Audits & More

A Nutrition and Food Service Audit Manual for Larger Adult Residental Community Care Facilities

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Chapter 1 – Overview

WHAT IS THE PURPOSE OF THIS MANUAL?

In British Columbia, residential community care facilities are required to be licensed under the *Community Care Facility Act.* The *Community Care Facility Act* requires that community care facilities are operated in a manner that will:

- maintain the spirit, dignity and individuality of the persons being cared for; and
- promote the health and safety of persons in care.

The *Community Care Facility Act* empowers government to make regulations. These regulations include the Adult Care Regulations. In 1997, the Adult Care Regulations were amended and required all licensed adult residential community care facilities to have a nutrition and food service audit program in place (Section 7.8 of the Adult Care Regulations). A nutrition and food service audit program assists facilities in maintaining basic health and safety standards as set out in the Adult Care Regulations. Refer to Appendix 1 - Resources for information on how to obtain a copy of the Adult Care Regulations and *Community Care Facility Act*.

This manual provides the provincial standard for a nutrition and food service audit program in larger residential community care facilities for adults (i.e. those with 25 residents or more). *Meals and More* (a manual published by British Columbia Ministry of Health) contains the nutrition and food service audit program for smaller facilities (i.e. those with 24 residents or fewer). Refer to Appendix 1 – Resources for information on how to obtain a copy of *Meals and More.*

This manual is intended for use by the interdisciplinary team working in adult residential community care facilities including, but not limited to, the Registered Dietitian Nutritionist (RDN), supervisor of food services/Nutrition Manager, Registered Nurse and other facility staff. This manual provides background information to assist facility staff in implementing an audit program for their facilities.

Regional Licensing/Community Nutritionists and Licensing Officers inspect and monitor licensed residential care facilities in order to promote and protect the health, safety and well being of persons cared for in licenced community care facilities (refer to Appendix 2 for information on Licensing Contacts).

IS THIS A NEW MANUAL?

This manual replaces "*Nutrition and Food Service Standards for Adult Care Facilities*" manual, in use since 1990. Prior to 1997, there was no requirement under the Adult Care Regulations for facilities to have a nutrition and food service audit program. This manual is different from the "*Nutrition and Food Service Standards for Adult Care Facilities*" manual as it focuses primarily on meeting the requirements of the regulations. The manual can also be used as a resource by facilities as it contains background information on a variety of nutrition and food service topics.

This manual does not include information on food safety. Information on food safety standards (including HACCP - Hazard Analysis Critical Control Points) for residential facilities should be obtained by contacting the regional Environmental Health Officer. The regional Environmental Health Officer inspects and monitors all food safety processes in facilities (refer to Appendix 3 - Food Safety Contacts).

Chapter 1 contains an overview of the manual and the audit requirements. Chapter 2 provides an easy to follow summary of the required nutrition and food service audit program for facilities. Each chapter between Chapter 3 – 13 focuses on a different nutrition and food service topic and uses the following format:

- Requirements of the Adult Care Regulations
- Required Audits and Frequency
- Optional Audits
- Background Information on the topic being addressed in the chapter

Copies of and instructions for the required nutrition and food service audits for all topics have all been grouped together in Chapter 14 to facilitate easy removal and photocopying by facility staff. Chapter 15 provides detailed information on optional nutrition and food service audits. Sample audits have been included in Chapter 14 and 15. The Appendices provide a variety of resource material including: Licensing and Food Safety Contacts, Sample Forms, Resource List and information to assist facility staff in menu planning.

HOW DO I USE THIS MANUAL?

The Adult Care Regulations require adult residential community care facilities to develop and implement a nutrition and food service audit program. This manual describes an acceptable nutrition and food service audit program.

The Registered Dietitian Nutritionist, supervisor of food services/Nutrition Manager and other members of the interdisciplinary team should:

- Read the manual to become familiar with the information and audits.
- Discuss the manual as an interdisciplinary team.
- Develop a facility audit plan:
  - determine who will be responsible for the audit;
  - timelines for audit completion;
  - plan for rotation of audits through different locations of the facility;
  - what location each audit will focus on i.e. special care unit, specific dining room or unit; and
  - how audit results will be communicated to the rest of the team.
- If the audit identifies areas of concern, the interdisciplinary team should discuss and develop a plan to correct the issue. Determine who on the team will be responsible for follow-up. Repeat the audit until the minimum acceptable score is met.

WHAT IF AN AUDIT RESULT IS UNACCEPTABLE?

If an audit result is unacceptable, the audit should be repeated to evaluate the effectiveness of the corrective actions. Facility staff should document audit results as well as corrective actions taken.

A nutrition and food service audit program assists facilities in maintaining basic health and safety standards as set out in the Adult Care Regulations. An effective and valid audit program will document acceptable and unacceptable audit results as well as the actions taken to correct any concerns identified.

ARE THERE OTHER TOOLS AVAILABLE FROM MINISTRY OF HEALTH SERVICES TO ASSIST FACILITIES IN ENSURING COMPLIANCE TO THE ADULT CARE REGULATIONS?

Facilities should have a copy of the Residential Facility Assessment Instrument – Self Assessment Version. Copies of this instrument can be obtained from the licensing staff in the local health region (refer to Appendix 2 – Licensing Contacts). This tool can be used by facilities to:

- determine if they are in compliance with the Adult Care Regulations;
- identify areas that require improvement; and
- inform and educate staff members about the requirements of the Adult Care Regulations.

All licensed adult residential community care facilities are expected to comply with all requirements of the *Community Care Facility Act* and Adult Care Regulations. Contact your local licensing office if you would like to discuss these requirements with your regional licensing staff (refer to Appendix 2 – Licensing Contacts). Copies of the Adult Care Regulations and *Community Care Facility Act* can be obtained from the government of British Columbia (refer to Appendix 1 – Resources).

CAN MY FACILITY USE AN ALTERNATIVE NUTRITION AND FOOD SERVICE AUDIT PROGRAM?

A nutrition and food service audit program, other than the one described in this manual, may be used by a facility as long as the alternative nutrition and food service audit program is acceptable to the Regional Medical Health Officer or delegate. Contact your Regional Licensing staff for more information (refer to Appendix 2 – Licensing Contacts).

ARE THERE OTHER NUTRITION AND FOOD SERVICE STANDARDS THAT MY FACILITY MUST MEET?

Check with your regional licensing staff (refer to Appendix 2 – Licensing Contacts) to determine if there are other nutrition and food service standards in your region.

WHAT OTHER RESOURCES DO I NEED?

This manual should be used in conjunction with the following resources (refer to Appendix 1 – Resources for more information):

Manual of Clinical Dietetics, developed by the Chicago Dietetic Association, The South Suburban Dietetic Association and Dietitians of Canada. American Dietetic Association, 2000.

Food and Nutrition for Quality Care: A Policy and Procedure Manual. Wong, C. ed. Vancouver/Richmond Health Board, 1999.

Geriatric Nutrition in Care Facilities: A Multidisciplinary Approach. Gerontology Practice Group. British Columbia Dietitians' and Nutritionists' Association, 1996.

Adult Care Regulations, *Community Care Facility Act.*

Community Care Facilities Programs: Policies and Procedure manual - Nutrition and Food Services policies.

Residential Facility Assessment Instrument – Self Assessment Version.

GLOSSARY

Facility

(definition under the Adult Care Regulations)

An adult residential community care facility as defined in the Community Care Facility Act.

Food Services

(definition under the Adult Care Regulations)

Means all of, or those parts of, the operation of a community care facility related to the provision of meals to the residents and includes, but is not limited to, menu planning, food purchasing, food storage and preparation, the serving of meals, space and equipment requirements and sanitation.

Food Services Audit

(definition from the Community Care Facilities Programs: Policies and Procedures manual)

Means a regular review of the critical aspects of nutrition and food services for a particular client group.

Health Care Provider

(definition under the Adult Care Regulations)

Means a practitioner who is authorized to provide health care by

(a) a regulatory body, listed under section 6 of the Health Professions Regulation, B.C. Reg. 237/92, or

(b) the board of registration for social workers established under the Social Workers Act.

(A resident's physician in most cases is the primary health care provider)

Interdisciplinary Team

The group of staff and consultants providing care to residents, which may include, but is not limited to: Physician, Nursing staff, Registered Dietitian Nutritionist, Supervisor of Food Services/Nutrition Manager, Pharmacist, Support Services staff, Rehabilitation staff, Recreation Therapy staff, Volunteer, Chaplain, and Social Worker. The interdisciplinary team provide care to the residents including assessing the nutritional needs of residents, weighing residents, feeding residents or supervising residents at mealtime.

Licence

(definition under the Adult Care Regulations)

Means a licence issued by the medical health officer to operate a community care facility.

Licensee

(definition under the Adult Care Regulations)

Means a person who holds a current interim permit or licence issued by the medical health officer.

Medical Health Officer

(definition under the Adult Care Regulations)

A medical health officer in British Columbia appointed under the Health Act or a person to whom a medical health officer has delegated his powers and duties under section 33 (4) of the Health Act.

Nutrition Care Plan

(definition under the Adult Care Regulations)

Means that part of each resident's care plan which assesses the resident's nutrition status and specifies the nutrition care to be provided to that resident.

Registered Dietitian Nutritionist

(definition under the Adult Care Regulations)

Means a person who is a member of the British Columbia Dietitians' and Nutritionists' Association (BCDNA).

Resident

(definition under the Adult Care Regulations)

Means a person who lives in and receives care in an adult community care facility.

Supervisor of Food Services

(definition under the Adult Care Regulations)

Means a person who is a member of, or who is eligible for membership in the Canadian Society of Nutrition Management or who is a member of the British Columbia Dietitians' and Nutritionists' Association (BCDNA).

Therapeutic Diet

(definition from the Community Care Facilities Programs: Policies and Procedures manual)

A therapeutic diet is any modification to the regular diet made on the recommendation of the resident's primary health care provider (e.g. medical practitioner).

Texture Modification

Texture modifications are modifications to the texture of food to allow a resident who has difficulty chewing and swallowing to consume food orally. Typical texture modifications include pureed, minced and cut up. Texture modifications can be ordered by the resident's primary health care provider (e.g. medical practitioner) or by the Registered Dietitian Nutritionist.

ROLES OF THE REGISTERED DIETITIAN NUTRITIONIST, SUPERVISOR OF FOOD SERVICES AND INTERDISCIPLINARY TEAM

ROLE OF THE REGISTERED DIETITIAN NUTRITIONIST (RDN)

A Registered Dietitian Nutritionist is required under the Adult Care Regulations in facilities with 25 or more residents to:

- develop the nutrition care plan for each resident;
- document the nutrition care plan as part of the resident's overall care plan;
- review the nutrition care plan;
- monitor the nutrition care plan to ensure implementation; and
- revise the nutrition care plan in response to the changing needs of the resident.

The Community Care Facilities Programs: Policies and Procedures manual states the Registered Dietitian Nutritionist should be scheduled for sufficient time to provide for:

- participation in care planning;
- liaison with administration, medication, nursing, care staff and the Medication Safety and Advisory Committee;
- resident/family counselling as needed;
- all required nutritional assessments/reassessments;
- approval of menus, including modified diets;
- participation in the development of policies and procedures;
- participation in staff education regarding food service, nutrition and assisted eating techniques;
- liaison and support to the supervisor of food services/Nutrition Manager where applicable; and
- evaluation of the food and nutrition services provided.

ROLE OF THE SUPERVISOR OF FOOD SERVICES

A supervisor of food services is required under the Adult Care Regulations in licensed adult residential facilities with 50 or more persons in residence to ensure adequate management of food services.

The Community Care Facilities Programs: Policies and Procedures manual states that the supervisor of food services should be scheduled for sufficient time in the facility to provide for:

- management and/or supervision of food services;
- participation in development of policies and procedures;
- development of menus, including modified diets;
- liaison with other caregivers;
- coordination and supervision of personnel in the production and distribution of food;
- coordination of food procurement;
- maintenance of safety, sanitation and security in food distribution and preparation;
- participation in care planning;
- participation in the audit program; and
- participation in staff education regarding food services.

ROLE OF THE INTERDISCIPLINARY TEAM

The members of the interdisciplinary team work together to ensure the health and safety of residents. Their roles will vary from facility to facility but will likely include (but is not limited to) the following:

- provision of assistance and supervision to residents at meals and snacks;
- participation in interdisciplinary care planning resulting in an overall care plan for each resident;
- participation in the nutrition and food service audit program;
- liaison with other members of the interdisciplinary team;
- communication of changes in the resident's status to other members of the team;
- participation in the development of policies and procedures;
- participation in staff education regarding food service, nutrition and assisted eating techniques; and
- facilitation of compliance with the *Community Care Facility Act* and Adult Care Regulations.

Chapter 2 – Summary of the Nutrition and Food Service Audit Program

REQUIRED NUTRITION AND FOOD SERVICE AUDITS

(Refer to Chapter 14 for copies of required nutrition and food service audits)

REQUIRED AUDIT	PURPOSE
Nutrition Care Plan Audit	To audit whether nutrition care plans are developed within two weeks of the resident's admission, reviewed within 14 weeks of admission, reviewed as set out in the resident's care plan, revised in response to resident need and monitored to ensure implementation.
Weight Record Audit	To audit whether weights are documented for each resident on a monthly basis.
Diet Order Implementation diet and Consumption Audit	To audit whether resident meals are served in compliance with the order in the overall care plan and to audit whether residents actually consume the food provided as indicated by their diet order.
Nourishment Order Implementation and Consumption Audit	To audit whether resident nourishments are served in compliance with the nourishment order documented in the residents' care plan and to audit whether residents actually consume the nourishment provided as indicated by their nourishment order.
Meal Service Audit	To audit the meals served to residents including the appropriateness of the food served, the accuracy of the place setting, and the taste and temperature of the food served.
Eating Aids and Assistance Audit	To audit the provision of eating assistance and supervision to residents.
Enteral feeding implementation audit	To audit the provision of enteral feeding to residents.
Menu Audit	To audit if each day of the cycle menu meets the minimum recommendations of Canada's Food Guide to Healthy Eating.
Resident Meal Questionnaire	To audit the satisfaction of residents with the nutrition and food service.

OPTIONAL NUTRITION AND FOOD SERVICE AUDITS

(Refer to Chapter 15 for copies of optional audits)

In addition to the required nutrition and food service audits, there are several optional audits included in this manual. The interdisciplinary team should determine whether they want to include these audits as part of the audit program for their facility.

OPTIONAL AUDIT	PURPOSE
Meal Consumption Audit	To audit the food intake of an individual resident for one or more meals
Dining Program Checklist	To audit the meal service in the facility dining program.
Plate Waste Audit	To audit the acceptance of a food or menu item.

FREQUENCY OF NUTRITION AND FOOD SERVICE AUDITS

A nutrition and food service audit program assists facilities in maintaining basic health and safety standards as set out in the Adult Care Regulations. Nutrition and food service audits need to be conducted on a regular basis. Minimum frequencies for audits have been established. Additional frequency of these audits should be determined by outcomes. If the outcomes are not acceptable, then the audits should be repeated more frequently until acceptable outcomes are achieved (i.e. when the minimum acceptable audit score is not met, the audit should be repeated until the concern is addressed).

Facilities with more than one food service area, dining room or specialized care unit need to ensure audits are conducted in all areas of the facility. For example, Meal Service Audits can be rotated between the main dining area and the special care unit dining area.

SUMMARY OF REQUIRED NUTRITION AND FOOD SERVICE AUDITS

On the next page is a form that summarizes the required frequency for each audit. Facility staff can use this form to:

- assign a staff member to complete each audit;
- schedule audits for the year; and
- document completion of the audits for the year.

SUMMARY OF REQUIRED NUTRITION AND FOOD SERVICE AUDITS

FACILITY NAME_____ **YEAR** _____

NAME OF AUDIT	RESPONSIBLE STAFF	STAFF ASSIGNED TO COMPLETE AUDIT	MINIMUM REQUIRED FREQUENCY PER YEAR	DATE SCHEDULED	DATE COMPLETED
Nutrition Care Plan audit	interdisciplinary		1		
Weight Record Audit	interdisciplinary		1		
Diet Order Implementation & Consumption Audit	interdisciplinary		1		
Nourishment Order Implementation & Consumption Audit	interdisciplinary		1		
Meal Service Audit	interdisciplinary		12 (select therapeutic diet and/or texture modified foods every second audit)		
Eating Aids & Assistance Audit	interdisciplinary		2		
Enteral Feeding Implementation Audit	interdisciplinary		1		
Menu Audit	RDN or supervisor of food services/ Nutrition Manager		1		
Resident Meal Questionnaire	interdisciplinary		1		

SAMPLE

SUMMARY OF REQUIRED NUTRITION AND FOOD SERVICE AUDITS

FACILITY NAME__*British Columbia Care Home*_____ **YEAR**_____*2001*_____

NAME OF AUDIT	RESPONSIBLE STAFF	STAFF ASSIGNED TO COMPLETE AUDIT	MINIMUM REQUIRED FREQUENCY PER YEAR	DATE SCHEDULED	DATE COMPLETED
Nutrition Care Plan audit	interdisciplinary	*L. Smith*	1	*February 1*	*February 1*
Weight Record Audit	interdisciplinary	*D. Roome*	1	*June 22*	*June 22*
Diet Order Implementation & Consumption Audit	interdisciplinary	*L. Smith*	1	*May 22*	*May 23*
Nourishment Order Implementation and Consumption Audit	interdisciplinary	*D. Roome*	1	*November 2*	*November 2*
Meal Service Audit	interdisciplinary	*L. Smith* *D. Roome* *N. Station* *R. Trim* *L. Smith* *D. Roome* *N. Station* *R. Trim* *L. Smith* *D. Roome* *N. Station* *R. Trim*	12 (select therapeutic diet and/or texture modified foods every second audit)	*January 15 – general* *February 15 – texture modified* *March 15 – general* *April 17 – therapeutic* *May 15 – general* *June 15 – texture modified SCU* *July 16 – general* *August 15 – therapeutic* *September 17 – general SCU* *October 15 – texture modified* *November 15 – general* *December 3 – therapeutic SCU*	*January 15* *February 15* *March 16* *April 17* *May 15* *June 15* *July 16* *August 15* *September 17* *October 15* *November 15* *December 3*
Eating Aids and Assistance Audit	interdisciplinary	*D. Roome*	2	*March 20* *September 24*	*March 20* *September 24*
Enteral Feeding Implementation Audit	interdisciplinary	*N. Station*	1	*October 22*	*October 22*
Menu Audit	RDN or supervisor of food services Nutrition Manager	*D. Roome*	1	*May 31*	*May 31*
Resident Meal Questionnaire	interdisciplinary	*N. Station*	1	*April 23*	*April 23*

Note: Increase frequency of audit if minimum acceptable score is not met

Chapter 3 – Nutrition Care

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.1 which states:

A licensee of a facility with 25 or more persons in residence must ensure that a registered dietitian-nutritionist

(a) develops a nutrition care plan for each new resident within 2 weeks of admission,

(b) documents the nutrition care plan in the resident's care plan,

(c) reviews the nutrition care plan as set out in the resident's care plan and at least once within 14 weeks of admission,

(d) monitors the nutrition care plan to ensure implementation, and

(e) revises the nutrition care plan in response to the changing needs of the resident.

Section 7.7 (a) which states:

A licensee must ensure that the nutrition needs of each resident are monitored to a level acceptable to the medical health officer,

Section 7.8 which states:

A licensee must ensure that a nutrition and food services audit program acceptable to the medical health officer is in place.

Section 9.3 which states:

(1) A licensee must ensure that staff develop and implement an individualized care plan for a resident who remains in an adult care facility for two or more weeks.

(2) A care plan must include…(c) a nutrition care plan…

(3) A care plan must take into consideration the abilities, the physical, social and emotional needs and the cultural and spiritual preferences of the resident.

(4) A care plan must be…(c) accessible at all times to staff who provide direct care to the resident.

(5) A licensee must encourage a resident to participate in the development and review of his or her care plan.

REQUIRED AUDITS AND FREQUENCY

(Refer to Chapter 14 for copies of required audits)

NUTRITION CARE PLAN AUDIT

Purpose of Audit:

To audit whether nutrition care plans are developed within two weeks of the resident's admission, reviewed within 14 weeks of admission, reviewed as set out in the resident's care plan, revised in response to resident need and monitored to ensure implementation.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Nutrition Care Plan Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team. In many facilities, the Registered Dietitian Nutritionist does not audit their own charting on residents. Instead they work with other members of the team and trade auditing tasks. This requires development of an interdisciplinary policy and educational support.

OPTIONAL AUDITS

(Refer to Chapter 15 for copies of optional audits)

MEAL CONSUMPTION AUDIT

To audit the food intake of an individual resident for one or more meals.

NUTRITION CARE – BACKGROUND INFORMATION

NUTRITION CARE PLANS

(Refer to Appendix 4 – Nutrition Assessment and Care Plan Sample Form)

The nutrition care plan is an important communication tool for caregivers. The nutrition care plan guides the activities of care staff and therefore is the foundation for quality nutrition care. In facilities with 25 or more persons, the Registered Dietitian Nutritionist must develop, review, monitor, revise and document the nutrition care plan for each resident. The resident's nutrition care plan should be an accurate assessment of the resident's current status. Pertinent information including changes in the resident's condition should be communicated by the Registered Dietitian Nutritionist to the supervisor of food services/Nutrition Manager, where one is on staff, and to staff providing care.

The nutrition care plan must be documented in the resident's overall care plan. It is acceptable to cross-reference the nutrition care plan in the overall care plan as long as the nutrition care plan is accessible to all care staff. A nutrition care plan must be developed by a Registered Dietitian Nutritionist for each resident and needs to be:

- completed within two weeks of admission of the resident;
- reviewed at least once within 14 weeks of admission;
- reviewed as set out in the resident's care plan (at least once per year);
- monitored to ensure implementation; and
- revised in response to resident needs (including changes in nutritional needs or health of the resident).

The nutrition care plan is developed with the input of the resident and the resident's family or advocate. It takes into account the abilities, the physical, social and emotional needs, and the cultural and spiritual preferences of the resident. The care plan must be accessible to all staff who provide direct service to the resident.

The Registered Dietitian Nutrition must develop the nutrition care plan. The following steps are required in developing the nutrition care plan:

1. Assessment of Nutrition Concerns

The nutrition care plan starts with an assessment of the resident's health to identify nutrition concerns. Nutrition assessment starts with gathering information regarding the resident's health, eating habits and food preferences. This information is gathered from sources

including the health record, the resident, the resident's family, medical staff, nursing and other care staff, and through meal observation. Nutrition concerns must be documented in the resident's overall care plan.

2. Setting Goals

Setting goals in response to the nutrition concerns identified is the second stage in developing the nutrition care plan. The resident should participate, if possible, in the development of these goals. For each concern, develop a goal. Goals should be realistic, resident-centered, and measurable. Set a reasonable date for achieving each goal. Goals in the nutrition care plan must be documented in the resident's overall care plan.

3. Assigning Actions

List all the actions or approaches that are going to be implemented for each goal. For each action, state what is to be done, by whom and by when. State the date by which the action should be started. Provide simple, clear instructions for caregivers to follow. Actions in the nutrition care plan must be documented in the resident's overall care plan.

4. Ongoing Evaluation and Review of the Care Plan

Reviewing and reassessing the nutrition care plan on a regular basis is essential. The resident should be encouraged to participate, when possible, to participate in the review of their nutrition care plan. The Adult Care Regulations require that the nutrition care plan be reviewed as set out in the resident's overall care plan and at least once within 14 weeks of admission; and is revised in response to resident's needs. Resident needs include the presence of new or changed conditions that have a strong influence on an individual's nutrition status, such as:

- permanent loss of ability to ambulate freely or use the hands to grasp small objects;
- deterioration in behaviour, mood or relationships;
- deterioration in resident's health status, e.g. weight loss, abnormal lab values, dysphagia;
- marked or sudden improvement in the resident's health status; and/or
- significant changes in medication.

The interdisciplinary team needs to discuss how changes in the resident's status are communicated to the Registered Dietitian Nutritionist so the nutrition care plan can be revised to reflect the resident's needs. The overall care plan will also need to be revised to reflect any changes in the nutrition care plan. The facility will need to develop a policy and procedure on this issue (Section 9 of the Adult Care Regulations requires facilities to develop and implement written policies to guide staff actions in all matters relating to the care of residents).

The goals and actions need to be reviewed and evaluated to ensure that they are effectively implemented and successful in dealing with resident's nutrition concerns. Goals and actions must also be evaluated, reviewed and revised in response to changes in the resident's concerns.

INTERDISCIPLINARY CARE CONFERENCES

Many facilities have interdisciplinary care conferences to facilitate development of comprehensive care plans. At these conferences, the nutrition care plan is incorporated into the overall care plan for the resident. The interdisciplinary team may include, but is not limited to: Physician, Nursing staff, Registered Dietitian Nutritionist, Supervisor of Food Services/Nutrition Manager, Pharmacist, Support Services staff, Rehabilitation staff, Recreation Therapy staff, Volunteer, Chaplain, and Social Worker. The resident or resident's substitute decision maker (i.e. the person who is authorized to make decisions on behalf of a resident) participate in the care conference, whenever possible.

SIGNIFICANT WEIGHT CHANGE

(Refer to Appendix 5 - Significant Weight Loss Table)

The Adult Care Regulations require that appropriate intervention is initiated when a resident experiences a significant weight change. A significant weight change is defined as an unintentional change in weight greater than 5% over one month, greater than 7.5% over three months, and greater than 10% over six months. Appropriate intervention means suitable professional advice (e.g. Registered Dietitian Nutritionist, physician) should be obtained and the cause for the weight loss or gain be identified and resolved, wherever possible. The issue of significant weight change and response by the facility should be documented in the resident's care plan.

In assessing nutrition status of the resident, it is important to note that changes in weight over time suggest nutritional repletion or depletion. Therefore, weight gains/losses over time are usually more valuable indicators than a comparison to height-weight tables. Lifetime or usual weight must also be considered when assessing what the ideal or goal weight for an individual should be.

NUTRITION TRANSFER FORM

(Refer to Appendix 6 - Sample Nutrition Transfer Form)

A Nutrition Transfer Form may be used to provide information on a resident's nutrition needs and care plan, including therapeutic diet, when a resident is discharged to a hospital or another care facility. Providing resident nutrition information to the receiving facility can help ensure consistency and continuity of care for the resident.

Chapter 4 - Weight Records

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.7 which states:

(1) A licensee must ensure that

(a) the nutrition needs of each resident are monitored to a level acceptable to the medical health officer,

(b) the height and weight of each resident is recorded on admission,

(c) the weight of each resident is monitored and recorded monthly thereafter, and

(d) appropriate intervention is initiated when a resident experiences a significant weight change.

(2) Despite subsection (1), an alternate schedule of monitoring and recording weight may be established with the approval of the medical health officer.

Section 7.8 which states:

A licensee must ensure that a nutrition and food services audit program acceptable to the medical health officer is in place.

REQUIRED AUDITS AND FREQUENCY

(Refer to Chapter 14 for copies of required audits)

1. WEIGHT RECORD AUDIT

Purpose of Audit:

To audit whether weights are documented for each resident on a monthly basis.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Weight Record Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

OPTIONAL AUDITS

None.

WEIGHT RECORDS – BACKGROUND INFORMATION

DOCUMENTING WEIGHT

(Refer to Appendix 7 – Weight Graph Sample Form)

Resident weights must be documented on admission and thereafter monthly. Resident weight records provide an ongoing measure of the resident nutrition status. To facilitate accurate and timely weighing of residents, facilities need to have in place a policy and procedure to guide care staff who are usually responsible for weighing residents. The development of this policy and procedure should be an interdisciplinary process (Section 9 of the Adult Care Regulations requires facilities to develop and implement written policies to guide staff actions in all matters relating to the care of residents).

Weights may need to be measured and documented more frequently than monthly according to the nutrition care plan. However, permission from the regional Medical Health Officer must be obtained in order to measure weights less frequently than once per month. Consult with the Regional Licensing staff for more information (refer to Appendix 2 - Licensing Contacts).

Weights may be graphed to illustrate the weight history of a resident over 1 or 2 years. If a resident has an amputation, the absent body section must be accounted for.

Hand	0.7% loss	Foot	1.5% Loss
Lower arm + hand	2.3% loss	Lower leg + foot	5.9% loss
Entire arm	5.0% loss	Entire leg	16.0% loss

(Reference: Osterkamp LK. Current perspectives on assessment of human body proportions of relevance to amputees. J Am Diet Assoc. 95:215-218, 1995. Source: *Manual of Clinical Dietetics*, developed by the Chicago Dietetic Association, The South Suburban Dietetic Association and Dietitians of Canada. American Dietetic Association, 2000)

HEIGHT AND WEIGHT REFERENCE TABLES

1. Body Mass Index

The Body Mass Index (BMI) is a reliable and accurate method to assess body weight and may be correlated with mortality and other health-related factors.

BMI = weight (kg) divided by height squared (m2)

BMI can be interpreted as follows:

- **FOR MALES AND NONPREGNANT FEMALES FROM 20 TO 65 YEARS**

BMI	Interpretation
less than 20	May be associated with health problems for some people
20.0 – 24.9	Healthy weight for most people
25 – 27	May be associated with health problems
more than 27	Increased risk of developing health problems

- **FOR MALES AND FEMALES AGED GREATER THAN 65 YEARS**

BMI	Interpretation
less than 24	May be associated with health problems for some elderly
24 – 29	Healthy weight for most elderly
more than 29	May be associated with health problems in some elderly

(Reference: Beck AM, Ovesen L. At which body mass index and degree of weight loss should hospitalized elderly patients be considered at nutritional risk? Clin Nutrician. 17:195-198, 1998. Source: *Manual of Clinical Dietetics*, developed by the Chicago Dietetic Association, The South Suburban Dietetic Association and Dietitians of Canada. American Dietetic Association, 2000)

2. Masters table for the elderly

The "Masters" tables originally published in 1960 provide averages of actual weight measurements rather than optimal or ideal figures.

HEIGHT (CM) WEIGHT (KG) FOR MEN 65 YEARS OF AGE AND OVER

HEIGHT (CM)	AGES 65 – 69	AGES 70 – 74	AGES 75 – 79	AGES 80 – 84	AGES 85 – 89	AGES 90 - 94
155	58 – 71	57 – 69	56 – 68			
157	59 – 72	58 – 70	57 – 69	55 – 67		
160	59 – 73	58 – 71	58 – 70	55 – 67	54 – 66	
163	61 – 74	59 – 73	58 – 71	56 – 69	55 – 67	
165	62 – 76	61 – 74	59 – 72	58 – 70	57 – 69	53 – 65
168	63 – 77	62 – 76	61 – 74	59 – 72	58 – 70	54 – 66
170	63 – 78	63 – 77	62 – 75	60 – 74	59 – 73	55 – 68
173	65 – 79	64 – 78	63 – 76	61 – 75	61 – 74	57 – 70
175	66 – 81	66 – 81	64 – 79	63 – 77	62 – 76	59 – 72
178	67 – 83	67 – 82	66 – 81	65 – 79	63 – 78	61 – 74
180	70 – 86	69 – 84	67 – 83	67 – 81	65 – 81	63 – 77
183	72 – 88	70 – 86	70 – 85	69 – 85	67 – 83	
185	74 – 90	73 – 89	71 – 87			

HEIGHT (CM) WEIGHT (KG) FOR WOMEN 65 YEARS OF AGE AND OVER

HEIGHT(CM)	AGES 65 – 69	AGES 70 – 74	AGES 75 – 79	AGES 80 – 84	AGES 85 – 89	AGES 90 - 94
147	54 – 66	51 – 63	50 – 61			
150	54 – 67	52 – 63	51 – 62	46 – 55	45 – 54	
152	55 – 67	53 – 64	51 – 63	48 – 59	46 – 56	
155	57 – 68	53 – 65	52 – 65	49 – 60	47 – 58	
157	57 – 69	54 – 67	53 – 65	51 – 62	49 – 60	48 – 59
160	58 – 70	56 – 68	54 – 67	52 – 64	51 – 62	48 – 59
163	59 – 72	57 – 70	56 – 68	53 – 66	52 – 63	49 – 60
165	60 – 73	59 – 72	57 – 70	55 – 67	54 – 66	51 – 62
168	62 – 76	60 – 73	58 – 71	57 – 70	56 – 69	53 – 64
170	63 – 77	62 – 75	59 – 73	59 – 71	58 – 70	
173	65 – 80	63 – 77				
175	67 – 82	65 – 80				

(Source: Arthur M. Master, et al., Tables of average heights and weights of Americans aged 65 to 94 years. JAMA. 172:662, 1960)

Chapter 5 – Preparation and Service of Food

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.3 which states:

(1) A licensee must ensure that meals and snacks

(a) are nutritious,

(b) are of adequate caloric value, based on the most recent edition of Canada's Food *Guide to Healthy Eating* published by the government of Canada,

(c) meet the requirements of each resident depending on age, gender, level of activity and other relevant factors,

(d) fulfil the requirements of the resident's nutrition care plan, and

(e) fulfil the requirements of any therapeutic diet ordered by the resident's primary health care provider.

(2) A licensee must ensure that a resident receives an adequate amount of fluids throughout the day to ensure hydration.

(3) A licensee must ensure that meals and snacks are prepared and served in a manner which

(a) preserves their nutritive value,

(b) offers variety, appeal and texture,

(c) fulfils the requirements of the resident's nutrition care plan, and

(d) as far as is reasonably practical, recognizes the resident's personal dining and food preferences, religious practices, and cultural customs.

(4) A licensee must ensure that meals and snacks are provided in designated dining areas.

(5) Despite subsection (4), meals and snacks may be provided by room tray service where this need has been identified in the resident's care plan or where the resident is unable to attend the dining room.

(6) A licensee must ensure that residents receive ample time to finish meals.

(7) A licensee must apply any additional standards regarding the preparation and service of food set by the medical health officer.

Section 7.8 which states:

A licensee must ensure that a nutrition and food services audit program acceptable to the medical health officer is in place.

REQUIRED AUDITS AND FREQUENCY

(Refer to Chapter 14 for copies of required audits)

1. DIET ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

Purpose of the Audit:

To audit whether resident meals are served in compliance with the diet order in the overall care plan and to audit whether residents actually consume the food provided as indicated by their diet order.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Diet Order Implementation and Consumption Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

2. NOURISHMENT ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

Purpose of the Audit:

To audit whether resident nourishments are served in compliance with the nourishment order documented in the residents' care plan and to audit whether residents actually consume the nourishment provided as indicated by their nourishment order.

Minimum Acceptable Audit Score: 100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Nourishment Order Implementation and Consumption Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

3. MEAL SERVICE AUDIT

Purpose of the Audit:

To audit the meals served to residents including the appropriateness of the food served, the accuracy of the place setting, and the taste and temperature of the food served.

Minimum Acceptable Audit Score:

Part 1 Accuracy = 100%
Part 2 Food Evaluation = 100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Meal Service Audit twelve times per year. Select therapeutic diet and/or texture modified foods every second audit.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

OPTIONAL AUDITS

(Refer to Chapter 15 for copies of optional audits)

1. DINING PROGRAM CHECKLIST

To audit the meal service in the facility dining program.

PREPARATION AND SERVICE OF FOOD – BACKGROUND INFORMATION

The preparation and service of food in a facility should ensure that the quality and quantity of fluids, food, and meal service will meet residents' nutrition and health needs. Residents with medical and/or nutrition concerns should receive the appropriate diet to meet their individual needs. Regular and therapeutic menu plans must be established and followed. The meal service should promote adequate nutrition intake, improve or maintain health, and enhance quality of life. The delivery of the meals and snacks according to the nutrition care plan assists in meeting the health and safety needs of the resident.

The Adult Care Regulations require that the energy and nutrient needs of residents are met and food preferences of the resident are considered. In order to meet these requirements the interdisciplinary team must develop, implement and evaluate their food service systems. This involves developing and implementing appropriate policies and procedures to ensure that meals and snacks are meeting the minimum standards as set out in the Adult Care Regulations. These policies should use an interdisciplinary approach as the distribution of meals and snacks usually involves several departments of the facility including food services, activation, and nursing (Section 9 of the Adult Care Regulations requires facilities to develop and implement written policies to guide staff actions in all matters relating to the care of residents).

In all components of the food service operation, it is essential that there are systems in place to facilitate communication between the interdisciplinary team to ensure that residents receive the appropriate meals and snacks to meet their individual needs. The interdisciplinary team needs to discuss and develop policies that focus on areas where responsibility for meals and snacks passes from one department to another (Section 9 of the Adult Care Regulations requires facilities to develop and implement written policies to guide staff actions in all matters relating to the care of residents). For example, the food service department may be responsible for the preparation and service of meals and nourishments while the nursing department may be responsible for delivering the meal or nourishment to the resident for consumption.

Food service systems encompass all the activities of the nutrition and food service department. All the complex operations of the food service must be planned, documented and evaluated. These operations include, but are not limited to:

- planning and evaluating the cycle menu (including adapting the menu for therapeutic and texture modified diets);
- developing specifications of the quality of food purchased;
- ensuring there is appropriate equipment and space to store food;
- developing food production plans to maximize the human and physical resources of the department;
- developing standardized recipes to ensure a consistent food product which will have an impact on food quality, quantity, budget and resident satisfaction;

- planning of food delivery systems to ensure that the taste, temperature and texture of food is maintained during the delivery process;
- developing systems to ensure appropriate service of food to residents, including adequate assistance at meals and snacks;
- developing systems to ensure that food waste is handled safely and appropriately. The amount of waste may be used as a part of the process of evaluating quality and resident satisfaction, and contributes to understanding of resident satisfaction and acceptance;
- planning a dining program that meets the needs of the residents; and
- reviewing the physical environment of designated dining room areas including space, lighting, temperature and sound. These factors can positively affect residents' appetites and therefore, their nutritional health.

The development, implementation and evaluation of a dining program to guide staff in interacting with residents in the dining room and in creating a positive environment in the dining room can result in improved resident food consumption and greater resident satisfaction with food service. The interdisciplinary team should review their present dining program to determine strengths and weaknesses. Facilities can then develop and implement a dining program that meets the needs of their unique resident population. Refer to *Geriatric Nutrition in Care Facilities* for more detailed information and suggestions for dining programs (refer to Appendix 1 – Resources).

The dining program should address the following:

- preparation of residents prior to meals, including dentures, hearing aids;
- assistance and supervision at meals;
- interaction of staff with residents, e.g. polite, respectful, conversation directed to residents;
- ambiance of the dining room, e.g. lighting, temperature, décor choices, music choices, seating and table heights and wheel chair space;
- appetizing smells to help enhance residents' appetites;
- respecting the compatibility of table-mates;
- seating plan acceptable to residents and regularly reviewed;
- order of meal service acceptable to residents and regularly reviewed;
- timing of clearing and cleaning of tables to ensure that residents are allowed ample time to finish meals; and
- celebrations and special themes.

Chapter 6 - Food Service Schedule

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.4 which states:

(1) A licensee must ensure that

(a) a breakfast is available between 7:00 a.m. and 9:00 a.m.,

(b) a noon meal is available between 11:45 a.m. and 1:00 p.m.

(c) an evening meal is served after 5:00 p.m., and

(d) a minimum of 2 nutritious snacks are provided, one of which must be provided in the evening.

(2) Despite subsection (1) (a), (b) and (c), if a resident will be absent during a meal period the licensee must ensure that a packed meal is provided if required.

(3) Despite subsection (1) (a) and (b), if residents choose, arrangements may be made for a brunch to be served on weekends and holidays.

(4) Despite subsection (1) (a), (b) and (c), meal times may be varied if, in the opinion of the medical health officer, the variation is in the best interests of the residents.

(5) A snack or packed meal provided under this section must be included in the daily or monthly charge.

REQUIRED AUDITS AND FREQUENCY

There are no audit tools included for this section of the manual. The facility should use the Residential Facility Assessment Instrument – Self Assessment Version to assess compliance to these sections of the Adult Care Regulations. Obtain a copy of the Residential Facility Assessment Instrument from the Community Care Facility Licensing Program in your health region (refer to Appendix 2 - Licensing Contacts).

OPTIONAL AUDITS

None.

FOOD SERVICE SCHEDULE – BACKGROUND INFORMATION

Meals and snacks should be provided to residents at times of the day which reflect the daily pattern of life in the community. Resident choice should be respected where residents prefer to sleep in on weekends, and to have a large brunch rather than a separate breakfast and lunch. Mealtimes can be varied in response to scheduled activities or resident traditions. The Regional Medical Health Officer (MHO) may approve ongoing variations to mealtimes when in the MHO's opinion it is in the best interest of the resident. The facility must obtain written approval from the MHO to vary mealtimes – contact your regional licensing staff for more information (refer to Appendix 2 – Licensing Contacts).

Residents will be provided with meals and snacks if required, when they are absent from the facility during a meal and/or snack period. There should be no additional cost to the resident for packed meals and snacks. The packed meal or snack should be nutritionally equivalent to the meal or snack that it replaces.

Chapter 7 – Nutrition Supplements, Tube Feedings, Eating Aids and Assistance/Supervision

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.5 which states:

A licensee must provide each resident with

(a) any nutrition supplements required by the resident's nutrition care plan or ordered by the resident's primary health care provider,

(b) any tube feedings ordered by the resident's primary health care provider, and

(c) any eating aids, personal assistance or supervision if required if the resident has difficulty eating or where required by the resident's nutrition care plan.

Section 7.8 which states:

A licensee must ensure that a nutrition and food services audit program acceptable to the medical health officer is in place.

REQUIRED AUDITS AND FREQUENCY

(Refer to Chapter 14 for copies of required audits)

1. NOURISHMENT ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

Purpose of the Audit:

To audit whether resident nourishments are served in compliance with the nourishment order documented in the residents' care plan and to audit whether residents actually consume the nourishment provided as indicated by their nourishment order.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Nourishment Order Implementation and Consumption Audit once per year.
- The minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

2. EATING AIDS AND ASSISTANCE AUDIT

Purpose of Audit:

To audit the provision of eating assistance and supervision to residents.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Eating Aids and Assistance Audit twice per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

3. ENTERAL FEEDING IMPLEMENTATION AUDIT

Purpose of Audit:

To audit the provision of enteral feeding to residents.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Enteral Feeding Implementation Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

OPTIONAL AUDITS

(Refer to chapter 15 for copies of optional Audits)

1. DINING PROGRAM CHECKLIST

To audit the meal service in the facility dining program

NUTRITION SUPPLEMENTS, TUBE FEEDINGS, EATING AIDS AND ASSISTANCE/SUPERVISION – BACKGROUND INFORMATION

Nutrition supplements are products which provide calories and nutrients to promote optimal health and functioning when a resident's nutrition needs cannot be met through their regular diet. Nutrition supplements are usually prescribed by a primary health care provider (e.g. medical practitioner) and/or required by a Registered Dietitian Nutritionist.

When a specific nutrition supplement is ordered by the primary health care provider (e.g. medical practitioner), the facility must provide this specific product. If the facility would like to provide a different nutrition supplement then they should discuss this with the primary health care provider (e.g. medical practitioner) and request a change in the order for the nutrition supplement.

Nutrition supplements must be supplied by the facility as long as the resident requires it. Homemade milkshakes may be used as an alternative to commercial meal replacements if they meet the energy and nutrient needs of the resident receiving the supplement.

The facility must provide the tube feeding formula as specified by in the resident's nutrition care plan or as ordered by the resident's primary health care provider (e.g. medical practitioner). The care plan for the resident should include the name of the tube feeding product, feeding volume, method of administration (including rate of feeding, temperature of feeding), precautions to prevent bacterial contamination and aspiration, flushing instructions, medication administration, and criteria for monitoring. Tube feeding formulas must be supplied by the facility for as long as the resident requires it. For more information on tube feeding, refer to Appendix 1 – Resources, *Manual of Clinical Dietetics.*

Residents will receive encouragement, supervision, appropriate eating aids, and assistance with food to promote their safety, comfort and independence in eating. Eating aids must be supplied by the facility. All residents, including those who are receiving meals and snacks by room tray service or eating in alternate dining areas, must receive adequate supervision and assistance.

Chapter 8 - Menu Planning

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.3 (1) which states:

A licensee must ensure that meals and snacks

(a) are nutritious,

(b) are of adequate caloric value, based on the most recent edition of Canada's Food Guide to Healthy Eating published by the government of Canada,

(c) meet the requirements of each resident depending on age, gender, level of activity and other relevant factors,

Section 7.3(3) which states:

A licensee must ensure that meals and snacks are prepared and served in a manner which

(a) preserves their nutritive value,

(b) offers variety, appeal and texture,

(c) fulfils the requirements of the resident's nutrition care plan, and

(d) as far as is reasonably practical, recognizes the resident's personal dining and food preferences, religious practices, and cultural customs.

Section 7.6 which states:

(1) A licensee must ensure that

(a) a cycle menu written for a minimum of 4 weeks is developed and used,

(b) menu substitutions are made from the same food groups and provide similar nutrition value, and

(c) any additional standards set by the medical health officer are applied to menu planning.

(2) Despite subsection (1), if a facility offers only emergency or short-term stay programs, a weekly menu may be developed and used.

Section 7.8 which states:

A licensee must ensure that a nutrition and food services audit program acceptable to the medical health officer is in place.

REQUIRED AUDITS AND FREQUENCY

(Refer to Chapter 14 for copies of required audits)

1. MENU AUDIT

Purpose of Audit:

To audit if each day of the cycle menu meets the minimum recommendations of Canada's Food Guide to Healthy Eating.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Menu Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Registered Dietitian Nutritionist or supervisor of food services/Nutrition Manager.

OPTIONAL AUDITS

1. COMPUTER ANALYSIS OF MENUS

A computer analysis of a section of a menu or the entire cycle menu is an optional activity that depends on facility resources. A computer analysis of the menu can provide valuable information of the nutrient quality, especially vitamin and mineral content, of the foods provided.

MENU PLANNING – BACKGROUND INFORMATION

CYCLE MENU

The menu is the focal point of food service operations. Decisions regarding kitchen space, equipment, staffing, food purchasing and food storage depend on the menu. A well planned menu allows for consistency in food service, and ensures that the nutritional needs of the residents are met. The menu should offer variety in texture, taste, and colour in food items. As much as possible, the menu must also reflect the food preferences and cultural and religious practices of residents.

Cycle menus should:

- provide a variety of foods;
- emphasize high fibre foods;
- limit foods high in fat and salt;
- provide adequate fluids;
- be varied to reflect seasonal variation;
- be different for the same days of each week;
- be documented to include portion sizes;
- be dated;
- be posted each week in the kitchen; and
- be posted daily for residents.

The daily menu must meet the minimum recommendations of Canada's Food Guide to Healthy Eating.

Residents on therapeutic and texture modified diets should be considered when planning the menu. The master menu should either include space to identify alternative foods for therapeutic diets and texture modifications or be documented separately and kept with the cycle menu. Therapeutic and texture modified diets should follow the cycle menu and wherever possible be comprised of the same foods being served to other residents.

Menu substitutions and changes must be documented (including date of substitution or change), filed and saved. Menu substitutions could be written permanently on a copy of a dated cycle menu and these menus kept for one year. Alternatively, the facility could have a book to record menu changes. It is also necessary to electronically save substitutions and changes in a computerized menu. Documentation on menu substitutions and changes must be made available on request of licensing staff.

Substitutions and alternatives must provide equivalent nutritional value. Menu substitutions are intended to provide flexibility for special occasions. It is important to note the reason for a menu

substitution (e.g. special occasion, ingredient not in stock, recipe not available, residents do not enjoy, staff not trained to prepare) to determine if a revision to the menu is required or if operational changes need to be made.

For information that will assist in menu planning, refer to Appendix 8 - Suggested Serving Sizes and Canada's Food Guide Equivalents for Elderly Residents, Appendix 9 - Suggested Menu Items and Appendix 10 - Conversions and Equivalents. For information on nutritional needs of the elderly, refer to the Appendix 1 – Resources, *Manual of Clinical Dietetics* (Chapter 9 – Older Adults).

STANDARDIZED RECIPES

Standardized recipes are used to make sure the same quantity of food is obtained each time a food item is produced. This procedure prevents waste that could occur with overproduction or production of an unusable food item. A standardized recipe ensures that the food item tastes and looks the same every time it is prepared. Standardized recipes should include:

- recipe name;
- number of portions and serving size;
- list of ingredients and amounts;
- method of combining ingredients;
- equipment used in preparation and serving;
- cooking time and temperature; and
- special instructions for therapeutic diets and texture modifications, if needed.

CULTURAL AND RELIGIOUS CONSIDERATIONS

The facility menu must take into account the cultural and religious food practices of the residents. Respect for these food practices enhances the quality of life and satisfaction with food service for residents. The traditional food practices of some residents may preclude the consumption of specific foods, or may require that certain foods be prepared in a specific manner or in specific combinations.

Menus can be evaluated with respect to special food practices, and modifications can be planned within the resources of the individual facility. Information on specific cultural and religious food practices can be obtained by interviewing the resident, the resident's family and facility staff who share similar cultural practices and by consulting references. Information gathered should include:

- How is food normally served? In a plate, or in a bowl?
- Is food normally eaten with a fork, spoon, soup spoon, Chinese soup spoon, chopsticks, or scooped up with a bread product such as roti?
- Is food served plain or with sauces?

- Is there a “most preferred” food, i.e. rice, noodles, potatoes, soup? Is this food served at each meal?
- Are there forbidden foods or forbidden food combinations?
- Are there special foods that are usually served during illness?
- Are special foods served at feasts and celebrations? When do the celebrations occur?
- Are dairy products eaten on a regular basis? Are they served hot, cold, cooked with rice or tapioca, served as buttermilk or yogurt?
- Are vegetables usually served raw, cooked or pickled?

Kitchen equipment should be reviewed to determine if special equipment, for example a rice steamer, could make food preparation easier. The resident’s table setting should be reviewed so that familiar dishes and utensils are available.

Often only small modifications of the menu or changes to the dining program are required. For example, a resident originally from China could be served baked chicken chopped in a bowl of rice with sauce and cooked vegetables. A South Asian resident could be served the baked chicken with rice, plain cooked vegetables, and chutney. A resident who practices vegetarianism could be served tofu or beans with vegetables and rice. Sauces and spices such as chutneys, hoisin or oyster sauce or garam masala can be provided “on the side”. Chopsticks and a bowl can be provided to Chinese residents instead of a fork and knife.

Chapter 9 - Resident Satisfaction

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.3(3) which states:

A licensee must ensure that meals and snacks are prepared and served in a manner which

(a) preserves their nutritive value,

(b) offers variety, appeal and texture,

(c) fulfils the requirements of the resident's nutrition care plan, and

(d) as far as is reasonably practical, recognizes the resident's personal dining and food preferences, religious practices, and cultural customs.

Section 7.3(6) which states:

A licensee must ensure that residents receive ample time to finish meals.

Section 7.5 (c) which states:

A licensee must provide each resident with any eating aids, personal assistance or supervision if required if the resident has difficulty eating or where required by the resident's nutrition care plan.

Section 7.8 which states:

A licensee must ensure that a nutrition and food services audit program acceptable to the medical health officer is in place.

Section 11.3 which states:

(1) A licensee must facilitate a forum for residents and for family members and substitute decision makers, to meet in order to promote the collective and individual interests of residents and the involvement of residents in decision making on matters and concerns which affect their day to day living.

(2) The forum referred to in subsection (1) may consist of a resident council or a resident/family council.

(3) If no resident council or resident/family council is established, a licensee must provide an opportunity, at least annually, for residents, family members or contact persons, or all of them together, to establish a council or similar organization.

REQUIRED AUDITS AND FREQUENCY

(Refer to Chapter 14 for copies of required audits)

1. RESIDENT MEAL QUESTIONNAIRE.

Purpose of Audit:

To audit the satisfaction of residents with the nutrition and food service.

Minimum Acceptable Audit Score:

70%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Resident Meal Questionnaire once per year.
- If the minimum acceptable audit score is not met, repeat the questionnaire until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team; trained volunteers, family members or students

OPTIONAL AUDITS

(Refer to Chapter 15 for copies of optional audits)

1. PLATE WASTE AUDIT.

To audit the acceptance of a food or menu item. Each food or menu item should be evaluated 3 times for a valid result. To be completed when new food or menu items are introduced and when menu changes are made.

RESIDENT SATISFACTION– BACKGROUND INFORMATION

Resident satisfaction with food service should be assessed to identify any concerns with the present food service and to assist the Registered Dietitian Nutritionist and the supervisor of food services/Nutrition Manager to plan departmental goals and objectives. Resident satisfaction with food service is an indicator of the overall evaluation of the department's performance.

The supervisor of food services/Nutrition Manager and Registered Dietitian Nutritionist should select the most appropriate methods of obtaining resident satisfaction information, according to the skills and abilities of the facility's residents. Facilities should complete the required audit, the Resident Meal Questionnaire, and if desired the optional audit, the Plate Waste Audit. Other methods for obtaining resident satisfaction information, if desired, include:

1. Resident/Family Council Meetings

Section 11.3 of the Adult Care Regulations requires facility staff to facilitate a forum for residents and for family members and substitute decision makers, to meet in order to promote the collective and individual interests of residents and the involvement of residents in decision making on matters and concerns which affect their day to day living. Council meeting minutes should be kept for one year. Food and menu issues should be highlighted in the minutes and passed onto the Food Advisory Committee, if available. Departmental responses to issues should be documented.

2. Menu Planning/Food Advisory Committees/Focus Groups

These committees or focus groups can operate on an ongoing or ad hoc basis to evaluate all issues of food service. Minutes of these committees and outcomes of the focus groups should be kept for one year.

3. Meal Rounds

Regular observation of meals provides direct feedback on both food and menu items and the dining room program. Meal rounds can be done by the Registered Dietitian Nutritionist, the supervisor of food services/Nutrition Manager, or by care staff who have received education and training on meal observation and documentation. Meal rounds should be completed at least two meals per week.

4. Suggestion Box

A suggestion box can provide a method for residents and families to give anonymous feedback on food service issues. Suggestions and the facility response to each suggestion should be documented.

Chapter 10 - Resident Participation in Food Service

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.9 which states:

(1) A licensee must encourage residents to participate in food services activities such as menu planning, meal preparation and related activities as far as is reasonably practical, or if required by a resident's nutrition care plan.

(2) A licensee must ensure that a resident who is involved in the preparation of food is adequately supervised to ensure that the food is safely prepared and handled.

REQUIRED AUDITS AND FREQUENCY

There are no audit tools included for this section of the manual. The facility should use the Residential Facility Assessment Instrument – Self Assessment Version to assess compliance to these sections of the Adult Care Regulations. Obtain a copy of the Residential Facility Assessment Instrument from the Community Care Facility Licensing Program in your health region (refer to Appendix 2- Licensing Contacts).

OPTIONAL AUDITS

None.

RESIDENT PARTICIPATION IN FOOD SERVICE - BACKGROUND INFORMATION

Residents should be assisted in maintaining or in acquiring skills in daily living. Where residents participate in food service activities, the licensee shall ensure there is adequate supervision to ensure resident safety and that food is safely prepared and handled.

The objective of this section of the Adult Care Regulations is to promote resident choice and involvement, as well as to maintain or promote skills of daily living. This concept was originally initiated by some programs which support individuals living in residential care homes or group homes in order to promote a normal household routine, and to assist residents in acquiring skills in daily living. However, it is now recognized that activities such as baking and small meal preparation are also very important to residents living in larger facilities, and that these activities can enhance

one's quality of life as well as assist in maintaining skills. For example, many larger facilities now have small resident "kitchens" where residents can make a cup of tea, a snack, or bake, with the help and supervision of staff, as part of the activity program. The care plan should provide information on the resident's participation in food service activities, if appropriate, and the level of supervision required to ensure resident and food safety.

Chapter 11 – Nutrition and Food Service Records

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.11 which states:

A licensee must maintain a record for at least one year of

(a) food purchases,

(b) menu plans and menu substitutions,

(c) food services audits, and

(d) food services education and training programs attended by those individuals involved in providing food services to residents.

REQUIRED AUDITS AND FREQUENCY

There are no audit tools included for this section of the manual. The facility should use the Residential Facility Assessment Instrument – Self Assessment Version to assess compliance to these sections of the Adult Care Regulations. Obtain a copy of the Residential Facility Assessment Instrument from the Community Care Facility Licensing Program in your health region (refer to Appendix 2 - Licensing Contacts).

OPTIONAL AUDITS

None.

NUTRITION AND FOOD SERVICE RECORDS – BACKGROUND INFORMATION

All facilities shall maintain clear and legible records of food purchases, menu plans and menu substitutions, nutrition and food services audits, and food services education and training programs for at least one year. These records shall be made available to licensing staff and funding programs on request.

Records may be kept as paper files or in computer files according to facility resources. Computer files must be made available in the same manner as paper files.

Although the minimum requirement for maintaining records is one year, facilities may choose to keep records for a longer period of time. This will assist facilities in establishing baselines and tracking improvements in services. The accreditation process may require records be kept for longer periods of time.

The following food services records must be kept for at least one year:

1. Food Purchases

- Bills or invoices must be available on request of licensing staff.

2. Menus

- Each menu rotation is kept for 1 year.
- Menus should be dated.

3. Menu Substitutions

- Any changes to the cycle menu must be recorded. In this way frequency of, and reasons for changes (e.g. special occasion, ingredient not in stock, recipe not available, residents do not enjoy, staff not trained to prepare), can be checked to determine if a revision to the menu is required or if operational changes need to be made.
- Menu substitutions must be dated. Menu substitutions could be written permanently on a copy of a dated cycle menu and these menus kept for one year. Alternatively, the facility could have a book to record menu changes.
- Specific items provided for generic items on the cycle menu should be recorded. For example, if the cycle menu states “fruit” then the actual fruit provided should be documented e.g. peach slices. If the cycle menu lists “Chef’s Choice” or “Resident Choice” then the actual food item served should be documented.

4. Food Service Audits

- Copies of all nutrition and food service audits should be maintained.

5. Ongoing Education and Training Plan

- Records state the topic/name of program, name of presenter/trainer, date, time, location, names of staff in attendance.

FOOD COSTING

Food cost documentation is not a requirement of the regulations, but facilities typically record food costs for budgeting and planning purposes. There are many different ways to calculate food costs, and this can lead to confusion when facilities attempt to compare food costs. Consistent reporting of food costs among facilities will facilitate comparisons of food costs.

The following formula is one way that facilities that do not provide any free food or beverages to staff, management or guests can calculate gross resident food costs per month. Do not include cleaning or paper supplies and equipment costs.

Total of inventory at the beginning of the reporting period		$ _____
Total purchases for the month (including nutrition supplements and tube feeding formulas)	+	$ _____
Total inventory at end of the reporting period	-	$ _____
Gross food cost for the reporting period	=	$ _____

$$\frac{\text{Gross food cost per reporting period}}{\text{Number of residents x number of days in reporting period}} = \textbf{Cost/Resident Meal day}$$

Facility staff should discuss what items will be included in the food cost calculation to allow comparison between different reporting periods. Items to consider in food cost calculations include:

- cost of food and beverages provided or sold to staff, management, guests or meals-on-wheels (and any actual revenue and/or equivalent revenue value from these food and beverages);
- other relevant food items including bottled water, emergency food supply, ice and soft drinks;
- non-food items such as tube feeding supplies, disposable supplies, recycling charges, fuel surcharge and chemicals for dishwashing; and
- food service recovery items including non-resident catering charges, recycling charge refunds, and additional tube feeding funding.

Chapter 12 - Training of Staff

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 7.10 which states:

A licensee must ensure that staff responsible for food services

(a) have the training necessary to ensure that food is safely prepared and handled and meets the nutrition needs of the residents, and

b) receive on-going education regarding food services, nutrition and, where required, assisted eating techniques.

Section 7.11 (d) which states:

A licensee must maintain a record for at least one year of food services education and training programs attended by those individuals involved in providing food services to residents.

REQUIRED AUDITS AND FREQUENCY

There are no audit tools included for this section of the manual. The facility should use the Residential Facility Assessment Instrument – Self Assessment Version to assess compliance to these sections of the Adult Care Regulations. Obtain a copy of the Residential Facility Assessment Instrument from the Community Care Facility Licensing Program in your health region (refer to Appendix 2 - Licensing Contacts).

OPTIONAL AUDITS

None.

TRAINING OF STAFF – BACKGROUND INFORMATION

Staff must be provided with initial and ongoing training to ensure:

- safe and appropriate food preparation and service;
- provision of appropriate care to meet resident's nutritional needs; and
- adequate assistance and supervision of residents during meals and snacks.

Training and education taken by staff should be specific and relevant to the needs of the resident. The interdisciplinary team should develop an education and training plan by evaluating the education needs, skills and abilities (including literacy) of staff. Initial and ongoing training can be provided using a variety of methods including:

- orientation of new staff;
- staff meetings;
- written direction using a communication book;
- meetings with individual staff;
- inservices with staff groups; and/or
- community college or technical school courses.

Education and training events should be provided in response to items identified during the nutrition and food service audit process. Staff turnover should be considered when developing the training plan. The facility must keep records to document training events. These records should state the topic/name of program, name of presenter/trainer, date, time, location, names of staff in attendance. Refer to Appendix 11 - Sample Education and Training Attendance Form.

Some suggested topics for education and training include:

- Auditing Methods;
- Choking prevention;
- Constipation;
- Dining room program;
- Dysphagia;
- Emergency preparation;
- Food Preparation for different cultures;
- Food Safety Plan;
- FoodSafe, Level 1 and Level 2 as appropriate;
- HACCP (Hazard Analysis Critical Control Points);

- Hydration;
- Meal management;
- Nourishment delivery;
- Personal hygiene and Infection control;
- Portion control;
- Recording food and fluid intake;
- Resident weighing policies and techniques;
- Supervision of room tray service (if room tray service is provided);
- Texture modifications;
- Therapeutic diets; and
- WHMIS (Workplace Hazardous Materials Information System).

If volunteers are involved in the care of residents (e.g. assistance and supervision at mealtimes, cooking activities) then the volunteers should receive appropriate training to ensure the health and safety of residents.

Chapter 13 - Policies and Procedures

REQUIREMENTS OF THE ADULT CARE REGULATIONS

Section 9 which states:

A licensee must develop and implement written policies to guide staff actions in all matters relating to the care of residents.

REQUIRED AUDITS AND FREQUENCY

There are no audit tools included for this section of the manual. The facility should use the Residential Facility Assessment Instrument – Self Assessment Version to assess compliance to these sections of the Adult Care Regulations. Obtain a copy of the Residential Facility Assessment Instrument from the Community Care Facility Licensing Program in your health region (refer to Appendix 2 - Licensing Contacts).

OPTIONAL AUDITS

None.

POLICIES AND PROCEDURES – BACKGROUND INFORMATION

The interdisciplinary team must develop and implement written policies to guide staff actions in all matters relating to the nutrition care of residents. There should be policies on all components of the nutrition and food service in the facility. Comprehensive, well-written resident care policies:

- support and direct resident care;
- assist staff in adhering to legal, professional and legislative requirements;
- provide guidance to new and existing staff in the provision of care in the event of staff absences;
- communicate the facility's vision, mission, values and expectations, to staff, residents and families; and
- promote information sharing and opportunities for learning.

It is recommended that the policy development process is continuous; it includes development, implementation, regular review and revision as necessary. The interdisciplinary team should discuss

timelines for regular review of policies. Policies may need revision due to changes that effect the facility operation including:

- revision of the Adult Care Regulations;
- new organizational structure; and
- shift in client needs or client group.

Policies provide guidance and direction which address resident care and support; promote consistency in care and services; and reflect acceptable industry and professional practices. Policies should be made available to residents, families, facility staff and the public.

The interdisciplinary team needs to develop policies that provide guidance to staff in communicating nutrition concerns to each other. Some examples of policies that may need to be developed include how:

- changes in the resident's status (e.g. weight changes, abnormal lab values, swallowing or chewing problems, etc) are communicated to the Registered Dietitian Nutritionist in order that the nutrition care plan can be revised to reflect the resident's needs.
- changes to the nutrition care plan will be incorporated into the overall care plan.
- changes to the nutrition care plan will be communicated to all staff.

The facility will need to develop policies on the following:

- Nutrition Care (such as bowel management, discharge planning, drug-nutrient interactions, dysphagia management, eating aids, food intake record, height and weight records, hydration, nutritional assessment and care plans, nutrition supplements, pressure ulcers, short stay, tube feeding).
- Food Service Purchasing (such as food and supplies procurement, inventory control, receiving, storage).
- Food Production (such as production sheets, standardized recipes, use of leftovers).
- Menu and Meal Service (such as brunch, catering for special events, contingency plan, emergency plan, guest meals, meal rounds, meal service for infection containment, menu planning, nourishments, packed meals and snacks, portion standards, posted menu, resident dining, resident participation in food service activities, supervision and assistance of residents, tray service).
- Food Safety (contact the regional environmental health officer for more information on suggested policies).

The *Food and Nutrition for Quality Care: A Policy and Procedure* manual contains generic policies and is written in a format that allows residential health care facilities to individualize the policies and procedures, thereby making them facility specific. It also promotes an interdisciplinary approach to the greatest extent possible (Refer to Appendix 1 – Resources).

Chapter 14 – Required Nutrition and Food Service Audit Tools

NUTRITION CARE PLAN AUDIT

(Refer to Chapter 3 – Nutrition Care for Background Information)

Purpose of Audit:

To audit whether nutrition care plans are developed within two weeks of the resident's admission, reviewed within 14 weeks of admission, reviewed as set out in the resident's care plan, revised in response to resident need and monitored to ensure implementation.

Minimum Acceptable Audit Score:

100%

Minimum Audit Frequency:

- If the minimum acceptable audit score is met, complete the Nutrition Care Plan Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team. In many facilities, the Registered Dietitian Nutritionist does not audit their own charting of residents. Instead they work with other members of the team and trade auditing tasks. This requires development of an interdisciplinary policy and educational support.

Procedure:

1. Complete the audit.

- Randomly choose 10% (maximum of 20, minimum of 4) charts. Charts can be chosen by taking every Xth chart, alphabetically or by any other random sample. Charts can be selected for type of diagnosis, nutrition risk or acuity of illness, but then results will only be valid for the specific parameter chosen and not applicable to the resident population as a whole.
- Audit charts. Use one nutrition care plan audit form for each resident or use the nutrition care plan audit summary form for all residents.

  Remember that the Adult Care Regulations were revised in January 1997 and that there were significant changes to the requirements for nutrition care plans at this time. The facility should not be expected to comply with these regulations prior to January 31, 1997. For each resident, review the following items:

  – Nutrition care plan developed within two weeks of admission. Check the date of admission. The initial nutrition care plan should be dated within two weeks of the admission date.

  – Nutrition care plan documented in the resident's overall care plan. Check that the nutrition component of the care plan is documented in the overall care plan. In some facilities, the overall care plan may cross-reference the nutrition care plan.

  - Nutrition care plan reviewed within 14 weeks of admission. Check the date of admission. The review of the initial nutrition care plan should be dated within 14 weeks of the admission date.
  - Nutrition care plan reviewed as set out in the resident's care plan. For example, if the overall care plan indicates that all components of the care plan will be reviewed every 6 months then the nutrition care plan should be reviewed within this time frame.
  - Nutrition care plan revised in response to resident's needs. Resident needs include the presence of new or changed conditions that have a strong influence on an individual's nutrition status, such as:
    - permanent loss of ability to ambulate freely or use the hands to grasp small objects;
    - deterioration in behaviour, mood or relationships;
    - deterioration in resident's health status, e.g. weight loss, abnormal lab values, dysphagia;
    - marked or sudden improvement in the resident's health status; and/or
    - significant changes in medication.
  - Nutrition care plan monitored to ensure implementation. Evaluate whether the facility is actually following the action plan specified for the resident in the nutrition care plan.
  - Nutrition care plan completed by the Registered Dietitian Nutritionist. Check that the nutrition care plan is signed by a Registered Dietitian Nutritionist.
  - Appropriate intervention (suitable professional advice e.g. RDN, physician) when a resident experiences a significant weight change. Review the weight record of the resident for significant weight change. If there was a significant change, determine whether there was appropriate intervention for the resident.

- For each item, put a tick (✔) mark in the appropriate column.
  - Yes indicates that the nutrition care plan was appropriate for this item of the audit.
  - No indicates the nutrition care plan was inappropriate for this item of the audit.
  - N/A indicates that this item was not applicable.

2. Score the audit.

- Use the nutrition care plan audit summary form to collate the results of the audit.
- Audit score (%) = $\frac{\text{Total \# Yes + Total \# N/A}}{\text{Total \# charts audited}} \times 100$

3. Determine whether the minimum audit score is met or not met for all items.

4. Document any problems identified, corrective actions taken, and date for re-audit.

NUTRITION CARE PLAN AUDIT

NAME OF AUDITOR	DATE OF AUDIT
NUTRITION CARE PLAN AUDIT #	RESIDENT INITIALS
ADMISSION DATE	

ISSUE	YES	NO	N/A	COMMENTS
Nutrition care plan developed within two weeks of admission				
Nutrition care plan documented in the resident's overall care plan				
Nutrition care plan reviewed within 14 weeks of admission				
Nutrition care plan reviewed as set out in the resident's care plan				
Nutrition care plan revised in response to resident's needs				
Nutrition care plan monitored to ensure implementation				
Nutrition care plan completed by the Registered Dietitian Nutritionist				
Appropriate intervention (suitable professional advice e.g. RDN, physician) when a resident experiences a significant weight change (> 5%/one month, > 7.5%/3 mos., >10%/ 6 mos.)				

NUTRITION CARE PLAN AUDIT SUMMARY

FACILITY NAME	# NUTRITION CARE PLANS AUDITED
DATE OF AUDIT	NAME OF AUDITOR

Y = YES N = NO N/A = NOT APPLICABLE

ISSUE	NUTRITION CARE PLAN AUDIT NUMBER										AUDIT SCORE (%) = Y + N/A x 100 / # CHARTS
	1	2	3	4	5	6	7	8	9	10	
Nutrition care plan developed within two weeks of admission											
Nutrition care plan documented in the resident's overall care plan											
Nutrition care plan reviewed within 14 weeks of admission											
Nutrition care plan reviewed as set out in the resident's care plan											
Nutrition care plan revised in response to resident's needs											
Nutrition care plan monitored to ensure implementation											
Nutrition care plan completed by the Registered Dietitian Nutritionist											
Appropriate intervention (suitable professional advice e.g. RDN, physician) when a resident experiences a significant weight change (> 5%/one month, > 7.5%/3 mos., >10%/ 6 mos.)											

ACCEPTABLE AUDIT SCORE (100%) ☐ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

NUTRITION CARE PLAN AUDIT

Note: Only Audit for one Resident provided as sample. Refer to Audit Instructions for Min. Number to Audit

NAME OF AUDITOR	DATE OF AUDIT
R. Smith	*November 15, 2001*
NUTRITION CARE PLAN AUDIT #	**RESIDENT INITIALS**
1	*AA*
ADMISSION DATE	
October 30, 2000	

ISSUE	YES	NO	N/A	COMMENTS
Nutrition care plan developed within two weeks of admission	✓			
Nutrition care plan documented in the resident's overall care plan	✓			
Nutrition care plan reviewed within 14 weeks of admission	✓			*Reviewed January 15, 2001.*
Nutrition care plan reviewed as set out in the resident's care plan	✓			*Nutrition care plan indicates to review at minimum annually.* *Annual review completed October 15, 2001.*
Nutrition care plan revised in response to resident's needs			✓	*No change in resident need noted.*
Nutrition care plan monitored to ensure implementation	✓			
Nutrition care plan completed by the Registered Dietitian Nutritionist	✓			*Nutrition care plan signed by RDN.*
Appropriate intervention (suitable professional advice e.g. RDN, physician) when a resident experiences a significant weight change (> 5%/one month, > 7.5%/3 mos., >10%/ 6 mos.)			✓	*Weight was stable since admission.*

SAMPLE

NUTRITION CARE PLAN AUDIT SUMMARY

FACILITY NAME	# NUTRITION CARE PLANS AUDITED
Facility A	*10*
DATE OF AUDIT	**NAME OF AUDITOR**
November 15, 2001	*R. Smith*

Y = YES N = NO N/A = NOT APPLICABLE

ISSUE	NUTRITION CARE PLAN AUDIT NUMBER										AUDIT SCORE (%) = Y + N/A x 100 / # CHARTS
	1	2	3	4	5	6	7	8	9	10	
Nutrition care plan developed within two weeks of admission	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*100*
Nutrition care plan documented in the resident's overall care plan	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*100*
Nutrition care plan reviewed within 14 weeks of admission	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*N/A*	*Y*	*Y*	*100*
Nutrition care plan reviewed as set out in the resident's care plan	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*100*
Nutrition care plan revised in response to resident's needs	*N/A*	*Y*	*Y*	*Y*	*N/A*	*Y*	*Y*	*N/A*	*Y*	*Y*	*100*
Nutrition care plan monitored to ensure implementation	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*100*
Nutrition care plan completed by the Registered Dietitian Nutritionist	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	*100*
Appropriate intervention (suitable professional advice e.g. RDN, physician) when a resident experiences a significant weight change (> 5%/one month, > 7.5%/3 mos., >10%/ 6 mos.)	*N/A*	*Y*	*N/A*	*Y*	*N/A*	*N/A*	*Y*	*N/A*	*N/A*	*Y*	*100*

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
November 2002	*R. Smith*

WEIGHT RECORD AUDIT

(Refer to Chapter 4 – Weight Records for Background Information)

Purpose of Audit:

To audit whether weights are documented for each resident on a monthly basis.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Weight Record Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

- Choose 10% of charts to a maximum of 20 charts (minimum of 4 charts). Charts can be chosen a variety of ways, but avoid choosing charts based on acuity of diagnosis.
- Review the weight records for the previous 12 months.
- Column definitions:
  Column A = the number of months the resident has been in the facility to a maximum of 12.
  Column B = the total number of months that either:
  - the resident's weight is recorded in the resident chart; or
  - there is a reason documented why a resident's weight is not recorded
    e.g. resident on holidays, resident refused.

For example:

- if there are 7 months where the weight is recorded and 5 months where weight is not recorded with no documented reason why the weight was not taken, B= 7;
- if there are 7 months where the weight is recorded and 5 months where the weight was not recorded but the weight record notes that the resident was in hospital then B= 12.

2. Score the audit.

- Total Audit score (%) = $\frac{\text{Total of column B}}{\text{Total of column A}} \times 100$

3. Determine whether the minimum acceptable audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

WEIGHT RECORD AUDIT

NAME OF AUDITOR	DATE OF AUDIT

RESIDENT INITIAL	A. NUMBER OF MONTHS RESIDENT IN FACILITY (MAXIMUM 12)	B. TOTAL NUMBER OF MONTHS RESIDENT WEIGHT RECORDED OR REASON FOR MISSING WEIGHT RECORDED	COMMENTS
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
TOTALS =			

TOTAL AUDIT SCORE = TOTAL COLUMN B / TOTAL COLUMN A X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

WEIGHT RECORD AUDIT

NAME OF AUDITOR	DATE OF AUDIT
L. Scott	*August 1, 2001*

	RESIDENT INITIAL	A. NUMBER OF MONTHS RESIDENT IN FACILITY (MAXIMUM 12)	B. TOTAL NUMBER OF MONTHS RESIDENT WEIGHT RECORDED OR REASON FOR MISSING WEIGHT RECORDED	COMMENTS
1.	*AB*	*12*	*12*	
2.	*BC*	*12*	*12*	*In hospital May and June 2001*
3.	*CD*	*12*	*12*	
4.	*DE*	*6*	*6*	*Resident admitted February 5, 2001*
5.	*EF*	*12*	*12*	
6.	*FG*	*12*	*10*	*Missing March and April 2001 weights*
7.	*GH*	*12*	*12*	
8.	*HI*	*8*	*8*	*Resident admitted December 10, 2000*
9.	*IJ*	*12*	*12*	
10.	*JK*	*12*	*12*	
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
	TOTALS =	*110*	*108*	

TOTAL AUDIT SCORE = **TOTAL COLUMN B** / **TOTAL COLUMN A** **X 100 =** *98* **%**

ACCEPTABLE AUDIT SCORE (100%) ☐ **MET** ☑ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
Missing two weights for resident FG. Resident on Unit 2.	• *Discussion at interdisciplinary*	*L. Scott*
	team meeting occurred on	
	August 4, 2001	
	• *To discuss documentation of*	*Director of Care*
	weights with Unit 2 staff on	
	August 15, 2001	
	• *Repeat audit in Sept. 2001*	*L. Scott*

DATE OF NEXT AUDIT	
September 2001	*L. Scott*

DIET ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

(Refer to Chapter 5 - Preparation and Service of Food for Background Information)

Purpose of the Audit:

To audit whether resident meals are served in compliance with the diet order in the overall care plan and to audit whether residents actually consume the food provided as indicated by their diet order.

Minimum Acceptable Audit Score:

Diet Order Implementation – 100%

Diet Consumption – 100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Diet Order Implementation and Consumption Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the Audit.

- Consider assigning two members of the interdisciplinary team to complete the audit - one team member to record the information in Column 1 – 5 and another team member to record the information in Column 6. This will facilitate an interdisciplinary approach to auditing diet order implementation and diet consumption.
- Randomly select 10% of residents or select residents who are at high nutrition risk to a maximum of 20 (minimum of 4), prior to meal service. Do not select residents who are in the hospital.
- In column 1 (Resident Initials) record the resident's initials.
- In column 2 (Resident Location) record the location of the resident during meal time (room number, dining room and/or seating arrangements in the dining area).
- In column 3 (Care Plan Diet Order) record the diet order from the care plan. Review the care plan to determine the most current diet order (including portion sizes, texture modification, therapeutic diet, dietary restrictions and any other special instructions).
- In column 4 (Diet Kardex) determine whether the diet order in the kitchen (i.e. diet kardex) corresponds to the diet order in the care plan (including portion sizes, texture modification,

therapeutic diet, dietary restrictions and any other special instructions). Put one tick (✔) under Y (Yes), N (No) or E (Exception).

  – If the diet order in the care plan and diet kardex does match then put a tick (✔) under Y (Yes).
  – If the diet order in the care plan and diet kardex does not match then put a tick (✔) under N (No).
  – If there is a valid reason for inconsistency between the diet order in the care plan and diet kardex (e.g. diet order changed in the 24 hours prior to the meal service) then put a tick (✔) under E (Exception). Document the reason for the exception in the comments area of the audit.

- In column 5 (Diet Provided) determine whether the food provided to the resident corresponds to the diet order in the care plan. Put one tick (✔) under Y (Yes), N (No) or E (Exception).

  – If the diet order in the care plan and diet provided to the resident does match then put a tick (✔) under Y (Yes).
  – If the diet order in the care plan and diet provided to the resident does not match then put a tick (✔) under N (No).
  – If there is a valid reason for inconsistency between the diet order in the care plan and the diet provided to the resident (e.g. resident refusal to follow diet order in care plan, resident has stomach flu and served alternate diet) then put a tick (✔) under E (Exception). Document the reason for the exception in the comments area of the audit.

- In column 6 (Diet Consumed) determine whether the resident actually consumes at least 75% of the food provided. Put one tick (✔) under Y (Yes), N (No) or E (Exception).

  – If at least 75% of the food is consumed by the resident then put a tick (✔) under Y (Yes).
  – If less than 75% of the food is consumed by the resident then put a tick (✔) under N (No). If the resident consumes less than 75%, try to determine why the resident did not finish their meal (e.g. discuss with care staff, talk to resident).
  – If there is a valid reason for the resident not consuming the food provided (e.g. resident out for meal, resident refusal to eat meal, resident has stomach flu and served alternate diet) then put a tick (✔) under E (Exception). Document the reason for the exception in the comments area of the audit. If the resident refuses to consume their meal then this information should be communicated to the Registered Dietitian Nutritionist.

2. Score the audit.

- Diet Order Implementation

  – Under column 4 (Diet Kardex), total the number of tick marks under Y and total the number of tick marks under E.

– Under column 5 (Diet Provided) total the number of tick marks under Y and total the number of tick marks under E.

– Total Audit Score (%) = $\frac{\text{Column 4 (Y + E) + Column 5 (Y + E)}}{\text{\# Resident Diet Orders Audited x 2}}$ x 100

• Diet Consumption

– Under column 6 (Diet Consumed) total the number of tick marks under Y and total the number of tick marks under E.

– Use the formula on the audit form to determine the Total Audit Score.

– Total Audit Score (%) = $\frac{\text{Column 6 (Y + E)}}{\text{\# Resident Diets Audited}}$ x 100

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

DIET ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

NAME OF AUDITOR	DATE OF AUDIT
LOCATION / UNIT	

Y = YES E = EXCEPTION N = NO

1. RESIDENT INITIALS	2. RESIDENT LOCATION	3. CARE PLAN DIET ORDER	4. DIET KARDEX			5. DIET PROVIDED			6. DIET CONSUMED (AT LEAST 75% OF MEAL)		
			Y	E	N	Y	E	N	Y	E	N
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
					+						

DIET ORDER IMPLEMENTATION TOTAL AUDIT SCORE = $\frac{\text{COLUMN 4 (Y+E) + COLUMN 5 (Y+E)}}{\text{\# RESIDENT DIET ORDERS AUDITED X 2}}$ X 100 = _____ %

DIET CONSUMPTION TOTAL AUDIT SCORE = $\frac{\text{COLUMN 6 (Y+E)}}{\text{\# RESIDENT DIET ORDERS AUDITED}}$ X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

Adapted from *Food and Nutrition for Quality Care: A Policy and Procedure Manual*

SAMPLE

DIET ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

NAME OF AUDITOR	DATE OF AUDIT
I. Turner and L. Robb	*October 5, 2001*
LOCATION / UNIT *Main Floor*	

Y = YES E = EXCEPTION N = NO

1. RESIDENT INITIALS	2. RESIDENT LOCATION	3. CARE PLAN DIET ORDER	4. DIET KARDEX			5. DIET PROVIDED			6. DIET CONSUMED (AT LEAST 75% OF MEAL)		
			Y	E	N	Y	E	N	Y	E	N
1. *AA*	*Main*	*General*	✓			✓			✓		
2. *BB*	*Main*	*General, Minced*	✓				✓		✓		
3. *CC*	*Main*	*General, Pureed*	✓			✓			✓		
4. *DD*	*Main*	*Diabetes Diet*	✓			✓			✓		
5. *EE*	*Main*	*General, Pureed Thick Fluids*	✓			✓				✓	
6. *FF*	*Main*	*General*	✓			✓			✓		
7. *GG*	*Main*	*General, Minced*	✓			✓			✓		
8. *HH*	*Main*	*General, Cut Up*	✓			✓			✓		
9. *II*	*Main*	*General, Minced*	✓			✓			✓		
10. *JJ*	*Main*	*General, Pureed*	✓			✓			✓		
			10	*0*	+	*9*	*1*		*9*	*1*	

DIET ORDER IMPLEMENTATION TOTAL AUDIT SCORE = COLUMN 4 (Y+E) + COLUMN 5 (Y+E) / # RESIDENT DIET ORDERS AUDITED X 2 **X 100 =** *100* **%**

DIET CONSUMPTION TOTAL AUDIT SCORE = COLUMN 6 (Y+E) / # RESIDENT DIET ORDERS AUDITED **X 100 =** *100* **%**

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS
Resident BB - exception for diet provided - resident has flu and was served alternate diet
Resident EE - exception for diet consumed - resident out for meal

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
October 2002	*L. Todd and I. Turner*

Adapted from *Food and Nutrition for Quality Care: A Policy and Procedure Manual*

NOURISHMENT ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

(Refer to Chapter 5 - Preparation and Service of Food and Chapter 7 - Nutrition Supplements, Tube Feedings, Eating Aids and Assistance/Supervision for Background Information)

Purpose of the Audit:

To audit whether resident nourishments are served in compliance with the nourishment order documented in the residents' care plan and to audit whether residents actually consume the nourishment provided as indicated by their nourishment order.

Minimum Acceptable Audit Score:

Nourishment Order Implementation – 100%

Nourishment Consumption – 100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Nourishment Order Implementation and Consumption Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

- Consider assigning two members of the interdisciplinary team to complete the audit - one team member to record the information in Column 1 – 5 and another team member to record the information in Column 6. This will facilitate an interdisciplinary approach to auditing nourishment order implementation and nourishment consumption.
- Randomly select 10% residents or select residents who are at high nutrition risk to a maximum of 20 (minimum of 4), prior to nourishment service. Do not select residents who are in the hospital.
- Select the nourishment time to be audited – morning, afternoon or evening nourishments
- In column 1 (Resident Initials) record the resident's initials.
- In column 2 (Resident Location) record the location of the resident during nourishment service (room number, dining room and/or seating arrangements in the dining area).
- In column 3 (Care Plan Nourishment Order) record the nourishment order from the care plan. Review the care plan to determine the most current nourishment order (including nourishments

that require texture modification, nourishments for therapeutic diet, and any other special nourishment).

- In column 4 (Diet Kardex) determine whether the nourishment order in the kitchen (i.e. diet kardex) corresponds to the nourishment order in the care plan (including nourishments that require texture modification, nourishments for therapeutic diet, and any other special nourishment). Put one tick (✔) under Y (Yes), N (No) or E (Exception).
  - If the nourishment order in the care plan and diet kardex does match then put a tick (✔) under Y (Yes).
  - If the nourishment order in the care plan and diet kardex does not match then put a tick (✔) under N (No).
  - If there is a valid reason for inconsistency between the nourishment order in the care plan and diet kardex (e.g. nourishment order changed in the 24 hours prior to the meal service) then put a tick (✔) under E (Exception). Document the reason for the exception in the comments area of the audit.
- In column 5 (Nourishment Provided) determine whether the nourishment provided to the resident corresponds to the nourishment order in the care plan. Put one tick (✔) under Y (Yes), N (No) or E (Exception).
  - If the nourishment order in the care plan and the nourishment provided to the resident does match then put a tick (✔) under Y (Yes).
  - If the nourishment order in the care plan and the nourishment provided to the resident does not match then put a tick (✔) under N (No).
  - If there is a valid reason for inconsistency between the nourishment order in the care plan and the food provided to the resident (e.g. resident refusal to follow nourishment order in care plan, resident has stomach flu and served alternate nourishment) then put a tick (✔) under E (Exception). Document the reason for the exception in the comments area of the audit.
- In column 6 (Nourishment Consumed) determine whether the resident actually consumes at least 75% of the nourishment provided. Put one tick (✔) under Y (Yes), N (No) or E (Exception).
  - If at least 75% of the nourishment is consumed by the resident then put a tick (✔) under Y (Yes).
  - If less than 75% of the nourishment is consumed by the resident then put a tick (✔) under N (No). If the resident consumes less than 75%, try to determine why the resident did not finish their nourishment (e.g. discuss with care staff, talk to resident).
  - If there is a valid reason for the resident not consuming the nourishment provided (e.g. resident out for nourishment, resident refusal to consume nourishment, resident has stomach flu and served alternate nourishment) then put a tick (✔) under E (Exception).

Document the reason for the exception in the comments area of the audit. If the resident refuses to consume their nourishment then this information should be communicated to the Registered Dietitian Nutritionist.

2. Score the audit.

• Nourishment Order Implementation

– Under column 4 (Diet Kardex), total the number of tick marks under Y and total the number of tick marks under E.

– Under column 5 (Nourishment Provided) total the number of tick marks under Y and total the number of tick marks under E.

– Use the formula on the audit form to determine the Total Audit Score.

$$\text{Total Audit Score (\%)} = \frac{\text{Column 4 (Y + E) + Column 5 (Y + E)}}{\text{\# Resident Nourishment Orders Audited x 2}} \times 100$$

• Nourishment Consumption

– Under column 6 (Nourishment Consumed) total the number of tick marks under Y and total the number of tick marks under E.

– Use the formula on the audit form to determine the Total Audit Score.

$$\text{Total Audit Score (\%)} = \frac{\text{Column 6 (Y + E)}}{\text{\# Resident Nourishments Audited}} \times 100$$

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

NOURISHMENT ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

NAME OF AUDITOR	DATE OF AUDIT
LOCATION / UNIT	NOURISHMENT TIME (CIRCLE ONE) AM PM HS

Y = YES E = EXCEPTION N = NO

1. RESIDENT INITIALS	2. RESIDENT LOCATION	3. CARE PLAN NOURISHMENT ORDER	4. DIET KARDEX			5. DIET PROVIDED			6. DIET CONSUMED (AT LEAST 75% OF MEAL)		
			Y	E	N	Y	E	N	Y	E	N
1.											
2.											
3.											
4.											
5.											
6.											
7.											
8.											
9.											
10.											
					+						

NOURISHMENT ORDER IMPLEMENTATION TOTAL AUDIT SCORE = $\frac{\text{COLUMN 4 (Y+E) + COLUMN 5 (Y+E)}}{\text{\# RESIDENT NOURISHMENT ORDERS AUDITED X 2}}$ X 100 = _____ %

NOURISHMENT CONSUMPTION TOTAL AUDIT SCORE = $\frac{\text{COLUMN 6 (Y+E)}}{\text{\# RESIDENT NOURISHMENT ORDERS AUDITED}}$ X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

Adapted from *Food and Nutrition for Quality Care: A Policy and Procedure Manual*

SAMPLE

NOURISHMENT ORDER IMPLEMENTATION AND CONSUMPTION AUDIT

NAME OF AUDITOR	DATE OF AUDIT
D. Parker and M. Smith	*December 1, 2001*
LOCATION / UNIT	**NOURISHMENT TIME (CIRCLE ONE)**
Unit 4	**AM PM (HS)**

Y = YES E = EXCEPTION N = NO

1. RESIDENT INITIALS	2. RESIDENT LOCATION	3. CARE PLAN NOURISHEMENT ORDER	4. DIET KARDEX			5. DIET PROVIDED			6. DIET CONSUMED (AT LEAST 75% OF MEAL)		
			Y	E	N	Y	E	N	Y	E	N
1. *AA*	*Unit 4*	*General*	✓			✓			✓		
2. *BB*	*Unit 4*	*General*	✓			✓			✓		
3. *CC*	*Unit 4*	*General*	✓			✓			✓		
4. *DD*	*Unit 4*	*4 oz milk*		✓			✓			✓	
5. *EE*	*Unit 4*	*Pureed Fruit*	✓			✓				✓	
6. *FF*	*Unit 4*	*General*	✓			✓			✓		
7. *GG*	*Unit 4*	*General*	✓			✓			✓		
8. *HH*	*Unit 4*	*2 digestives*	✓				✓			✓	
9. *II*	*Unit 4*	*1/2 meat sandwich*	✓			✓			✓		
10. *JJ*	*Unit 4*	*General*	✓			✓			✓		
			9	*1*	+	*8*	*2*		*7*	*3*	

NOURISHMENT ORDER IMPLEMENTATION TOTAL AUDIT SCORE = **COLUMN 4 (Y+E) + COLUMN 5 (Y+E)** / **# RESIDENT NOURISHMENT ORDERS AUDITED X 2** **X 100 =** *100* **%**

NOURISHMENT CONSUMPTION TOTAL AUDIT SCORE = **COLUMN 6 (Y+E)** / **# RESIDENT NOURISHMENT ORDERS AUDITED** **X 100 =** *100* **%**

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS	
Resident DD	*- exception for diet kardex - nourishment order changed this afternoon*
	-exception for nourishment provided - resident has stomach flu
	- exception for nourishment consumed - resident has stomach flu
Resident EE	*- exception for nourishment consumed - resident out with family*
Resident HH	*- exception for nourishment provided - resident refusal to follow nourishment order in care plan*
	- exception for nourishment consumed - resident refusal to consume nourishment.
	Refer issue to Registered Dietitian Nutritionist for follow-up.

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
December 2002	*I. Turner and M. Smith*

Adapted from *Food and Nutrition for Quality Care: A Policy and Procedure Manual*

MEAL SERVICE AUDIT

(Refer to Chapter 5 - Preparation and Service of Food for Background Information)

Purpose of the Audit:

To audit the meals served to residents including the appropriateness of the food served, the accuracy of the place setting, and the taste and temperature of the food served.

Minimum Acceptable Audit Score:

Part 1 Accuracy = 100%

Part 2 Food Evaluation = 100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Meal Service Audit twelve times per year. Select therapeutic diet and/or texture modified foods every second audit.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

Part 1 Accuracy – Answer the 4 questions by ticking (✔) either Yes or No.

- Evaluate whether tables are set to the facility and dining area standard prior to the start of meal service.
- Obtain a copy of the cycle menu to determine if foods offered to residents correspond to the menu.
- Obtain a copy of information on portion sizes from the food service department. Observe the service of the meal to audit portion sizes.
- Observe the meal service to audit the overall presentation of meals.

Part 2 Food Evaluation

- Determine menu items to be audited.
- Order menu items from the food service department. Ensure that audited menu items are the same as the menu items served to the residents. Every second audit must focus on either menu items for texture modified foods (minced, pureed or thickened), and/or a menu items specific to a therapeutic diet.

- For each menu item selected tick (✓) on the audit whether the aroma, temperature, appearance, taste and texture is acceptable or unacceptable.
    - A menu item with an acceptable aroma has pleasant odor. Food modified for texture or therapeutic diets should smell similar to food that has not been modified in texture.
    - A menu item with an acceptable temperature is served at a temperature that is appropriate i.e. hot foods should be served hot and cold foods should be served cold.
    - A menu item that is acceptable in appearance will look appetizing. The appearance of cut up, minced or pureed items is acceptable when the items are separated on the plate and when they are the same colour as the food that has not been modified in texture.
    - A menu item with an acceptable taste will taste good. Food modified for texture or therapeutic diets should taste similar to food that has not been modified in texture.
    - A menu item with an acceptable texture will feel appropriate in the mouth when tasted. Some examples of acceptable texture include: a salad that is crunchy, mashed potatoes that are smooth without lumps, roast beef that is easy to chew and pureed foods that have a smooth, semiliquid texture. Some examples of unacceptable texture include: a salad that is limp and soggy, mashed potatoes that are lumpy, roast beef that is tough and pureed foods that are lumpy.

2. Score the audit.

$$\text{Part 1 Accuracy (\%)} = \frac{\text{Total \# Yes}}{4} \times 100$$

$$\text{Part 2 Food Evaluation (\%)} = \frac{\text{Total \# Acceptable}}{\text{\# menu items audited} \times 4} \times 100$$

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

MEAL SERVICE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
MEAL	DINING AREA / LOCATION
DIET / TEXTURE	

PART 1 ACCURACY

	Yes	No
1. Is table set to facility and dining area standard (cutlery, dishes, etc)?	☐	☐
2. Are foods offered correct according to the menu?	☐	☐
3. Are portion sizes correct according to facility standard?	☐	☐
4. Is overall presentation of meal acceptable (clean, tableware intact, attractive)?	☐	☐

PART 2 FOOD EVALUATION

Menu Items Selected	Aroma		Temperature		Appearance		Taste		Texture	
	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable
1.										
2.										
3.										
4.										
5.										
Total # Acceptable =		+		+		+		+		

PART 1 ACCURACY AUDIT SCORE = $\frac{\text{\# YES}}{4}$ X 100 = _____ %

PART 2 FOOD EVALUATION AUDIT SCORE = $\frac{\text{TOTAL \# ACCEPTABLE}}{\text{\# OF MENU ITEMS AUDITED X 4}}$ X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

MEAL SERVICE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
C. James	*July 15, 2001*
MEAL	**DINING AREA / LOCATION**
Lunch	*Special Care Unit*
DIET / TEXTURE	
General Diet	

PART 1 ACCURACY

	Yes	No
1. Is table set to facility and dining area standard (cutlery, dishes, etc)?	☑	☐
2. Are foods offered correct according to the menu?	☑	☐
3. Are portion sizes correct according to facility standard?	☑	☐
4. Is overall presentation of meal acceptable (clean, tableware intact, attractive)?	☑	☐

PART 2 FOOD EVALUATION

Menu Items Selected	Aroma		Temperature		Appearance		Taste		Texture	
	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable
1. *Beef Stew*	✓		✓		✓		✓		✓	
2. *Mashed Potatoes*	✓		✓		✓		✓			✓
3. *Peas*	✓		✓		✓		✓		✓	
4. *Canned Peaches*	✓		✓		✓		✓		✓	
5.										
Total # Acceptable =	*4*	+	*4*	+	*4*	+	*4*	+	*3*	

PART 1 ACCURACY AUDIT SCORE = $\frac{\text{\# YES}}{4}$ X 100 = *100* %

PART 2 FOOD EVALUATION AUDIT SCORE = $\frac{\text{TOTAL \# ACCEPTABLE}}{\text{\# OF MENU ITEMS AUDITED X 4}}$ X 100 = *95* %

ACCEPTABLE AUDIT SCORE (100%) ☐ MET ☑ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
Mashed potatoes were lumpy - texture was unacceptable	*• Review of standardized recipe*	*L. Smith*
	for mashed potatoes. Revise	
	recipe to ensure appropriate	
	texture in the future.	
	Complete by July 20, 2001	
	• Discussion with cook	*L. Smith*
	regarding preparation	
	of potatoes by July 20, 2001	
	• Repeat audit on July 22,	*C. James*
	2001 by C. James when	
	mashed potatoes served again.	

DATE OF NEXT AUDIT	
July 22, 2001	*C. James*

SAMPLE

MEAL SERVICE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
D. Bruce	*August 15, 2001*
MEAL	**DINING AREA / LOCATION**
Supper	*2nd Floor*
DIET / TEXTURE	
General Diet; Pureed Foods	

PART 1 ACCURACY

	Yes	No
1. Is table set to facility and dining area standard (cutlery, dishes, etc)?	☑	☐
2. Are foods offered correct according to the menu?	☑	☐
3. Are portion sizes correct according to facility standard?	☑	☐
4. Is overall presentation of meal acceptable (clean, tableware intact, attractive)?	☑	☐

Menu Items Selected	Aroma		Temperature		Appearance		Taste		Texture	
	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable	Acceptable	Unacceptable
1. *Beef Stew*	✓		✓		✓		✓		✓	
2. *Mashed Potatoes*	✓		✓		✓		✓		✓	
3. *Peas*	✓		✓		✓		✓		✓	
4. *Canned Peaches*	✓		✓		✓		✓		✓	
5.										
Total # Acceptable =	*4*	+	*4*	+	*4*	+	*4*	+	*4*	

PART 1 ACCURACY AUDIT SCORE = $\frac{\text{\# YES}}{4}$ X 100 = *100* %

PART 2 FOOD EVALUATION AUDIT SCORE = $\frac{\text{TOTAL \# ACCEPTABLE}}{\text{\# OF MENU ITEMS AUDITED X 4}}$ X 100 = *100* %

ACCEPTABLE AUDIT SCORE (100%) ☑ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
September 15, 2001	*L. Hart*

EATING AIDS AND ASSISTANCE AUDIT

(Refer to Chapter 7 - Nutrition Supplements, Tube Feedings, Eating Aids and Assistance/Supervision for Background Information)

Purpose of Audit:

To audit the provision of eating assistance and supervision to residents.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Eating Aids and Assistance Audit twice per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

- With interdisciplinary staff, discuss how audit will be conducted to respect both residents' and staffs' sensitivity to being observed. Inform residents and staff.
- Select up to four residents who require eating aids, assistance and/or supervision with feeding. Note residents' initials on audit form.
- Check care plan for each resident to determine level of assistance and/or supervision and type of eating aids required.
- Put one tick (✔) under Y (Yes), N (No) or N/A (Not Applicable).

2. Score the audit.

$$\text{Total Audit Score} = \frac{\text{Totals (Y + N/A)}}{\text{\# Residents audited x 20}} \times 100$$

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit. If eating aids, skills or assistance behaviors are scored "no", identify education and training needs for staff and develop an education plan to address those needs.

EATING AIDS AND ASSISTANCE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
DINING AREA / LOCATION	MEAL

Y = YES N/A = NOT APPLICABLE N = NO

	RESIDENT 1			RESIDENT 2			RESIDENT 3			RESIDENT 4		
	INITIALS			INITIALS			INITIALS			INITIALS		
	DIET			DIET			DIET			DIET		
	COMMENTS			COMMENTS			COMMENTS			COMMENTS		
CRITERIA	Y	N/A	N	Y	N/A	N	Y	N/A	N	Y	N/A	N
1. Resident treated with dignity												
2. Resident not rushed												
3. Resident prepared (clothing protector, groomed, etc)												
4. Resident seated at correct place												
5. Resident positioned according to care plan												
6. Eye and/or physical contact made with resident appropriate												
7. Conversation directed to resident as appropriate												
8. Assistant seated while assisting												
9. Assistant's tone of voice friendly and pleasant												
10. Fluids encouraged verbally as appropriate												
11. Fluids given according to care plan												
12. Safe feeding skills encouraged according to care plan												
13. Food prepared and appropriate to care plan (cut up, condiments used appropriately, etc)												
14. Eating aids and utensil present according to care plan												
15. Beverages placed within reach												
16. Spill, dribbles cleaned up courteously												
17. Seconds offered if appropriate												
18. Alternate food provided if requested												
19. Pureed foods served separately (not mixed together by assistant)												
20. Resident provided with safe/timely supervision and assistance												
Totals =			+			+			+			

TOTAL AUDIT SCORE = $\frac{\text{TOTALS (Y + N/A)}}{\text{\# RESIDENTS AUDITED X 20}}$ X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

EATING AIDS AND ASSISTANCE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
D. Webb	*April 15, 2001*
DINING AREA / LOCATION	**MEAL**
3rd Floor	*Supper*

Y = YES N/A = NOT APPLICABLE N = NO

	RESIDENT 1			RESIDENT 2			RESIDENT 3			RESIDENT 4		
	INITIALS *AA*			INITIALS *BB*			INITIALS *CC*			INITIALS *DD*		
	DIET *General*			DIET *Pureed Foods/ Thick Fluids*			DIET *Pureed Foods*			DIET *Minced Foods*		
	COMMENTS *Cut Up Foods Special Utensils*			COMMENTS *Nosy Cup*			COMMENTS *Requires Total Assistance. Nosy Cup*			COMMENTS *Special Utensils*		
CRITERIA	**Y**	**N/A**	**N**	**Y**	**N/A**	**N**	**Y**	**N/A**	**N**	**Y**	**N/A**	**N**
1. Resident treated with dignity	✓			✓			✓			✓		
2. Resident not rushed	✓			✓			✓			✓		
3. Resident prepared (clothing protector, groomed, etc)	✓			✓			✓			✓		
4. Resident seated at correct place	✓			✓			✓			✓		
5. Resident positioned according to care plan	✓			✓			✓			✓		
6. Eye and/or physical contact made with resident appropriate	✓			✓			✓			✓		
7. Conversation directed to resident as appropriate	✓			✓			✓			✓		
8. Assistant seated while assisting	✓				✓		✓			✓		
9. Assistant's tone of voice friendly and pleasant	✓			✓			✓			✓		
10. Fluids encouraged verbally as appropriate	✓			✓			✓			✓		
11. Fluids given according to care plan	✓			✓			✓			✓		
12. Safe feeding skills encouraged according to care plan	✓			✓			✓			✓		
13. Food prepared and appropriate to care plan (cut up, condiments used appropriately, etc)	✓			✓			✓			✓		
14. Eating aids and utensil present according to care plan		✓		✓			✓			✓		
15. Beverages placed within reach	✓			✓			✓			✓		
16. Spill, dribbles cleaned up courteously	✓			✓			✓			✓		
17. Seconds offered if appropriate	✓			✓			✓			✓		
18. Alternate food provided if requested	✓			✓			✓			✓		
19. Pureed foods served separately (not mixed together by assistant)		✓		✓			✓				✓	
20. Resident provided with safe/timely supervision and assistance	✓			✓			✓			✓		
Totals =	*18*	*2*	**+**	*19*	*1*	**+**	*20*	*0*	**+**	*19*	*1*	

TOTAL AUDIT SCORE = TOTALS (Y + N/A) / # RESIDENTS AUDITED X 20 X 100 = *100* **%**

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
October 2001	*D. Smith*

ENTERAL FEEDING IMPLEMENTATION AUDIT

(Refer to Chapter 7 - Nutrition Supplements, Tube Feedings, Eating Aids and Assistance/Supervision for Background Information)

Purpose of Audit:

To audit the provision of enteral feeding to residents.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Enteral Feeding Implementation Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

- With interdisciplinary staff, discuss how audit will be conducted to respect both residents' and staffs' sensitivity to being observed. Inform residents and staff.
- Select up to three residents who require enteral feeding. Note resident's initials on audit form.
- Check care plan for each resident to determine enteral feeding order (including product, amount to tube feeding, length of time, flushing instructions, weight records, weight goals, positioning instructions).
- Check facility policy and procedure for enteral feeding (including flushing instructions, disposal or washing of feeding bags, instructions regarding leftover product, etc)
- Observe feeding procedure and complete audit.
- Put one tick (✓) under Y (Yes), N (No) or E (Exception). If an exception is ticked, document the reason for the exception in the comments area of the audit.

2. Score the audit.

$$\text{Total Audit Score (\%)} = \frac{\text{Total (Y + E)}}{\text{\# Residents Audited x 10}} \times 100 =$$

3. **Determine whether the minimum audit score is met or not met.**

4. **Document any problems identified, corrective actions taken, and date for re-audit. If questions are scored "no", identify education and training needs for staff and develop an education plan to address those needs.**

ENTERAL FEEDING IMPLEMENTATION AUDIT

NAME OF AUDITOR	DATE OF AUDIT

Y = YES E = EXCEPTION N = NO

	RESIDENT 1			RESIDENT 2			RESIDENT 3		
	INITIALS			INITIALS			INITIALS		
CRITERIA	**Y**	**E**	**N**	**Y**	**E**	**N**	**Y**	**E**	**N**
1. Appropriate product used									
2. Correct amount of product administered									
3. Correct length of time of product administered									
4. Tube flushed appropriately									
5. Bag washed or disposed of appropriately									
6. Unused tube feeding disposed of appropriately									
7. Enteral feeding symptoms monitored and documented									
8. Resident weight taken and documented as per care plan									
9. Weight goals achieved									
10. Resident positioned appropriately									
Totals =			+			+			

TOTAL AUDIT SCORE = TOTALS (Y + E) / # RESIDENTS AUDITED X 10 X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

Adapted from *Document Basics: Nutrition Forms for Long Term Care*, 1999.

SAMPLE

ENTERAL FEEDING IMPLEMENTATION AUDIT

NAME OF AUDITOR	DATE OF AUDIT
A. Ross	*November 20, 2001*

Y = YES E = EXCEPTION N = NO

	RESIDENT 1			RESIDENT 2			RESIDENT 3		
	INITIALS *AA*			INITIALS			INITIALS		
CRITERIA	**Y**	**E**	**N**	**Y**	**E**	**N**	**Y**	**E**	**N**
1. Appropriate product used	✓								
2. Correct amount of product administered	✓								
3. Correct length of time of product administered	✓								
4. Tube flushed appropriately	✓								
5. Bag washed or disposed of appropriately	✓								
6. Unused tube feeding disposed of appropriately	✓								
7. Enteral feeding symptoms monitored and documented	✓								
8. Resident weight taken and documented as per care plan	✓								
9. Weight goals achieved	✓								
10. Resident positioned appropriately	✓								
Totals =	*10*		+			+			

TOTAL AUDIT SCORE = $\frac{\text{TOTALS (Y + E)}}{\text{\# RESIDENTS AUDITED X 10}}$ X 100 = *100* **%**

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
November 2002	*A. Ross*

Adapted from *Document Basics: Nutrition Forms for Long Term Care*, 1999.

MENU AUDIT

(Refer to Chapter 8 - Menu Planning for Background Information)

Purpose of Audit:

To audit if each day of the cycle menu meets the minimum recommendations of Canada's Food Guide to Healthy Eating.

Minimum Acceptable Audit Score:

100%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Menu Audit once per year.
- If the minimum acceptable audit score is not met, repeat the audit until the concern is addressed.
- If desired, complete the audit every time a new cycle menu is implemented.

Responsible Staff:

Registered Dietitian Nutritionist or supervisor of food services/Nutrition Manager.

Procedure:

1. Complete the Menu Audit.

- Collect a copy of the facility cycle menu, the nourishment rotation (if not included on the cycle menu) and the standard facility portion sizes.
- Use the Canada's Food Guide to Healthy Eating Serving Size Guidelines table (p. 138) and compare to the standard facility portion sizes to determine the number of servings provided on each day of the menu for the four food groups in Canada's Food Guide.
- For each day of the menu, tick (✔) the number of servings in each food group (M = Milk Products, MA = Meat and Alternatives, VF = Vegetables and Fruit, G = Grain Products). Each cell in the table represents one (1.0) Canada's Food Guide serving of a food or menu item.
- If the menu is selective, use first choice items only. If the menu is non-selective, use all offered menu items (Note: on occasion, a resident may receive less than the offered items on the menu if the resident's nutrition care plan so indicates). For an "a la cart system", use the equivalent of first choice or use a rotation of entrée choices, documenting which choice is used. Total the number of servings for each or the four food groups for each day.
- For each day of the menu determine if the minimum recommendations of Canada's Food Guide are met

Food Group	Minimum number of recommended servings
MILK PRODUCTS (M)	2 SERVINGS
MEAT AND ALTERNATIVES (MA)	2 SERVINGS
VEGETABLES AND FRUIT (VF)	5 SERVINGS
GRAIN PRODUCTS (G)	5 SERVINGS

2. Score the audit.

$$\text{Total Audit Score (\%)} = \frac{\text{\# Days CFG Met}}{\text{Total \# Days of Menu Audited}} \times 100$$

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

CANADA'S FOOD GUIDE TO HEALTHY EATING SERVING GUIDELINES FOR USE WITH THE MEAL PATTERN / MENU AUDIT

MILK PRODUCTS		SERVINGS
Milk	4 oz (125 ml)	0.5
Skim Milk Powder	1/3 cup (75 ml)	1.0
Yogurt	6 oz (175 ml)	1.0
Cheese, cheddar or processed	1 1/2 slices (50 g)	1.0
Cheese, Cottage	#8 Scoop (125 ml)	0.25
Cheese, Parmesan	5 Tbsp (75 ml)	1.0
Ice Cream	#8 Scoop (125 ml)	0.25
Milk Pudding, Custard	#8 Scoop (125 ml)	0.5
Cream Soup, made with milk	125 ml	0.25
GRAIN PRODUCTS		**SERVINGS**
Bread	1 slice	1.0
Cereal, cooked	4 oz (125 ml)	1.0
Cereal, ready to eat	1 oz (30 g)	1.0
Muffin	1	1.0
Muffin, English	1/2	1.0
Biscuit, Baking Powder	1 (30 g)	1.0
Roll, Dinner	1 (30 g)	1.0
Roll, Hamburger, or Wiener	1/2	1.0
Pizza Crust 10"	1/8	1.0
Bagel or Pita	1/2	1.0
Cake	1 1/2" x 1 1/2" piece	1.0
Cookies, plain	2	1.0
Crackers, soda	6 – 8	1.0
Pretzels	1 oz (30 grams)	1.0
Flour	2 1/2 Tbsp (40 ml)	1.0
Popcorn	3 cups (750 ml)	1.0
Pasta, Cooked	4 oz (125 ml)	1.0
Rice, cooked	#8 Scoop (125 ml)	1.0
MEAT AND ALTERNATIVES		**SERVINGS**
Meats, Fish, Poultry: boneless, cooked	2 oz (50 g)	1.0
Chicken: with bone, cooked	3 1/2 oz (100 g)	1.0
Egg	1 medium	1.0
Beans, Lentils, Dried Peas: cooked	4 oz (125 ml)	1.0
Peanut Butter	2 Tbsp. (30 ml)	1.0
Nuts	1/4 cup (50 ml)	
Tofu	1/3 cup (100g)	1.0
VEGETABLES AND FRUIT		**SERVINGS**
Potato	#8 Scoop (125 ml) 1 medium whole	1.0
Fruits or Vegetables: cooked, mashed or pureed	#8 Scoop (125 ml)	1.0
Fruits: fresh, whole	1 medium	1.0
Juices	4 oz (125 ml)	1.0
Raisins	2 Tbsp (30 ml)	1.0
Salad: leaf salad	1 cup (250 ml)	1.0
Salad: grated vegetable salad	1/2 cup (125 ml)	1.0
COMBINATION FOODS: *(due to recipe variation, these are examples only)*		
Beef and Vegetable Stew	6 oz (175 ml) = 1.0 Meat and Alternatives, .5 Vegetables and fruit	
Macaroni and Cheese	6 oz (175 ml) = 1.0 Grain Products, 0.25 Milk Products	
Tuna Noodle Casserole	6 oz (175 ml) = 1.0 Grain Products, 1.0 Meat and Alternatives	
Cream Soup (made with milk)	4 oz (125 ml) = 0.25 Milk Products	

MENU AUDIT

NAME OF AUDITOR	DATE OF AUDIT

FOOD GROUP	MINIMUM NUMBER OF RECOMMENDED SERVINGS
MILK PRODUCTS (M)	2 SERVINGS
MEAT AND ALTERNATIVES (MA)	2 SERVINGS
VEGETABLES AND FRUIT (VF)	5 SERVINGS
GRAIN PRODUCTS (G)	5 SERVINGS

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
M																												
M																												
M																												
MA																												
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TOTAL AUDIT SCORE = **# DAY CFG MET** / **TOTAL # DAYS OF MENU AUDITED** **X 100 =** ____________ **%**

ACCEPTABLE AUDIT SCORE (100%) ☐ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

Adapted from *Menu Checklist, Community Nutritionists Council of British Columbia* (Standing Committee on Licensing)

MENU AUDIT

NAME OF AUDITOR	DATE OF AUDIT
W. Clark	*March 10, 2001*

FOOD GROUP	MINIMUM NUMBER OF RECOMMENDED SERVINGS
MILK PRODUCTS (M)	2 SERVINGS
MEAT AND ALTERNATIVES (MA)	2 SERVINGS
VEGETABLES AND FRUIT (VF)	5 SERVINGS
GRAIN PRODUCTS (G)	5 SERVINGS

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
M	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M	✓	✓		✓		✓	✓		✓		✓	✓		✓	✓		✓		✓	✓	✓		✓		✓		✓	✓
MA	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MA	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MA	✓				✓				✓				✓	✓		✓			✓		✓	✓		✓	✓		✓	
VF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓			✓			✓	✓	✓	✓
VF	✓				✓						✓				✓			✓				✓				✓	✓	✓
VF																												
VF					✓										✓													
VF																												
G	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
G	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
G	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
G	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
G	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
G	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓		✓	✓	✓	✓	✓	✓	✓	✓	
G	✓	✓	✓	✓			✓		✓			✓	✓	✓	✓			✓		✓	✓				✓	✓	✓	
G	✓		✓				✓		✓					✓							✓						✓	
G	✓													✓														
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CFG MET	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

TOTAL AUDIT SCORE = **# DAY CFG MET / TOTAL # DAYS OF MENU AUDITED** X 100 = *100* %

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
March 2002	*W. Clark*

Adapted from *Menu Checklist, Community Nutritionists Council of British Columbia* (Standing Committee on Licensing)

RESIDENT MEAL QUESTIONNAIRE

(Refer to Chapter 9 – Resident Satisfaction for Background Information)

Purpose of Audit:

To audit the satisfaction of residents with the nutrition and food service.

Minimum Acceptable Audit Score:

70%

Audit Frequency:

- If the minimum acceptable audit score is met, complete the Resident Meal Questionnaire once per year.
- If the minimum acceptable audit score is not met, repeat the questionnaire until the concern is addressed.

Responsible Staff:

Member of the interdisciplinary team; trained volunteers, family members or students.

Procedure:

1. Complete the audit.

- Select the group of residents to be surveyed or distribute to all residents.
- Inform residents and care staff how and when questionnaires will be distributed and collected. Explain how information will be used.
- Consider involving volunteers/family members in assisting residents with completing questionnaires.

2. Score the audit.

- Use the Resident Meal Questionnaire Scoring Form to collate answers.
- For each question (question 1 – 8 only):
  - total the number of residents that responded yes
  - total the number of residents that responded no
  - determine the number of responses by adding a) + b)
- Score each question

$$\text{Score for Question (\%)} = \frac{\text{\# Yes} \times 100}{\text{\# responses to question}}$$

3. Determine whether the minimum audit score is met or not met for question 1 - 8.

4. Document any problems identified, corrective actions taken, and date for re-audit.

RESIDENT MEAL QUESTIONNAIRE

We would like to know what you think about the food you are offered and how it is served. Please help us keep improving the food we serve to you. Please answer the questions below, and give it to a staff member or leave it at the nursing desk. If you would like help to fill this out, someone will be happy to help you.

1. Does your food taste good? ☐ Yes ☐ No

   Comments _____

2. Does your food look good? ☐ Yes ☐ No

   Comments _____

3. Are your foods served at the correct temperature? ☐ Yes ☐ No
   (hot foods served hot and cold foods served cold)

   Comments _____

4. Are your servings the right size? ☐ Yes ☐ No

   If no, are your servings too small? ☐ too large? ☐

5. Do you eat most of the food you receive at each meal? ☐ Yes ☐ No

   Comments _____

6. If you do not like the meal you are served, are you offered another choice? ☐ Yes ☐ No

   Comments _____

7. Do you receive the help you need to eat at your meals? ☐ Yes ☐ No
(If you do not need help, do not answer this question)

Comments _____

8. Have your meals been served to you in a pleasant manner? ☐ Yes ☐ No

Comments _____

9. What are your least favourite dishes that we offer? _____

_____

10 What are the favourite dishes that we offer? _____

_____

11 What are your favourite dishes that we do not offer? _____

_____

12. Do you have any other comments? _____

_____

_____

Thank you for completing the questionnaire.

RESIDENT MEAL QUESTIONNAIRE SCORING FORM

NAME OF AUDITOR	DATE OF AUDIT

QUESTIONNAIRES RETURNED

QUESTION	# YES	# NO	# RESPONSES TO QUESTION	SCORE FOR QUESTION (%) = # YES X 100 / # RESPONSES TO QUESTION
1. Does your food taste good?				
2. Does your food look good?				
3. Are your foods served at the correct temperature?				
4. Are your servings the right size?				
5. Do you eat most of the food you receive at each meal?				
6. If you do not like the meal served, offered another choice?				
7. Do you receive the help you need to eat at your meals?				
8. Have your meals been served to you in a pleasant manner?				

ACCEPTABLE AUDIT SCORE (70%) FOR QUESTION 1-8 ☐ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

RESIDENT MEAL QUESTIONNAIRE SCORING FORM

NAME OF AUDITOR	DATE OF AUDIT
C. Kane	*September 2, 2001*
# QUESTIONNAIRES RETURNED	
100	

QUESTION	# YES	# NO	# RESPONSES TO QUESTION	SCORE FOR QUESTION (%) = # YES X 100 / # RESPONSES TO QUESTION
1. Does your food taste good?	*84*	*16*	*100*	*84 %*
2. Does your food look good?	*80*	*15*	*95*	*84 %*
3. Are your foods served at the correct temperature?	*95*	*5*	*100*	*95 %*
4. Are your servings the right size?	*78*	*16*	*94*	*83 %*
5. Do you eat most of the food you receive at each meal?	*72*	*19*	*91*	*79 %*
6. If you do not like the meal served, offered another choice?	*85*	*10*	*95*	*89 %*
7. Do you receive the help you need to eat at your meals?	*89*	*10*	*99*	*90 %*
8. Have your meals been served to you in a pleasant manner?	*87*	*13*	*100*	*87 %*

ACCEPTABLE AUDIT SCORE (70%) FOR QUESTION 1-8 ☑ **MET** ☐ **NOT MET**

COMMENTS
No concerns identified by audit.

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
September 2002	*C. Kane*

Chapter 15 - Optional Nutrition and Food Service Audits

MEAL CONSUMPTION AUDIT

OPTIONAL AUDIT

(Refer to Chapter 3 – Nutrition Care for Background Information)

Purpose of Audit:

To audit the food intake of an individual resident for one or more meals.

Minimum Acceptable Audit Score:

75% for each resident.

Responsible Staff:

Member of the interdisciplinary team.

The Meal Consumption Audit can be used as an optional method of resident nutrition monitoring which can be used in conjunction with the required audits. This audit is used to assess how much of the food served is eaten by the resident and is therefore a measure of the energy and nutrient intake of the resident. The Meal Consumption Audit can be used to monitor the intake of residents who are at moderate or high nutrition risk. An alternate method to determine nutrient intake for an at-risk resident could be a multi-day food record.

This audit should not be used to determine widespread resident acceptance of a single food or menu item; use Plate Waste Audit for this.

Procedure:

1. Complete the audit.

- Choose resident/s and meal/s to be audited. Audit should be "blind", i.e. Residents must be unaware that their meal is to be audited.
- Instruct staff not to clear tables until audit has been completed, or to clear meal trays to a separate cart until audit can be completed.
- Indicate menu item to be audited for each resident.
- Estimate the portion of food "left over" for each menu item for each resident, and tick (✔) the appropriate cell (F, 3/4,1/2,1/4, 0).
  F = full portion left
  3/4 = 3/4 portion left
  1/2 = 1/2 portion left
  1/4 = 1/4 portion left
  0 = 0 portion left

Note: If a meal appears untouched, investigate and if justified, eliminate it from your audit (e.g. resident out for meal).

2.Score the audit.

- An acceptable score for **each** resident is at least 75%. This indicates that the resident has eaten 75% of the menu items served.
- Score each resident's meal separately.
- Total the number of ticks (✔) in each column.
- Calculate totals
  Multiply number of ticks in F column by 0.
  Multiply number of ticks in ¾ column by 1.
  Multiply number of ticks in ½ column by 2.
  Multiply number of ticks in ¼ column by 3.
  Multiply number of ticks in 0 column by 4.
- Determine audit score for each resident.

$$\text{Audit score for resident (\%)} = \frac{(\text{Total F} + \text{Total } ¾ + \text{Total } ½ + \text{Total } ¼ + \text{Total 0})}{\text{\# menu items audited} \times 4} \times 100$$

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

MEAL CONSUMPTION AUDIT

NAME OF AUDITOR	DATE OF AUDIT

RESIDENT						RESIDENT						RESIDENT					
MEAL						MEAL						MEAL					
PORTION SIZE						PORTION SIZE						PORTION SIZE					
DIET						DIET						DIET					
	FOOD LEFT						FOOD LEFT						FOOD LEFT				
MENU ITEM	F	3/4	1/2	1/4	0	MENU ITEM	F	3/4	1/2	1/4	0	MENU ITEM	F	3/4	1/2	1/4	0
TOTAL # OF ✓						TOTAL # OF ✓						TOTAL # OF ✓					
MULTIPLY BY	0	1	2	3	4	MULTIPLY BY	0	1	2	3	4	MULTIPLY BY	0	1	2	3	4
TOTALS						TOTALS						TOTALS					
AUDIT SCORE = TOTALS X 100 / # MENU ITEMS X 4 = _____%						AUDIT SCORE = TOTALS X 100 / # MENU ITEMS X 4 = _____%						AUDIT SCORE = TOTALS X 100 / # MENU ITEMS X 4 = _____%					

ACCEPTABLE AUDIT SCORE (75% OR MORE) FOR EACH RESIDENT ☐ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

MEAL CONSUMPTION AUDIT

NAME OF AUDITOR	DATE OF AUDIT
C. Bender	*November 22, 2001*

RESIDENT	*AA*
MEAL	*Lunch*
PORTION SIZE	*Regular*
DIET	*General*

MENU ITEM	FOOD LEFT F	3/4	1/2	1/4	0
Chicken				✓	
Rice					✓
Carrots					✓
Pudding					✓
Milk					✓
TOTAL # OF ✓	*0*	*0*	*0*	*1*	*4*
MULTIPLY BY	0	1	2	3	4
TOTALS	*0*	*0*	*0*	*3*	*16*

AUDIT SCORE = TOTALS X 100 / # MENU ITEMS X 4 = *95* %

RESIDENT	
MEAL	
PORTION SIZE	
DIET	

MENU ITEM	FOOD LEFT F	3/4	1/2	1/4	0
TOTAL # OF ✓					
MULTIPLY BY	0	1	2	3	4
TOTALS					

AUDIT SCORE = TOTALS X 100 / # MENU ITEMS X 4 = _____ %

RESIDENT	
MEAL	
PORTION SIZE	
DIET	

MENU ITEM	FOOD LEFT F	3/4	1/2	1/4	0
TOTAL # OF ✓					
MULTIPLY BY	0	1	2	3	4
TOTALS					

AUDIT SCORE = TOTALS X 100 / # MENU ITEMS X 4 = _____ %

ACCEPTABLE AUDIT SCORE (75% OR MORE) FOR EACH RESIDENT ☑ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		
Repeat audit on Resident AA on November 29, 2001 to assess food intake.		

DATE OF NEXT AUDIT	
Repeat audit on Resident AA on November 29, 2001	*C. Bender*

DINING PROGRAM CHECKLIST

OPTIONAL AUDIT

(Refer to Chapter 5 - Preparation and Service of Food and Chapter 7 - Nutrition Supplements, Tube Feedings, Eating Aids and Assistance/Supervision for Background Information)

Purpose of Audit:

To audit the meal service in the facility dining program.

Minimum Acceptable Audit Score:

100%

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

- Observe meals for eating aids, assistance and supervision.
- Complete checklist by ticking (✔) Y, N or E. Y = Yes, N = No, E = Exception. If an exception is ticked, document the reason for the exception in the comments area of the audit.

2. Score the audit.

$$\text{Total Audit Score} = \frac{\text{Total \# Y + \# E Responses}}{14} \times 100$$

An acceptable score is 100%.

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions taken, and date for re-audit.

DINING ROOM PROGRAM CHECKLIST

NAME OF AUDITOR	DATE OF AUDIT

Y = YES N = NO E = EXCEPTION

	Y	N	E
Inservice training on assisted eating and feeding skills is provided to all relevant staff at least annually.			
Meals are observed to be served at posted times.			
Regular rotation of the service of meals (so no residents are always served last).			
Special occasions, holidays and birthdays are celebrated.			
Residents do not wait more than 10 minutes for assistance with meals.			
Residents who require assistance receive their meals at the appropriate temperature.			
Meals are served at the same time for everyone seated at the same table.			
Dining rooms are homelike, attractive, and provide adequate space for residents to maneuver.			
Lighting in the dining room is appropriate for facility residents.			
Temperature of the dining room is kept at an acceptable level according to resident preferences.			
TVs or loud music is discontinued at meal times.			
Resident preference of soft music is provided at meals.			
Staff who serve food are observed to be polite and respectful to residents.			
Dining room conversations are directed to resident.			
Totals =		**+**	

TOTAL AUDIT SCORE = $\frac{\text{TOTALS (Y + E)}}{14}$ X 100 = _____ %

ACCEPTABLE AUDIT SCORE (100%) ☐ **MET** ☐ **NOT MET**

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

Adapted from the North Shore Health Region, 1999.

SAMPLE

DINING ROOM PROGRAM CHECKLIST

NAME OF AUDITOR	DATE OF AUDIT
A. Wing	*May 14, 2001*

Y = YES N = NO E = EXCEPTION

	Y	N	E
Inservice training on assisted eating and feeding skills is provided to all relevant staff at least annually.	✓		
Meals are observed to be served at posted times.	✓		
Regular rotation of the service of meals (so no residents are always served last).	✓		
Special occasions, holidays and birthdays are celebrated.	✓		
Residents do not wait more than 10 minutes for assistance with meals.	✓		
Residents who require assistance receive their meals at the appropriate temperature.	✓		
Meals are served at the same time for everyone seated at the same table.	✓		
Dining rooms are homelike, attractive, and provide adequate space for residents to maneuver.	✓		
Lighting in the dining room is appropriate for facility residents.	✓		
Temperature of the dining room is kept at an acceptable level according to resident preferences.	✓		
TV's or loud music is discontinued at meal times.	✓		
Resident preference of soft music is provided at meals.	✓		
Staff who serve food are observed to be polite and respectful to residents.	✓		
Dining room conversations are directed to resident.	✓		
Totals =	*14*	**+**	*0*

TOTAL AUDIT SCORE = $\frac{\text{TOTALS (Y + E)}}{14}$ X 100 = *100* **%**

ACCEPTABLE AUDIT SCORE (100%) ☑ **MET** ☐ **NOT MET**

COMMENTS
No concerns identified by audit.

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
May 2002	*A. Scott*

Adapted from the North Shore Health Region, 1999.

PLATE WASTE AUDIT

OPTIONAL AUDIT

(Refer to Chapter 9 - Resident Satisfaction for Background Information)

Purpose of Audit:

To audit the residents' acceptance of specific food or menu items. The audit does not assess an individual's acceptance of a food; it evaluates the overall acceptance of a food or menu item by a group of residents.

Minimum Acceptable Audit Score:

0 - 30%. This indicates how much of the food/menu item was left.

Responsible Staff:

Member of the interdisciplinary team.

Procedure:

1. Complete the audit.

- Select 10% of residents, up to 25 residents (minimum of 4).
- Select one food or menu item to audit.
- With staff, develop a procedure to identify and collect all dishes that contain the food or menu item being audited. This may include the dining room cart or meal trays. Tables should not be cleared.
- Estimate the amount of food or menu item left by the resident and tick (✔) the appropriate column:
  F = full portion
  $^{3}/_{4}$ = $^{3}/_{4}$ portion
  $^{1}/_{2}$ = $^{1}/_{2}$ portion
  $^{1}/_{4}$ = $^{1}/_{4}$ portion
  0 = Nothing left

2. Score the audit.

- Total the number of times each response has been selected in each column.
- Add the scores for each column
  total # F x 4
  total # $^{3}/_{4}$ x 3
  total # $^{1}/_{2}$ x 2
  total # $^{1}/_{4}$ x 1
  total # 0 x 0

- Determine the Total Score
  (total # F x 4) + (total # 3/4 x 3) + (total # 1/2 x 2) + (total # 1/4 x 1) + (total # 0 x 0)
- Total audit score (%) = $\frac{\text{Total Score}}{4 \times \#\text{plates audited}} \times 100$

3. Determine whether the minimum audit score is met or not met.

4. Document any problems identified, corrective actions identified and taken, and date for re-audit.

PLATE WASTE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
MENU OR FOOD ITEM	MEAL B L S
DINING AREA	

PLATE OR TRAY	AMOUNT LEFT					COMMENTS
	F	3/4	1/2	1/4	0	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						
TOTALS						TOTAL THE NUMBER OF UNITS IN EACH COLUMN
MULTIPLY BY	4	3	2	1	0	
COLUMN SCORE						

TOTAL SCORE = (TOTAL # F X 4) + (TOTAL # 3/4 X 3) + (TOTAL # 1/2 X 2) + (TOTAL # 1/4 X 1) + (TOTAL # 0 X 0)

TOTAL AUDIT SCORE = $\frac{\text{TOTAL SCORE}}{\text{4 X PLATES AUDITED}}$ X 100 = _____ %

ACCEPTABLE AUDIT SCORE (0 - 30%) ☐ MET ☐ NOT MET

COMMENTS

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE

DATE OF NEXT AUDIT	

SAMPLE

PLATE WASTE AUDIT

NAME OF AUDITOR	DATE OF AUDIT
R. Dawn	*August 15, 2001*
MENU OR FOOD ITEM *Macaroni and cheese*	**MEAL** B (L) S
DINING AREA *1st Floor Dining Room*	

PLATE OR TRAY	AMOUNT LEFT					COMMENTS
	F	3/4	1/2	1/4	0	
1.					✓	
2.					✓	
3.					✓	
4.					✓	
5.					✓	
6.				✓		
7.				✓		
8.		✓				
9.					✓	
10.					✓	
11.					✓	
12.					✓	
13.					✓	
14.					✓	
15.					✓	
16.				✓		
17.					✓	
18.					✓	
19.					✓	
20.				✓		
21.						
22.						
23.						
24.						
25.						
TOTALS	*0*	*1*	*0*	*4*	*15*	TOTAL THE NUMBER OF UNITS IN EACH COLUMN
MULTIPLY BY	4	3	2	1	0	
COLUMN SCORE	*0*	*3*	*0*	*4*	*0*	

TOTAL SCORE = (TOTAL # F X 4) + (TOTAL # 3/4 X 3) + (TOTAL # 1/2 X 2) + (TOTAL # 1/4 X 1) + (TOTAL # 0 X 0)

TOTAL AUDIT SCORE = $\frac{\text{TOTAL SCORE}}{\text{4 X PLATES AUDITED}}$ X 100 = *9* **%**

ACCEPTABLE AUDIT SCORE (0 - 30%) ☑ **MET** ☐ **NOT MET**

COMMENTS
No concerns identified by audit.

CONCERNS IDENTIFIED	CORRECTIVE ACTION (INCLUDE DATE OF EACH ACTION)	STAFF RESPONSIBLE
No concerns identified by audit.		

DATE OF NEXT AUDIT	
December 2001 at supper time	*R. Dawn*

Appendices

APPENDIX 1 - RESOURCES

1. *Adult Care Regulations and Community Care Facility Act*. Copies available for purchase from Crown Publications, 521 Fort Street, Victoria, B.C., V8W 1E7, phone 250-386-4636, E-mail crown@pinc.com. Copy also available on the internet www.health.gov.bc.ca/ccf but not the official version of the legislation.

2. *Community Care Facilities Programs: Policies and Procedure manual.* Contact your local licensing office in your health authority for a copy of the policies related to nutrition & food services (refer to Appendix 2 – Licensing Contacts).

3. *Food and Nutrition for Quality Care: A Policy and Procedure Manual.* Wong, C. ed. Vancouver/ Richmond Health Board. To purchase contact Callie Wong at callie_wong @vrhb.bc.ca or 604-730-7686.

4 .*Food Service Policies and Procedures for Health Care Facilities.* Rusch, P. et al. Dietary Directions Publications, Fresno Ca. 1996.

5. *Food Service Policies and Procedures for Residential and Intermediate Care Facilities.* Rusch, P. The American Dietetic Association, 1997.

6. *Foods the Chinese Way, Selected Recipes for Chinese Seniors.* New Horizons Program, Vancouver BC. 1995. (contact Long Term Care Nutritionist of the Vancouver/Richmond Health Board).

7. *Geriatric Nutrition in Care Facilities: A Multidisciplinary Approach*. Gerontology Practice Group. British Columbia Dietitians' and Nutritionists' Association. 1996.

8. *Manual of Clinical Dietetics, developed by the Chicago Dietetic Association,* The South Suburban Dietetic Association and Dietitians of Canada. American Dietetic Association, 2000. Available for purchase, call 1-800-665-1148 for ordering information.

9. *Meals and More: Quality Improvement and Resource Guide for Small Adult Care Facilities (24 beds or less).* BC Ministry of Health and Ministry Responsible for Seniors. Nutrition, Preventative Health Branch. June 1999. Available on the internet www.health.gov.bc.ca/prevent/nutrition.html or contact your local health unit.

10. Professional Resource: Laura Cullen, MBA, R.D.N. Department Chair, Nutrition and Food Service Management Program. Langara College, Vancouver BC.

11. *Residential Facility Assessment Instrument – Self Assessment Version.* Contact your local licensing office in your health authority for a copy (refer to Appendix 2 – Licensing Contacts).

APPENDIX 2 - LICENSING CONTACTS

Contact information for you local licensing program is available on the Ministry of Health Services, Community Care Facilities Licensing web site www.health.gov.bc.ca/ccf

APPENDIX 3 - FOOD SAFETY CONTACTS

Contact information for you local Environmental Health Officer is available at www.healthplanning.gov.bc.ca/socsec/contacts.html.

APPENDIX 4 - NUTRITION ASSESSMENT AND CARE PLAN SUMMARY

NAME	SEX ☐ M ☐ F	DATE OF BIRTH	AGE	ROOM NUMBER

M.D.	NEXT OF KIN	ADMISSION DATE

DIAGNOSIS / MEDICAL CONCERNS

FOOD ALLERGY / INTOLERANCE / REACTION

MEDICATIONS

NUTRITIONAL SUPPLEMENTS	LAXATIVES	NATURAL LAXATIVES

POSSIBLE DRUG NUTRIENT INTERACTIONS

SIGNIFICANT LAB DATA

A ADMIT WEIGHT	ADMIT / CURRENT HEIGHT

CURRENT WEIGHT	USUAL WEIGHT	BMI

WEIGHT HISTORY

AVERAGE WT./HT./AGE/SEX

B

	Good	Fair	Poor
APPETITE	☐	☐	☐
CHEWING	☐	☐	☐
SWALLOWING	☐	☐	☐
FLUID INTAKE	☐	☐	☐

C

DENTITITION ☐ Own ☐ Denture ☐ Used
☐ Upper ☐ Lower ☐ Fits

HEARING ☐ Functional ☐ Non-Functional
☐ Aide ☐ L ☐ R ☐ Used

SIGHT ☐ Functional ☐ Non-Functional
☐ Glasses ☐ Used

COMMUNICATIONS ☐ Yes ☐ No

COMPREHENSION ☐ Yes ☐ No

BOWEL FUNCTION ☐ No Concern ☐ Diarrhea
☐ Constipation

MOBILITY: _____

DEXTERITY: _____

FEEDING ☐ Self ☐ Set-Up ☐ Remind
☐ Assist ☐ Total Feed

SPECIAL NEEDS ☐ Plateguard ☐ Utensils
☐ Divided Plate
☐ Other _____

COMMENTS

NAME

FOOD PREFERENCE

MILK	JUICE	FLUIDS	BREAD	CEREAL	FRUIT LAX	FRUIT
RED MEAT	CHICKEN	FISH	CHEESE	SALAD	VEGETABLE	OTHER

NUTRITIONAL RISK FACTOR

- ☐ Alcohol / Drug / Tobacco Use
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Chewing / Swallowing Difficulties
- ☐ Chronic Infection
- ☐ Concern re Laboratory Values
- ☐ Constipation
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Drug-Nutrient Interaction
- ☐ Edema
- ☐ Elimination of One / More Major Food Groups
- ☐ GI Disorder
- ☐ Inability to Feed Self
- ☐ Major Appetite Change
- ☐ On-Going Diarrhea / Nausea / Vomiting
- ☐ Poor Appetite
- ☐ Poor Fluid Intake (less than 30 ml/kg BW)
- ☐ Poor Pain Control
- ☐ Pressure Ulcer / Delayed Wound Healing
- ☐ Recent Hospitalization (Date _____ / _____ / _____)
- ☐ Renal Disease
- ☐ Severe Trauma / Fracture / Surgery
- ☐ Severe Underweight / Overweight
- ☐ Specific Food Intolerance
- ☐ Tube Feeding
- ☐ Unplanned Weight Loss
- ☐ Uncontrolled / Controlled Diabetes Mellitus
- ☐ Other

COMMENT

DIET ORDER	DATE OF ORDER

RISK LEVEL	DEGREE OF INTERVENTION	SIGNATURE	DATE

NAME

DATE	NUTRITION CONCERN, GOALS, ACTIONS	BY WHOM & REVIEW DATE	RISK LEVEL	INITIAL

APPENDIX 5 - SIGNIFICANT WEIGHT LOSS TABLE

This convenient table can be used to quickly calculate significant weight loss.

Initial Weight (kg)	5%	7.5%	10%	Initial Weight (kg)	5%	7.5%	10%	Initial Weight (kg)	5%	7.5%	10%
30	29	28	27	55	52	51	50	80	76	74	72
31	30	29	28	56	53	52	51	81	77	75	73
32	30	30	29	57	54	53	51	82	78	76	74
33	31	31	30	58	55	54	52	83	79	77	75
34	32	31	31	59	56	55	53	84	80	78	76
35	33	33	32	60	57	56	54	85	81	79	77
36	34	33	33	61	58	57	55	86	82	80	77
37	35	34	33	62	59	57	56	87	82	81	78
38	36	35	34	63	60	58	57	88	84	81	79
39	37	36	35	64	61	59	58	89	85	82	80
40	38	37	36	65	62	60	59	90	86	83	81
41	39	38	37	66	63	61	59	91	86	84	82
42	40	39	38	67	64	62	60	92	87	85	83
43	41	40	39	68	65	63	61	93	88	86	84
44	42	41	40	69	66	64	62	94	89	87	85
45	43	42	41	70	67	65	63	95	90	88	86
46	44	43	42	71	67	66	64	96	91	89	87
47	45	44	43	72	68	67	65	97	92	90	88
48	46	44	43	73	69	67	66	98	93	91	88
49	47	45	44	74	70	68	66	99	94	92	89
50	48	46	45	75	71	69	67				
51	48	47	46	76	72	70	68				
52	49	48	47	77	73	71	69				
53	50	49	48	78	74	72	70				
54	51	50	49	79	75	73	71				

Adapted from *Pocket Resource for Nutritional Assessment*, CDHCF 1997; Reprinted with permission from *Food and Nutrition for Quality Care: A Policy and Procedure Manual*

APPENDIX 6 - NUTRITION TRANSFER FORM

TO	**NAME OF RESIDENT**	
FACILITY / UNIT	**DATE OF BIRTH**	**ADMISSION DATE**
CURRENT DIET PROVIDED		
FOOD ALLERGIES / PREFERENCES		
NOURISHMENTS / SUPPLEMENTS RECOMMENDED ☐ Yes ☐ No		
TYPE	**AMOUNT PER DAY**	**DURATION**
DENTITION ☐ Own ☐ Denture ☐ Upper ☐ Lower ☐ Used		

	Good	Fair	Poor	
APPETITE	☐	☐	☐	_____
CHEWING	☐	☐	☐	_____
SWALLOWING	☐	☐	☐	_____
FLUID INTAKE	☐	☐	☐	_____
FOOD INTAKE	☐	☐	☐	_____

SPECIAL NEEDS ☐ Plate Guard ☐ Deep Dish ☐ Other	
BOWEL FUNCTIONS ☐ No Concern ☐ Constipation ☐ Diarrhea	**DIETARY INTERVENTION**
FEEDING ☐ Self ☐ Remind ☐ Assist ☐ Total Feed	
WEIGHT (ON ADMISSION)	**HEIGHT (ON ADMISSION)**
WEIGHT HISTORY	
NUTRITION RISK LEVEL ☐ High ☐ Moderate ☐ Low	
PERTINENT DIAGNOSIS / MEDICAL CONCERNS	
NUTRITION CONCERNS	
PERTINENT LABORATORY DATA	

DATE	**SIGNATURE**	
	PHONE	**FAX**

APPENDIX 7 - MONTHLY WEIGHT GRAPH

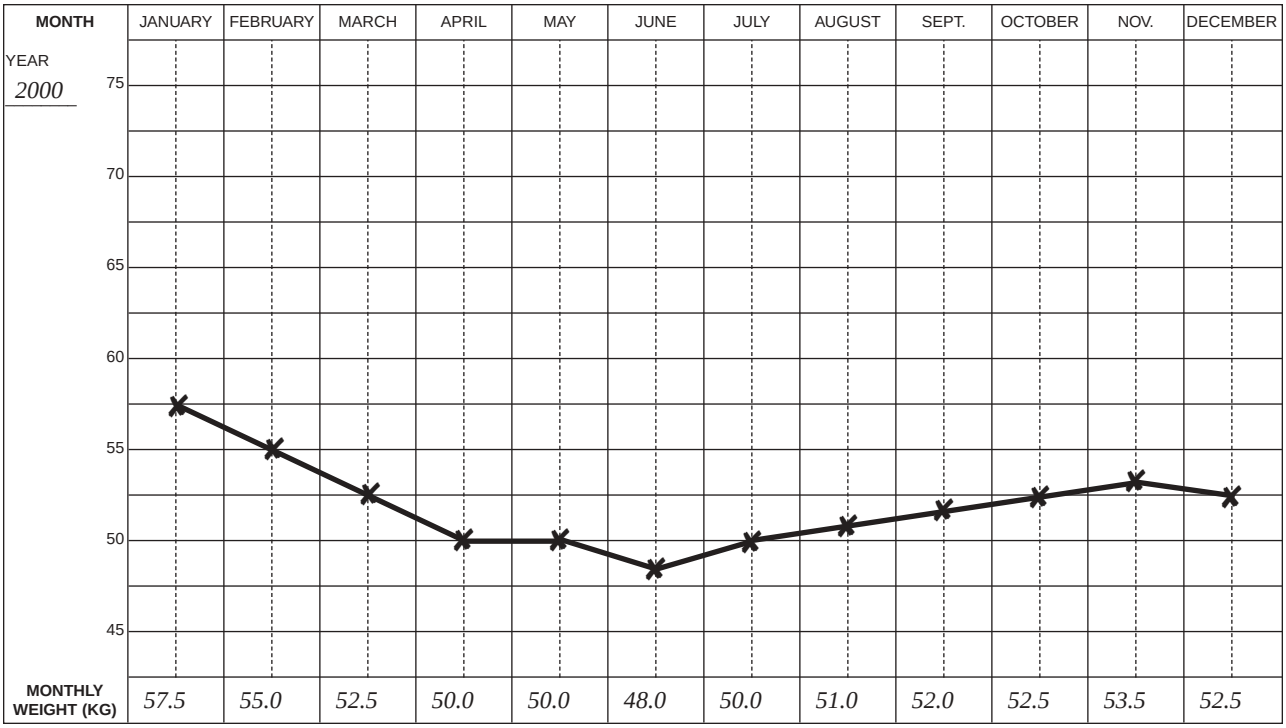
RESIDENT		ROOM NUMBER	ADMISSION DATE
WEIGHT ON ADMISSION KG	**USUAL WEIGHT** KGS	**HEIGHT**	**GOAL WEIGHT RANGE** KGS

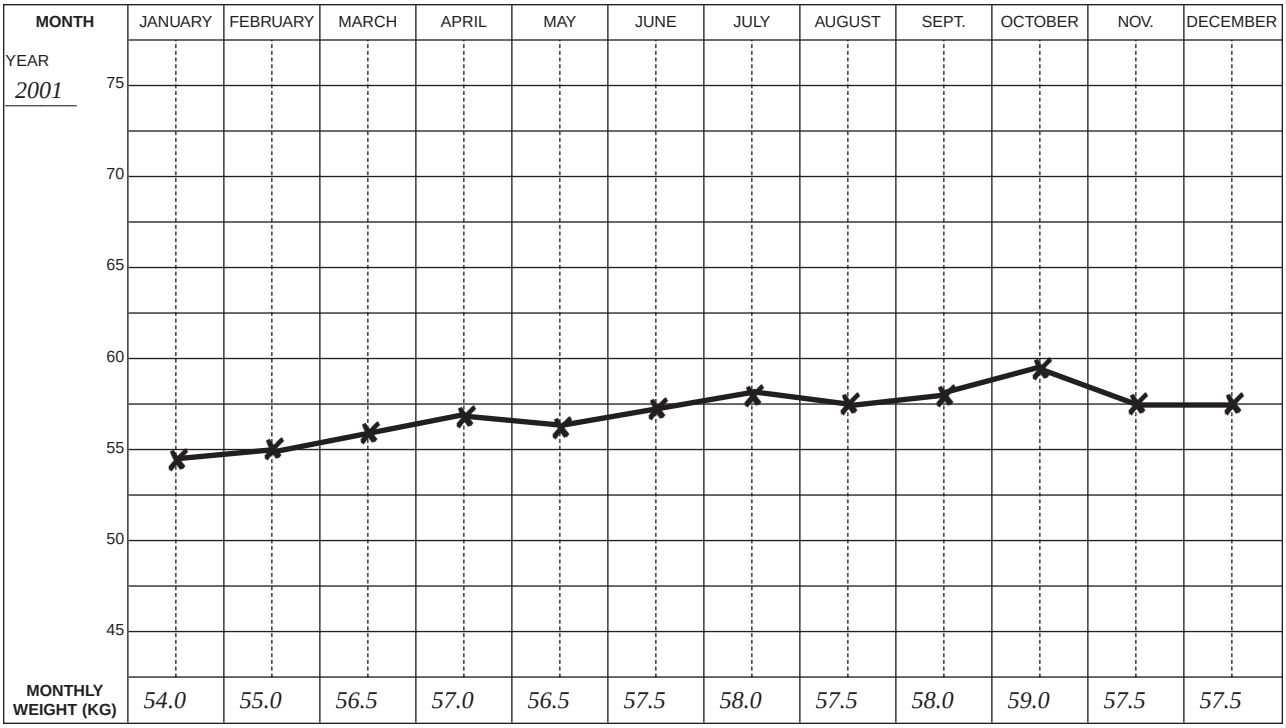
MONTH	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT.	OCTOBER	NOV.	DECEMBER
YEAR _____ 75												
70												
65												
60												
55												
50												
45												
MONTHLY WEIGHT (KG)												

MONTH	JANUARY	FEBRUARY	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT.	OCTOBER	NOV.	DECEMBER
YEAR _____ 75												
70												
65												
60												
55												
50												
45												
MONTHLY WEIGHT (KG)												

APPENDIX 7 - MONTHLY WEIGHT GRAPH

RESIDENT		ROOM NUMBER	ADMISSION DATE
J. Smith		*A 105*	*October 7, 1999*
WEIGHT ON ADMISSION	**USUAL WEIGHT**	**HEIGHT**	**GOAL WEIGHT RANGE**
58 KG	*55 - 60* KGS	*1.50 metres*	*54 - 65* KGS





APPENDIX 8 - SUGGESTED SERVING SIZES AND CANADA'S FOOD GUIDE EQUIVALENTS FOR ELDERLY RESIDENTS

Menu Item	Average Female		Average Male	
	Serving size	Canada's Food Guide Equivalent	Serving size	Canada's Food Guide Equivalent
Breakfast Items				
Juice	4 oz (125 ml)	1 VF	4 oz (125 ml)	1 VF
Prunes or fruit lax (60 ml pureed prunes + 30 ml juice or 3 whole prunes + 30 ml juice)	3 oz (90 ml)	1 VF	3 oz (90 ml)	1 VF
Cereals, cooked	4 oz (125 ml)	1 G	4 oz (125 ml)	1 G
Bran	1 tbsp (15 ml)		1 tbsp (15 ml)	
Dry cereal	1 oz (30 g)	1 G	1 oz (30 g)	1 G
Brown Sugar	1 tsp (5 ml)		1 tsp (5 ml)	
Toast, whole wheat	1 slice	1 G	2 slices	2 G
Margarine	1 tsp (5 ml)		2 tsp (10 ml)	
Eggs, medium	1	1 MA	1	1 MA
Milk, 1%	4 oz (125 ml)	0.5 M	4 oz (125 ml)	0.5 M
Jam, Jelly, Marmalade	1 Tbsp (15 ml)		1 Tbsp (15 ml)	
Main Dishes				
Meat: lean, boneless, cooked	2 oz (50 g)	1 MA	2 oz (50 g)	1 MA
Fish: cooked, boneless	2 oz (50 g)	1 MA	2 oz (50 g)	1 MA
Chicken: cooked, boneless	2 oz (50 g)	1 MA	2 oz (50 g)	1 MA
Chicken: cooked with bone	3.5 oz (100 g)	1 MA	3.5 oz (100 g)	1 MA
Stews, meat portion only	4 oz (125 ml)	1 MA	8 oz (250 ml)	2 MA
Served on Bun/English Muffin – Hamburger Pattie – Barbequed Beef or Turkey with sauce – Eggs Benedict, medium egg sauce	1/2 1 2 oz (50 g) 1 oz (30 ml) sauce 1 – 1 oz (30 ml)	1 G 1 MA 1 MA ☆	1 1 2 oz (50 g) 1 oz (30 ml) sauce 2 – 2 oz (60 ml)	2 G 1 MA 1 MA ☆
Baked Beans	4 oz (125 ml)	1 MA	6 oz (175 ml)	1 MA
Macaroni & Cheese	6 oz (175 ml)	☆	8 oz (250 ml)	☆
Quiche	2.5 oz (75 g)	☆	4 oz (120 g)	☆
Soup (not broth)	4 oz (125 ml)	☆	6 oz (175 ml)	☆
Sandwich made with – Whole Grain Bread, 2 slices – Margarine, 2 tsp – Meat, Fish, 2 oz (50 g) – Egg Salad, #12 scoop (80 g) – or Cheese (50 g)	1/2 sandwich	1 G 0.5 MA	1 sandwich	2 G 1 MA
Salad Bowls : Protein Portion				
– Cottage Cheese – Sliced Meat	4 oz (125 ml) 2 oz (50 g)	0.25 M 1 MA	4 oz (125 ml) 2 oz (50 g)	0.25 M 1 MA

Menu Item	Average Female		Average Male	
	Serving size	Canada's Food Guide Equivalent	Serving size	Canada's Food Guide Equivalent
Other Food				
Biscuit (baking powder)	1 (30 g)	1 G	1 (30 g)	1 G
Beans, Lentils, Dried Peas, cooked	4 oz (125 ml)	1 MA	4 oz (125 ml)	1 MA
Potatoes, whole Potatoes, mashed or salad Rice, cooked	1/2 medium(50 g) #8 scoop (125 ml) #8 scoop (125 ml)	0.5 VF 1 VF 1 G	1 medium (120 g) #8 scoop (125 ml) #8 scoop (125 ml)	1 VF 1 VF 1 G
Vegetables, cooked	#8 scoop (125 ml)	1 VF	#8 scoop (125 ml)	1 VF
Fresh Apple, Banana, Orange, Peach, Pear	1 medium	1 VF	1 medium	1 VF
Plums, canned	2 plus juice	1 VF	2 plus juice	1 VF
Apricots, canned halves	4 plus juice	1 VF	4 plus juice	1 VF
Fruit, other, canned	4 oz (125 ml)	1 VF	4 oz (125 ml)	1 VF
Ice Cream	4 oz (125 ml)	0.25 M	4 oz (125 ml)	0.25 M
Milk Pudding / Custard	#8 scoop (125 ml)	0.5 M	#8 scoop (125 ml)	0.5 M
Cake	1.5" x 1.5" piece	1 G	1.5" x 1.5" piece	1 G
Crisps, Cobblers, and Cake Type Desserts	1 (1.5" cube or 2x2x1")	☆	1 (1.5" cube or 2x2x1")	☆
Snacks				
A.M.Banana or Orange	1 medium or the equivalent in other fresh fruit	1 VF	1 medium or the equivalent in other fresh fruit	1 VF
P.M.Cookie	1 plain	0.5 G	1 plain	0.5 G
Evening: Milk, 1%	4 oz (125 ml)	0.5 M	4 oz (125 ml)	0.5 M
Sandwich	1/2	☆	1/2	☆

Note:
Suggested serving sizes given for meats, fish, and poultry are the weights as served after cooking. (Cooking losses are approximately 1/3.) These serving sizes may be adjusted to meet individual requirements and preferences.

Canada's Food Guide to Healthy Eating Key:

VF = Vegetables and Fruit
G = Grain Products
M = Milk Products
MA = Meat and Alternatives
☆ = Canada's Food Guide equivalent depends on recipe.

Combination Foods (Due to recipe variation, these are examples only):

Beef and Vegetable Stew:	6 oz (175 ml) = 1 MA, 0.5 VF
Macaroni and Cheese:	6 oz (175 ml) = 1 G, 0.25 M
Tuna Noodle Casserole:	6 oz (175 ml) = 1 G, 0.5 MA
Cream Soup (made with milk):	4 oz (125 ml) = 0.25 M
Split Pea Soup:	4 oz (125 ml) = 0.5 MA, 0.5 VF

APPENDIX 9 - SUGGESTED MENU ITEMS

Suggested Menu Items - ENTRÉES

Beans, Peas and Lentils
Baked Beans
Bean Casserole
Bean Salad
Lentil Burgers
Mexican Rice and Bean Casserole
Split Pea and Lentil Soup
Sweet and Sour Soybeans
Vegetable Chili

Beef
Beef Pot Pie
Corned Beef
Ground Beef
Cabbage Rolls
Casseroles
Chili con Carne
Hamburgers
Kebabs
Lasagna
Liver with Onions
Meatloaf
Steak and Kidney Pie
Salisbury Steak
Shepherd's Pie
Short Ribs, Barbecued
Steak – Minute/Swiss/Spanish
Meatballs – Sweet & Sour/Swedish
Stew
Stir Fry
Stroganoff
Roast – Pot Roast/Baron of Beef/Dip

Chicken
à la King
Barbecued
Crepes
Curried
Kebabs
Oven Baked
Pot Pie
Stir Fry
Roast

Fish
Cod/Halibut/Sole,
Salmon/Red Snapper
Baked/Breaded
Pan Fried
Poached
Scalloped

Ham (cured)
Baked Glazed
Steak

Lamb
Chops
Roast Leg
Stew, Irish

Other
Egg Foo Yong
Omelette
Pizza
Cold Plates (e.g. meat)
Quiche
Pork
Chops
Cutlets
Kebabs
Sausages
Spare Ribs
Stew
Stir Fry
Sweet and Sour
Tourtiere

Sandwiches
Beef (hot or cold)
Cold Cuts
Corned Beef
Chicken
Egg Salad
Ham
Peanut Butter
Tuna
Turkey (hot or cold)
Salmon

Seafood
Fettuccini with Mussels
Fish and Chips
Fish Burger
Tuna Melt

Tofu
Scrambled Tofu
Tofu Bean Salad
Tofu Burgers
Tofu Fried Rice
Tofu Onion Pie
Tofu Scalloped Potato
Tofu Stirfry
Tofu Stroganoff
Vegetable Lasagna
Vegetable Quiche
Vegetarian Chili

Turkey
à la King
Hot Turkey Sandwich
Pot Pie
Roast

Veal
Chopped
Cutlets
Roast
Scaloppini

Suggested Menu Items – GRAIN PRODUCTS

NOTE: USE WHOLE GRAIN PRODUCTS WHEN POSSIBLE

Bagels
Biscuits
Bread – white/whole wheat/rye/sesame/pumpernickel/multi-grain/raisin/egg
Buns
Breakfast Cereals – Five, Seven, Nine, Grains/Oatmeal/Oatbran/Red River®/Sunny Boy®
Cold Breakfast Cereals
Crackers
Noodles – macaroni/linguini/fettuccini/spaghetti
Muffins
Rice and other grains – barley, bulghur, ryes
Polenta
Scones
Tortillas

Suggested Menu Items – SOUPS

Cream Soups
Asparagus
Broccoli
Carrot
Celery
Chicken
Chowders – Corn, Clam, Fish
Corn
Leek and Potato
Mushroom
Onion
Pea
Potato
Tomato

Other
Bean and Bacon
Beef and Barley
Beef Bouillon
Beef Noodle
Beef Vegetable
Beef with Rice
Chicken Gumbo
Chicken Noodle
Chicken Rice
Creole
French Canadian Pea
Lentil
Mulligatawny
Pea Split
Pepper Pot
Scotch Broth
Tomato Rice
Turkey Vegetable
Turkey Noodle
Turkey Rice
Vegetable

Suggested Menu Items – VEGETABLES	
Asparagus Beans – green, yellow, french cut Beets Bok Choy Broccoli Brussels Sprouts Cabbage Carrot Cauliflower Celery Chard Chinese Vegetable Corn Cucumber Kale Onions Mustard greens Parsnips Peas Peppers – green/red/yellow Potato – Baked/Boiled/Mashed/Pan Fried/Scalloped Spinach Squash Sui Choy Sweet Potato Tomato Turnip Vegetable Marrow Yams Zucchini	**Salads** Asparagus Beets Carrot and Raisin Carrot Strips Caesar Celery Strips Cole Slaw Cucumber Gelatin Green Beans with Dill Greek Lettuce Macaroni Pasta Potato Spinach Three Bean Salad Tomato Tossed Green Turnip Strip Waldorf

Suggested Menu Items – FRUIT	
Canned Fruit Applesauce Apricots Cherries Fruit cocktail Peaches Pears Pineapple Plums Baked Fruit Desserts Apple Dumpling Baked Apples Brown Betty – Apple/Rhubarb Cobblers Cottage Puddings Crisps Crumbles – Apple Apricot Cranberry-Apple Peach/Pitted Plum/Rhubarb Stewed Rhubarb Stewed Fruit Compote	**Fresh Fruit** Apples Bananas Blackberries Blueberries Cherries Fresh Fruit Salad Grapefruit Grapes Melon – Cantaloupe/Honeydew/Watermelon Oranges Peaches Pears Pineapple Plums Raspberries Strawberries
Suggested Menu Items – DESSERTS	
Baked custard Cheesecake Cranberry Squares Date Squares Frozen Yogurt Fruit Trifle Gingerbread with Fruit Sauce Ice Cream Mincemeat Squares Pies	Puddings – vanilla/banana/butterscotch/chocolate coconut/Rice/Bread/Tapioca/Lemon Sherbet Shortcakes Tarts Upside-Down Cakes Yogurt - plain or with Fruit Sauce Shortcakes

APPENDIX 10 - CONVERSIONS AND EQUIVALENT

SCOOP SIZES/ VOLUME MEASURE	No. 8	4 ounces	= 125 ml
	No. 12	2 3/8 ounces	= 70 ml
	No. 16	2 ounces	= 60 ml
	No. 20	1 5/8 ounces	= 50 ml
	No. 24	1 1/3 ounces	= 40 ml
	No. 30	1 ounce	= 30 ml
WEIGHTS	1 ounce	= approximately 30 g	
	1 pound	= 16 ounces	= 454 g
	2.2 pounds	= 1 kilogram	
MEASURES	3 teaspoons	= 1 tablespoon	= 15 ml
	2 tablespoons	= 1 fluid ounce	
	16 tablespoons	= 1 cup	= 8 fluid ounce
IMPERIAL MEASURES	1 cup	= 250 ml	
	2 1/2 cups	= 1 pint	= 20 ounces = 600 ml
	5 cups	= 1 quart	= 40 ounces = 1200 ml
	4 quarts	= 1 gallon	= 160 ounces = 4800 ml
AMERICAN MEASURES	1 cup	= 250 ml	
	2 cups	= 1 pint	= 16 ounces = .47 litres
	4 cups	= 1 quart	= 32 ounces = .946 litres
	4 quarts	= 1 gallon	= 128 ounces = 3875 ml
SI METRIC UNITS (SYSTEM INTERNATIONAL)	**Volume**		
	250 ml	= approximately 1 cup	
	1000 ml	= 1 litre	
	Mass		
	25 g	= approximately 1 ounce	
	1 kg	= 2.2 pounds	

APPENDIX 11 - EDUCATION AND TRAINING ATTENDANCE FORM

TOPIC/NAME OF PROGRAM:	
PRESENTER/TRAINER:	LENGTH OF EDUCATION SESSION:
DATE:	LOCATION:
OBJECTIVES OF EDUCATION/TRAINING SESSION:	

NAME	POSITION	COMMENTS

RESULTS OF EVALUATION:

Adapted from *Food Service Policy and Procedures for Health Care Facilities*, 1996.