Audits & More

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

BRITISH COLUMBIA
Ministry of Health Services

Audits & More

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

BRITISH COLUMBIA
Ministry of Health Services

National Library of Canada Cataloguing in Publication Data
British Columbia. Ministry of Health Services
Audits & more : a nutrition and food service manual for larger adult residential community care facilities

This manual replaces "Nutrition and food service standards for adult care facilities", in use since 1990. Cf. P. [4].
Includes bibliographic references: p.
Also available on the Internet.
ISBN 0-7726-4681-3

1. Long-term care facilities – Food service - British Columbia - Auditing.
2. Nursing homes – Food service - British Columbia - Auditing.
I. Title. II. Title: Nutrition and food service standards for adult care facilities.

RA999.F65B74 2001 362.1'76 C2001-960313-4

ACKNOWLEDGEMENTS

More than eighty food and nutrition professionals from across British Columbia contributed their time and expertise to the development of *Audits and More*. The members of the Advisory Committee are gratefully acknowledged for their tremendous dedication and contribution to the project.

Catherine Atchison, Fraser Valley Health Region

Christine Chou, South Fraser Health Region

Lisa Forster-Coull, BC Ministry of Health Services

Cindy Jorgensen, East Kootenay Community Health Services

Teresa Rivera-Mildenhall, Tabor Home Society

Rhonda Smyl, Westcoast Dietetics Ltd.

Maria van Sloun, Capital Health Region

Erna Verstraten, Windermere Care Centre Inc.

Judy Watson, Oak Bay Lodge Society

Callie Wong, Vancouver/Richmond Health Board

Irene Zilinski, Lynn Valley Lodge Society

TABLE OF CONTENTS

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).