and productivity improvements is undeniable. And the range of possible contributions to be gained from computerization is almost limitless.

Already it has trimmed expensive inventory, streamlined purchasing, facilitated employee scheduling, predicted costs, tracked trends, and estimated customer preferences.

Clinical nutritionists are excited about the potential lessons to be learned about the nutritional needs of the retarded and the handicapped and the aged and how their food preferences vary.

Foodservice directors are excited about the new community services they can offer as their student enrollments level off. Hospital dietitians are gathering data on the interaction of nutrition and medication and of nutrition with major illnesses.

University directors are predicting the varying number of hot dogs that will be consumed at football games for every five degrees of temperature change.

Supervisors in large programs are studying regular computer reports to pinpoint at a glance areas that need immediate attention.

Independent operations within a centralized system are using computer-produced information as a running report card on performance.

No doubt there are many decisions to make if and when selecting a computer system. The choice is probably one of

the most important foodservice directors will make during your new career.²⁵

But whatever the decision, standards must be established. The feeding of hospitalized patients poses special problems not encountered in other institutional feeding situations. Many of these arise from the fact that patients' appetites and moods are often altered as a consequence of their illness, lowered level of physical activity, or the administration of medications. In addition, many patients are restricted to diets that have been modified by the removal of condiments or to diets low in calories, cholesterol, and so forth. Consequently, special effort should be made to improve the acceptability of hospital food and foodservice to ensure that the food served to the patient is eaten.

Standard - The Recipe

One of the tools for quality assurance control is the standardized recipe, or formula. A recipe is considered "standardized" only when it has been tried and adapted for use by a given foodservice operation. Tested quantity recipes are available from many sources, such as cookbooks, magazines, materials distributed by commercial food companies from their own experimental kitchens, and from other foodservice directors. Regardless of the source, all must be adapted and standardized for use in a particular situation. Each

²⁵Ibid, p. 76.

recipe must be tried in one's own institution kitchen with its particular equipment, available ingredients, and skills and abilities of its personnel, and then adjusted for the quantities required, based on the number of people to be served and the portion size desired. Only then is standardization possible. Accuracy in the use of standardized recipes and in weighing and measuring ingredients takes the guesswork out of quantity food production. Patients and guests expect and should be able to depend on having a food item the same each time it is selected. This is not possible if the recipe is kept in the "head of the cook" and is not written for use by the relief or substitute cook.

A standardized recipe is a control used to produce a specific quantity of food of a known quality. It should be set up to give in an organized manner all the information needed to produce the item.

There are many acceptable forms of quantity recipes, but a standard should be established. Some of the major rules for establishing this standard for this type of presentation are:

1. Place title in the center of the top line and the code letters or numbers on the same line, top right.
2. In the line below, on the left, indicate the total yield and portions and opposite, on the right, indicate the portion size.
3. On the next line, list as headings: Ingredients, Weights, Measures, and Methods. Leave space for columns below these.
4. List the ingredients in order of use in the first column on the left. Separate ingredients into

groups. In the Methods column, list by number the various procedures that must be used to prepare these ingredients.

5. At the bottom of the card note the pan or baking container size, panning or baking instructions, temperatures, times, special notes or substitutions. Sometimes special portioning instructions must be given.
6. Use only one side of a recipe card. The back of the card can be used for information on quality of product or observations noted in preparation, etc. Use two cards if more space is needed.
7. Recipes for certain categories of menu items are frequently put on colored cards with the color indicating the kind of food. Thus, meat and entree recipes may be on pink cards; cakes, on white, etc.
8. It is desirable to indicate total time needed to produce the recipe and not only the time needed for a worker to put the ingredients together.

Ingredients should be precisely identified. The word "flour" is not enough; there could be confusion between cake, pastry, rye, bread, potato, or another kind of flour. For the same reason, do not put the word "sugar" down without describing the type required; it may be "granulated," "brown," or "Powdered" or whatever is needed to assure use of the right ingredient.

List all ingredients by weight and measure. Some thick liquids and a few other ingredients may be listed by measure only. The best cooks and bakers weigh rather than measure.

Use precise terms; there is a big difference in the action taken in a recipe depending on whether the words "whip," "beat," "stir," and "fold," are used. Using one technique for another can ruin a product. Give exact

quantities needed. Use spaces or capitals to emphasize. Seldom italicize or underline. Do not say "season to taste." Give exact quantities.²⁶

Standards - Quality Food

The task of planning meals for institutions that provide so large a share of the total food consumed is the responsibility of management. It is the "heart" of the entire establishment on which all activity is centered. The menu determines the foods to be purchased, the equipment and personnel needed, the work schedules, and the supervision required, and it is the basis for precosting food to be served. Success or failure of a foodservice often can be traced to the menu. The well-planned menu reflects careful thought and represents three points of view: the patients or guests who desires and expects variety and ample amounts of food to satisfy his appetite and bring him pleasure; the employees on whom falls the burden of work in translating the written word into attractive, palatable, and nourishing food; and the management who derives satisfaction from work well done in the tangible form of profits and a satisfied, happy clientele.

Translating the well-planned menu into high-quality foods is a prime responsibility of the foodservice food quality varies widely from place to place and often from time to time at the same place. This is attributable to two major factors: the standards of the foodservice director and the degree and

²⁶Lendal H. Kotschevar, Ph.D. Foodservice for the Extended Care Facilities, (Boston, Mass: CAHNERS Books, 1973

the standards of the foodservice director and the degree and amount of supervision given to those who prepare and serve it. Each person has his own perception of what constitutes "quality" food and each considers himself an expert, based on his own likes and dislikes.

The wise foodservice director is well aware of the several factors that tend to influence individual opinion about food quality; age, cultural, and socio-economic backgrounds, past experiences relating to foods, education and scientific knowledge, and emotions. Using this information, the foodservice director is better prepared to satisfy the many people who make up the clientele than would be true if such factors were unknown or ignored when planning menus.

"Foodservice holds a unique position in health-care. Food is a common denominator in everyone's life, and almost all patients partake of the services. For this reason, foodservice departments are becoming the targets of formalized marketing plans. The goal of these plans is the generation of a positive attitude toward the institution. The major premise is that all patients can and will judge the quality of the foodservice."²⁷

"Although patient surveys are useful and can provide valuable information, they do not eliminate the need for personal visitation. Our floor teams have a visitation program which calls for each patient to be visited at least once

²⁷James C. Rose, "Cost Containment With Good Will," Food Management, July 1982, p. 23.

daily during or immediately after meal service. I was pleased to see that the program was carried out in practice. There is a definite correlation on the patient surveys between visitations and favorable comments."

"Whenever the number of visits is below normal, due to a staff shortage or other commitments, invariably the overall rating in the foodservice area is less favorable. When you are confined to a bed with tubes and needles in various parts of your anatomy it can be comforting to know that someone cares enough to visit.

"For example, it has always been difficult to provide toast in good condition at breakfast time. We tried bagging it and the result was soggy toast. When we tried buttering it, the patient received greasy toast. Unbuttered and unbagged it is either hot and dry, or cold and dry, depending on which side of the split tray we placed it on. The problem was solved by removing toast from the printed menu and substituting a variety of rolls, buns, and pastries. Not a new or earthshattering idea but one that I probably would not have executed without personal exposure to the problem."²⁸

Standards - Food Production

We can live without poetry, music or art,
 We can live without conscience or live without heart,
 We can live without friends or live without books,
 But civilized man cannot live without cooks.

Author Anonymous

²⁸ Alan McLaren, "The Toast Problem," Food Management, September 1982, p. 46.

Production of high-quality food involves a number of interrelated steps, each dependent on the other. The transformation of raw or processed foods into an acceptable finished product ready for service requires the purchase of high-quality food, initial storage and "holding" at optimum temperatures at various points in its production and, generally, one or more processing procedures under controlled conditions.

Traditionally, these procedures have been carried out in the individual foodservice. Today, however, there is a marked increase in the number of foodservice systems that are centralizing all or part of their food production in a location removed from the serving areas. Preparation in these facilities may range from controlled production of items such as desserts and baked goods; preparation of meats ready for cooking; preparation of fruits and vegetables for salads or for final cooking in the individual foodservice units; or complete preparation and cooking of menu items, packaged in individual or bulk containers, chilled or frozen for delivery to serving units.²⁹

Many hospitals with multiple units find that commissaries provide a more efficient utilization of facilities, manpower, and equipment, than do on-site production areas. The proponents of the "food factories" claim better quality control and a greater variety of foods at a lower cost.

In spite of this trend centralization, many foodservices

²⁹Bessie West, et al., Foodservice in Institutions, (New York: Wiley and Sons, Inc., 1977), p. 204.

prepare either all or part of the food in their own kitchens. Some purchase certain menu items in the ready-to-cook or ready-to-serve forms, and most use some type of convenience ingredients or components. Today's quantity food production has been simplified also through the use of automation and modern functional equipment.

The principles of food preparation in large quantity are much the same as those for small quantity food preparation, but there are some differences in procedures because of the larger masses of food involved. Mechanized equipment is essential for heavy processes and for time-consuming procedures especially in the larger operations. Steam-jacketed kettles with stirring paddles in which food can be chilled after cooking; timers on steam-cooking equipment; metering devices on steam-jacketed kettles for measuring water; and high-speed vegetable cutters are examples of labor-saving equipment in use. Convection ovens and high-pressure steamers are used in many foodservices to reduce the time required for cooking, and no-transfer cooking equipment saves time and possible damage to the food quality through additional handling. For example, the steam-jacketed kettle and tilting frypan enable food to be browned, braised, and combined with other ingredients in the same kettle.

Also essential to attaining high standards in food production is the training of personnel to follow correct procedures of food preparation. Management is responsible for the development of the procedures written into standardized

recipes and job breakdowns. Supervision is the key word, however; if the manager allows even slight deviation from the established standards, all too soon they will be far below the desired level.³⁰

Observance of certain basic rules for foodservice workers will aid greatly in promoting efficient work habits. The student learning quantity food production or the new food-service employee should find the following suggestions helpful in the planning and carrying out of his duties.

1. Check assignment to be sure that there is no question as to what is to be done or how it is to be accomplished.
2. Plan work so that everything can be done within the time limit. Often several preparation procedures can be carried on simultaneously, but those that are preliminary or require the longest time should be started first.
3. Assemble any equipment or ingredients not at hand and arrange them conveniently for use before beginning work.
4. Use proper equipment for the job.
5. Use power equipment whenever possible. Economy of effort and time can soon pay for additional conveniences.
6. Arrange equipment and materials in the work area so that tasks can be accomplished in logical sequence with minimum movement of the worker.
7. Use of smooth, continuous motions will keep fatigue to a minimum. Use both hands simultaneously whenever possible. Comfortable working heights and good lighting also reduce fatigue.
8. Carry through one step in a procedure before beginning the next for speed in accomplishing a task.

³⁰Ibid, p. 208.

9. Keep the working area clean and orderly. Cleaning the work area will be simplified by the use of a tray on which to work or to place soiled equipment.
10. Accomplish something each time you pass one part of the kitchen to another.
11. Attempt to make each motion rhythmic.

The objectives of good food preparation are to: (1) conserve the nutritive value of the food, (2) improve the digestibility, (3) develop and enhance flavor and attractiveness of the original color, form, and texture, and (4) free it from injurious organisms and substances.

The preparation of food may or may not include cookery, chilling, and freezing processes. Preparation influences chiefly the appearance and palatability of food and may determine the relation between the cost and the selling price or profit. The application of heat through one of the cookery processes or the exposure to low temperature, as in the freezing of food, is necessary, if the food is not to be served raw.

Careful planning and scheduling of food preparation assures the efficient use of employee time and a minimum of production problems. Foods that are ready for service at the scheduled time without undue holding will be superior in quality to those that are prepared early to avoid a last minute "panic."

Scheduling requires a knowledge of the steps through which a product must go and the time required for each, as well as the steps that can be completed early without affecting

the quality of the food.

Producing food in quantity is a highly specialized task. It requires a well planned foodservice department with good equipment, good organization and planning, a skilled staff, well planned menus, accurate recipes, good purchasing and cost control and good cooks. The cook is one of the most important factors and must be an individual who possesses knowledge and skill plus a real interest in doing a good job.³²

Many of our finest chefs are not only skilled in the physical manipulation needed to produce meals, but they are highly trained in the technical problems involved in quantity production.

The planning, organization service and other techniques which are used in quantity cooking must be of a professional standard and if one is to gain proficiency one must learn these standards.

Standards - The Delivery

The food must be brought from the centralized kitchen to the patient's room. This causes a new variety of problems. Since the distance from the kitchen to the room varies with the size of the hospital and the location of both the room, there cannot be a uniform way of getting food ready to be eaten and delivered to the patients. The major problem is

³²Lendal H. Kotschevar, Ph.D. Foodservice for the Extended Care Facility, (Boston, Mass: CAHNERS Books, 1973, p. 237.

keeping the hot foods hot, while keeping the cold foods chilled to a desirable temperature as well, as in the case of salads and gelatin desserts which are more appetizing in the chilled form. Of course the reverse is true for soups.

The preparation standards often reflect the delivery standards. Often there are no established standards, thereby leading to the stigma of hospital food. There is a hypothesis that the hospital food "stigma" is a creation of the employees' cafeteria food which is literally forced upon them.

A limited selection, brought about by a limited dietary budget, causes resentment among employees and staff who must pay for food, although at a liberally discounted rate. They believe the cafeteria meals should be part of the employees' benefits. This resentment is often verbalized throughout the hospital and causes the patients to believe that if the staff says so, it must be true.

Another source of patient dissatisfaction originates from foodservice workers' desires (often directed by orders from supervisors) to stretch the dietary dollar, limiting and overengaging in portion control. Standards are definitely needed in this area.

Foods prepared in the conventional kitchen, on-premises, may be distributed for service directly to an adjacent serving area as a cafeteria, dining room, or lunch counter. Or, in hospitals or other health-care facilities where tray service to patients is required, the service of the food onto

the trays may be centralized or decentralized.

Centralized service means serving the individual portions of food onto the trays that have been assembled and set up at some central point in or close to the kitchen. All trays are so prepared under common supervision. They are then distributed by carts or vertical conveyors to patient floors; from there they are carried to the patient's bedside.

Decentralized service means the distribution of bulk quantities of food in sufficient amount to serve a given number of patients in one section of the facility. This system requires some means of transporting the food, for example, in heated or refrigerated trucks or carts, to serving pantries located throughout the building.

Trays for the patients are set up in these serving pantries, usually on a conveyor belt, and food is served onto the trays at the several locations instead of all at one place, as with the centralized service. Decentralized service requires duplication of some equipment for service; often dishes are also washed in the decentralized pantries.

More employees are needed to serve in the various pantries than for centralized service. A greater number of supervisors is also required unless serving times can be staggered so that one supervisor could move from serving area to another as the food arrives for service. Usually decentralized service is more practical for use when the building structure is low and sprawling, making it difficult to serve centrally and have the food hot on arrival if it must travel one-half mile

of corridor.

Examples of these methods of distribution will be discussed under the heading Service for different types of foodservices. An automated cart transport system (often known as the monorail) may be built into the facility for use by all departments, including dietary. It can carry trays to patient areas in a few seconds in its own specially built-in corridors, out of the way of other traffic in the building. This is a costly system that must be designed and built in at the time of building construction; it cannot be added to a facility already constructed.

This delivery system is particularly suitable for hospitals or other large facilities with more than one department to utilize it. It is effectively used with any of the on-premises production systems.

Advantages of the conventional system are many. Usually it is more adaptable to individual preferences, and foods are more easily prepared to satisfy various cultural and socio economic backgrounds of the consumers. From an economic standpoint, it is often possible to take advantage of price fluctuations and seasonal items unless bids are let too far in advance.

Other advantages include greater flexibility in menu planning without restrictions imposed by the availability of commercially prepared entrees and other menu items. This gives individuality to the food of the establishment also.

Distribution costs are minimal, which is a real consideration in times of fuel and energy shortages. There is no out-of-building delivery required.

Disadvantages to this system have to do with the peaks and accompanying stress caused by meal period demands. Work distribution is uneven and so productivity is lower than desired. Labor costs are therefore high. Foodservices that offer three or more meals a day or are open for continuous service may have overlapping shifts of employees, which adds to the labor cost if the number on duty at one time is more than necessary. Labor cost is the one major factor primarily responsible for the gaining popularity of other systems.³³

Foodservice organizations with many serving units have sought ways to curtail labor and other costs by centralizing production and other activities. A commissary is one solution. It is a large production kitchen, usually equipped with sophisticated, automated equipment.

Another centralized facility for food production is a central kitchen. This is thought of as smaller than a commissary and with more conventional equipment, but it is separate from the serving unit, as is the commissary.

The term "satellite" foodservice is sometimes used synonymously with commissary. If there can be a distinction drawn between the two, it is that a satellite kitchen is used

³³Bessie West, et al., Foodservice in Institutions, (New York: Wiley & Sons, Inc., 1977), p. 303.

to refer to an existing kitchen adapted for use to produce for several like-units in the same geographical area. It is thought of as being smaller, less sophisticated, and not built especially for large-scale centralized production. Prepared food is trucked to other schools in the area. This interpretation of a satellite kitchen has not been generally used, however, and so satellite is considered a variation of the commissary system. A satellite serving unit, however, is any facility where food prepared centrally is delivered for service.

Menu items processed in the commissary may either be held in bulk or portioned before storage. Three alternatives for storage following food production are available; frozen, chilled or hot-held. Each method requires different types of foodservice equipment and careful managerial monitoring for quality and micro-biological consideration.

Bulk foods may be placed in counter-size pans for freezing. Or, if they are to be transferred to serving units in the chilled or hot state instead of frozen, they are placed in heavy containers with lids that clamp on securely. Otherwise, spillage may result during transportation to the foodservice facility. Individual portions may be placed in casserolelike dishes, onto TV-like portioned aluminum tray plates, on plastic or paper plates, or wrapped in wax paper as sandwiches for a school foodservice lunch.

Carriers to hold the portioned food in their containers are filled at the commissary. At scheduled times each day, other types of carriers, which may be heated or refrigerated

or not, whatever is appropriate to maintain optimum food temperature, are loaded onto a truck for transfer to the service unit. In many cases, the driver is responsible for unloading the truck and taking the food carriers to the storage or service area as required. Carriers from the last delivery are collected and returned empty to the commissary on the delivery truck.

Advantages of the commissary foodservice system may readily be seen. The economics of the system mentioned have been the benefit of centralized, large-volume purchasing, no need for duplication of equipment and personnel for each unit as would be required in the conventional system, and reduced amount of supervision required. Another advantage is the uniformity of quality of products for all units. With the conventional system, quality sometimes varies considerably, causing complaints from the consumers.

With the consolidation into one facility, it is usually possible to purchase more sophisticated equipment, such as computer-controlled, automated foodservice equipment. Although initial investment of such equipment is expensive, the savings that can be realized over a period of time through use of it can be sizeable.

Each foodservice director must determine the standard that best fits his own facility.

Prior to further discussion, certain points regarding the facility's objectives and goals is necessary. Also, this author would like to ascertain that the foodservice standards

established in any health-care facility must be due to the effects of the entire department.

Legitimacy has an important impact on efficiency and effectiveness. When the goals of an organization are not seen as legitimate by the parties whose support and cooperation are vital to accomplishing these goals, the support of these parties is likely to be incomplete. If effectiveness is seen as the accomplishment of the organization's purposes, the question of the legitimacy of the purposes becomes critically important. If one's end results are of questionable utility, does it really matter whether or not the organization has been efficient and effective in realizing them?

Effectiveness is hurt by the budget-based institution. For organizations that function on a budget, it becomes dangerous even to raise the question of what business one is in, since the question by its very nature is controversial. Since "controversy is likely to alienate support," it will probably be avoided by the budget-based institution. Deception as to the nature of the business is likely to result, or the organization and the environment will define purpose in such global terms as "health-care" so that no one could question the basic integrity of the organization.

People who think they are working toward similar goals may not be. The broad definition allows considerable room for individual interpretation while maintaining the pretext of consensus. Unfortunately, the illusion of agreement impedes

effectiveness when multidisciplinary groups attempt to work together and find themselves at cross-purposes even when they think they share a common goal. The problem is everyone assumes the goal is shared. People rarely bother to explicate individual interpretations of what constitutes health care. As a result, many are actually surprised when conflict ensues and impedes the implementation of activities aimed at satisfying the goals on which agreement was assumed.³⁴

Thus, in the opinion of the author, it is of extreme importance that controls be established and enforced.

The Standards - The Controls

Good control is achieved when waste is minimized and resources are still adequately allocated to provide for needs. Good control requires that standards be established so performance can be evaluated. Standards that provide a measure of quality, quantity or nutritional adequacy for food are needed in foodservices. Other standards that relate to work procedures, timing and the organization of work are also required. Proper supervision is a necessary adjunct to good control.

It is possible to over-control. Employees must not feel that they are completely controlled in everything they do; actually they should feel they are more guided than controlled. Over-control can result in a loss of efficiency and can bring.

³⁴Rita M. Numeroff, Practice of Management for Health-Care Professionals, (New York: 1982) p. 38.

about confusion, duplication, unnecessary work and poor quality products.

Good production control assures that work processes are properly maintained at an efficient level. It should eliminate inefficiency, waste and other losses. Work reports, accomplishment records and a work simplification program can assist in improving production control. Workers should be motivated to achieve standards of quality and quantity. Unless standards are established and quality and quantity checks made throughout the production process, good production control cannot be achieved.³⁵

Some of the basic food service records of quantities of food produced, over or under production, meals served, food and supply costs, inventories, labor hours and costs, and income are basic control documents. It is necessary to set up and use adequate reporting procedures for gathering data needed to judge performance and productivity. Directors must train themselves to analyze data at regular intervals so that prompt corrective action can be taken to remedy problems indicated in reports.

With the high cost of food, labor, and everything else today standardized controls are essential if health-care foodservice, as we know it today, is to survive.

³⁵ Lendal H. Kotschevar, Ph.D. Foodservice for the Extended Care Facility, (Boston, Mass: Cahners Books, 1973), p. 25.

To control means to keep things going according to plan, and in accordance with organizational objectives and goals.

Nearly eight percent of a health-care facility's overall budget is allocated to the foodservice department. Adequate control must occur to avoid waste, gain maximum benefits and prevent over-expenditures.

A cost can be controlled better if its existence, cause and magnitude are known. Cost information can come from the accounting department, foodservice records, recipe costing, market prices, food yield studies, etc. But having such information does not control; it merely informs. After we get the information, we must do something about it. Unless we are informed, action usually is not taken. The first thing to be done in cost control, then, is to set up a good information system.³⁶

Although controls are necessary in every phase of a foodservice operation, health-care facilities and their administrations do not have a control system, a preventive maintenance system, or if you will, an operational standard for the most important resource--their management people. Nationwide there is a lack of economic incentive for talented foodservice. However, money is not the entire answer.

Standards - Marketing

The emphasis on proactive, purposefully integrated active targeted for a specific group is sharply different from the

³⁶ Ibid, p. 32.

reactive, diffuse approach that has traditionally characterized health-care marketing management. This traditional approach, variously called the service concept or minimal marketing, reflects the assumption that the mere possession of high-quality services and facilities is enough to ensure adequate utilization. This is further buttressed by an equally erroneous faith that holds that growth is assured by an expanding population and that there is no competitive substitute for the institution's product. Such an approach is characterized by exclusive pre-occupation with the product--bigger, newer, better facilities and service, expansion and sophistication for its own sake--and public relations efforts to make the presence of these things known.³⁷

- "We can't compete with commercial foodservice."

- "We can't advertise."

- "We can't constantly change our menus."

- "We can't afford the caliber of chefs."

- "We can't spend big bucks on decor."

- "We can't support costly training and research programs."

- "We can't conduct extensive market surveys."

- "We can't...but we wish we could."

Years ago this was the message coming from much of institutional foodservice.³⁸ It was definitely the message from the health-care foodservice industry.

³⁷ Rita M. Numeroff, Practice of Management for Health-Care Professionals, (New York: 1982), p. 40.

³⁸ "Eyeing the Competition," Food Management, April 1983, p. 41.

While there are no wizards standing in kitchens waving magic wands to produce millions of budget dollars, some directors have nevertheless banned the word "can't."

Foodservice director's are making every effort to turn their departments into dynamic, exciting, and competitive operations.

Directors have followed their (the customers) favorite eating places, sat down, have eaten a meal, and taken notes. They began to look at their own operations with a critical eye. They questioned the consistency of their quality. Were their menus keeping up with consumer eating trends? They decided that a "dining experience" had to be more than hanging plastic plants.

Somehow these innovative foodservice directors found a way, without high finance, to call upon the talents of their employees, and beg, borrow, or steal whatever they needed to sell their customers.

Those who are truly successful created an exclusive image for their foodservices. They developed menus, product all of which delivered a message.

The message was that "selling" was not only cosmetic; it meant real creativity, not only in the back of the house, but in the front of the house as well.

Foodservice directors nationwide should emulate these innovative pacesetters who have set standards for us all to build upon.

Today marketing, promotion and advertising are no longer the luxuries they were in bygone years. The health-care institution that survives will know precisely how it is viewed by patients, community residents and the physicians it serves.

Hospital administrators must voluntarily accept the subtle but crucial difference between their historic role and that of the true manager. The aggressive, for-profit world does not rely on administrators. It depends on managers with a solid base of authority, results-oriented freedom to commit resources, and a willingness to make decisions.

Marketing will receive more than a token commitment in the healthy hospital of 1990, and the prediction of the management recruiter may come true after all. Hospitals must begin now to rethink budget commitments, discarding fears that mechanization and efficiency will destroy humanistic values. Good operations will serve patients well, since better-informed patients will demand it and even travel far to get it.

Foodservice directors can do no less for their department than does the administrator for the entire hospital. (Naturally, the foodservice director's efforts must be in proportion to that of the hospital administrator.)

Standards - The Importance

Don Jacobs, in his article "Expanding the Bounds of Professionalism," (Food Management, June 1983) relates the anecdote about a well-known foodservice director who had recently arrived at a Midwestern facility and very quickly scolded his boss who had entered the kitchen to offer him advice: "Listen, you hired a professional; so stay out of my way and let me do my job." The same foodservice director gave an ultimatum to a professional association by stating that, "The Professional Standards Committee will never set foot in my facility to evaluate my operation."

What is a professional? How should a professional relate to his boss, his associates, his profession? As co-chairperson of the PSC of the National Association of College and University Foodservices, Jacobs has developed a firm conviction he believes that there is a correct professional attitude and that there is a direct relationship between attitude and success.

A professional is a person who conforms to the technical and ethical standards of a profession. A professional must be willing and able to learn the technical aspects of the trade, and must be willing and able to prove he has acquired such knowledge.

The professional does more than produce a bottom line profit. He/she understands the correct accounting and forecasting methods, and more and more is learning to understand the value of computer assistance.

He/she is confident in their knowledge and understanding of the industry and most often reflect this confidence by associating themselves with a highly regarded network of peers. Ideas are developed and shared. Concepts are tested and evaluated. The professional develops an in-depth understanding.

Unfortunately, according to Jacobs there are a core of individuals who equate position alone with professionals: they think, "I am the director, therefore I am a professional." Although these self-proclaimed professionals run profitable operations, they rarely accept the judgement of their colleagues, customers, or even their bosses. In the end they often fail.

A professional can take the skills they have learned to a new position, but in order to continue one's own development, one must accept input and be willing to be judged.

It is well known that the professional athlete who refuses to adjust to the rules of the sport and work with the team eventually fails. The same holds true in our profession, where the legitimate plays within the rules participates on the team, and is willing to come under the judgement of others, and advances within the industry, while the self-proclaimed professional often becomes a dropout.³⁹

³⁹ Don Jacobs, "Expanding the Bounds of Professionalism," Food Management, June 1983, p. 29.

Alan McLaren, Foodservice Director of the Community Hospital of Indianapolis, Indiana wrote on an article for the February 1979 issue of Food Management which sums up the attitude of the self-proclaimed professional. The article, written with a tongue-in-cheek style, is herein reproduced in its entirety, not to engage in plagiarism, but simply to imbue good prose to the reader:

"Some years ago when I was trying to sell the concept of foodservice systems involving convenience foods and microwave ovens to hospitals, I did not find it difficult to get foodservice directors to listen. However, after my sales pitch the first question invariably was either, "Where can I see it working?" or "Who is doing it?" I discussed the difficulty of introducing a new idea in hospitals with a former hospital foodservice director who is now in business for himself as a consultant. He said, 'Hospital foodservice directors are conservative by nature and training. Have you noticed when you go into a director's office you will usually find his diploma on the wall facing his desk so he can see it and have the constant comforting reminder he is qualified?'

"From my own experience and from the comments of colleagues, that was a good evaluation of many hospital foodservice directors. But to be fair our business almost demands conservatism. After all you cannot take chances with life and health or money. So here are a few guidelines for success and security as a hospital foodservice director.

"We've Always Done It This Way

1. Stick with the tried and true. If you hear of a new idea, try to find all the possible reasons why it will not work. Point out that you are comfortable with your present setup and that it works pretty well. 'We've always done it this way' is a good argument for not changing.
2. Don't buy a pig in a poke. If a new system or technique has not been proven in at least 50

other hospitals for 10 or more years, be suspicious. Bear in mind money does not grow on trees and even though there might be a great potential for future cost reductions, you cannot afford to take the chance.

3. Don't forget you will have to justify any changes, especially if they involve expenditures. Beware of enthusiasm and creative thinking because you know how hard it is to plan thoroughly and carefully and anticipate the awkward questions. You are too busy getting today's meals out to worry about tomorrow.
4. Remember your employees will not accept changes. It has taken you years to get your department to do a reasonable job with things as they are. Just think how difficult the training would be, and as you know training time is non-productive. If you ask your staff to do something different they will probably say, "It's not my job" because nobody takes any pride in his work these days.
5. Never attend seminars or workshops. There is no point in exposing yourself to the insidious ideas of obsessive colleagues who are never satisfied. After all you have the statistical reports, and as long as your costs are in line with the averages, that is the only comparison you would be interested in. If you are forced to attend a workshop or seminar, it is a good rule to avoid discussion. Or even better monopolize it by stating loudly how smoothly your operation runs and how few problems you have.

Don't Threaten The Status Quo

6. Avoid visiting other hospitals and discourage people from visiting yours. After all you are happy with the way you run things so what could you possibly learn? And you certainly don't want anybody judging you. You can always find reasons for not visiting or having visitors. There is the upcoming JCAH or public health inspection, or the annual Board dinner or your assistant is on vacation; your peers know about these things. After a while they will stop asking you, and you won't need to worry about it.

7. It is OK, however, to join your professional associations. Pay your dues but at all costs do not seek or accept office. Even though these organizations are pretty conservative your might be involved in a project that threatens the status quo. Every once in a while associations do come up with something new and progressive, so don't take a chance. Don't attend meetings regularly for the reasons outlined in the two previous guidelines.
8. Above all don't make waves. Inside and outside the hospital, maintain a low profile. Learn by heart the expression, 'Yes, sir' so it becomes an automatic response in conversations with the hospital administrator. Comply with every whim of every physician and treat the words of nurses as gospel. Accept blindly the regulations of the JCAH and all other regulatory agencies. Never ask the question, 'Why?' Wait patiently for the state and federal governments to pass laws affecting your operation without ever challenging them or expressing an opinion to your representatives. Respect tradition and authority unquestioningly.

Most Institutions Want Followers

"These guidelines are, of course, presented tongue-in-cheek. Unfortunately they may be close to the actual rules of daily life for many hospital foodservice directors. Recently there have been several articles dealing with the differences between a manager and a leader. It is my belief that most institutions, contrary to what they may say, do not want leaders as managers, they want followers. I have a great distrust of anyone, be he administrator, politician or president, who thinks he has a monopoly on ideas and initiative. Such persons must have contempt for others, but sadly, the others often accept their opinions.

Walt Whitman said it like this: 'There is to me something profoundly affecting in large masses of men following the lead of those who do not believe in men.'" 40

⁴⁰ Alan McLaren, "Playing Follow-The-Leader Skillfully," Food Management, February 1979, p. 15.

Standards--If Any

When establishing the standards of a foodservice system in a health-care facility, certain considerations must be kept in mind, primarily, what are the existing standards, if any?

The standards of foodservice must be determined by the available equipment, personnel and the physical layout of the facility. This must be done by the Foodservice Director.

The foodservice Department can provide:

1. Nourishing food at the lowest possible cost, adequate, but without embellishments.
2. Foodservice equal to a good restaurant, that is, a limited selection of popular entrees, with limited embellishments.
3. Meals and service equal to that found in luxury restaurants.
4. Provide service by those who simply do their jobs and really don't care, thereby lowering any standards that have been successfully established.

After the standards of foodservice are determined and raised then the standard of service must be established and also raised.

This can range from total convenience food to full-scratch production. The type and quality of equipment will dictate this standard. Total raw production, seldom used today, requires specific production equipment; whereas total convenience requires less production equipment but more storage space. The type of service influences tray assembly and temperature maintenance delivery systems, but there is no hard and fast rule which states that one particular type of

service requires a certain tray assembly or temperature maintenance system. Therefore, this is a wide open area limited only by the inventiveness of those who are setting the standards.

The size of the hospital will also add to the determination of the standards especially the tray assembly system. Larger hospitals demand greater amounts of equipment, especially tray assembly lines where often multiple lines are needed to handle the high capacity. A tray assembly line can produce five trays per minute which means that 300 trays can be assembled in one hour. Computers, naturally have increased this rate of efficiency and the rate of production. Hospital size will determine the time it takes for food to be transported from the central kitchen to the patient. This is critical in a centralized system.

It is said that people eat with their eyes. This is especially true when people are sick. They say, "I'm sick, nothing looks good to me." The tray and its presentation should make the patient feel at ease with the food. The thing to avoid is anything which might turn the patient off because the food is important to the recovery of the patient.

The major problem is keeping the hot food hot, while keeping the cold foods chilled to a desirable temperature as well, as in the case of salads and gelatin desserts which are more appetizing in the chilled form. Of course the reverse is true for soups.

The preparation standards often reflect the delivery standards. Often there are no established standards, thereby leading to the stigma of hospital food. It is this author's hypothesis that the hospital food "stigma" is a creation of the employees' cafeteria food which is literally forced upon them.

A limited selection, brought about by a limited dietary budget, causes resentment among employees and staff who must pay for food, although at a liberally discounted rate. They believe the cafeteria meals should be part of the employees' benefits. This resentment is often verbalized throughout the hospital and causes the patients to believe that if the staff says so, it must be true.

Another source of patient dissatisfaction originates from foodservice workers' desires (often directed by orders from supervisors) to stretch the dietary dollar, limiting and overengaging in portion control. Standards are definitely needed in this area.

Often hospital food is served on disposable plastic plates accompanied by heavy duty plastic flatware. The plastic plate is thrown away while the flatware is rinsed and taken home by relatives to be used at the next family picnic.

With the high cost of hospital care today, patients feel cheated when they have to dine with plasticized platters for dishes. He senses a declining budget. "For what I'm paying per day, I could at least eat from a china plate." This is a statement often made within the confines of a hospital room.

The use of convenience foods has grown tremendously in the last few years. With this growth the urgency for the establishment of standards is obvious. These standards must be set especially in the areas of storage and preparation so that the nutrient value of the product will not be lost.

Many of the diets, and they vary with each doctor, out of necessity must be created from scratch. Providing standards have been followed in purchasing, receiving, and storage, preparation of the food should adhere to standardized recipes.

As a rule, hospital food in general is not too highly seasoned although it is nourishing. As stated by Lendal H. Kotschevar in his book, Management by Menu, "A hospital food-service is very much a necessity rather than luxury type."⁴¹

A standardized recipe is a control used to produce a specific quantity of food of known quality. It should be set up to give in standardized methods, all the information needed to produce the recipe.

As Kotschevar states:

"Important as food is to the normal person, food and its role are far more important to the ill, aged, or handicapped. It is more critical to their well being and health. Slight nutritional imbalances may result in serious health changes which would not occur in a normal person under the same mild stress....

"The health facility that cares for the ill... must realize that a good food program is essential for adequate care and the facility must give food proper emphasis in its care program. A failure

⁴¹Lendal H. Kotschevar, Ph.D., Management by Menu, (Chicago, Illinois: National Institute for the Foodservice Industry, 1975), p. 28.

to do this may negate all other efforts to provide needed care. All the values food can give--nutritional, psychological and social--must be utilized to a maximum degree.⁴²

If the hospital patient is generally pleased with his food, his outlook will improve. Conversely, the patient who is unhappy with the food will also tend to be unhappy with the hospital stay and thereby--nothing will cause him to be satisfied. The latter situation of the patient eating less can therefore impede his recovery.

The importance of the food we eat for good health and physical fitness is no longer questioned.⁴³ Today nutrition is finally beginning to be recognized as an important factor in the treatment and convalescence from almost every disease.⁴⁴

⁴²Lendal H. Kotschevar, Ph.D., Foodservice for the Extended Care Facility, (Boston, Mass: Cahners Books, 1973), p. 3-4.

⁴³Dorothy L. Callahan, ed., Focus on Nutrition (Mass: Department of Education, 1970), p. 3.

⁴⁴W.H. Sebrell, Jr., American Journal of Clinical Nutrition, XV no. 11, 1064.

PART III

THE RESEARCH METHODOLOGY

Many books, dissertations, theses and articles are quoted during this study. However in researching the material for the study of Health-Care Foodservice Management, little data was available.

Data sometimes lie buried deep within the minds or within the attitudes, feelings, or reactions of men and women. A commonplace instrument for observing data beyond the physical reach of the observer is the questionnaire. The questionnaire may be sent to human beings whom the researcher may never see.

The basic structure of the descriptive survey as a method of research, indicates its salient characteristics:

1. The descriptive survey method deals with a situation that demands the technique of observation as the principal means of collecting the data.
2. The population for the study must be carefully chosen, clearly defined, and specifically delimited in order to set precise parameters for ensuring discreteness to the population.
3. Data in descriptive survey research are particularly susceptible to distortion through the introduction of bias into the research design. Particular attention should be given to safeguard the data from the influence of bias.
4. Although the descriptive survey method relies upon observation for the acquisition of the data, those data must then be organized and presented systematically so that valid and accurate

conclusions may be drawn from the.⁴⁵

Special Treatment of the Data

The purpose of this study is to develop a program that will establish standards for food products served in health-care facilities in the South Florida area.

The Data Needed - The data needed for the analysis of this study are (a) information as to individual hospital's present standards, (b) information as to requirements of individual foodservice directors in the South Florida area that pertain to their standards that address themselves to that specific subject. Several books and reports address themselves to dietetics and to the nutritional end of foodservice. These are oriented to practically all branches of the foodservice industry except health-care foodservice and none emphasized management. Foodservice management texts are available, but again, not in the realm of the specific subject.

A major source of information are personal interviews and surveys of professionals now active in the health-care foodservice field at the executive level and at other levels of corporate management. In addition, the author's own experience as well as an in-depth and extended personal interview with a retired professional served as a guide to assessing the future needs of the industry.

⁴⁵Paul D. Leedy, Practical Research Planning and Design, (New York, NY: Macmillan, 1980), p. 98-99.

The Treatment of the Data

How the Data Will Be Screened - The data received will be used in toto so that the full impact of this information will not be lost. Even incomplete returns will be used in areas that are applicable.

All unanswered questions will be eliminated from this study.

How the Item Analysis Will Be Made - The data will be categorized into the five major principles of management: planning, organizing, directing, staffing, and controlling.

Each positive response will receive a rating of 1.

Each negative response will receive a rating of 0.

The data will be analyzed according to W.G. Cochran's "Q" Test, which is based on three or more related sets of observations.

How the Data Will be Interpreted - As stated, responses shall be analyzed according to Cochran's "Q" Test. The formula for Q is:

$$Q = \frac{(k-1) [k(\sum S_1^2 + \sum S_2^2 + \sum S_3^2 + \sum S_4^2 + \sum S_5^2) - (\sum L)^2]}{k(\sum L) - \sum L^2}$$

where:

k is the number of categories (samples)

S_{12345} is the sum of the favorable responses to each of the five categories

L is the total number of favorable responses for each foodservice director

L^2 direct on to square the total number of favorable responses for each director and then to sum them.⁴⁶

The value of Q will determine the acceptance or rejection of the null hypothesis, as compared to the Chi-square chart with $K-1$ degree of freedom. The null hypothesis states that there are not sufficient standards for foodservice departments in Health-Care facilities.

$$Q = \frac{(k-1) [k(\Sigma S_1^2 + \Sigma S_2^2 + \Sigma S_3^2 + \Sigma S_4^2 + \Sigma S_5^2) - (\Sigma L)^2]}{k(\Sigma L) - \Sigma L^2}$$

$$Q = \frac{(5-1) [5(5^2 + 13^2 + 6^2 + 2^2 + 4^2) - (30)^2]}{5(30) - (30)^2}$$

$$Q = \frac{4 - [5(25 + 169 + 36 + 4 + 16) - 900]}{150 - 900}$$

$$Q = \frac{4 - [1250 - 900]}{-750}$$

$$Q = \frac{4 - [350]}{-750}$$

$$Q = \frac{-346}{-750}$$

$$Q = .046$$

⁴⁶Robert D. Mason. Statistical Techniques in Business and Economics, (Homewood, Illinois: Richard D. Irwin, Inc., 1982), p. 452.

Nominal level = 0.01

4 Df

Computed value = .046

Critical value = 13.28

Therefore the computed value (.046) is less than the critical value of chi-square at the nominal level of 13.28. The null hypothesis of there not being sufficient standards for foodservice departments in health-care facilities.

Further results of the survey have convinced experienced eyes, accustomed to reading between the lines, that the respondents have problems.

Among the problems are:

1. Most respondents confessed to a lack of space.
2. Most stated an inadequacy of cafeteria seating.
3. Most admitted their organizations offered no praise or positive reinforcement for their foodservice department employees.
4. Most foodservice department depicted, in answers to the questions a lack of standards for delivery of patient food.
5. The surveys provide information conotating a lack of high standards in staffing.
6. Most respondents are concerned over the lack of standards for in service training.
7. Most respondents present a picture of frozen food thawing out on a loading platform while waiting for a loading dock employee to bring food to the kitchen.

On the positive side, some foodservice directors are promoting gourmet style meals for both patients and employees and are promoting ethnic entrees on a cyclical basis.

Some hospitals show evidence of forming employee committees which act as a positive influence on the food-service department.

It is obvious that wherever the foodservice departments are gaining wider acceptance, expanding their reputations, and beating the competition, standards are high and are being adhered to.

Summary

One of the dictionary definitions of the word "standard" is "of recognized excellence or authority." In the foodservice industry, especially in health-care segment of that industry, standard means establishing concrete, measurable methods of operation that must be adhered to everyday.

Most foodservice departments agree that standards are important to have--but the less you have to deal with them, the better. Standards have an image problem, but there are tremendous benefits to be gained by establishing daily, written routine recognized levels of excellence.

The foodservice business is a business of providing quality dining services on a daily basis. It is easy for that quality to vary greatly from day to day when standards are merely memos in the minds of foodservice directors. Without a specified standard, in other words without a recognized level of excellence there can be a detectable difference in quality that can cost reputations, profits, and customers.

Without standards the quality of health-care foodservice is in jeopardy from meal to meal, and from cook to cook. By supplying a staff with standardized pre-tested recipes published with exact instructions for preparation and garnishing each cook will prepare a meal of precisely the same quality as the next cook.

Food quality although a vital element of all health-care foodservices, is only one area for which standards of recognizable excellence should be established.

The standards for most facets of health-care foodservice have previously been discussed in this study. It would be advisable for health-care foodservice directors to look at the structure of their menus and its cycles. Is there menu mix appropriate? Is there sufficient contrast for flavor, texture, color and style? Are the menus pre-costed to meet the budget?

Have standards been set for the purchasing, receiving, and forecasting of supplies? Have standards been established in the areas of storage and production?

These questions are only miniscule when compared to the monumental amount of with facets that must be dealt in the overall picture of any health-care foodservices.

There are standards that must be established with regard to clinical services, safety, sanitation, energy-conservation, personnel, finance, administration, employee, patient, and union relations, public relations and regulatory agencies.

Today, the profitable way of conducting a health-care foodservice is to contact a management company that specializes in such services. However the signing of a contract is not sufficient. There must be a standard of recognizable excellence to which the contractor must adhere.

Today's foodservice director may eliminate the possibility of being replaced by a contractor by establishing, maintaining, and if need be fighting for, a standard that is high enough to satisfy the patient, and the administrator and profitable enough to satisfy investors.

This study has discussed high standards which are applicable to each and every facet of a health-care foodservice operation. This author suggests that being aware of these high standards is not sufficient. Every foodservice director, in his own mind, must establish the standards that he himself can adhere to and surpass.

The inspiration and the motivation that can be imbued into a foodservice director's staff will create the standard of "pride" that will continue to raise the established standards.

APPENDIX A



FLORIDA INTERNATIONAL UNIVERSITY

TAMIAMI CAMPUS • MIAMI, FLORIDA 33199 • (305) 552-259

HOSPITALITY MANAGEMENT

May 8, 1983

Dear Foodservice Director:

As a member of the graduate program at F.I.U., it is my responsibility to prepare an industry project.

As my project pertains to the Health-Care Foodservice Industry and due to the fact that the lack of funds and the lack of time prevent me from visiting you personally, I am enclosing a survey for your perusal.

The answers to the questions will be very important to me as they will set the basis for my hypotheses. Please be assured that the information you will convey will remain anonymous. I will naturally, honor your request.

It would be gratefully appreciated if you grant me the time necessary to complete the enclosed survey. For your convenience an addressed return envelope is enclosed.

Thank you for your cooperation and your speedy reply.

Sincerely,

Shira L. Bush

SLB/egd

APPENDIX B

SURVEY OF HOSPITAL
FOODSERVICE DIRECTORS

1. Facility name: _____
address: _____
telephone: _____
2. Number of beds: _____
3. Occupancy rate: _____
4. Name of Foodservice Director: _____
5. School Graduated: _____ Year _____
6. Degree Earned: _____
7. Name of Dietitian: _____ RD? Yes No
8. If contractor, co. name: _____ Independent Y N
9. Does Foodservice Director have full responsibility and authority for Dietary department? yes ___ no ___ OR Does Dietitian have full responsibility and authority for Dietary Department? yes ___ no ___
10. Who does department scheduling? _____
11. Any in-service programs or on-going training programs?
yes ___ no ___

Dining Room/Cafeteria

Number of seats: _____
Hours open: _____
Remodeling Planned? Yes ___ No ___
Who is responsible for housekeeping? _____

Meal Planning

Responsibility for planning menus is assigned to: _____
What is the cycle, if any? _____ weeks, _____ days.
Is menu conference held? Yes ___ No ___
How are modified diets planned and cycled? _____

Is there an operational nourishment system? yes ___ no ___

Food Purchasing Systems

Person responsible for purchasing: _____

Person responsible for receiving, weighting and inspection:

Are bids, comparison shopping, or any form of guaranteed prices in effect? Which one, if any: _____

Does hospital have central receiving? Yes ___ No ___

Are deliveries made directly to kitchen? Yes ___ No ___

What inventory system is in effect? _____

Is inventory computerized? Yes ___ No ___

Food Preparation

Are tally sheets used in prepping amounts? Yes ___ No ___

Are standardized recipes used? Yes ___ No ___

Are they always available? Yes ___ No ___

Is product forecast accurate? Yes ___ No ___

What system is used for forecasting? _____

What is control of left-overs? _____

Is all food portion-controlled? Yes ___ No ___

If not, what food is not? _____

What is approximate food cost? _____ %

Who is in charge of department when Foodservice Director is off duty? _____

Foodservice

Number of meals service on cafeteria line _____ per day

Any special policies concerning employee meals? _____

Number of employees in foodservice department? _____

Number of employees under control of dietitian? _____

How many "special functions" are catered by the foodservice department during the year? _____

Type of special functions: Board meetings ___ Committee meetings ___ Fund raisers ___ Associations ___ Nurses week ___ other _____

Does a designated dietary employee(s) contact patients routinely? Yes ___ No ___

Are there any special promotions during the year? Yes ___ No ___

Is a selective menu used for patients? Yes ___ No ___

Is there an effort made to make menus more acceptable to both patients and employees? If so, what are they? _____

Describe method of making diet menus acceptable _____

Are patients preferences recorded? Yes ___ No ___

Types of dishes used: China _____ Silverware _____

Disposables _____

Plastic Reusables _____

Other _____

What type of delivery system is employed? Heat Cart ___

Hot Plates ___ Thermal Trays ___ Pre-prepared food reheated in micro-wave ovens in satellite kitchen ___ On floor ___

Other _____

Approximate time from kitchen to floor _____ min.

Approximate time from floor to patient _____ min.

Organization

Are job descriptions posted? Yes ___ No ___

Is organizational chart posted? Yes ___ No ___

Are budget allocations posted? Yes ___ No ___

Employee Turnover? 0-25% _____ 26-50% _____

51-75% _____ 76-100% _____

Over _____

Controls Used

Yes

No

Reports

Food Cost

Payroll Cost

Expenses written up as received

Food written up as received

Standard food specifications

Standard non-food specifications

Portion Controls

Ingredient Room Used

Stock Room Controls

Major Problem Areas:

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VITA

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