Marriott Corporation
Health Care Division East

10 Tower Lane
Avon, CT 06001

Ted W. Kinkel
Regional Vice President
203/678-1023

August 7, 1989

Mr. William Thompson
Interim Superintendent
Augusta Mental Health Institute
Arsenal Street
Augusta, ME 04330

Dear Mr. Thompson:

The consulting report on the Food and Nutrition Services Department that was prepared at your request is enclosed for your review and comments. We hope that you find this report helpful in your effort to maximize the quality of patient care and the overall operation at AMHI.

Of course, we stand ready to answer any questions that you may have regarding our findings and recommendations. Thank you for giving Marriott the opportunity to provide this service to the health care community and the State of Maine. We are pleased and complimented that you called on us in a time of need and that we were able to respond.

Sincerely yours,

Ted W. Kinkel, R.D.

TK/mmf
Enclosure

cc: C. Kelsey
M. Smith
P. Bridger

"EXECUTIVE BRIEF"

CONSULTING VISIT PERFORMED BY

THE HEALTH CARE SERVICES DIVISION OF MARRIOTT CORPORATION

for

FOOD AND NUTRITION SERVICES

AUGUSTA MENTAL HEALTH INSTITUTE

AUGUSTA, MAINE

Marriott corporation
Health Care Services

STATEMENT OF PURPOSE

At the request of Mr. William Thompson, Interim Superintendent, Augusta Mental Health Institute, management from the Health Care Services Division of Marriott Corporation performed an on-site consulting visit to the Food and Nutrition Services Department.

The purpose of this visit was to develop a report for Augusta Mental Health management designed to evaluate the status of the department in the following key result areas:

- Quality of Food and Clinical Services
- Food Service Systems and Equipment
- Labor Efficiency and Productivity

In addition to this status report, we have made recommendations regarding the future steps that may be taken to ensure quality of patient and resident care and maximum efficiency in the use of resources.

CONSULTING TEAM MEMBERS

The representatives of the Marriott Consulting Team who have prepared the components of this report come from varied health care backgrounds and speciality areas with extensive industry experience. In order to assist in your appraisal of the quality of the consulting report, it is important to know these team members.

Theodore W. Kinkel, R.D., Regional Vice President, Marriott Health Care Services, New England Region. Mr. Kinkel is responsible for food and nutrition services in over sixty acute care hospitals, nursing homes and specialty hospitals. He is a registered dietitian and earned an M.B.A. in Institutional Management and B.A. in Hotel and Restaurant Management from Michigan State University. He brings over 20 years of industry experience which includes seven years as a food service director, five years in human resources and training, and the remainder supervising multi-unit health care operations. He is a major, Army Medical Specialty Corps, in the United States Army Reserve and a member of the American Dietetic Association.

Peri Bridger, R.D.,Human Resource Manger, Marriott Health Care Services, New England Region. Ms. Bridger is responsible for human resource aspects of the region employing over 300 management and clinical professionals. She is active in recruitment, retention, training, benefit administration, EEO/Affirmative Action, and wage and salary administration. She graduated Cum Laude from Villa Maria College with a B.S. in Dietetics and is currently completing her masters degree. Her past experience includes two years as the Regional Clinical Manager responsible for food and nutritional standards in 55 health care facilities in the Southeastern United States. She has worked as a chief dietitian in a major community hospital as well as a food

service director responsible for acute care and a skilled nursing home in New York State. She possesses expertise in the areas of Quality Assurance as well as State and Federal Standards for Nutritional Services. She is a member of the American Dietetic Association and is a licensed Dietitian in the State of Georgia.

Martin Smith, Food Service Director, Hale Hospital, Haverhill, MA. Mr. Smith is responsible for all aspects of the food service and clinical program at this 181 bed acute care hospital. He earned an M.S. in Industrial Management from Clarkson University and holds a B.S. in Accounting. He has extensive experience in food production, purchasing, patient food service systems and public cafeteria operations. He has over twenty years of industry experience as food service director in hospitals ranging in size from 120 to 600 beds. Mr. Smith's major assignments include experience in municipal hospitals dealing with organized labor.

METHODOLOGY

The site visit to the Augusta Mental Health Institute was conducted on July 19, 1989. Both the food service and clinical programs were extensively reviewed through interviews with key members of administration and staff to include:

Mr. William Thompson, Interim Superintendent

Mr. Richard L. Hanley, M.Ed., Assistant to the Superintendent.

Mr. Richard E. Besson, Chief of Hospital Services

Mr. Daniel D. Spofford, R.D., Director, Food and Nutrition Services

Ms. Mona VanWart, R.D.

Mr. Lee Corbin, Food Service Manager

Patient meal service observation was conducted in all units and selected records and documents reviewed that pertained to nutrition standards of care and clinical quality assurance. The facilities, equipment and spatial relationships were reviewed in order to evaluate labor productivity as well as the ability of the department to provide wholesome, nourishing and tasty food prepared under hygienic conditions and served at optimum temperatures.

FINDINGS

SERVICE LEVELS AND PROGRAM QUALITY

FOOD SERVICE PROGRAM

STRENGTHS

Levels of sanitation were consistent and no deficiencies were noted.

The resident menu appeared appropriate for regional and ethnic preferences.

Food was adequately and appropriately seasoned.

Meats were properly prepared and those tasted were "fork" tender.

Staff was friendly, uniforms and hair coverings were in place with a neat and clean appearance.

Checklists and logs existed for sanitation inspections, dish machine temperature, refrigerator temperatures.

Storage areas were neat, orderly and clean with no raw foods stored above or adjacent to cooked foods. Thermometers were in place.

The staff displayed an awareness of the principles of food safety to include proper food handling.

Some scratch or "homemade" preparation is emphasized in the preparation of soups and stocks.

AREAS FOR IMPROVEMENT

The procurement system which emphasizes on-site warehousing of significant quantities of inventory, encourages product slippage and overproduction leading to waste and increased cost.

Food production systems used to instruct cooks on quantities to prepare are inadequate.

Food temperatures at the point of service did not consistently meet federal and state Standards. Because of the age of equipment, delivery distances, and number of people involved in serving, food temperatures will be, at best, marginal and can routinely be expected to be non compliant with federal and state minimum requirements.

The decentralized kitchens, by their nature, encourage food waste and loss of supervisory control.

Food was not generally displayed attractively and the plate presentation was extremely institutional. No garnishing program was in evidence.

CLINICAL PROGRAM: To evaluate and appreciate the challenges in the clinical program, an understanding of the clinical needs of the patients is required. AMHI is a facility that provides for all age groups from pediatrics to geriatrics. The care is strongly focused towards mental health rehabilitation but inevitably carries with it a myriad of

other medical diagnosis. Optimum nutrition care is the foundation for the well being and potential improvement of any patient. Currently, AMHI is staffed with one clinical dietitian and one diet technician to meet the needs of approximately 380 patients.

Greenlawn and Senior Rehabilitation is a 100 patient, long term care unit with intermediate level of care requirements. A registered dietitian should attend IDT meetings six hours a week at a minimum. This ensures active communication between the dietitian and other healthcare members regarding the goals and outcomes of each individual patient's care plan. The State guidelines require that these patients, at a minimum, receive annual comprehensive assessments and quarterly updates in the medical record. The ability to meet this minimum requirement in a thorough and effective manner requires individual time in observation of food and nutrient intake. In addition, proper follow through and training with the dietary department staff is critical for the delivery of meals that are therapeutically accurate. This patient services division requires at least 24 hours per week of clinical dietitian time. Given the anticipated future intensity of federal and state requirements and the fact that some of these residents will be classified as "skilled", the attention to clinical time in this area is imperative.

The Psychiatric Divisions (North, South and Marquardt) treat approximately 255 patients of varying diagnosis and age. Of these, 27% or 70 patients are on modified diets. This component of the facility, if under state regulation, would more than fill a full time registered dietitians time schedule.

Administrative components of the patient clinical program consist of inservice training, quality assurance, routine interdepartmental communications, policy and procedure development, personnel administration, monthly reports, menu development and analysis, etc.. These functions are on-going each and every week.

STRENGTHS

Nutritional screening and assessment is being conducted on all new admissions by the physician assistants in the Psychiatric Sites.

Physicians actively ordering dietitian consults which average about 15 per month.

The dietitian has appropriately prioritized her attention and time toward the Greenlawn and Senior Rehabilitation Units which consists of 100 patients with intermediate level of care requirements.

AREAS FOR IMPROVEMENT

The dietitian has no clinical support from the dietetic technician because she is consumed in the supervision of dietary aides in the decentralized serving sites.

There are no proactive nutrition programs in place such as patient or nursing staff education.

The psychiatric patients are not benefiting from the dietitian's and dietetic technician's nutrition education and teaching expertise.

Although nutritional assessment is being conducted by the physician assistants, the AMHI dietitian does not have time to respond to their findings with positive nutritional intervention.

Patient adherence to modified diets and the staffs ability to deliver appropriate diets with the current decentralized food delivery system is questionable at best.

Only minimal clinical dietitian involvement exists in teaching, discharge planning, development of halfway house menu protocols, and drug-nutrient interaction.

Administrative programs are not being optimally performed.

The lack of administrative time has eroded the key relationship with nursing that is essential to communicating individual needs of patients.

LABOR PRODUCTIVITY

GENERAL OBSERVATIONS

The clinical component, consisting of the dietitian and dietetic technician, is severely understaffed to meet the nutritional needs of the patient population.

The current decentralized food service system lends itself to labor inefficiency due to duplication of effort, high employee waiting time, and the inability to supervise operations adequately.

The current decentralized system, by its very nature, builds in increased staff requirements.

Food and Nutrition employees are performing house keeping work and housekeeping employees are performing Food and Nutrition Department work.

FOOD SERVICE SYSTEMS AND EQUIPMENT

GENERAL OBSERVATIONS

The decentralized kitchens contain numerous individual single tank dishwashers that are very old and ineffective in cleaning and sanitizing. These machines will require replacement in the very near future at significant capital investment.

The decentralized serving warming units are old and not in optimum condition. To maintain food hot, the wells should be filled with water to provide moist heat. Unfortunately, the high heat and moisture content contribute further to patient discomfort in the dining rooms. The warming units do not have radiant strip heaters installed above the food to provide additional heat maintenance capability.

The decentralized kitchens are not well planned for labor efficiency or presentation of food. They are extremely inefficient.

Because of the building layout and number of kitchens, meal time supervision is not possible from responsible individuals in Food and Nutrition. If a problem occurs in more than one area, it is doubtful that it can adequately be corrected and addressed.

The central kitchen is large and spacious. Much of the equipment is too large for the intended use. It offers excellent space to support a

centralized tray make-up system. Floor surfaces were in good condition considering the age of the facility.

The patient dining rooms are outdated, unattractive, and generally not conducive to a positive patient atmosphere and high morale on the part of staff.

Ample refrigeration exists in the form of walk-in refrigerators.

PREFACE TO RECOMMENDATIONS

The recommendations that follow are intended to provide a basis for dialogue between AMHI administration, "user groups", and the Food and Nutrition Services that will provide clear direction for this department. It was very evident to the members of the consultant team that the present director, Mr. Daniel D. Spofford possess significant, accurate insight regarding the needs of the food and clinical program. He speaks with great care and concern for the patients of AMHI and his thoughts and recommendations, which are overall reasonable, appropriate and valid, require the support of the Department of Mental Health and Mental Retardation.

Although our visit was conducted over an intensive one day period, we feel that we have developed an accurate picture of the needs of the department. Our viewpoint has taken on a fairly global perspective. It will be up to the leadership of AMHI to accept, reject or modify our recommendations and build a detailed plan of action with complete costs, staffing, and service implications. This will provide the ownership of the plan that is vital to its' success.

In order for AMHI to take its' rightful place as a provider of quality care, "bold" action is required in the Food and Nutrition Services Department. This will require not only the expenditure of capital resources but the involvement of many individuals and groups to identify the strategic direction of the department. You can be assured that if the planning process is conducted adequately and the funds are spent appropriately, patients will benefit from improved food and clinical services and the State of Maine will be rewarded with a model food service program that is cost effective and meets all state and federal requirements.

RECOMMENDATIONS

A **STRATEGIC PLAN** should be developed by the Food and Nutrition Services Department. This plan should address Food and Nutrition Service requirements and cover, as a minimum, the following areas:

I. Departmental goals, operational parameters and a program plan that take into consideration:

A. Patient needs as determined by their psychological, medical, and nutritional status as well as their plan of care. Attention should be given to:

1. Patient mobility
2. Need for socialization
3. Security
4. Safety
5. Patient psychiatric status
6. Patient medical status
7. Patient nutritional status
8. Patient supervision capability
9. Modified and therapeutic diet requirements
10. Self care status, i.e., ability to feed

B. The impact of current and future state and federal regulations and standards required to maintain approval by the Joint Commission on Healthcare Organization.

C. Level of service required such as selective versus non selective menu.

D. The future needs of an aging population with increased medical requirements.

E. The styles, and mixes of styles of service appropriate for this population. That is to say:

1. Will meal tray service be a more appropriate mode of service versus decentralized cafeteria style service?

2. Is it possible that nursing units requiring cafeteria service can be consolidated together?

3. Could the current employee and patient vending area be relocated to allow for the installation of a higher ambience consolidated patient dining room?

F. The role of the "Clinical" component (dietitians and dietetic technicians). The expectations of these individuals should compliment their resource capability.

II. Resources necessary to accomplish the stated objectives and operational parameters.

As a consulting team with a heavy orientation and bias to operations, we have approached AMHI as if we had the authority and responsibility as managers to run the operation ourselves. We simply attempted to answer the question: "How would we responsibly run it?" Again, we recommend that serious consideration be given to the following recommendations for resource allocation:

A. The physical facilities require remodeling. It is felt that the best use of resources can be gained by:

1. Converting to centralized tray service utilizing a chilled food concept with rethermalization on the nursing units for patients that do not have the ability or freedom to move about the campus. The chilled food concept should be of a design that uses rapid chilling and holding of product for a maximum shelf life of 5 days. You are urged to keep the system as simple as possible. A sophisticated and costly chilled food system is not necessary due to your menu requirements, patient population and employee skill level. The rethermalization tray system should also be a basic system that will withstand abuse, deliver a quality product where hot foods are hot and cold foods are cold. Again, a sophisticated system with high cost is not necessary. There are several very good ones on the commercial market.

2. Consolidating, upgrading and relocating patient cafeterias to one facility in the present vending and canteen area. Many psychiatric health care facilities are increasingly emphasizing cafeteria style service. This would allow the patients to make their own food choice or be served according to their diet prescription.

B. A diet office management computer system that will control patient menus, ensure that modified diets are delivered as prescribed, and provide increased production systems and cost controls should be purchased. Currently, we are only aware of one system commercially available that is appropriate. The total cost of this system to include hardware and software does not exceed $12,000.00. It is relatively simple and the start up time is short.

C. The Food and Nutrition Department requires restructuring and reorganizing to provide increased clinical and supervisory capability. As a minimum, one additional Registered Dietitian and one more Registered Dietetic Technician are needed. Depending upon the mix of patients served by tray versus those served cafeteria style as well as the number of remote cafeterias, total staffing may be reduced from its current level. Of course, final staffing levels will be determined by the evolving policies and procedures of the institution, the physical resources and constraints and the ability of management to provide the leadership necessary to gain maximum labor efficiency and productivity. The more centralization of services designed into the program plan, the more resources that can be shifted into the clinical program without an increase in full time equivalents. It must be recognized that a "chilled food system" requires management in adequate numbers and knowledge to ensure a quality product. Hours can be shifted with the proper food service systems and facilities from staff to clinical and supervisory.