TC 8-502

NUTRITION CARE OPERATIONS

AUGUST 2002

HEADQUARTERS, DEPARTMENT OF THE ARMY

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NUTRITION CARE OPERATIONS

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PREFACE

This circular presents information that may be used by officers (AOC 65C), enlisted personnel (MOS 91M), and civilian personnel assigned to or employed by the Nutrition Care Division/Directorate of an TDA Army medical treatment facility. It is designed primarily for supervisors in those facilities. When used in this publication, the term Nutrition Care Division will apply to the Nutrition Care Directorate as well.

Described herein are the duties and responsibilities of the Chief, Nutrition Care Division; to include policy, planning, budgeting, the Nutrition Care Activities Report, the Medical Expense and Performance Reporting System, civilian personnel issues, training, research, supply management, and safety. It discusses the Clinical Dietetics Branch, its staffing and operations, and dietary treatment. In discussing the Production and Service Branch, it talks about meal service management, subsistence management, the A La Carte Meal Service, food production instruments and guides, and food preparation. Also discussed is sanitation, holiday meals, and emergency mass feeding.

The proponent of this publication is the U.S. Army Medical Department Center and School. Submit changes for improving this publication on DA Form 2028 (Recommended Changes to Publications and Blank Forms) and forward to Department of Training Support, ATTN: MCCS-HT, 1750 Greeley Road, Suite 135, Fort Sam Houston, TX 78234-5078.

When used in this publication, "he," "him," "his," and "men" represent both the masculine and feminine genders unless otherwise stated.

The use of trade names in this publication does not imply endorsement by the US Army, but is intended only to assist in the identification of a specific product.

CHAPTER 1

MISSION, ORGANIZATION, AND RESPONSIBILITIES

1-1. Introduction

This chapter describes policies and procedures for the operation of the Nutrition Care Division (NCD) in Army table of distribution and allowances (TDA) medical treatment facilities (MTFs). Army Regulation (AR) 40-3 prescribes the policies for operation of the NCD in a TDA MTF. Operations in a TDA NCD are distinctly separate from, and operate differently than, the monetary allowance ration system for garrison dining facilities governed by AR 30-1. Policies and procedures for nutrition care operations in table of organization and equipment (TOE) MTFs are defined in the following:

- AR 30-1, The Army Food Service Program.
- AR 30-21, The Army Field Feeding System.
- FM 8-505, Army Medical Field Feeding Operations.

1-2. Mission

The mission of the NCD is to provide —

- Comprehensive nutritional care.
- Safe, wholesome foods for patients and personnel authorized to subsist in the MTF.
- Dietary/nutritional assessment of authorized beneficiaries.
- Medical nutrition therapy for authorized beneficiaries.
- Nutrition education and health promotion to support readiness.
- A dietetic internship program approved by the Commission on Accreditation for Dietetics Education (CADE).
- Consultation and support for commanders on the nutritional aspects of Army programs, field training exercises, and joint training exercises.
- Applied research.

1-3. Organization and Functions

a. The organization and functions of the NCD will be as the major Army command (MACOM) or medical command (MEDCOM) having jurisdiction over the MTF prescribes. The information depicted in this circular represents the organization and functions of a typical TDA NCD. Staffing or mission may require some deviation. The usual organization of the NCD consists of the Office of the Chief and two or three subordinate branches. These include the –

- Clinical Dietetics Branch (CDB).
- Production and Service Branch (PSB).
- Education and Training Branch (ETB).

The functions of these branches and the division are discussed in separate chapters throughout this circular. The NCD organizational structure shown in Figure 1-1 is adaptable to all Army TDA MTFs and permits effective use of assigned personnel. Staffing and supervision will vary between medical centers (MEDCENs) and medical department activities (MEDDACs).

b. In an NCD too small to require staffing for each section, duties should be combined, but the titles of all sections used. For example, a dietitian may serve as Chief, NCD; Chief, CDB; and Chief, PSB in a small MTF. Another common adaptation is for the senior Nutrition Care Specialist to serve as noncommissioned officer in charge (NCOIC), NCD and Chief, PSB. In a large NCD, it may be necessary to staff the sections with supervisors for each shift. One supervisor may be needed to coordinate the activities of all shifts. Where more than one dining facility is operated, the subsections of the organization may have to be duplicated.

1-4. Responsibilities and Duties

a. Chief, Nutrition Care Division will –

(1) Define and communicate the NCD's mission, vision, and plans.

(2) Gather, assess, and act on information regarding patient and family satisfaction with the services provided.

(3) Efficiently operate all nutrition care activities and provide nutritionally adequate meals within the value of the patient Basic Daily Food Allowance (BDFA) and the MTF BDFA.

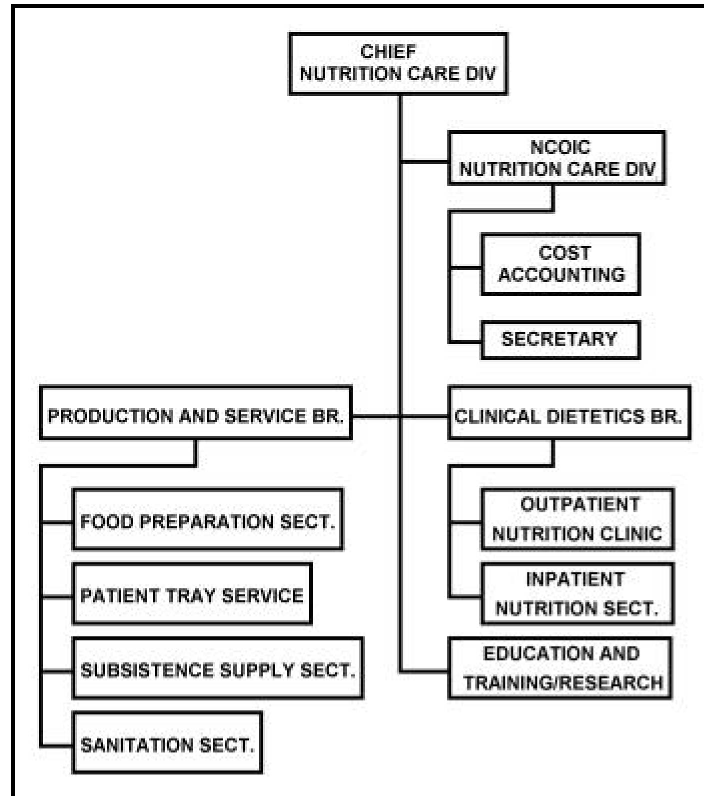

Figure 1-1. Nutrition Care Division.

(4) Plan and control the overall operation of the division and supervise all phases of food preparation and service.

(5) Establish and enforce administrative controls to ensure that prescribed reimbursement is collected for all meals and/or subsistence items consumed and to safeguard subsistence during receipt, storage, issue, preparation, and service.

(6) Ensure that the NCD meets or exceeds applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) dietetic standards.

(7) Standardize nutrition care practices.

(8) Initiate internal control measures to promote economical and effective use of personnel, equipment, supplies, and funds.

(9) Maintain a Hazard Analysis Critical Control Point program.

(10) Ensure maintenance of sanitation, pest control, and safety.

(11) Identify patient nutrition care needs and collaborate with other disciplines to meet those needs.

(12) Ensure that meals served are documented to account for subsistence issued and that a system is established to safeguard funds collected for subsistence consumed.

(13) Establish and implement a performance improvement plan to set priorities and systematically measure, assess, and improve performance.

(14) Establish, implement, and upgrade information systems and automation support for the NCD.

(15) Ensure staff competency.

(16) Develop and maintain comprehensive written internal and external disaster plans for the NCD.

(17) Promote effective personnel management through performance appraisals, awards, discipline, and negotiated agreements with unions.

(18) Function as the Contracting Officer's representative and monitor contract performance using the contract surveillance plan.

(19) Support command initiatives (for example, nutrition education and health promotion).

(20) Establish procedures for safeguarding the change fund and moneys collected by cashiers until these funds are transferred to the Medical Services Accountable Officer (MSAO) or authorized representative.

(21) Plan and conduct meetings as necessary to efficiently manage information, resources, and plan actions to improve the organization.

b. Medical Services Accountable Officer. This officer is responsible for the collection and disposal of funds used in the NCD. He is also responsible for the security of those funds.

c. Medical Corps and Dental Corps Officers. These officers are responsible for prescribing the dietary treatment for patients. They will indicate whether meals are to be served on the ward or eaten in the dining facility. The medical or dental officer may order supplemental snacks/beverages. He should also indicate whether a patient needs a modified diet after discharge from the MTF. Diets will be ordered IAW the Manual of Clinical Dietetics published by the American Dietetics Association (ADA).

d. Nurse Corps Officers. These officers ensure the correct transcription of patients' diet orders from the medical records to the diet roster. They also ensure that changes in diet orders are communicated to the NCD on a meal-by-meal basis. They confer with CDB personnel and physicians regarding relevant observations of dietary treatment. The Nurse Corps officer manages the ward and has a vital impact on day-to-day operations. A good working relationship with the head nurse is essential because he sets the climate for accomplishing objectives.

e. Veterinary Corps Officers. These officers inspect subsistence items for wholesomeness and safety. They are consulted for the inspection of questionable food items prior to preparation or use. When food has been determined unfit for human consumption, the veterinarians recommend the proper disposition.

f. Preventive Medicine Officer. This officer is responsible for making recommendations and providing technical guidance for sanitation procedures prescribed in AR 40-5 and TB MED 530. Local policy will determine the frequency of sanitation inspections by Preventive Medicine. Nutrition Care Division supervisors should inspect daily regardless of the date of the official inspection. Providing safe, wholesome food is a critical food service responsibility. Patients are already medically compromised and may not be able to tolerate a food-borne infection that would have only minimal effects on a healthy person.

g. Administration and Support Elements. The administrative and support elements of the MTF provide the NCD a variety of services. Examples of these elements are the –

- Deputy Commander for Administration (DCA).
- Inspector General.
- Information Management Officer.
- Patient Administration Division (PAD) Officer.
- Logistics Officer.
- Resource Management Officer (RMO).

1-5. Staff

a. Officer Personnel.

(1) The Commission on Dietetic Registration (CDR) registers dietitians after they successfully complete prerequisites and a comprehensive registration examination. They are designated within the Army Medical Specialist Corps (AMSC) by the Area of Concentration (AOC) 65C. The senior military

dietitian assigned to the MTF is designated Chief, NCD. Details of the classification system for commissioned officers are in Department of the Army (DA) Pamphlet (Pam) 611-21. Some facilities employ civil service dietitians and/or contract dietitians if there is an authorized need for the additional manpower.

(2) Dietitians are assigned on the basis of authorized manning levels and the strength of the AMSC. The employment of a civilian dietitian where an Army dietitian is assigned does not relieve the military dietitian of responsibility for operation of the NCD.

(3) Contracting direct health care providers is covered in AR 40-1. Contract dietitians may be hired if a military or civilian authorization cannot be filled and the command approves.

b. Dietitian (AOC 65C).

(1) Detailed responsibilities of the Chief, NCD are listed in paragraph 1-4. The Chief, NCD is also a staff officer for the MTF commander, usually under the direct supervision of the DCA, who may also be referred to as the Chief of Staff (CofS).

(2) Dietitians serve as resource managers as well as clinicians, making the most efficient use of –

- Personnel (military and civilian).
- Funds.
- Materiel.
- Equipment.
- Information.

(3) Dietitians supervise the two major functional areas controlling the various aspects of the operation. In the CDB, the dietitian works with inpatients and outpatients and participates in the Army's focus on fitness and wellness initiatives with other members of the Army community. In the PSB, the dietitian is responsible for food purchasing; receipt, storage and issue; preparation; and service via the MTF dining facility and a centralized patient tray service (PTS). In those facilities having an ETB, the dietitian's primary function is to educate dietetic interns and plan employee training and continuing professional education (CPE) for the staff.

(4) The dietitian meets and maintains the professional standards of the Army as defined in –

- Department of the Army Pamphlet (DA Pam) 611-21.
- The registration requirements set by the CDR.

- The standards in the ADA Code of Ethics.

(5) A registered dietitian must meet the CPE requirements of 75 credit hours every 5 years. Army Regulation 351-3 requires 25 CPE credit hours annually for Army dietitians.

(6) Dietitians in the CDB have a direct impact on patient care and are an integral part of the health care team. Dietitians should provide inservice training to the nursing and medical staff to inform them of the expertise and services available in the CDB. Open lines of communication among the health care team members are important. Participating in and nurturing professional relationships with other departments are also important. The Chief, CDB should meet periodically with other department representatives to review goals, objectives, and problems.

c. Enlisted Personnel. DA Pam 611-21 provides the details of the enlisted classification system. It also identifies the duties and qualifications for enlisted personnel by Military Occupational Specialty (MOS). Nutrition Care Specialists are classified as MOS 91M. Completion of the Food Service Specialist Course (MOS 92G10) is a prerequisite for the Nutrition Care Specialist Course (MOS 91M10). The 91M MOS has five skill levels based on duties performed. The Nutrition Care Branch at the AMEDD Center and School maintains a list of the tasks trained at each skill level. This list will assist in planning MOS proficiency training.

NOTE

DA has approved the change in the title of MOS 91M from Hospital Food Service Specialist to Nutrition Care Specialist. This change will be implemented on 1 October 2003.

(1) *MOS 91M10.* Under the supervision of a dietitian or noncommissioned officer (NCO) performs –

- Basic clinical dietetic administrative functions.
- Basic nutrition assessment patient interviews.
- Modified and regular diet food production inservice functions.

(2) *MOS 91M20.* Performs and supervises basic clinical dietetic administrative functions. Supervises, prepares, cooks, and serves modified and regular food items.

(3) *MOS 91M30.* Supervises the clinical dietetic management aspects in nutrition clinics, CDBs, or PSBs in an NCD. Supervises and assists in food preparation, cooking, and service.

(4) *MOS 91M40.* Supervises the PSB in large NCDs. Serves as NCOIC, NCD in small- and medium-sized MEDDACs and TOE units.

(5) *MOS 91M50.* Supervises the NCD or holds an appropriate headquarters staff position.

d. Civilian Personnel.

(1) Nutrition Care Division civilians are employed under the Office of Personnel Management (OPM) merit system and paid from funds that Congress appropriates. The MTF commander is responsible for the management of civilian personnel. Administration of the civilian personnel program at all levels must be within the framework of law, executive order, and directives of the Department of Defense (DOD), DA, and the OPM. Neither DOD nor DA may take actions inconsistent with OPM regulations.

(2) The NCD employs both general schedule (GS) and wage grade (WG) civilian personnel. Local nationals are often employed in MTFs outside the continental United States (OCONUS) to perform both GS and WG functions. Examples of GS positions in the NCD are –

- Registered dietitian.
- Clerk-typist.
- Cost-accounting clerk.
- Secretary.
- Diet assistant.
- Diet technician.
- Patient appointment clerk.

(3) Wage grade employees occupy positions such as cook and food service worker.

1-6. Improving Organizational Performance

a. The JCAHO delineates institutional measures to ensure the quality, appropriateness, and timeliness of care. Scoring guidelines, which JCAHO surveyors use, are updated and published annually in the JCAHO Accreditation Manual For Hospitals. The JCAHO maintains a web site that lists timely information and catalogs from which to order manuals and other useful publications. The web site address is www.jcaho.org.

b. Army Regulation 40-68 details the Army's approach to the improvement of quality. AR 40-48 specifically addresses privileges, duties, and supervision of dietitians. To be successful, the program must have the commitment of top management. The focus is on the ongoing processes of health care delivery instead of individuals and outcomes measured against standards. The NCD and the MTF develop monitoring and assessment techniques to assist in the process of providing quality care. Indicators and a schedule by which to monitor them are initially developed, but are changed or updated as necessary. Active involvement of all NCD members is required to ensure that quality care is provided to all beneficiaries. The NCD program will be integrated with the MTF's performance improvement structure, and documentation will provide evidence of ongoing improvement. Educating the staff through periodic and timely inservice training reinforces the importance of improving organizational performance (IOP) and provides current information.

c. The NCD actively participates in planning, delivering, and evaluating the care it provides. Quality of care is determined by a number of factors to include –

- Accessibility.
- Timeliness.
- Effectiveness.
- Efficiency.
- Safety.
- Appropriateness.
- Continuity.
- Participation of the patient and family in the patient's care.

CHAPTER 2

ADMINISTRATION

Section I. POLICY, PLANNING, BUDGETING, AND STAFFING

2-1. Introduction

This section discusses the requirements and preparation involved in implementing policies, selecting and purchasing equipment, formulating a budget, and identifying personnel requirements. It also discusses the personnel authorized to subsist in the MTF dining facility. A business plan is a useful tool that incorporates policy, planning, budgeting, and staffing. See Appendix A for a brief discussion and sample of a business plan.

2-2. Policy

a. The Chief, NCD is responsible for developing and implementing local policies and procedures IAW AR 40-3. Policies are the basis for developing procedures. Procedures provide instructions for performing activities. As a minimum, procedures required to meet JCAHO requirements will be developed and documented. Nutrition Care Division policies and procedures must be consistent with applicable directives and coordinated with other MTF elements. Policies and procedures should be written concisely, reviewed annually, and updated when necessary. They should be readily available for use in training new personnel and ensuring accuracy and efficiency of daily operations.

b. Written policies and procedures should be kept in a binder for easy access. A loose-leaf format will facilitate changes. A practical method for indexing the contents of the material should be developed. All routine work procedures should be written and incorporated into this binder. Copies of procedures should be kept in each work center. Samples of forms completed according to local policy provide valuable information. See Appendix B for a list of suggested policies and procedures to be included in the binder.

2-3. Planning

a. *General.* The Chief, NCD is responsible for all planning in the division. Providing the best nutritional care for patients within the framework of an efficient and economical NCD operation requires thoughtful continuous planning. Medical treatment facilities plan budgets and commit funds for the future. The Chief, NCD makes long-range decisions on layout and equipment needs, food procurement, and meal delivery systems. Flexibility in planning is required due to changing technology in the various areas of the NCD. The Chief, NCD maintains a knowledge of equipment and trends through reading food service journals and equipment catalogs and by attending trade shows.

b. Space Requirements. The Chief, NCD works closely with the facilities planners on space allocation for the division. The Chief, NCD should discuss layout and design projects with the health facility planning agency staff officer. Every effort should be made to consolidate activities and design the area for maximum efficiency. Consolidation reduces the number of personnel needed to accomplish the mission and decreases duplication of work effort and resources.

c. Layout and Equipment Planning Guidelines. There must be a direct flow of raw foods from the point of receipt through processing and preparation work centers to the Patient Tray Service (PTS) and dining facility. This is the basis for an efficient and economical nutrition care operation. The following points should be considered in planning layout and equipment:

(1) Minimum use of permanent wall partitions.

(2) Maximum use of mobile equipment.

(3) Maximum use of vertical space.

(4) Maximum use of multipurpose equipment.

(5) Maximum use of wall-mounted equipment.

(6) Duplication of high use equipment.

(7) User friendly equipment.

(8) Quick release water and gas lines.

(9) Use of tubular adjustable legs for easy cleaning and proper work heights.

(10) Adjustment of working surfaces to a convenient height for increased efficiency and comfort of personnel.

(11) Provision of self-cleaning exhaust systems which meet the standards of TB MED 530.

(12) Installation of recessed lighting for sanitation and safety.

(13) Installation of acoustical ceilings to reduce noise in the kitchen and dining areas.

NOTE

If a drop or lay-in ceiling is used, vinyl covered tile panels with plastic or aluminum channels to prevent rusting or corrosion is preferable.

(14) Installation of noise dampening materials under the stainless steel countertops.

(15) Maximum use of conveyor belts to automate operations.

(16) Use of automatic washing facilities in the pot and pan areas to improve sanitation.

(17) Use of appropriate waste disposal and recycling equipment in all areas generating garbage.

NOTE

To reduce odors and maintenance problems, install external grease traps that can be serviced and cleaned from outside the facility.

(18) Provision of electronic devices, temperature and timing controls, and signal devices at eye level on all required equipment.

(19) Maximum use of appropriate pans.

(20) Provision of required safety devices such as latches, alarms, and electronic controls in walk-in refrigerators and freezers.

(21) Maximum use of portable shelving in refrigerators and storage areas.

(22) Provision of adequate space and security devices for storing and safeguarding food and supplies.

(23) Installation of adequate electrical outlets of suitable voltage to accommodate electric cooking equipment and portable electrical equipment. Consideration must be given for emergency power for certain pieces of equipment.

(24) Nonslip quarry floor tile is recommended to prevent falls and accidents.

(25) Equipment must meet the standards of the Underwriters Laboratory, National Sanitation Foundation, and/or American Gas Association. Connections must comply with the Occupational Safety and Health Act standards.

(26) There must be a plan for adequate fire control systems such as an automatic fire extinguishing system in exhaust hoods and accessible fire extinguishers. Contracts must be in place for periodic inspections of the fire control systems and cleaning of exhaust hoods.

d. Layout and equipment selection guidelines.

(1) Define the necessary functions to be performed and identify all tasks for these functions. Consider flow of supplies, employees, patients, guests, and equipment, minimizing movement and cross traffic. Flow diagrams assist in physically placing work centers where functions occur and can identify problem areas. Space estimates must reflect required space for each functional area.

(2) The Chief, NCD determines the location for a piece of equipment before selecting it. He must determine space requirements for each piece of equipment. Equipment that must be cleaned with a spray of water must be located near a water source and a drain. He must consider the frequency of use and demands placed on the equipment and plan for storage of component parts. The Chief, NCD also considers the location and characteristics (volts, amps, cycle, and phase) of the power source. If possible, he should observe equipment in use before purchasing it. Equipment requests should be closely coordinated with the Logistics Division and facilities engineers.

(3) The Chief, NCD should develop a 5-year equipment plan which prioritizes and forecasts equipment needs. This list should be updated annually. Development of this plan will ensure that equipment is identified for purchase prior to the availability of funds. The Chief, NCD should begin selection of equipment before preparation of annual budgetary requests and not wait until funds for purchasing are approved. Justification must be provided to ensure that the appropriate equipment is received. The opinions and evaluations of users should be included when comparing the merits of available equipment. Factors affecting the selection of kitchen and serving equipment are—

(a) Budget.

(b) Available space.

(c) Type of menu and service.

(d) Number of persons to be fed.

(e) Length of serving period.

(f) Energy source.

(g) Type and amount of labor required to operate the equipment.

(h) Cleaning and maintenance costs.

e. Location of the clinical dietetics branch office. The Chief, NCD must consider the advantages and disadvantages of locating the CDB office near the main kitchen or the wards. The CDB works closely with the PSB; therefore, too much distance between them can contribute to communication problems. The Chief, NCD should also consider the need for a nutrition clinic and a small classroom. Medical treatment facility layout, availability of space, and the number of patients visiting the office will influence placement. In larger MTFs, the Nutrition Clinic may be located away from the main CDB office. The ideal location would be near the patient care area, but with ready access to the main kitchen. A large MTF may benefit from satelliting CDB offices into patient care areas.

f. Menus.

(1) The Chief, NCD will ensure that standard MTF diets derived from the Manual of Clinical Dietetics are planned, approved, and made available as prescribed in AR 40-3.

(2) The Chief, NCD establishes the procedure to be followed in planning menus. The MTF menu provides nutritionally adequate meals within established monetary limitations. The menu is preplanned, approved, and signed by a registered dietitian. The Chief, NCD may delegate the actual preparation of the menu to another registered dietitian.

(3) The Chief, NCD will determine the —

- Type of menu to be used (cycle or other).
- Length of the menu cycle.
- Period of time for use of the menu.
- Types of foods to be used (preportioned meats, frozen or fresh foods, individually packaged items).
- Number of choices to be offered to patients and personnel on regular and modified diets.

(4) The Chief, NCD will incorporate the provisions of AR 40-25 into the MTF menus as applicable.

2-4. Budgeting

a. Program and Budget.

(1) In accordance with the Army Resource Management System, each MTF is required to develop a program of what it plans to accomplish in the forthcoming fiscal year (FY). This program is formalized in writing. Chiefs of departments, services, and divisions are required to estimate the resources necessary to carry out the program. Resources include personnel, supplies, equipment, funds, and services. The cost of these resources projected for the FY is called a budget.

(2) The operating programs and budgets of all elements of the MTF are reviewed by its Program and Budget Advisory Committee (PBAC), which is composed of personnel designated by the commander. During the review, chiefs of clinical and administrative staffs are permitted to defend resource requirements. The commander establishes project priorities and approves the final allocation of resources.

b. Responsibility of the Chief, Nutrition Care Division. The Chief, NCD prepares the operating program and budget for the division. It is recommended that the Chief serve as a member of the PBAC. The Chief, NCD manages the budget and monitors expenditures. The Chief, NCD should be directly involved in the mid-year review process. The Chief, NCD may work with others on business plans and initiatives as appropriate.

c. Preparation of the Operating Program and Budget. The categories for which FY fund requirements must be estimated for the NCD include —

- Subsistence.
- Personnel (payroll).
- Conference registration fees.
- Temporary duty (TDY).
- Supplies.
- Equipment.

- Contractual services, if applicable.

A mid-year review is conducted to assess the use of funds for the first half of the year. The mid-year review may result in the NCD budget being decreased or increased, depending on changes in mission, past financial management, or other factors.

d. Subsistence Estimates.

(1) The authorized MTF daily food allowance (ration) rate is calculated IAW AR 30-18.

(2) To provide information on which to base estimates of future fund requirements for subsistence, the following monthly data from previous FYs should be maintained:

(a) Number of meals served.

(b) Basic daily food allowance.

(c) Food inventory value.

(d) Projected earnings.

(3) From trends noted in review of the above data and from other pertinent information such as projected changes in the MTF mission and assigned personnel, estimates of future budget requirements for subsistence can be made. Estimates of the number of meals to be served and total cost of subsistence should be made for each month of the following FY.

(4) After the monthly food cost accounting records are closed, a review of the subsistence budget is required, as determined locally by the RMO. Records are usually closed at the end of each quarter or semiannually. Estimated and actual daily food allowances served to date and estimated and actual daily food allowance rates should be compared. Based on this comparison, the subsistence budget for the remainder of the FY can be reevaluated and adjusted as necessary. Subsistence funds should be used for food items only. A periodic review is essential to ensure that adequate funds are programmed for subsistence for the entire fiscal year.

e. Conference Travel and TDY Funds Estimates.

(1) Conference travel for attendance at professional and scientific meetings and registration fees for local training are funded locally. They must be programmed on a projected basis in the FY budget by the Chief, NCD IAW local procedures.

(2) Travel for short courses at civilian institutions and military schools and courses funded by the Office of the Surgeon General (OTSG) requires advance planning and coordination by the Chief, NCD. This enables more people to receive the benefits of CPE without stressing the local NCD budget.

f. *Supply Estimates.*

(1) The following information on which to base estimates of future fund requirements for supplies should be maintained from previous FYs:

(a) Total number of meals served per month.

(b) Daily status of funds obligated for supplies with monthly totals by designated categories such as —

- Office.
- Paper goods.
- Cleaning supplies.
- Cleaning equipment.
- Repair parts.
- China.
- Silverware and trays.
- Serving utensils.
- Diet kits.
- Linens.
- Uniforms.

(c) Monthly consolidated totals of funds consumed by the designated categories in paragraph 2-4*f*(1)(*b*) above.

(2) From a review of the above data and consideration of anticipated changes in supply requirements due to modifications in workload and systems, estimates of fund requirements for future supplies may be made. Substantial increases in requirements should be identified, justified, and requested.

(3) At a time established locally by the RMO, a comparison of actual consumption of supplies with budget estimates should be made. Results will indicate whether or not adjustments should be made in the amount of funds allocated for supplies for the remainder of the year. (See mid-year review, paragraph 2-4*c*).

g. Equipment Estimates and Purchasing.

(1) Equipment requirements are programmed and budgeted through the development and maintenance of a five-year equipment replacement program. This program consists of a priority listing of equipment items which the Chief, NCD has determined will be needed for the orderly replacement of food service equipment in the division. Consideration should be given to proposed renovations and changes in systems, procedures, work flow, mission, and workload contemplated for the future. Once requirements are determined, the program is prepared by listing items according to priority of need. The information usually recorded for each piece of equipment includes —

- Line item.
- Federal stock number.
- Description.
- Unit cost.
- Quantity.
- Total cost.
- Age of item to be replaced.
- Life expectancy of replacement item.
- Number of years an item has been deferred.
- Installation costs.
- Cost of removing old equipment, if necessary.

- Location in the division where item will be used.
- Power requirement (gas, electric).

The overall program is reviewed continuously throughout the FY and updated annually. Additions, deletions, and changes in priority ensure that only essential equipment is purchased to accomplish the present and contemplated mission and workload.

(2) Equipment is obtained either by purchase from the NCD budget, through the Medical Care Support Equipment (MEDCASE) Program or Capital Expense Equipment Program (CEEP), or by lateral transfer from one MTF property book to another. Seek assistance from the MEDCASE/CEEP managers in the Logistics Division. The MEDCASE program is a centralized program which funds capital investment equipment required to support health care activities at TDA Army medical and dental treatment facilities worldwide. Medical Care Support Equipment Program funds are received by OTSG and are distributed to the participating commands and activities. Activity commanders prioritize approved requirements and execute them either through local purchase procedures or by requisition to a wholesale supply source. The determining factor for when this program is used is the cost of the item.

(3) The CEEP provides a means for regular, planned replacement of obsolete equipment. The commander establishes the policy, and the PBAC allocates resources to each department. The Chief of Logistics administers the program which is maintained in the Property Book Branch. The justification must explain the tangible and intangible cost savings and discuss the impact the request will have on the mission if not approved. Look to the future for —

- Proposed renovations and system changes.
- Procedures.
- Work flow.
- Mission.
- Workload contemplated for the future.

Once requirements are determined, the program is prepared by listing items according to priority of need. The information usually recorded for each piece of equipment includes —

- Line item.

- Federal stock number.
- Description.
- Unit cost.
- Quantity.
- Total cost.
- Age of item to be replaced.
- Life expectancy of replacement item.
- Number of years item has been deferred.
- Installation costs.
- Removal of old equipment if necessary.
- Service warranty.
- New equipment training.
- Location in the division where the item will be used.
- Location compatibility (adequate space and appropriate power source).

The equipment purchasing program is reviewed continuously throughout the FY and brought up to date annually. Additions, deletions, and changes in priority ensure that only essential equipment is purchased to accomplish the present and projected mission and workload.

h. Contractual Services Estimates. A budget will be prepared for contractual services and submitted to the RMO for approval. Justify the need and hiring of contract personnel to ensure mission accomplishment.

i. Budgeting for Holiday Items. The Chief, NCD investigates local procedures and deadlines for submitting requests for the purchase of holiday menus, decorations, and napkins. Payment for printing menus for use at Army MTFs at Thanksgiving and Christmas is an authorized expenditure.

j. Cost and Performance Information. Each month, the RMO forwards budget information to the Chief, NCD. This information indicates the —

- Amount of money spent for each program for the current month.
- Amount of money spent to date.
- Balance remaining for each program for the FY.

It gives the rate of expenditure of program funds by categories and shows when programs need review because of over- or under-expenditure of funds.

2-5. Staffing

a. Staffing Guide. AR 71-32 provides guidance for staffing the NCD. The personnel authorizations included in the TAADS are documented on the TDA upon approval of the MACOM.

b. Changes in Personnel Requirements. The Chief, NCD should alert the DCA and RMO to a change in personnel requirements. Forecasting or early identification of personnel requirement changes is critical.

c. Work Measurement (Performance Analysis). Work measurement can be used to determine manpower or staffing needs. See Section II of this chapter for a discussion of the Medical Expense and Performance Reporting System (MEPRS).

d. Relationship of Staffing Needs to Methods of Scheduling Personnel.

(1) The NCD usually operates 12 to 18 hours a day. The majority of work occurs from 0430 to 1900 hours. The most advantageous coverage may be obtained by careful planning of personnel schedules. Consideration should be given to the use of part-time employees during peak load periods. The chief should consider matching of personnel hours to operational hours needed; for example, low demand weekends or holidays usually require fewer personnel. Hours and tours of duty are discussed in OPM regulations.

(2) Rotating duty schedules and staggered duty hours provide the most equitable distribution of off-duty days and workloads. Most schedules adhere to existing OPM regulations; however, some recommended tours of duty do not conform entirely to the regulations. These must be approved by the local civilian personnel agency and negotiated with the labor union if necessary before being implemented.

Each organization has an employee handbook that addresses policies and procedures for employees. Frequent updates of this handbook should alleviate confusion over MTF policies and employee issues.

(3) Overprinted duty schedules save time in schedule preparation, particularly when many employees are involved. Schedules should be posted in advance IAW local union contract and/or installation civilian personnel agency regulations.

e. Critical Evaluation of Staffing Needs.

(1) Personnel costs are the most expensive factor in operating an NCD. The NCD costs represent a large part of the total MTF budget. To assess efficient and economical use of resources, the Chief, NCD constantly reviews —

- Management policies.
- Services provided.
- Work procedures.
- Scheduling.
- Productivity.
- Types of food and equipment.
- Existing layouts.

(2) Required numbers of supervisors, layers of supervision, and command and control need to be reviewed when evaluating staffing requirements.

(3) Position management specialists in the local civilian personnel agency should be consulted in designing organizations and positions for optimum use of available skills.

2-6. Personnel Authorized to Subsist in the MTF Dining Facility

a. The primary purpose of the NCD is to feed inpatients and enlisted personnel entitled to subsistence-in-kind (SIK). The MTF commander may authorize other personnel access on a regular or occasional basis. This may include the following:

- Assigned or attached personnel including staff enlisted personnel entitled to separate rations.
- Officers.
- Civilian staff.
- Guests.

Authorization to subsist may be on a regular basis or for holiday meals. In some instances it may be preferable to authorize separate rations in lieu of furnishing SIK.

b. An approved MTF publication will specify the categories of personnel authorized to subsist, means of identifying each diner's category, and the meal rates by category. The NCD may write and be the proponent for this publication.

c. If any food, beverage, or condiment is consumed, diners will pay the full meal price unless the A La Carte system is in use. Box meals should not be brought into the NCD dining room, and areas designated for box meals should be separate from NCD areas. Dining facilities may operate a box meal take-out program which will increase total rations served, but implementation of an A La Carte system may preclude the need for this program. NCD resources will not be used to support MTF break areas.

d. Personnel receiving SIK must be issued a meal card (DD Form 714) or other identification signifying their status. A positive means to readily identify other individuals routinely authorized to subsist in the dining facility (such as meal card, identification badge or card, or magnetically-coded card) will be used as the MACOM/MEDCOM dictates. Each MTF will establish local procedures for controlling the diner identification method.

Section II. Medical Expense and Performance Reporting System

2-7. Introduction

The MEPRS is a unit costing system that accumulates and reports expenses, manpower, and workload. It is a valuable information tool which can greatly enhance your ability to manage. Although MEPRS is referred to as a single system, it actually consists of several systems or programs.

2-8. Uniform Chart of Accounts Personnel Utilization/Defense Medical Human Resources System

The portion of MEPRS that most individuals use is the Uniform Chart of Accounts Personnel Utilization System (UCAPERS). It is the system that captures man-hours and calculates salary costs. The local finance and accounting office provides the MTF with salary, supply, and equipment costs through the Standard Financial System/Defense Civilian Payroll System and Standard Civilian Personnel System. The local installation provides the base operations costs such as utilities and depreciation. The UCAPERS is currently being refocused to include staff benchmarking.

2-9. Expense Assignment System

a. The Expense Assignment System (EAS) is a computer program that distributes costs or assigns expenses between accounts and performs calculations. This program produces the Medical Expense and Performance Report that goes to the U.S. Army MEDCOM and Assistant Secretary of Defense for Health Affairs.

b. The EAS version III (EAS-III) MEPRS data is used for local managed care initiatives, economic analysis, manpower decisions, cost studies, direct care/Civilian Health and Medical Program of the Uniformed Services cost comparisons, and so forth. The EAS-III/MEPRS will be the resourcing mainstay for virtually every aspect of military health care management for the foreseeable future.

2-10. Functional Categories

a. The MEPRS gathers expenses and workload data into functional categories. These functional categories are further divided into summary accounts and subaccounts. The MTF then tailors the subaccounts to meet its specific needs.

b. The MEPRS employs an alphabetic coding structure to identify these different levels. *Everything* the MTF does is classified into one of the following functional categories represented by a first level MEPRS Code (see Table 2-1).

Table 2-1. First level MEPRS codes.

Functional Category	1st Level MEPRS Code
Inpatient Care	A
Ambulatory Care	B
Dental Care	C
Ancillary Services	D
Support Services	E
Special Programs	F
Medical Readiness	G

c. The second level MEPRS codes (the summary accounts) represent the general areas within the functional categories (for example, medical, surgical, OB/GYN, dental, pathology). Table 2-2 shows ambulatory care broken into summary accounts and the appropriate second level MEPRS codes.

Table 2-2. Second-level codes.

SUMMARY ACCOUNT	MEPRS CODE
Medical	BA
Surgical	BB
OB/GYN	BC
Pediatric	BD
Orthopedic	BE
Psychiatric	BF
Family Practice	BG
Primary Medical	BH
Emergency Medical	BI
Flight Medicine	BJ
Rehab Services	BL

d. The summary accounts are further divided into subaccounts (third level MEPRS code) which describe the actual activities of an MTF (for example, internal medicine, cardiology, pediatric, pulmonary function). Table 2-3 shows ambulatory medical care broken into subaccounts with the appropriate MEPRS codes.

e. Although DOD has standardized MEPRS codes at the third level, the MEPRS code for a clinic does not consist of only three letters. All MEPRS codes must consist of four letters. The fourth letter permits the local MTF to tailor the capturing of workload and full time equivalent (FTE) data to its specific needs (to capture data at a specific geographic location or to identify man-hours, workload, and expenses of contract providers). For example, BALA may identify the Outpatient Nutrition Clinic at an MTF. The fourth level MEPR code BALQ could be used to capture the workload at a satellite Outpatient Nutrition Clinic. Each MTF has an account subset definition that defines and serves as an index to that particular MTF's fourth level MEPRS codes. The MEPRS is a valuable source to track and identify the costs and impacts to an operation. It is imperative that the Chief, NCD takes the responsibility to increase managerial awareness and understanding of the MEPRS system and assure the accuracy of reported data. The MEPRS is an integral component in evaluating and measuring the success of a nutrition care operation.

Table 2-3. Third-level codes.

SUBACCOUNTS	MEPRS CODE
Internal Medicine Clinic	BAA
Allergy Clinic	BAB
Cardiology Clinic	BAC
Diabetic Clinic	BAE
Endocrinology Clinic	BAF
GI Clinic	BAG
Hematology Clinic	BAH
Hypertension Clinic	BAI
Nephrology Clinic	BAJ
Neurology Clinic	BAK
Outpatient Nutrition Clinic	BAL
Oncology Clinic	BAM
Pulmonary Disease Clinic	BAN
Rheumatology Clinic	BAO
Dermatology Clinic	BAP
Infectious Disease Clinic	BAQ
Physical Medicine Clinic	BAR
Combined Clinic Cost Pool	BAX

NOTE

An X in the third level depicts a cost pool, an account that collects expenses and FTE data for the purpose of distributing or spreading the expenses and FTEs into several other subaccounts. For example, if allergy and pulmonary disease share ancillary staff, the expenses, such as salaries and other shared costs, would go into the cost pool. It would then be distributed between allergy and pulmonary disease based on their workload.

2-11. Outpatient Nutrition Clinic BAL

a. Function. The nutrition clinic provides medical nutrition therapy to outpatients. Functions performed include

- Screening and assessment.
- Patient education.
- Diet calculation planning.
- Group and individual diet instruction.
- Material development.
- Health promotion.
- Medical record documentation.

b. Costs. The Outpatient Nutrition Clinic work center account shall include all operating expenses incurred in operating and maintaining the clinic. Included are –

- Appointment scheduling if accomplished by the dietary department.
- Publication management for patient handouts.
- Telephone consultations with patients.
- Workload reports and documentation.

c. Performance Factor. Visit.

d. Assignment Procedure. This is a final operating expense account and shall not be reassigned.

2-12. Dietetics EI

a. Function. Dietetics provides comprehensive dietetic services for patients and staff. Functions here include –

- Operation and management of food production and service activities.
- Preparation and service of food.
- Clinical dietetic services.
- Nutrition education.
- Subsistence management and cost accounting.
- Sanitation.
- Quality assessment/improvement.

Dietetics shall include the following work centers. Each will be specifically charged with the expense incurred in performing its individual functions and activities:

- Patient Food Operations.
- Combined Food Operations.
- Inpatient Clinical Dietetics.

b. Costs. The dietetics account shall be a summary account that includes all operating expenses incurred by the accounts listed above. Excluded is the expense of nursing service personnel who assist in serving food to patients. The aggregate of expenses in the dietetics account shall be assigned through a stepdown process.

NOTE

The expenses incurred to conduct a nutrition clinic shall be assigned to BAL and nonpatient feeding assigned to FDC

2-13. Patient Food Operations EIA

a. Function. Patient Food Operations provides meal service to patients including all workload involved in providing meal service to inpatients and transient patients. Included here are –

- Routine inpatient rounds to determine food acceptability.
- Menu slip preparation.
- Therapeutic menu development.
- Patient tray assembly.
- Nourishment preparation and service.
- Cooked therapeutic in-flight meal preparation.
- Therapeutic diet cooking.
- Related quality improvement activities.
- Sanitation of tray carts, patient tray assembly areas, and patient tray components.
- Any other tasks unique to patient feeding.

b. Costs. Patient Food Operations includes all in-house expenses incurred in operating and maintaining meal preparation and service to patients. Excluded is the expense of nursing service personnel who assist in serving food to patients. One exception is that inpatient Clinical Dietetics will be assigned to EIC, Inpatient Clinical Dietetics. The cost of all subsistence and inventory management will be assigned to EIB, Combined Food Operations.

c. Performance Factor. Patient meal days served.

d. Assignment Procedure. The aggregate expenses assigned to direct patient care shall be based on the ratio of patient rations served to each receiving account to the total patient rations served in the MTF. Patient rations are all rations served to inpatients and transient patients. Inpatient rations are those served to inpatients, excluding transient patients, whether served on the inpatient units or in the dining room. Transient patient rations are those served to transient patients either on inpatient units or in the dining room and are reported under the appropriate "FE" account in Special Programs.

2-14. Combined Food Operations EIB

a. Function. Combined Food Operations provides subsistence, food preparation, department management, and services that are used for –

- Inpatient, transient patient, or nonpatient feeding in the dining room.
- Menu and recipe development for regular menu items.
- Sanitation of combined areas, such as cooking islands and pots and pans.
- Related quality improvement activities.
- Subsistence accounting.

b. Costs.

(1) Combined Food Operations includes all in-house operating expenses incurred in

- Purchasing and maintaining subsistence.
- Operating and maintaining the meal preparation and service function that provides meals used for inpatient tray assembly, transient patients, or nonpatients in the dining room.

(2) Exceptions to the above are –

- The expense to provide Inpatient Clinical Dietetics will be directly assigned to EIC, Inpatient Clinical Dietetics.
- Outpatient Nutrition Clinic expenses will be assigned to BAL, Nutrition Clinic.

- Expenses (labor or supplies) used solely for inpatient meal service or transient patients will be assigned to Patient Food Operations.

- Expenses used solely for nonpatient feeding and dining room operations will be assigned to FDC, Nonpatient Food Operations.

c. Performance Factor. Total meal days served.

d. Assignment Procedure. The aggregate expenses to be assigned to Patient Food Operations and Nonpatient Food Operations will be based on the ratio of patient rations served and nonpatient rations served to the total rations served in the MTF. The assignment of expenses to the Patient Food Operation, EIA, shall be based on the ratio of inpatient and transient patient rations served to the total rations served in the medical facility. The remaining aggregate expenses shall be assigned to Nonpatient Food Operations, FDC, in the Special Programs section.

2-15. Inpatient Clinical Dietetics EIC

a. Function. Inpatient clinical dietetics provides basic and comprehensive nutritional care for inpatients. Functions here include

- Coordination of changes in diet requirements.
- Dietary patient index maintenance.
- Developing nutritional care plans.
- Nutritional assessment and reassessment.
- Diet and nutrient calculations.
- Nutritional care recommendations and documentation.
- Interdisciplinary health care activities.
- Nutritional counseling for inpatients.
- Discharge planning.
- Quality improvement activities.

- Management of clinical dietetics activities.

b. Costs. Inpatient clinical dietetics costs include all expenses incurred for providing inpatient clinical nutritional care. However, the expense of dietetics personnel will be included in Patient Food Operations when –

- Distributing and collecting menus.
- Preparing menu slips and tallies.
- Conducting routine inpatient rounds to determine patient satisfaction and food preferences.

c. Performance Factor. Weighted Inpatient Nutrition Procedures.

d. Assignment Procedure. The aggregate expenses are assigned to Patient and Nonpatient Food Operations.

2-16. Nonpatient Food Operations FDC

a. Function. This account is provided to accumulate expenses incurred by the dietetics department that are not related to direct patient care. It is that portion of dietetics service operations that support staff and visitors.

b. Costs. Nonpatient Food Operations includes all costs of maintaining and operating Nonpatient Food Operations in the dining room. The applicable portion of the dietetics account that is attributable to staff and visitors shall be assigned to this account.

c. Performance Factor. Nonpatient meal days served.

d. Assignment Procedure. This is a final operating expense account and shall not be reassigned.

NOTE

For additional information on MEPRS, refer to the website: http://www.meprs.amedd.army.mil.

Section III. CIVILIAN PERSONNEL ISSUES

2-17. Introduction

The Chief, NCD is responsible for managing civilian resources in the NCD; therefore, he should be familiar with the regulations that govern civilian employment. Each civilian personnel agency offers basic civilian supervisory courses. All new supervisors must attend this training. When possible, officers and NCOs should attend this training prior to assuming their supervisory responsibilities. The Chief, NCD should build a solid relationship with members of the civilian personnel agency to include the Management Employee Relations Branch, the MTF's RMO, and union representatives. This will assist in the effective management of civilian assets.

2-18. Policies

The OPM establishes policies. The commander maintains overall responsibility for ensuring implementation of these policies. The TDA dictates the total number of personnel (military and civilian) authorized to a command. Actual allocations are determined within the command based on budgetary limitations.

2-19. Civilian Merit Promotion System

The Civilian Merit Promotion System is decentralized and managed individually by post. Civilian grades (and, therefore, pay) are based on official job descriptions. These job descriptions should be reviewed periodically. When staffing or missions change, the officer in charge must pay special attention to ensuring that job descriptions contain all of the duties required to do the job. Scheduling employees to work overtime should be kept to a minimum, should have the NCD Chief's approval, and often needs prior approval of the RMO.

2-20. Civilian Vacancies

Civilian positions are primarily filled through open competition, with multiple sources of potential candidates. Managers can best assist the civilian personnel agency and themselves by forecasting possible employee shortages and coordinating this with the RMO and civilian personnel agency.

2-21. Supervisor Functions

The supervisor of a civilian employee will--

a. Prepare the narrative contents of the job description.

b. Prepare the performance standards.

c. Complete the performance appraisals.

d. Provide counseling as required by the Civilian Performance Appraisal System.

e. Approve/disapprove leave requests.

f. Submit award recommendations.

2-22. Total Army Performance Evaluation System

a. In July 1993, the Civilian Performance Management System was replaced by the Total Army Performance Evaluation System (TAPES). There are two systems in TAPES. The base system is used for the evaluation of all Work Leader, WG, Work Supervisor (WS), and GS employees in grades 1 through 8. The senior system is used for evaluating the professional staff and employees in grades WS/GS-9 and above.

b. Both systems emphasize the importance of ratee input and linking job tasks to the mission. To elicit this input, face-to-face discussion between the rater and employee is required. An initial counseling session within the first 30 days of the rating period and a midpoint session must be verified on the supporting documents for both systems. The base system uses DA Form 7223-1 (Base System Civilian Performance Counseling Checklist/Record). The senior system uses DA Form 7222-1 (Senior System Civilian Evaluation Report Support Form).

c. The base system emphasizes the simplicity of the program through standardization of documents and procedures, the requirement for periodic counseling by the rater, and documentation of employee training and development needs. DA Form 7223 (Base System Civilian Evaluation Report) has a format similar to the Noncommissioned Officer Evaluation Report. This should facilitate the personnel management and evaluation tasks of raters who are likely to be skilled in writing bullet comments for military personnel.

d. The senior system stresses professional development and individual performance objectives for the employee. These objectives are listed on the DA Form 7222-1, which is similar to the Officer Evaluation Report Support Form. DA Form 7222 (Senior System Civilian Evaluation Report) summarizes major duties, provides the format for the rater to evaluate the employee's contributions, discusses potential, and assesses adherence to DA values.

e. AR 690-400 introduces and explains TAPES and instructs rating officials in preparing the new forms. Every officer and NCO responsible for rating civilian employees must have a copy of AR 690-400 and be familiar with its contents. Contact the servicing civilian personnel agency or your publications officer for assistance in obtaining this document.

2-23. Discipline

The Management Employee Relations Branch will aid supervisors in handling employee disciplinary problems. There are informal actions (verbal counseling, warnings, and memoranda for record) and formal disciplinary actions (official written reprimands, suspensions, and removals). Always consult the Management Employee Relations Branch representative before taking action against an employee. If proper procedures are not followed, management may lose the opportunity to discipline a problem employee.

2-24. Local National Employees Outside the Continental United States

Employment parameters for local national employees for OCONUS differ from CONUS (continental United States) standards. Work hours, holiday schedules, annual leave policies, and so forth are IAW host nation standards. In addition to the basic supervisory course, OICs and NCOICs are required to attend a course regarding the supervision of local nationals when overseas.

2-25. Workers' Compensation

This provides compensation benefits to employees for disability due to personal injury or disease sustained while in the performance of duty. The Chief, NCD or his representative must contact the appropriate office in the local civilian personnel agency immediately after an employee sustains an injury that may result in an extended absence. The program is primarily administered by the Office of Workers' Compensation, an agency of the Department of Labor.

2-26. Leave

The local union policy states the leave policy. Requests for leave are submitted and approved within the department. Leave falls into the following categories: annual, sick, military, court, administrative, and leave without pay.

2-27. Incentive Awards

Reward employees' performance appropriately. Awards are either monetary or honorary. Supervisors usually recommend employees for an award in conjunction with their performance ratings or for a special act.

2-28. Reduction in Force

It may become necessary to abolish positions because of reorganization, consolidation, closures, relocation, or reclassification of positions due to changes in duties. Reduction-in-force procedures decide which employees will be retained and which must be separated, changed to a lower grade, or displaced. Consult closely with the command and the local civilian personnel agency if directed to undertake such action.

2-29. Civilian Personnel Files

Supervisors are required to maintain a variety of information concerning their employees. A number of civilian personnel forms (certificates of training, job descriptions) should be maintained in the division. Inquire at the local civilian personnel agency for a complete list of pertinent forms. Employee files should be safeguarded to ensure privacy.

CHAPTER 3

TRAINING AND RESEARCH

3-1. Introduction

a. Establishment and maintenance of an orientation and training program in the NCD are essential to mission accomplishment. A planned, continuous training program assures improved work methods, develops the potential abilities of individuals, and meets the changing needs of the NCD. Training, at a minimum, will include topics identified by the JCAHO and other regulatory agencies. Registered dietitians (RDs); dietetic technicians, registered (DTRs); and certified dietary managers (CDMs) are required to participate in CPE activities to maintain registration. These include

- Seventy-five contact hours per 5-year reporting period for RDs.
- Fifty50 contact hours per 5-year reporting period for DTRs.
- Forty-five contact hours per 3-year reporting period for CDMs.

b. Research plays an important and necessary role in the NCD. Changes in technology, administration, personnel, and resources require constant readjustment and reevaluation of the methods, equipment, and techniques used to accomplish the mission. Army facilities that conduct research have clinical investigation divisions that coordinate research. Clinical investigation divisions provide assistance to ensure that research is conducted properly. The Army dietitian desiring to conduct research should inform the Regional Medical Command (RMC) senior dietitian and the Chief, Dietitian Section of proposed research protocols. Nutrition may play a part in many studies being primarily investigated by members of other departments. This may provide the dietitian with opportunities to be a co-investigator. The Clinical Investigation Division maintains a list of all ongoing studies.

3-2. Training

a. *Methods of Training*. The training method will be determined by organizational and individual needs, training objectives, training facilities available, and the number of personnel to be trained. FM 25-101 (Battle Focused Training) contains guidance for training.

b. *U.S. Military Dietetic Internship Consortium.* The Army conducts approved MTF dietetic internship programs at selected MTFs. The program of instruction is planned to meet the overall goals and objectives established by the CADE for accredited internships. Staff dietitians and other MTF personnel provide formal classroom instruction and supervise the dietetic interns in their learning experiences. Upon satisfactory completion of the internship, the interns are qualified to take the registration examination of the Commission on Dietetic Registration and become RDs.

c. *Educational Program for Staff Dietitians and DTRs.* The Chief, NCD is responsible for conducting a planned program for CPE and development of staff dietitians and DTRs. The program

should provide information on recent developments in dietetics and related professions through weekly staff meetings, reading of professional journals, active participation in professional organizations, and short courses at nearby colleges and universities. Dietitians should be encouraged to consultthe local Army Education Center for help in planning advanced study for which they may be eligible and qualified.

d. Military Occupational Specialty Training for Enlisted Personnel. All TDA NCDs are responsible for a training program for Nutrition Care Specialists that emphasizes career development. The program should include MOS proficiency training (MPT) for soldiers from TOE and reserve component units. The AMEDD Systematic Modular Approach to Realistic Training (ASMART) Manual 10-89-012 provides guidelines for MPT. The Chief, NCD is the liaison for Nutrition Care Specialists and should ensure that NCOs train and document proficiency according to the ASMART manual. The NCOIC, NCD should assist those who are CDMs or DTRs with maintaining their certification.

e. Training for Military Staff and Civilian Employees.

(1) *General.* Training programs must be planned and the schedule and procedures for accomplishing training documented. The Chief, NCD may appoint a committee of supervisors to help organize training. This committee may include professional and support personnel, but will be headed by the Chief, NCD. The committee should be familiar with JCAHO training requirements and mission requirements as well as MTF training policies and available resources outside the NCD for accomplishing training.

(2) *Steps in planning training.*

(*a*) *Identify needs.* The first step is listing needs based on mission requirements (both for individuals and groups) that require training. The list will contain more needs than can be given immediate attention. The training needs are prioritized and resources are allocated as the training budget permits. All training should be evaluated and training programs updated to reflect additions or deletions based on the training's usefulness.

(*b*) *Establish goals and objectives for each training session.* Goals should be logical and attainable. Establish both long-range and immediate goals to provide a realistic progression of training experiences. A plan must be established for determining when or to what degree goals will be attained. The learners should clearly understand both the goals and the method of evaluation.

(*c*) *Prepare schedule.* The third step is the scheduling of training. This requires answers to the following questions:

- Who will receive this training?
- Who will do the teaching?
- Where will the classes or training event be conducted?

- How much time will be allotted for each class period or training event, and for the series of classes?

Committee members must carefully consider each question. In deciding who will receive what training, they must look again at persons who need training. Training should not be provided for an entire group if only a small percentage will benefit from it. Time management is critical to ensure that training does take place. Classes should be given more than once to allow all employees to participate.

(*d*) *Select the trainers.* In deciding who will do the training, planners should strive to bring lowest-level supervisors into the program as teachers. If immediate supervisors cannot provide required training, subject matter experts should be brought in to teach. Both teacher and pupil can learn when these supervisors/teachers are adequately advised, encouraged, and directed by their superiors. Plans should accommodate those personnel who are off-duty at the time of training so that everyone who needs the training receives it.

(*e*) *Select a training site.* The question of where to conduct classes is a minor problem in most NCDs. Usually the dining room and various work areas are readily available and provide adequate facilities.

(*f*) *Prepare for the class or training event.* The next step is preparation for teaching and conducting the classes. Consult FM 25-101 for specific methods and techniques designed to ensure successful teaching. One essential step in preparation is developing lesson plans. FM 25-101 contains formats and examples of lesson plans. Visual aids and handouts assist with teaching and promote better understanding of material.

f. *Record of Training.* The Chief, NCD will ensure the maintenance of a training record for all NCD personnel. Instructors will maintain a record of attendance, participation in exercises, and progress for each student. The Chief, NCD should review the records frequently to ensure that training is progressing as expected.

g. *Evaluate Class Effectiveness.* Develop a survey or other evaluation tool to enable participants to provide feedback at the completion of training.

3-3. Research

Medical treatment facilities engaged in research generally request other MTFs to help with the research or to evaluate and test findings before completion of the project. Each NCD chief should assess the capabilities of the staff and facilities for assuming these responsibilities. Every staff dietitian is required to stay current with the latest research in order to meet CPE requirements and to continually update skills. The reading, analysis, and application of current professional literature stimulates interest and participation in

research and experimental studies. The RDs at each MTF should continually look for opportunities to conduct or assist in research projects.

CHAPTER 4

MANAGEMENT OF SUPPLIES, EQUIPMENT, PUBLICATIONS, AND BLANK FORMS

4-1. Introduction

The Chief, NCD, a senior NCO, or a civilian employee is designated as the hand receipt holder for the equipment in the NCD. In larger facilities, each branch may have its own hand receipt holder. Hand receipt holders are responsible for ensuring proper maintenance and use of the equipment. Under the supervision of the Chief, NCD, a designated individual orders, receives, inspects, stores, issues, and safeguards equipment and supplies (forms, publications, office supplies, janitorial, and cleaning supplies). This may be either military or civilian personnel, and it may be a full-time job or an additional duty. This designated individual maintains stock levels as required and keeps property files and records IAW local procedures. He ensures that local procedures are followed for equipment maintenance and security. Equipment maintenance problems should be directed through the MTF's engineer section or appropriate contractor. The Chief, NCD or a designated representative must sign all requests for supplies and equipment. Supplies and equipment are requested and received from the MTF's logistics division through the property management branch. The Chief, NCD or designated representative must follow up on purchase requests to assure timely delivery of supplies and equipment. Maintenance of a document register provides a method to track purchases and deliveries of supplies and equipment. Timely delivery of supplies and equipment can only occur with an organized supply-management system. The property management branch in the logistics division is responsible for ordering and issuing all consolidated (general) supplies and equipment which it obtains from the installation supply support activity (ISSA). It also orders and issues all nonexpendable medical equipment obtained from the materiel branch.

4-2. Expendable Supplies

Expendable supplies are broadly defined as items that are consumed or lose their identity through use. Items such as china, paper goods, trays, cleaning materials, and repair parts with a low intrinsic value are classified as expendable.

a. Procurement of Expendable Supplies.

(1) Expendable supplies may be requested either as standard or nonstandard items. Standard items are those listed in the Federal Supply Catalog. National stock numbers (NSNs) are used with requests for standard items. Requests for nonstandard items must be accompanied by a written justification and, when possible, source of supply information. The forms used to request expendable supplies are prescribed locally. When DA Form 2765-1 (Request for Issue or Turn-In) is used, the property management branch should record the request on a DA Form 2064 (Document Register for Supply Actions).

(2) When requested items are received in the NCD, the property section representative should inspect them for quantity and quality before signing the receiving document.

(3) To request expendable supplies, the PSB and CDB may use DA Form 2930 (Hospital Food Service - Kitchen Requisition). Supplies should be requested by NSN, nomenclature, and quantity to facilitate accurate issue and recording of issues. Provide requisitioners with a property list citing stock number and proper nomenclature. When supplies are issued, an issue entry should be annotated in the supply ledger. Completed DA Forms 2930 should be costed out to determine the amount of money spent on supplies each month. This amount is reported on the monthly report to the US Army MEDCOM along with other financial and administrative data.

b. Self-Service Supply Center. The self-service supply center system provides an economical and efficient means for distributing nonmedical, expendable supplies. Expendable items are displayed and marked with an item description, stock number, and price. The ISSA publishes a price list which is distributed to all customers on the installation. Each unit or activity is assigned a monetary allowance, an account number, and a credit card. The subsistence supply NCO or other authorized representative pays for the selected items with the credit card. The purchases are charged to the unit or activity account. This is a primary source for nonmedical expendable supplies. Some installations may be phasing this service out, and supplies may be ordered through the logistics division or other designated alternative.

c. Emergency Resupply. The emergency preparedness plan should discuss how supplies will be provided during an emergency and the number of days of expendable supplies that should be on hand. Any additional equipment that might be needed should be addressed in the plan. This plan should be coordinated with the MTF plan and the logistics division.

d. Controls for Expendable Supplies. Local procedures should be established to monitor the issue and consumption rates of expendables. A supply ledger can be used for this purpose. A record of requests, receipts, issues, and a perpetual inventory can be maintained in the ledger. Stock levels may also be recorded there with established reorder points to facilitate the ordering process. Comparing on-hand balances with stock levels also facilitates timely reordering of items. Monthly expenditures for items and the value of the inventory can be quickly determined since the unit cost can also be recorded in the ledger. This ledger would include daily commitments, expressed in monetary terms, made for supplies in locally-determined categories, cumulative totals for commitments, and the daily balance of funds available in the MTF budget for the purchase of supplies for the FY. Valuable information for control is also provided by the use of a ledger where monthly issues of supplies, expressed in monetary terms and broken down into desired categories, are recorded. Averaging monthly issue costs by category totals and grand totals provides figures to be used for budgeting purposes. In situations where unusually large or small amounts of supplies are issued, notations may be made on the ledger; these monthly totals would not be included in the averaging operation. Separate ledger pages may be kept for sensitive items like silver, trays, and china. These records enable a comparison of requests with actual usage and serve as a management tool for budgeting.

e. Ordering Expendable Supplies. Requests for expendable medical supplies are usually submitted on a DA Form 2765-1. The supply supervisor prepares the DA Form 2765-1, submits one to the medical supply officer (MSO) and retains a duplicate. The suspense copy is retained until the requested

supplies are delivered, then it may be destroyed. A DA Form 3161 (Request for Issue or Turn In) may be used for requesting expendable medical supplies if authorized by the installation MSO.

4-3. Nonexpendable Equipment and Supplies

Nonexpendable equipment and supplies are not consumed in use and do not lose their identity through use. They, therefore, require accountability.

a. Ordering Nonexpendable Supplies. Requests for nonexpendable supplies are also submitted on DA Form 2765-1. The carbons are retained for suspense and/or due-outs.

b. Accounting for Nonexpendable Items. Nonexpendable items are accounted for IAW AR 735-5. The user of the property has primary responsibility for safeguarding it. The Chief, NCD should establish additional schedules and procedures for the inventory of equipment and supplies to prevent loss or damage and to gain information for requisitioning replacements. Equipment loaned to other sections of the MTF should be covered by a hand receipt.

4-4. Procuring Equipment

NOTE

Prior to purchasing any piece of equipment, it is highly recommended that the Chief, NCD or a representative contact as many other NCDs as possible for their professional opinion of and experience with similar pieces of equipment.

a. Equipment Requests. Equipment is ordered IAW local procedures. Submit requests for nonexpendable property to replace items which have been lost, damaged, destroyed, or rendered unserviceable through normal use. Purchase requests for equipment are usually classed according to the item's cost.

b. Standard Versus Nonstandard Equipment. The NCD usually requests standard equipment from the logistics division by a memorandum, on which the NSN, identifying nomenclature, quantity, unit cost, total cost for each item, and justification for the request are recorded. Nonstandard items are requested on DA Form 3953 (Purchase Request and Commitment) and prepared for the property book officer's (PBO's) signature. The written justification is critical for approval of the purchase of nonstandard equipment. The item number, description, quantity, unit, unit price, total cost, justification, and a minimum of two sources are included for each item. Whenever possible, the NCD should use items for

which military specifications have been written. The written justification for new equipment should include the following:

- Contribution to improvement of patient care.
- Amount of labor and other resources to be saved.
- Sanitation advantages of the equipment.

The number of meals served in the dining room and on the wards should also be shown. If the item requested is a replacement, the justification should also include the age, life expectancy, and general condition of the item to be replaced. Maintenance requirements of the equipment to be replaced should be emphasized. If information on hand or received from other Army MTFs indicates that a particular piece of equipment has proved unsatisfactory, that information should be noted on the request with an explanation of why that brand of equipment is not acceptable.

c. Accountability. Nonexpendable equipment is carried on the MTF consolidated property book. It is issued to the NCD on DA Form 2062 (Hand Receipt Annex Number).

d. Receiving Equipment. When the logistics division receives the equipment, it should be inspected by an NCD representative before accepting . This will ensure that it meets the specifications indicated on the purchase request. The logistics division issues equipment to the NCD on DA Form 2765-1. When received in the NCD, the equipment should be inspected again for quality and quantity before the authorized representative signs the DA Form 2765-1. Once signed, the DA Form 2765-1 becomes an official part of the hand receipt.

e. Equipment Warranties. There must be strict adherence to provisions of the warranty for equipment. The MTF engineers should not attempt to repair any item of equipment that is still under a manufacturer's warranty.

NOTE

Do not authorize or request equipment maintenance from any source without first consulting the contract or warranty for that piece of equipment. Failure to do so may result in negation of the contract or liability for repair costs.

f. Equipment Ledger. For future planning purposes, a ledger may be kept for new equipment received. The ledger may be set up to show stock number, nomenclature, quantity, unit cost, and source of funds. Receipts may be posted daily, with monthly cost totals. Since equipment is budgeted by item rather than cost, an accurate recording of items received is valuable in planning for equipment replacement.

g. Equipment Maintenance History. In the management of equipment, a maintenance history is essential. A DA Form 2404 (Equipment Inspection and Maintenance Worksheet) will be used to record new equipment, maintenance, inspection, and repairs. Maintenance history is also useful in writing justifications for item replacement.

h. Equipment Inventory. Knowing the exact location of equipment saves time in inventorying it. A DA Form 2404 is used to record location and changes in location. For rapid identification of equipment, the hand receipt holder may mark it with the stock number and attach a photograph to the DA Form 2404.

i. Storing Property. The Chief, NCD is responsible for determining adequacy of storage facilities. In making this determination, the chief considers the condition, type, and dollar value of government property to be stored. The Chief, NCD must ensure that property is stored as required by ARs and local security procedures.

j. Maintaining Property.

(1) Each NCD branch chief ensures that supplies are used economically and that equipment is used, cleaned, and stored IAW prescribed directions. The proper cleaning agents must be used to prevent damage to the surfaces of equipment.

(2) The Chief, NCD is responsible for maintenance of property the division uses. When it is beyond their capabilities, the NCD requests maintenance support through the logistics division. Installation support and the capabilities of the logistics division affect how a request is routed. A DA Form 2407 (Maintenance Request) may be used in requesting repair of such items as food carts and office machines, unless they are under contract or warranty. Requests for removal, relocation, or major repairs of equipment should be made using DA Form 4283 (Facilities Engineering Work Request). All requests should be recorded on DA Form 2405 (Maintenance Request Register). This register reflects the current status of work orders submitted on DA Forms 2407 and 4283.

k. Equipment Log Book. At some installations, an equipment log book is maintained on a 7-day week, 24-hour day basis. Recorded here are not only routine repair requests, but emergency work orders telephoned to the appropriate emergency repair unit. This log contains such information as -

- Date and time the request was submitted.
- Name of individual requesting the work.
- Location and nomenclature of equipment to be repaired.
- Malfunction.
- Action taken.

- Estimated date and time for completion of repair.
- Actual date and time of completion of repair.
- Work order number (to expedite follow up)

l. Adjusting for Losses or Turn-ins. In cases where DA property is lost, damaged, or destroyed by causes other than fair wear and tear, a report of survey or other appropriate administrative action is accomplished to determine the facts in the case. Should such a loss, damage, or destruction occur in the NCD, the person in charge must report it immediately to the PBO in the logistics division. Equipment which is no longer useful for the purpose intended is turned in to the PBO IAW local procedures. Additional information on supply accountability is in AR 735-5.

4-5. Publications

a. DA Publications. Department of the Army publications contain Army-wide policy and doctrine of a permanent or temporary nature. Publications of a temporary nature have the expiration date stated on them. Army publications can be found at www.usapa.army.mil. Indexes to the publications are provided in DA Pamphlet 25-30. The four basic categories of publications are—:

(1) *Administrative.* Administrative publications pertain to the conduct of military affairs and the internal management of an activity or unit.

(2) *Training or technical.* Training and technical publications impart doctrine, tactics, techniques, and procedures for training individuals and units.

(3) *Supply.* Supply publications provide instructions for the procurement, distribution, maintenance, and salvage of supplies.

(4) *Miscellaneous.* These are publications that do not fit into any of the above categories.

b. Medical Treatment Facility Publications. These publications contain local policies and procedures and other information. They are distributed to the various elements of the MTF on the basis of a local formula.

c. Manufacturers' Publications. These publications contain information regarding equipment and supplies. They may be obtained directly from the manufacturer. Each NCD should establish a reference library of these publications for use in planning replacement of equipment and in operating and maintaining equipment. A method of indexing the material should be developed to facilitate its use. Publications may be indexed by type of equipment or supplies, alphabetically by manufacturer's name, or a combination.

4-6. Forms

a. Forms Management. The forms management program is designed to control the production and use of forms throughout DA. A forms management officer, either military or civilian, is appointed at each installation to conduct a continuous forms management program. The Chief, NCD should consult with this officer when a new form is needed in the division. Existing higher echelon forms will be used when available. Detailed justification stating how the new form is to be used, average monthly usage, distribution of copies, and retention instructions should accompany every request for the creation of a local form. Army forms can be found at www.usapa.army.mil and on local electronic forms programs.

b. Obtaining Forms. NCD operations require the use of many blank forms. The property supply NCO obtains the required forms IAW local procedures. Many NCDs commonly use a computer software program capable of generating many standard forms. This may dramatically reduce the number and amount of forms maintained by the NCD. The compact disc (CD) version of DA Pam 25-30 (distributed quarterly) contains numerous forms which can be accessed by most software programs.

c. Forms Index. The NCO responsible for expendable supplies should maintain a current index with samples of all forms used in the NCD. This index would serve as an easy reference for ordering forms. The index may contain form number, nomenclature, monthly usage, and justification for usage, such as ARs citing use of the form.

d. Approval of New Forms. Forms developed for CDB use in patients' medical records must be submitted with a DD Form 67 (Form Processing Action Request) to the Forms Management Office, where they will be evaluated. From there, they are directed to the PAD, followed by a quality management committee for final approval.

CHAPTER 5

SECURITY

5-1. Introduction

The Chief, NCD establishes procedures to achieve and maintain adequate security standards in the division. Employees must be instructed on the procedures to follow to achieve maximum security for NCD buildings or areas and the property within them. Action must be taken against persons who willfully destroy, steal, or damage government property. Written security procedures must be developed in coordination with the MTF security office. These procedures should be reviewed with employees during orientation and periodically thereafter.

5-2. Building

a. The Chief, NCD specifies --

- The number of keys to be made.
- Who receives a key.
- Action taken for lost or missing keys.

b. The chief will monitor the frequency of key inventories. He will determine when the building or area is to be secured, who secures the building, and who will do the final security check. Written procedures which explain emergency access procedures in situations such as a fire or power outage must be developed. The procedures should describe the process for performing periodic security checks and should reference the key roster which lists authorized key holders. Access to the building or area after hours will be limited to those individuals listed on the roster. AR 190-51 provides guidance on facility security.

5-3. Subsistence Items

See paragraph 12-4*c* for the security procedures recommended for subsistence.

5-4. Equipment and Supplies

Equipment and supplies should be kept in locked storerooms before issue. Items will be issued with proper documentation in the amount needed and requested. Stock level records, receipt and issue records, and

inventories are excellent tools for preventing excessive accumulation or use of items. Written procedures for NCD linen and white uniform exchange will be developed IAW MTF policy. Temporary hand receipts should be used when "loaning out" equipment.

5-5. Funds From Cash Collection for Meals

The Chief, NCD and the MSAO (in PAD) should coordinate procedures for the safe handling of cash IAW AR 40-3 and AR 40-330.

5-6. Other Security Measures

a. Precautions must be taken to restrict the parking of private vehicles near the storage area or near entrances to the NCD. Vehicle inspections can only be conducted with prior approval of the commander responsible for the area where the vehicles are parked and prior coordination with the civilian personnel officer, judge advocate general (JAG), and military police (MP). If there is an established problem or cause for random searches, the same approval and coordination are required. (The MP can conduct a vehicle search without prior approval if a suspected act has just occurred.)

b. Periodic inspections of trash and garbage areas must be conducted to ensure that only authorized items are being removed from the premises. Empty cartons and containers offer a means for pilferage.

c. There must be enforcement of rules which prohibit employees from eating between meals and eating foods other than those authorized to be eaten at a specified time.

d. To secure against breaches in privacy or disruption of the computer management information systems, efforts should be made to limit access to personnel files, training files, and computer software.

CHAPTER 6

SAFETY

6-1. Introduction

The Army Safety Program is published in AR 385-10. The MTF safety program is the commander's responsibility. The program is formalized with the establishment of a safety office and an individual identified as the MTF safety officer or manager. The overall safety program evaluates work places, operating procedures, and hazardous material data to determine hazards and health risks.

6-2. The NCD Safety Program

The Chief, NCD establishes the safety program in the NCD IAW MTF safety guidelines and recommendations. The Chief, NCD will designate a dietitian, NCO, or civilian employee to be the "safety officer" for the division. This may be an additional duty of the person responsible for training. The safety officer establishes program objectives and content and coordinates training and periodic inspections of equipment and facilities. In addition, the safety officer ensures documentation of training specific to each employee. He attends the MTF safety committee meetings as the division representative. The NCD safety officer should review accident reports, causes and frequencies of personnel injuries, and equipment damage in the division. Data analysis may indicate the need for structural changes to eliminate unsafe conditions as well as changes in methods of work routine to control unsafe procedures and prevent safety hazards.

6-3. General Requirements

A safety program can be individualized to meet MTF requirements, but all programs should meet general administrative and procedural requirements. Standard procedures should be written to explain actions that can be taken against persons who willfully or negligently destroy, steal, or damage government property; these actions should be discussed during employee orientation. Orientation of new employees should address the following areas:

a. *Training*. Procedures, processes, equipment, fire prevention, and occupational health requirements.

b. *Housekeeping*. Orderly, sanitary food service areas; clean microwave ovens; clean utility closets; proper cleaning supply storage; proper trash disposal; clean break areas.

c. *Walking, Working Surfaces, Aisles, and Passageways*. Layout, condition, floor surfaces, floor sloping, and drains.

d. Electrical. Repair, receptacles, plugs, extension cords, ground-fault circuit interrupters, equipment grounding.

e. Illumination. Foot candle requirements.

f. Machinery and Equipment, Machine Guarding, and Power Transmissions. Manufacturer's operating manuals and local procedures, required personal protective equipment, machine layout, maintenance and repair, guarding.

g. Fire Prevention. See paragraph 6-4.

h. Exits and Exit Markings. According to the National Fire Protection Association and life safety code.

i. Personal Protective Equipment. Required provided equipment.

j. Personal Hygiene and Sanitation. See Chapter 16.

k. Hazardous Materials. Proper storage and use of hazardous materials in the NCD, location of material safety data sheets, name of person responsible for the NCD hazardous materials program.

6-4. Fire Prevention

One must comply with local MTF and installation policies for timely monitoring of fire extinguishers. At regular intervals, designated individuals will check and initial all fire extinguishers to ensure that they are in proper working condition. On notification that an extinguisher has been used, these individuals ensure that it is promptly serviced and replaced. Fire prevention training should include the following:

a. How to report a fire.

b. Location of fire alarms and how to operate them.

c. Where equipment circuit breakers and power disconnects are located.

d. Location of emergency exits.

e. Evacuation procedures that include assisting physically handicapped patients or patrons.

f. Procedures for extinguishing a gas fire.

6-5. Safe Equipment Use

Employees must be trained initially in the use and maintenance of food service equipment in their areas and their performance must be evaluated periodically. Training principles must be reinforced through inservice training, and operating manuals and procedures must be maintained in an accessible place. Safety training should assist in injury prevention.

6-6. Safety Self-Assessment Checklist

Periodic self-assessment assists in identifying problem areas before accidents occur. The following questions should be reviewed in assessing your safety status.

a. Are NCD employees trained and evaluated in proper lifting, safe use of equipment, hot food handling, and the identification and elimination of hazards?

b. Are combustible cleaning materials stored in closed metal containers separately from other combustibles?

c. Are flammable liquids prohibited for cleaning purposes?

d. Are floors kept clear of water or other slippery materials? Are spills cleaned up immediately?

e. Are warning signs such as, "Wet Floor," used to identify hazardous areas?

f. Are passageways cleared during inclement weather?

g. Are electrical outlets, switches, and junction boxes guarded with cover plates to prevent accidental contact with a live conductor?

h. Is a means provided to ensure no electrical power is available to machines before maintenance, adjustment, or cleaning is started?

i. Are manufacturer's manuals and/or local procedures available for machinery and equipment?

j. Do operators inspect equipment prior to each shift to ensure that everything is in good working order?

k. Is adequate guarding provided on machines or equipment to protect the operator and other employees in the area from machine or equipment hazards?

l. Is personal protection equipment provided, used as required, and maintained in satisfactory condition by employees?

m. Are nonskid shoes worn by employees working in areas where floors may become wet, greasy, or slippery?

n. Are the material safety data sheets easily accessible, and are employees trained in their purpose and content?

6-7. Accident Reporting.

AR 385-40 requires NCD supervisors to report on-the-job accidents involving soldiers or civilian employees. This report is made to the MTF safety officer on DA Form 285-AB-R [US Army Abbreviated Ground Accident Report (AGAR)]. In addition, the Department of Labor requires that civilian employees be reported on Form CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation). If injured, the supervisor refers the employee to the emergency room for medical treatment and initiates Form CA-16 (Authorization for Examination and/or Treatment) by completing Part A of the form. If possible, and time permits, the CA Form-16 should accompany the employee. This will allow the emergency room physician to complete Part B of the form. Circumstances surrounding the accident and the severity of the employee's injury may require additional documentation. When developing the safety program, the NCD safety officer should coordinate it with the C, NCD and MTF safety officer to ensure that all reporting requirements are met.

CHAPTER 7

CLINICAL DIETETICS BRANCH

7-1. Introduction

The primary function of the CDB is to provide medical nutrition therapy to inpatients and outpatients and nutrition education for the military community. These services reflect the latest acceptable practices in the ever-changing field of nutrition and clinical dietetics. CDB personnel are members of the health care team who establish specialized dietary treatment regimens that physicians, dentists, and other appropriately privileged health care providers, to include possibly dietitians, prescribe.

7-2. Clinical Dietetics Management

The dietetic treatment of patients consists of medical nutrition therapy which provides nutritional risk screening, assessment, nutrition care plans, and dietary counseling to —

- Enhance patients' recovery.
- Promote or maintain optimum nutritional status.
- Encourage consumption of nutritious foods.
- Comply with JCAHO standards.

Dietitians, dietetic technicians, diet assistants, and Nutrition Care Specialists perform the professional and supportive duties required to ensure patients receive and consume the appropriate diet.

7-3. Personnel Structure

The CDB is usually staffed with a chief, staff dietitians; an NCOIC; diet technicians, and in some facilities diet aids. The facility's size and mission determines the number of personnel authorized and assigned. The CDB is closely involved with the PSB and maintains a cooperative working relationship which promotes a positive working environment.

a. Chief, CDB. A registered dietitian (AOC 65C or civilian) serves as chief of the CDB. In a large MTF, the Chief, CDB is primarily responsible for CDB administrative duties. This person may also be involved in patient care as a clinical dietitian depending on the workload and personnel strength. In a one-dietitian MTF, the Chief, NCD must allocate time for accomplishing NCD administrative duties as well as clinical duties. The chief manages and provides the professional guidance necessary for the CDB

to accomplish its mission. The Chief, CDB serves in an advisory capacity to dietitians and other MTF personnel on matters relating to clinical dietetics.

b. Staff Dietitians. The staff dietitians assigned to the CDB are supervised by the branch chief. Their duties entail the application of their professional knowledge and skills pertaining to foods, nutrition, and supplements to attain therapeutic results. These duties include calculation of nutritional components and formulation of individual menu plans for nonstandard MTF diets. The dietitians are responsible for screening patients, performing nutritional assessments, and providing specialized dietary treatment and monitoring as required. In some facilities, the diet technician may perform these duties, thus freeing the dietitian to perform in-depth nutritional assessment and intervention. Staff dietitians provide nutrition care plans and dietetic counseling to promote proper dietary intake through the use of selective menus. They also conduct surveys to determine the patient's satisfaction with meals and service. Individual MTFs may privilege dietitians to order nutritional supplements, prescribe diets, and order specific laboratory tests for patients. Privileges will be granted IAW AR 40-68. Staff dietitians make ward rounds with the physicians, serve as consultants to the medical and nursing staffs, and consult with them in the interest of increasing overall effectiveness of dietary treatment. The dietitians and other CDB personnel evaluate the patients' dietary progress and enter pertinent notes in the patients' medical records. They collaborate with the medical staff in conducting nutrition-related research protocols, special food studies, and dietary analyses. The dietitians supervise the performance of other CDB personnel and enforce MTF and departmental regulations regarding the nutritional care of patients.

c. Clinical Dietetics Branch NCOIC. A Nutrition Care Specialist serves as the CDB NCOIC. He conducts training for the CDB support personnel and directs and coordinates their work. He understands the established policies, procedures, and dietetic principles involved in the branch's operation and interprets them for personnel and patients. He contacts medical and nursing personnel to establish a liaison essential to proper dietetic treatment and provides nutritional counseling. He remains current in new developments in clinical dietetics and attends MOS-specific training to enhance his skills. The CDB NCOIC receives guidance and supervision from the dietitians and the NCD NCOIC.

d. Diet Technicians. The diet technicians provide support in the areas of —

- Nutritional risk screening and assessments.
- Reviewing patients' medical records.
- Participating in meal rounds.
- Giving simple diet instructions.
- Writing patient menus.

- Drug/nutrient interaction instructions.

e. Diet Aide Supervisors. The diet aide supervisors function under the supervision of the NCOIC or a civilian supervisor. They receive additional guidance from dietitians regarding therapeutic diets for patients. They contact the ward nursing staff and patients, exchanging such information as required to accomplish their work. They may perform the duties of a diet aide, depending on the work-load. The diet aide supervisors assign and check the work of the diet aides and solve problems based on established policies and procedures. They attend meetings to help solve problems and develop improved procedures. They also help train the diet aides, evaluate their performance, provide periodic performance ratings, and approve sick or annual leave when requested.

f. Diet Aides. Diet aides work under the direct supervision of a diet aide supervisor or the NCOIC of CDB; dietitians provide additional guidance as needed. The diet aides perform the clerical and meal service tasks required in the CDB according to established policies and procedures. They interact with nursing personnel and patients as required. They remain current in their profession through atten-dance at training meetings and classes. Specific duties which may be performed by the diet aides include —

- Distributing and collecting selective menus.
- Checking patients' menu choices for nutritional adequacy using the Food Guide Pyramid as the basis for evaluation.
- Preparing and assembling menus, nourishment labels, and nourishment summary rosters for use by the PSB.
- Recording the census by type of diets.

The diet aides inform the dietitian of any feeding problems observed during their ward rounds.

7-4. Other Members of the Health Care Team

a. In addition to the NCD staff, other members of the health care team responsible for the patient's dietetic treatment are —

- Physicians and dentists.
- Nurses and nurse practitioners.

- Social workers.
- Physical therapists
- Pharmacists.
- Speech pathologists

b. Facilities with nutritional support teams have designated individuals from these disciplines, who are directly responsible for patients receiving enteral or parenteral nutritional support. To provide maximum benefits to all patients, each team member accomplishes his specific duties in coordination with other team members.

c. The physician or dentist—

- Prescribes the diet for each patient.
- Determines if the patient's meals are served on the ward or in the dining facility.
- Orders additional nourishments or feedings as needed.
- Requests patients be counseled on modified diets.

d. Nursing personnel transmit orders from the medical records to the CDB. They prepare the patient to receive his meals and provide needed assistance while eating. Meal-by-meal contact will be maintained with patients and nursing staff to verify the accuracy of diet orders and to assist with problems that may arise in the patient's dietetic treatment. Nursing personnel may also conduct a nutritional risk screen.

e. Pharmacists prepare parenteral nutritional formulas according to physician orders. The dietitian recommends the composition of the formula after completing an in-depth nutritional assessment. The pharmacist is also a resource for information on drug-nutrient interactions.

f. Social workers coordinate the activities of the health care team to develop a comprehensive discharge plan.

g. Occupational therapists and speech pathologists evaluate the patient's ability to feed himself. They also determine if the patient has problems swallowing food or beverages.

CHAPTER 8

CLINICAL DIETETIC OPERATIONS

8-1. Introduction

The effectiveness with which CDB personnel interact with the patient and other members of the health care team is of major importance in dietetic treatment. CDB personnel gather information to develop dietary treatment plans by means of —

- Medical record reviews.
- Interviews.
- Multidisciplinary team discussions.
- Observations.
- Selective menus.
- Nutritional assessment data.
- Surveys.

Various aspects of the treatment process are discussed below; detailed procedures for accomplishing each aspect should be established locally.

8-2. Aspects of Clinical Dietetic Care

a. Nutritional Assessment. Patients admitted to the MTF may be at nutritional risk or may become nutritionally compromised during hospitalization. Nutritional assessment involves collecting, integrating, and appraising nutrition-related data. It enables the dietitian to evaluate the patient's nutritional status and the extent and possible causes of any existing malnutrition. Data obtained from the assessment provide the objective basis for recommendations and evaluation of supportive nutritional care. The assessment may be a brief screening or an in-depth gathering of data using many different indicators. Upon admission every patient must be screened for nutritional risk. The criteria and mechanisms for screening will be developed locally and implemented. The screening information can be obtained from some combination of admission screening questionnaire, patient (or their significant other) interviews, and/or medical record as appropriate. The results of screening will be maintained with DA Form 2924 (Hospital Food Service — Dietary History Record) or automated equivalent. Depending on

results of screening, patients can be triaged to the most appropriate nutritional care provider (dietitian, diet technician, diet aide), and the appropriate nutritional care plan can be implemented.

b. Dietary History. DA Form 2924 or automated equivalent is used to record information obtained during the patient interview and facilitates communication among CDB personnel. It should include the patient's food likes and dislikes and other pertinent nutritional information such as —

- Chewing/swallowing difficulties.
- Food allergies/intolerances.
- Diagnosis.
- A continuing record of diet orders.

Food likes and dislikes are usually categorized by meals and/or food groups such as fruits, vegetables, soups, and meats. Reference is made to this dietary history card each time a diet or menu is written for the patient. Prior to each meal, the DA Form 2924 is checked against the ward diet roster If the diet is changed on the diet roster, it must be changed on the dietary history card with the date of the change. When the patient's name no longer appears on the roster, the dietary history record is usually discarded. If the patient is likely to return to the MTF, the record may be placed intact in an inactive or other appropriate file.

c. Dietary Counseling.

(1) Inpatient dietary counseling will be provided when requested on Standard Form (SF) 513 (Medical Record – Consultation Sheet) or if indicated by the nutritional risk screening process. Counseling should take place as early in the hospitalization as practical. Last minute diet counseling is often less effective because of the magnitude of other discharge instructions received. A patient who requires a specific modified diet intervention should be referred for continued outpatient counseling.

(2) Dietary counseling is ordinarily initiated during the first interview (see above) and continued in other sessions. Several short periods are preferable to one extremely long session. Dietary counseling should be based on the most current edition of the Manual of Clinical Dietetics. Printed dietary instructions should be given to the patient early in the course of his hospitalization to allow adequate time to study the instructional material.

d. Outpatient Nutrition Clinic.

(1) Ambulatory patients are counseled in the Outpatient Nutrition Clinic, under the direction of the Chief, CDB.

(2) Some facilities use a central appointment scheduling system while other nutrition clinics schedule appointments themselves. Patients may be seen on a group or individual basis.

(3) Documentation is accomplished on SF 513 and/or SF 600 (Health Record - Chronological Record of Medical Care).

(4) The CDB staff is often directly involved with fitness/wellness initiatives. These may be extended to retirees (health fairs), children (child care centers, school lunch programs), other beneficiaries, the local community, and active duty members . Other initiatives may include working with the commissary and other dining facilities on post during national nutrition month and throughout the year, as well as involvement with local health and professional organizations. Such nutrition education efforts will be provided to support —

- Preventive medicine programs.
- Health promotion programs.
- The Army Weight Control Program (AR 600-9)
- Child Development Services (AR 608-10).
- The military community
- Installation menu boards.

e. Third Party Collection Program.

(1) Title 10, United States Code 1095 authorizes the federal government to collect payments for inpatient and outpatient services provided to medically insured dependents and retirees. The resulting Third Party Collection Program (TPCP) began in FY 1988. The program had no resourcing and commanders were directed to deposit all collections into the General Treasury. The TPCP increased its momentum when the FY 90 Defense Authorization Act allowed commanders of MTFs to retain collections for resourcing the program and for enhancing the MTF's capability to provide health care. The TPCP for MTF departments and services is typically managed by the PAD. Local policy stipulates what percentage of collected reimbursements are credited back to the department or service filing the claim.

(2) Although Congress specified that collections under the TPCP were to remain at the MTF as additions to normal appropriated funding, the Office of the Secretary of Defense Comptroller reduced the services' budgets by an amount estimated to equal expected TPCP collections. This US Army decrement is passed to US Army MEDCOM for distribution among the MTFs. The US Army MEDCOM considers the beneficiary population mix and projected TPCP collection potential of each MTF when assigning the decrement.

(3) The number of inpatient reimbursement rates has been expanded as the TPCP has developed, based on diagnostic related groups (DRGs). With adequate documentation of nutritional diagnoses (such as malnutrition) and an accounting system to document true costs, inpatient reimbursement for these services is potentially possible.

(4) The number of outpatient reimbursement rates in the TPCP has also increased based on clinical service. These reimbursements are documented by "codes" which describe the type and level of care provided. Current procedural terminology (CPT) codes, devised by the American Medical Association, are organized into six categories, some of which are appropriate for documenting nutritional services. In addition to the CPT code, two more codes using the International Classification of Diseases, 9th Revision (ICD-9) are useful in documenting nutritional services. One ICD-9 code indicates the diagnosis and the other documents "dietary surveillance and counseling." This code is commonly used to generate reimbursements.

(5) Clinical dietitians with a responsibility to provide outpatient nutritional services should be familiar with the appropriate codes that result in reimbursement. As the TPCP continues to develop, codes that generate higher percentages of reimbursement may change. The ADA and local ADA chapter may provide insight to nationally or locally accepted codes that prove to be most effective. The MTF staff managing the TPCP should provide necessary guidance and training. Professional publications and reimbursement guides are also available for reference to maximize collections.

(6) Success with the TPCP is dependent on appropriate and complete documentation in the medical record. Some suggestions for a documenting checklist follow.

(*a*) *Initial visit*. Is patient demographic data listed in the record? Is the referring physician listed with the reason for the referral (for example, medical diagnosis with ICD-9 code(s) preferred)? Are appropriate laboratory results included with an explanation of significance? Is there an initial assessment based on data relating to nutritional history and/or assessment? Are treatment goals and/or recommendations listed? Is the relationship between treatment goals and medical outcome clearly identified? When appropriate, are drug and/or nutrient interactions examined and related to medical outcome? Is the length of time to achieve program goal included? Are all terms consistent and familiar to people not in health care?

(*b*) *Follow-up visit*. Is the patient's progress noted and defined in measurable terms? Are changes in laboratory results, weight, and blood pressure listed? Are initial treatment goals being achieved? Are changes in treatment goals and/or recommendations listed? Is the relationship between changes in treatment goals and medical outcome clearly defined?

(*c*) *Other tips for success*. There are other tips for success when dealing with the TPCP that do not directly relate to documentation of care, but are equally important. Get to know the insurance company representatives. Call or visit them and discuss their requirements and procedures. Keep in contact with the chief of PAD and/or TPCP manager to discuss updates on program policies and procedures received from US Army MEDCOM level. Make sure that coding is done properly and on all appropriate clients.

f. Selective and Nonselective Menus.

(1) Selective menus for certain patients on regular diets may foster maintenance of patients' nutritional status. The Chief, CDB is responsible for implementing selective menus. The use of nonselective menus may be a more customer-focused approach which enhances interaction between the CDB staff and patient. The use of nonselect menus requires that patients be interviewed for food preferences, food allergies, and dietary tolerances. These are recorded during the nutritional screening process on DA Form 2924 or automated equivalent and considered in meal planning. An interview is conducted by the dietitian, diet technician, Nutrition Care Specialist, or other trained interviewer. Nonselect menus may increase cost efficiency, prevent complaints from patients who do not receive the items they ordered, and increase communication between the CDB staff and patients.

(2) The method and time frame for distributing and collecting selective menus are determined locally. At distribution, CDB personnel explain to new patients how to complete the menu. CDB personnel often assist patients unable to mark their selections. As CDB personnel collect the menus, they check carefully to ensure proper completion, legible markings, and adequate selection. If a patient indicates a dislike for a particular food item, CDB personnel can offer a substitution. The substitution is then written on the patient's menu and initialed by the CDB person authorizing the substitution; the undesired item is deleted. Those collecting menus should carry a few extra menus with them for patients who may have been admitted or accidentally missed. Minimal time should elapse between menu distribution and service of meals selected.

g. Diet Menu Plans. A diet menu plan is developed for each type of diet that the approved Army diet manual establishes. Each type of food required on the diet menu plan is identified by a descriptive nomenclature which specifies the type of food and dietary modifications required. Substitution of food items to satisfy patient food tolerances can be made by indicating the portion size and name of the replacement item.

h. Therapeutic Nutritional Supplements. The Chief, CDB is responsible for recommending nutritional support supplements for inclusion in the MTF formulary. A local policy with written approval by the Pharmacy and Therapeutics Committee shall direct the procedures involved with dispensing commercial nutritional supplements to patients.

i. Patient Satisfaction Surveys. Two types of surveys, formal and informal, are conducted to determine if patients are satisfied with their meals and the meal service. The formal survey is conducted periodically as a JCAHO requirement. The informal survey is conducted daily by means of oral communication with the patients and nursing personnel. Informal survey findings should be considered during daily and weekly sessions for planning menus, food preparation, and food service. Local procedures define how each type of survey is conducted and the findings recorded.

(1) *Informal survey.* During meal periods, CDB personnel seek the patients' opinions regarding their meals and the meal service. They also note any deficiencies in food items and food temperatures as well as any mealtime situation which lessens the effectiveness of dietary treatment. PSB personnel periodically check the trays on each food cart as it is returned to the kitchen. When the food left on a tray indicates that the patient has not eaten or has eaten poorly, the menu is taken from the tray, noted with appropriate information, and forwarded to the CDB for investigation.

(2) *Formal survey.* The Chief, CDB shares in planning local and MEDCOM-directed surveys IAW established procedures. Survey activities are coordinated with the head nurse on each ward. Completed survey forms are forwarded to the Chief, NCD for evaluation. Data included are —

- Date of survey.
- Number and type of patients participating (to include type of diets).
- Number of patients unable to participate because of medical reasons.
- Number of patients refusing to participate.

The number of patients on both regular and modified diets as well as a copy of the regular diet for the survey date should be included. Data should also be recorded that demonstrates how the survey results compare to pre-established standards and how results have changed over time (last quarter, last year).

j. Performance Improvement.. Clinical dietitians will participate in locally-established peer review committees that use the patient's medical record as the basis for determining the quality and appropriateness of nutritional care. The Chief, NCD will use the JCAHO manual as a guide. He will also follow the guidance in AR 40-68 to establish IOP programs for the NCD.

8-3. Communication with Other Medical Personnel

a. Standard MTF Diets. Every MTF must have a diet manual which describes the nutritional adequacy of diets. The manual is reviewed annually, and the Chief, NCD and Deputy Commander for Clinical Services (DCCS) approve it locally. The approval date and signatures are recorded on a memorandum and filed. Once approved, the diet manual will be distributed to all nursing units and made available to medical, dental, nursing, and NCD personnel. A supplemental handbook containing Army specific information is also required in every NCD.

b. Diet Orders. Standard diet order titles are found in the diet manual. Nonstandard or MTF-specific diets will be approved during the diet manual's annual review. The practitioner responsible for the patient will order the initial diet, order any subsequent changes to the diet, and document the orders in the patient's medical record. The nurse in charge of the nursing unit is responsible for transmitting the diet order to the CDB by completing DA Form 1829 (Hospital Food Service - Ward Diet Roster) or through entries in an automated system accessible to the CDB.

c. Medical Rounds. RDs should participate in medical rounds and discharge planning meetings when feasible. Taking part in ward and other rounds provides opportunities for the dietitian to discuss the dietetic treatment of individual patients with the health care team, medical interns, and others in training programs. Knowledge of the patient's medical and ancillary treatment will be acquired through participation in rounds on the nursing unit, discharge planning meetings, and review of the patient's medical record.

d. Dietetic Progress Notes. Appropriate documentation of nutritional care or counseling will be made in the patient's medical record. This includes —

- Pertinent, subjective information obtained from the patient or patient's family.
- Objective data obtained from tests, analysis, or observation.
- Interpretation of subjective and objective data.
- Computed nutrient requirements and care provided.
- Recommendations for improving provision of nutritional care.
- Plans for patient nutritional care.

Locally developed nutritional practice guidelines should be used to the extent possible when providing and documenting clinical dietetic care. Inpatient nutritional care documentation is recorded on SF 509 (Medical Record - Progress Notes), and outpatient care is documented on SF 600 or authorized automated equivalent. Every entry made in the medical record must be legible, dated, and signed with signature block and position title. The key to reporting visits is adequate documentation of treatment in appropriate medical records to support an audit trail.

e. Dietetic Consultation. The SF 13 is used to document response to consultations requested by other health care practitioners. Dietetic consultations, as distinguished from nutritional care/counseling dietetic progress notes (see paragraph 8-3d), will be reported to the requesting practitioner by entry on SF 513 or automated equivalent. The dietitian will make a short entry referencing the completed consultation on either SF 509, SF 600, or automated equivalent.

f. Nutritional Support Team. The nutritional support team is an interdisciplinary team concerned primarily with appropriate nutritional support of patients requiring enteral/parenteral nutrition. RDs, especially those with advanced training in clinical nutrition and nutritional assessment, should be assigned to nutritional support teams whenever possible.

g. Nutrition Research, Special Food Studies, and Dietary Analyses. CDB personnel may become involved in nutritional research protocols, special food studies, and a dietary analysis in conjunction with medical or dental officers. The exchange of information among the medical, nursing, and CDB staffs is essential in planning and conducting these studies and analyses. Advance plans must include the anticipated duration of the study and the types of data to be recorded. Nursing and NCD personnel must coordinate the implementation and execution procedures for the study and follow procedures established by the MTF clinical investigation section.

h. Liaison with nursing personnel. Communication between CDB and nursing personnel takes place frequently throughout the day and impacts on patient care. Good communication is facilitated when procedures suitable to both groups are established and followed. Written communication must be supplemented with frequent face-to-face discussions of mutual problems to achieve optimum cooperation and communication in the problem solving process. The following means of written communication are used daily between CDB and nursing personnel:

(1) Ward diet roster.

(*a*) Nursing personnel transmit the orders for dietary regimens to CDB via DA Form 1829 or automated equivalent. This roster is maintained on the nursing unit where the head nurse is responsible for its preparation. Information included on the roster is —

- Room and bed number

- Name of patient
- Type of diet and patient dining location (ward or dining hall)

Appropriate nomenclature and standard abbreviations IAW established standards are used.

(*b*) At specified times, CDB personnel collect the rosters from the nursing units, ordinarily 1 to 3 hours before serving time, to decrease the number of telephone requests for changes. CDB personnel update their records as needed to reflect information on the diet rosters. Any possible discrepancy is discussed with the head nurse (or designee). Normally, CDB personnel return the rosters to the nursing units during or after the meal serving period. Each roster should be kept in a protective folder, along with —

- Extra copies of DA Form 1829.
- Copies of local policies and procedures pertaining to the dietary care of patients.
- A list of abbreviations for standard diets.
- Information such as —
  - The names of the dietitian and diet technicians.
  - The CDB telephone number.
  - Cart arrival and departure times.
  - Diet change call-in times.

(2) Telephone Diet Order.

(*a*) The log of telephone diet orders maintained in the CDB on DA Form 2927 (Hospital Food Service - Telephone Diet Order) or equivalent contains diet changes that nursing personnel make via telephone. Such requests are made when diet orders change after the ward diet roster is collected. Telephone requests are justified when a new patient is admitted, a patient is discharged, a diet is changed, or a diet is ordered prepared, held, or canceled for diagnostic or treatment purposes. Nursing personnel should otherwise enter changes on the ward diet roster for the following meal.

(*b*) Telephone requests for changes received after the menus are forwarded from the CDB to the PSB, are relayed by telephone or other means.

CHAPTER 9

BASIC DOCUMENTS USED IN DIETARY TREATMENT

9-1. Introduction

a. Basic Documents. The basic documents required in the dietary treatment of patients are the —

- Hospital master menu.
- Therapeutic worksheet.
- Production planning worksheet (PPW) and Production Planning Report (PPR).
- Special tally.
- Individual menus.
- Modified diet record.

Proper preparation and use of these documents ensure a planned, organized approach to dietary treatment for each patient.

b. Primary Purpose of Documents. Master menus are the initial documents used in planning for hospitalized patients to receive the foods that meet their requirements. The preplanned daily menu items will be consolidated on an automated worksheet. This daily listing of foods is the basis for advance and daily food orders, food production, and service of diets to patients. Special non-menu food items required will be recorded on a locally developed special tally form. Individual menus ensure that each patient receives the specific food items that meet his dietary requirements and are appetizing to him. A record of the number of diets served by category will be made daily. This record is maintained on a monthly basis to provide data for scheduling personnel, procuring food, and determining forms use. It is destroyed after one year.

9-2. Hospital Master Menu

The hospital master menu is a composite of food items for regular diets. The hospital master menu is usually prepared on a cycle basis. The number of weeks for which the menu is written may vary. Weekly evaluation of the hospital master menu permits the incorporation of seasonal foods and elimination of unpopular items.

a. Regular Diet Food Items. The regular diet food items constitute the basic menu designed to meet the general nutritional requirements of the hospitalized patient. The Chief, PSB develops the basic menu IAW AR 40-3 and local procedures, taking into consideration the —

- Requirements of the diet manual.
- Cost of food items.
- Availability of seasonal foods.
- Scheduled delivery dates for special food items.
- Availability and capabilities of personnel and equipment.

The hospital menu is planned to provide nutritionally adequate meals within established budgetary limitations. Consideration is given to current trends, principles of good menu planning, and current nutrition policy. The Chief, NCD approves and signs this basic menu and forwards it to the Chiefs, CDB and PSB for the addition of modified diet food items. The Chief, NCD will incorporate the provisions of AR 40-25 into the hospital menu as applicable.

b. Modified Diet Food Items. The modified diet food items constitute the menu for patients on modified diets. The Chief, CDB or a designee writes these items in compliance with the requirements of the approved diet manual and local procedures. The Chief, PSB reviews the modified diet food items with respect to--

(1) Their availability and cost.

(2) The availability of recipes and equipment needed.

(3) The workload which their preparation imposes on personnel. Agreement to any required adjustments or changes can best be reached in a meeting where the branch chiefs can discuss the needs and problems involved.

c. Menu Writing Guidelines. Following are general guidelines for writing the master menu:

(1) Food items that are appropriate for both regular and modified diets should be used to the maximum extent possible.

(2) Food items of sufficient variety should be selected to permit modification of individual menus according to the likes and dislikes of patients.

(3) In determining the specific food items to be listed, factors such as visual appeal, seasonal availability, and production requirements should be considered.

9-3. Therapeutic Worksheet

a. The therapeutic worksheet is a descriptive list of all food items to be served to patients for breakfast, lunch, and dinner on a particular date. The Chiefs, CDB and PSB are responsible for preparing the therapeutic worksheet. It may be published seven working days in advance of its effective date and in sufficient quantity to provide designated personnel in all NCD branches with personal copies for planning and operational purposes. The PSB personnel use this list as the basic guide —

- In determining food supply needs.
- In selecting and preparing food items.
- In assembling trays.
- For making daily work assignments.

CDB personnel use the therapeutic worksheet in preparing individual menus for patients and in making substitutions in food items according to the individual tolerances of patients.

b. The descriptive names of food items from the hospital master menu are transcribed to the therapeutic worksheet. Additional food items can be listed on the therapeutic worksheet and offered to satisfy the likes and dislikes of patients (for example, extra choices for nourishments, supplemental fluids, or between-meal feedings).

c. Some MTFs use other codes such as "R" and "S" to indicate foods designated for the selective menus. Selective menu items include the regular diet food items plus certain modified diet food items designated IAW local procedures. If the MTF also uses selective menus for patients on modified diets, the food items offered for selection should be marked on the therapeutic worksheet.

d. Whenever changes are made in the hospital master menus, corresponding changes must be made in the therapeutic worksheet.

9-4. Production Planning Worksheets

The PPWs are generated to determine the type and amount of foods to prepare at each meal. The PPWs will be prepared daily for both regular and modified diet foods to control food production. Completed therapeutic worksheets are attached to the appropriate PPW form.

9-5. Special Tally

CDB personnel prepare the special tally for the use of PSB; it serves as a quantitative guide in ordering food supplies and preparing food items that do not appear on the therapeutic worksheet. These items are termed write-ins on the menus. This special tally is submitted daily or at each meal (determined by local procedures) to the PSB. Procedural guides for preparation follow:

a. Following local procedures, those items that appear as write-ins must be listed on the menus, and the total number of times that each item is used must be entered. This information is attached to the appropriate section of the therapeutic worksheet. A local form may be developed for writing the special tally.

b. If additions or deletions in food items are made in the write-ins after the special tally is submitted to the PSB, a list of changes is either hand-carried or reported by telephone to the kitchen.

9-6. Individual Menus

Individual menus are the documents used to ensure each patient is served the particular foods required to fulfill his diet prescription. They make it possible to adjust each patient's food preferences thus enhancing his food intake and the benefits derived from dietary treatment. They also provide data for determining the quantities of foods needed. These menus are collated in CDB and forwarded to the PSB where they are used as orders in assembling patients' trays. They further serve as references in checking the accuracy of trays and in identifying the trays when served to the patients. The menu form will be compared to DA Form 1829 at each meal to ensure that each patient receives the appropriate diet as ordered. For purposes of this chapter, individual menus are classified as regular menus, selective menus, diet menu plans, and written menus.

a. *Regular Menu*. An individual regular menu is prepared for each patient whose condition requires no modification to the regular diet planned for hospitalized patients.

b. *Selective Menu*. The selective menu contains alternative regular food items and may contain some appropriate modified diet food items.

(1) Selective menus should be typed on a Nutrition Management Information System (NMIS) form or locally developed form, using food items listed for selective use on the daily therapeutic work-sheet.

(2) If used, selective menus should be sent for publication far enough in advance to meet the established schedule for distribution to patients.

(3) As selective menus are collected from the patients, CDB personnel should check them for completeness and nutritional adequacy.

c. *Diet Menu Plan.* A diet menu plan is a published meal plan that meets the requirements of a prescribed dietary regimen according to the approved diet manual. The appropriate published diet menu plan is furnished for every patient as required by the diet order. Diet menu plans commonly used may be requisitioned through normal publication channels. To prepare diet menu plans —

(1) The diet menu plans with titles corresponding to the diet orders are selected by using an up-to-date file of patients' dietary history records on which the diet orders from the medical or dental officer have been recorded.

(2) Diet menu plans are usually prepared one day prior to the effective date. The patient's name, ward number, and bed number are written clearly with a dark pencil in the spaces indicated on each diet menu plan.

(3) CDB personnel check each patient's food preferences written on his dietary history record (DA Form 2924) against the diet menu plan and the therapeutic worksheet for the particular day. The diet menu plan can be modified as required by using the following guidelines:

(*a*) If a patient dislikes a food being served, an appropriate substitution is made using other food items that will be available or prepared at that meal whenever possible. This is done by lining out the description printed on the diet menu plan and printing clearly, on the same line, the substituted description.

(*b*) Any additional descriptions of foods, which are to be served, are added.

(*c*) Each patient's menu is rechecked against his dietary history record.

(4) Following local procedures, the date the menu plans will be served is indicated.

(5) If the exact diet menu plan required to fulfill the prescribed dietary regimen is not available, the most appropriate plan available is adjusted. Each time the diet is written, the title of the diet menu plan is adjusted to reflect the diet ordered.

d. Special Modification Diet Menu. A special modification diet menu is one which is developed or calculated to fulfill a dietary regimen when a diet menu plan (see above) for a particular dietary regimen has not been published or when a patient's intolerances greatly alter the standard format of the diet. The development and calculation of special modification diet menus require the application of the dietitian's technical knowledge and judgment. These menus may also be written for some test diets, special formulas, and even some tube feedings.

e. Test diets. A test diet is prescribed for a patient to determine his body metabolism and reactions to diet components supplied or restricted. A special menu can be written to provide or eliminate foods containing these components. Two copies are used as attachments to the hot and cold portions of the special tally (see paragraph 9-5) to notify the PSB in advance of the need for special items. Any needed precautions or notes are written on the attached copies of the menu. A third copy is used as the individual patient menu. It is marked to indicate the need for special attention during tray assembly.

f. Special formulas and tube feedings. These are ordered, prepared, labeled, distributed, and served IAW local procedures. The diet order should state the specific supplement required, the volume desired (in cubic centimeters), the concentration desired, and the serving frequency.

9-7. Modified Diet Record

Daily entries of the various categories and numbers of modified diets will be listed on this form. This record is compiled by CDB and maintained on a monthly basis to provide data for reporting and planning personnel, food, equipment, and forms use; it is destroyed after one year. To prepare the modified diet record -

a. An automated form is used.

b. Identifying data are entered, and the titles of all diets used in the facility are listed in the first column.

c. The number of diets of each type being served is determined each day and entered in the appropriate spaces. This determination is made by checking the titles of individual diets as listed on the DA Form 1829.

d. On the last day of each month, the totals of the various diet types served are entered in the last column.

e. When using a diet not included in the Army diet manual is used, it is added to this record.

CHAPTER 10

MEAL SERVICE MANAGEMENT

10-1. Introduction

The management of meal services for hospitalized patients is the combined responsibility of the CDB and PSB. The two principal types of meal services provided are tray service for bed patients and dining room service for ambulatory patients. The Chief, NCD may modify the type of service depending upon the patient population and needs (room service or decentralized service). Clearance and notification must be coordinated with the dietetics consultant at USAMEDCOM. Between-meal nourishments and supplemental fluids are provided for both bed and ambulatory patients as required in the fulfillment of a prescribed diet. Other meal services, such as meals for patients in transit to other medical facilities, are provided IAW local procedures. Isolation procedures, if required, will be established in each MTF and be approved in writing by the Infection Control Committee. Duty personnel are prohibited from eating food intended for patients.

10-2. Centralized Tray Service for Bed Patients

a. Regardless of how carefully dietary treatment is planned to meet the needs of patients or how well the food is prepared, the final determinants of dietary treatment effectiveness are the--

(1) Accuracy with which each patient's food is dispensed.

(2) Palatability of the food when it reaches the patient.

b. The CDB personnel may conduct periodic random checks of "dummy" patient trays and regular meal rounds to check tray accuracy and meal acceptability. They are also responsible for the —

- Tray serving schedule.
- Individual menus.
- Diet roster.
- Nourishment and supplemental fluid roster.

c. The PSB is usually responsible for --

- Preparing food.

- Assembling food and loading food carts.

- Delivering food carts to the wards and ensuring that ward personnel are notified of delivery.

- Returning food carts to the kitchen and checking trays for excessive food left on them.

- Cleaning the carts.

- Sanitizing trays, dishes, and silverware.

d. Effective fulfillment of these responsibilities requires the PSB to maintain a cooperative, pleasant relationship with the CDB, nursing personnel, medical staff, and patients. All activities must be coordinated effectively to ensure appropriate nutritional intervention for each patient.

10-3. Basic Clinical Dietetics Branch Instruments Used in Tray Service Management

a. *Tray Serving Schedule.* The CDB and PSB personnel, in close coordination with nursing personnel, develop a schedule for serving trays on the wards and revise it as changes are needed.

(1) The head nurse of each ward is contacted to determine the most satisfactory times for meal service. To the extent that NCD personnel can meet them, these serving times should be those most acceptable to the patients, medical staff, and nursing personnel.

(2) A tentative schedule is developed which best meets the needs of the wards, taking into consideration the —

- Tray serving periods desired.

- Meal census on each unit.

- Number of persons available to deliver the carts.

NCD personnel can be used most effectively when the schedule provides for staggered tray serving periods in a group of adjacent units. NCD personnel will deliver patient food trays to the wards. Nursing personnel are usually responsible for distributing meals and nourishments to patients and returning trays to distribution carts after patients have finished their meals. However, most NCD chiefs are choosing to resume control over the entire feeding process and have food service or dietary personnel deliver trays to the patients.

(3) This tentative schedule is reviewed with the Chief, PSB who determines if modifications are necessary based on the time required to transport food carts to units and the number of personnel available to deliver carts.

(4) Necessary modifications are made in serving times, and the head nurse is notified. Written documentation of the approved serving times is provided for each ward.

b. Individual Menus. Prior to each meal, ward diet rosters are checked against the individual menus to ensure that the correct menu has been prepared for each patient. If a patient's diet has changed or additional names appear on the ward diet roster, appropriate menus are prepared at this time. Menus for patients whose names no longer appear on the roster are deleted. Menus are then submitted to the PSB.

c. Early, Late, or Delayed Tray. Patients requiring an early, late, or delayed tray will be annotated on the diet roster. CDB personnel will notify PSB personnel of these requirements prior to the meal.

(1) *Early trays.* An early tray is ordered for a patient who must be served prior to the time that the food cart is scheduled to arrive on the ward. The tray is delivered at the time designated or as soon as possible after the ward calls for it.

(2) *Delayed trays.* A delayed tray is ordered for a patient who will be ready to eat within 30 minutes after the other trays are served on the unit. Delayed trays are usually loaded onto the food cart last. If the trays are not served by the time the cart is removed from the ward, they are returned to the kitchen and called for as late trays

(3) *Late trays.* A late tray is ordered for a patient whose medical treatment makes it necessary for him to be served after the time limit for a delayed tray . The meal is delivered to the ward at the time designated or as soon as possible after it is requested. A full meal is always served on a late tray for a diabetic patient and for a patient on a special calculated diet. After a specified time following each meal, adjustments may be made in the types of foods served most other patients. Local procedures should state whether a complete or partial meal is served on such late trays. The cutoff hour when a late tray becomes an early tray for the next meal should also be stated.

d. Nourishment and Supplemental Fluid Roster. Planning for bed and ambulatory patients on modified diets to receive between-meal nourishments and supplemental fluids is a CDB function. CDB personnel prepare rosters for use by the PSB in the preparation and delivery of individual and bulk nourishments and supplemental fluids. CDB personnel record identifying information on labels or tags that are placed on the paper bags or other containers used in packaging the items. It is possible to establish bulk nourishment accounts for each ward. If this is done, the head nurse or representative is responsible for

ordering bulk nourishments and staying within their allotted budget. If this management procedure is used, nursing personnel should sign for nourishments received to provide an audit trail.

10-4. Basic Production and Service Branch Instruments Used in Tray Service Management

a. Therapeutic Worksheet. The therapeutic worksheet serves as the authority for using specific foods in the assembly of patient trays and as a guide for the production of food items.

b. Individual Menus. Individual menus are used in dispensing and serving food to patients. When the PSB receives the menus from CDB, they have been assembled to aid in dispensing food, assembling trays, and loading trays into the food carts. Menus are arranged for each ward (or for each food cart) in the sequence in which patients' trays are to be loaded into the food cart. Individual menus are used as orders in placing cold food on trays and hot foods on plates and are kept with the trays to identify them.

10-5. Tray Assembly and Cart Loading

a. Tray service activities are performed in a central kitchen. Tray assembly may take place at the same time as food is transferred to the dining hall for serving ambulatory patients. Therefore the Chief, PSB should select an area where the least cross-traffic will be created. Areas are needed for assembling both hot and cold foods, cleaning and storing food carts, and sanitizing and storing dishes.

b. Mobile equipment conserves space, allows for flexibility, and facilitates cleaning operations. Equipment requirements vary with MTF size and the time required for maintenance service. The number of food carts needed depends on the average number of trays served and the location of the wards. The proper grouping of the wards when preparing the cart delivery schedule ensures full-time use of all food carts. The number of dish dispensers needed is based on the average number of each item used for tray service for one meal. The number of grills, toasters, food warmers, and tables required depends on the menu, the average number of trays to be served, and the use of the equipment for other than tray service assembly.

(1) The following preparations should be made before the assembly of trays and loading of carts:

(*a*) Place cold food items in refrigerators for chilling to the proper temperature.

(*b*) If used for hot items, plug dish dispensers into electrical outlets in sufficient time to heat dishes.

(*c*) Portion individual salads and desserts; assemble condiments, dishes, and serving utensils; and, if necessary, place mats on trays. Pour beverages as close to serving time as possible. Individual portion packets of jelly, mustard, catsup, jam, sugar, salt, pepper, salad dressings, cookies, and crackers should be used as they are sanitary, neat, economical, and save time in food assembly.

(*d*) Patient tray service (PTS) personnel should pick up the patients' checked menus from CDB and ensure that the correct date and meal are recorded IAW local procedures.

(2) *Assembly of trays and loading of food carts.*

(*a*) *Assembly of cold food on trays.* Cold food assembly is the process of placing napkins, eating utensils, condiments, and cold food items on individual trays. The best arrangement is to have the trays move on a mechanical or roller conveyor belt in front of PTS personnel with the cold food and other items arranged on tables or shelves within easy reach above the conveyor belt. As the belt moves along, the first PTS worker places trays on the belt and an individual menu on each tray. As the trays move in front of other PTS workers, they read a certain portion of each menu and place the items for which they are responsible on each tray.

(*b*) *Assembly of hot food on trays.* Hot food assembly is the process of placing the correct portions of prescribed hot food items on preheated plates. The best arrangement is to have the hot food items for both regular and modified diets in food warmers with grills and toasters conveniently located nearby. Each food item is called while the cooks or designated personnel place the food on plates.

(*c*) *Tray accuracy.* The PTS supervisor or other responsible individual, stationed at the end of the conveyor belt, removes each tray from the belt. He checks to ensure that the correct items are on the tray before loading it into the food cart. Some facilities may use CDB personnel to check trays.

(*d*) *Additional items.* Some NCD operations place a service tray on each food cart. This service tray contains extra coffee cups, glasses, napkins, condiments, bulk and individual nourishments, flatware, and straws.

10-6. Tray Delivery and Return

a. Procedures. PTS workers transport the carts to the wards IAW the tray delivery schedule. The time the cart departs the kitchen for the ward should be documented. This assists with conducting time-temperature studies and evaluates time management.

b. Serving Trays on the Wards.

(1) Upon reaching the ward, the PTS worker delivers the food cart to the area designated. Nursing and NCD personnel jointly determine the delivery area based on convenience to the majority of patients. The PTS worker contacts the ward personnel to find out if patients are ready to receive the trays.

(2) If additional items are needed after the trays are delivered, nursing personnel will call CDB to request them. The CDB staff will log in the request, check it for appropriateness, and then pass it to PSB who will deliver the product to the ward. The unloaded cart stays on the ward until the trays are ready to be brought back to the kitchen, unless it is needed to transport trays to other wards.

c. Return and Cleaning of Food Carts.

(1) When the patients are through eating, nursing personnel return the soiled trays to the carts. The PTS worker returns to the ward to move the cart to the kitchen. Before leaving the ward, the PTS worker ensures that all soiled trays have been returned to the cart. He also ensures that soiled dishes and glasses used for between-meal nourishments and supplemental fluids are placed on the cart.

(2) The PTS worker returns the cart to the centralized dishwashing area where everything is removed from the cart. The menus of patients who have not eaten their food or who have eaten poorly are removed. Comments are entered on these menus and they are sent to CDB.

(3) The cart is completely emptied. The PTS worker moves it to the cart-washing area where it is thoroughly cleaned. The supervisor or leader inspects the washed carts for cleanliness.

10-7. Special Procedures for Centralized Patient Tray Service

a. Changes in Menus and Delivery of Trays. A written procedure should be developed to explain how late tray changes will be accomplished. Ward personnel occasionally telephone changes to the CDB after the checked menus have been delivered to the PTS area. The exact steps taken depend on how far the assembly of trays has progressed when the change is received in the PTS area. General guides for CDB personnel for making changes are as follows:

(1) *Change in diet.* A menu pattern reflecting the new diet order, with the patient's name and ward recorded, replaces the old menu. If assembly IAW the old menu has started or finished, the tray is withdrawn and a new one, assembled IAW the new menu, is placed in its position. If the cart has already left the kitchen, a new tray is assembled and sent up either individually or with a cart going to a nearby ward.

(2) *Request for additional tray.* A menu is prepared from the instructions recorded on the telephone diet order log and placed with other menus for that ward. If assembly for that ward has been completed, a tray is assembled and placed in the cart. If the cart has left the kitchen, a tray including all items required is assembled. The tray is appropriately covered and hand-carried to the ward or sent on a cart going to a nearby ward.

(3) *Tray cancellations.* If assembly of the tray has not started, the menu is withdrawn; otherwise, the tray is removed from the cart.

b. Assembly and Delivery of Diabetic Diets. Patients on diabetic diets must receive the exact amounts and types of food specified on their menus. The PTS personnel must be provided specific procedures and trained in the assembly of diabetic trays. Special markings or colored diabetic menu mats will alert PTS personnel. The meat portion size is always indicated on the menu by gram weight, and these items must be weighed. The portion sizes of most other foods are specified by weight, measure, or number. A special method is used in determining the weight of meat, such as chicken which contains bone, to ensure that patients receive the appropriate amounts.

c. Tray Service for Pediatric Patients. Procedures for providing tray service for pediatric patients should be developed in close coordination with CDB and nursing personnel. The PSB personnel can do much to facilitate the nursing service's work of serving meals to infants and children. The procedures should provide the following information as it pertains to various age groups.

(1) *Types of serving dishes.* Bowls may be preferred to plates. Plastic dishes may be required as a substitute for china.

(2) *Type of eating utensils.* A spoon may be the only eating utensil desired.

(3) *Elimination of condiments.* Extent to which various condiments should be eliminated from menu items.

(4) *Bulk or individual serving.* Whether desired condiments are to be provided in bulk amounts or individual portion packets.

(5) *Portion.* Portion sizes of the various types of menu items.

(6) *Special pediatric menu.* Whether or not a selective menu should be provided to the 7- to 12-year age group.

(7) *Baby food.* Whether commercially-packed baby food is to be served and, if so, the serving specification (original container or in a dish and the temperature of the food).

(8) *Preparation instructions.* Precutting specifications for meat (grind, mince, chop, or bite-size cuts) and instructions for cutting bread.

(9) *Feeding schedule.* Meal hours and the time for serving desserts after the main course.

(10) *Infection control procedures.* Special trays are not required by CDB guidelines.

(11) *Feeding during transportation.* Requirements for meals to be consumed by infants and children en route to another MTF.

d. Tray Service for Psychiatric Patients. Ambulatory psychiatric patients will eat in the dining facility with other patrons unless otherwise directed by the ward. If a tray is to be delivered to the ward, it should be assembled according to special instructions (for example, disposable dinnerware) provided by the psychiatric nurse via the CDB.

e. Other Tray Service. Ideally, all trays should be 100 percent accurate.

(1) A 100-percent accurate tray is required for the patient on a renal diet. Persons who prepare and serve this food must be alerted to the importance of accuracy in assembling this tray.

(2) Patients requiring calorie counts or other nutritional intakes recorded may have a special marking on their menus to alert the cook and PTS personnel to the added requirement.

(3) Because of illness or personality, other patients may have their menus specially marked to remind PSB personnel to use extra precautions when assembling their trays.

10-8. Daily Evaluation of Tray Service

a. Daily Evaluation. This evaluation is an integral part of tray service. Proper attention given each day to minor infractions prevents major problems later.

b. Collection of Evaluation Data. Surveys and patient interviews provide information on patient satisfaction with meal service. Performance improvement studies also provide pertinent data.

(1) *Accuracy of trays and adequacy of temperatures.* The accuracy of a tray is determined by checking the food items on the tray against those listed on the menu. Always use a calibrated food thermometer to check food temperatures on the tray line and on the ward. The palatability of foods when they reach the patient is greatly dependent upon their temperatures. Optimum serving temperatures

for each hot and cold food item should be determined. These are important performance improvement (PI) issues.

(2) *Prevention of conflicts caused by meal service on the wards.* The therapeutic effectiveness of dietary treatment depends to a great extent upon how closely the NCD and nursing service adhere to the established schedule for tray service (paragraph 10-3*a*). The trays must be delivered to patients on time to avoid interfering with nursing care and planned medical treatment. On the other hand, nursing care or medical treatment, which causes the patient to lose his appetite, should not be administered just before or during his scheduled meal period. Conflicts between meal service and nursing care or treatment can be detected by means of observation as well as by discussion with the patients.

(3) *Patient satisfaction.* During meal rounds, observing patients while they eat allows one to talk with patients and their families about the acceptability of the food served. Meal rounds can establish an accurate picture of the patient's changing needs for dietary treatment as his clinical course progresses. This information supplements formal patient satisfaction surveys.

10-9. Dining Room Service for Ambulatory Patients

Dining facility service is provided for ambulatory patients on regular and modified diets and for other personnel authorized to subsist in the MTF dining room. The PSB personnel are responsible for providing this service which entails setting up regular and modified diet serving lines, dispensing hot and cold menu items, and evaluating services. If local resources do not permit the establishment of a separate modified diet serving line, modified diets will be assembled in the PTS area and brought to the dining room for those personnel requiring them. Accountability must be maintained for all meals served.

a. Breakfast bars and short order lines add variety to the standard operation. Implementation of the A La Carte meal service will offer a larger variety of items than the standard system. This system will allow patrons and/or patients to select individual items or a full meal.

b. Patients who are able to leave the ward should eat in the dining facility as much as possible. It may improve intake, socialization, and morale.

c. Nutrition care and nursing personnel should establish a mutually satisfactory method for serving ambulatory orthopedic patients and others who cannot wait in line or carry trays. A modified family style service, the buddy system, or the carrying of trays by food service workers (FSWs) are satisfactory procedures. Medical treatment facility-specific procedures addressing this issue are recommended.

d. Local MTF regulations govern the attire of ambulatory patients. The Chief, NCD should make recommendations for proper attire to the DCA or CofS, DCCS, and nursing service. Infractions of local policy should be reported to the Department of Nursing.

10-10. Orientation of Patients on Modified Diets to Dining Room Service

a. Diet instructions which were initiated on the ward are continued when the patient becomes ambulatory. He is advised of his responsibilities for complying with his diet limitations. He is also advised of the procedure to follow as he goes through the modified diet serving line or receives his modified diet assembled by the PTS. If a patient is ambulatory from the start of his hospitalization, he is interviewed to obtain his diet history and to give him diet instructions as needed. A patient head-count sheet in the dining facility assists with maintaining accountability of patients and meals served. Although the DA Form 1829 indicates when an ambulatory patient on a modified diet is to be absent from meals or is on pass, it may not arrive in a timely manner and trays may be wasted.

b. Adequate control measures must be established for dining room service for patients on modified diets. Preparation of these modified diets can be coordinated with PTS to occur concurrently if necessary with the ward patient tray assembly. Local procedures must be developed to provide patients on modified diets with their appropriate tray in the dining facility.

10-11. Dispensing Menu Items in the Dining Room

a. Regular Diet Serving Line. NCD personnel are assigned to serve hot foods from the serving line. Patrons indicate to the server the desired food item. The PSB personnel determine standard portion sizes. Meat items are the most expensive menu items and portion control is critical. Local procedures will determine the serving of larger than standard meat portions and the ability of a patron to receive a second entree or meat item.

b. Menu Planning. CDB personnel are responsible for preparing a diet menu plan and instructing the patient on a modified diet before he is given dining room privileges. Local procedures will determine how a patient on a modified diet will receive his tray in the dining facility.

10-12. Evaluation of Dining Room Service

a. The evaluation of dining room service for ambulatory patients is a combined responsibility of the supervisors of both the CDB and PSB. Frequent evaluations help identify areas where improvements are needed. The two main areas of concern are the acceptance of menu items and the effectiveness with which patients receive their meals.

b. The PSB personnel make daily meal checks and observations to identify discrepancies in the preparation and serving of foods and to note customers' acceptance of the menu items. Formal satisfaction surveys similar to those for ward patients, and informal surveys such as suggestion slips and/or boxes can be effective in determining the overall quality of nutritional care provided patrons and patients. The chiefs of CDB and PSB should taste the various menu items regularly to determine quality. They should communicate daily to readily solve those problems for which both are responsible.

10-13. Nourishments and Supplemental Fluids

a. *General.* The NCD personnel deliver nourishments and supplemental fluids for bed and ambulatory patients to the wards. Nursing or NCD personnel distribute the nourishments and supplemental fluids to patients.

b. *Outdated Nourishments.* The PSB personnel remove outdated nourishments from ward refrigerators daily. Problems with excess numbers of outdated or leftover nourishments should be reported to the Chief, CDB. Prompt follow-up with corrective action will reduce food waste.

c. *Preparation of the Nourishment and Supplemental Fluid Roster.*

(1) After reviewing the ward diet roster and supplementary nourishment orders received, a nourishment roster is prepared for each ward to which these items are sent.

(2) On each roster are stated the required identifying information, patients' names, and the appropriate food items for each patient, taking into consideration his food preferences recorded in his dietary history . Items which are an integral part of a modified diet, such as beverages served to patients on liquid diets, must be included on this roster.

(3) The rosters are sent to the kitchen at locally-established times.

(4) When the rosters are returned after each delivery period, they are checked against the ward diet rosters and telephone diet orders (paragraph 8-3*h*), and needed changes are made.

d. *Identifying Containers.*

(1) For each patient listed on the nourishment and supplemental fluid roster, the appropriate identifying information is recorded. This information is recorded on the paper bag or other container, caps, labels, and tags used in packaging the patient's food. This includes the —

- Patient's name.
- Ward number.
- Date.
- Type of food item.
- Time for serving.

Bulk nourishments must be labeled with ward number, date, and type of food item.

(2) The identified items are assembled for each of ward in individual packets.

(3) These packets are sent to the PSB prior to each scheduled delivery of nourishments and supplemental fluids.

10-14. Emergency Requests

Requests for nourishments after a delivery is made, but for use before the next delivery, must be approved by a dietitian, DTR, or CDB supervisor before being filled by PSB personnel. The NCOIC, or other supervisor in PSB, approves requests received after the CDB office closes. All after hour emergency requests, approved or disapproved, are retained for the Chiefs, PSB and CDB review the following morning. Local procedures are developed which state how emergency meals are handled, for example, on-call roster for NCD, prepackaged meals or box meals, or preparation of extra trays at each meal. The procedures should also address delivery coordinated after hours through the duty officer.

10-15. Combined Responsibilities

This paragraph addresses the combined responsibilities of CDB and PSB personnel. Procedures for accomplishing these activities must be developed locally. Coordination is the key to achieving these goals.

a. Standard Food Portions.

(1) Food items are served to patients in standard food portions. These standards may be established locally or derived from the Nutrition Management Information System (NMIS). See Appendix C for specifics of the NMIS. Food portions are termed small, medium, and large. The quantities which these represent are expressed in weights, measures, or item counts. Medium portions are served to the

patient unless his menu indicates otherwise. When a patient is to be served a portion not equivalent to the standard small, medium, or large portion, the quantity must be stated on his individual menu.

(2) If local standards are used, the Chief, CDB establishes the standard quantity of the medium portion of each food item for patients.

(3) If local standards are used, the Chief, PSB in consultation with the Chief, CDB determines the standard quantities for small and large portions, which are modified as needed. If patients commonly leave food on their trays or complain of inadequate quantities, the standards may be too high or too low.

b. Prevention of Food Waste and Misuse.

(1) The prevention of food waste and misuse requires the coordinated efforts of NCD and nursing personnel. A thorough knowledge of regulations pertaining to nutritional care activities and strict adherence to established procedures are essential. Close supervision is necessary to ensure that meals and between-meal nourishments are served to the patients for whom they are intended.

(2) The CDB personnel strive to ensure that patients receive their food preferences as closely as possible within their dietary restrictions. They accomplish this by —

- Patient interviews.
- Dietary histories.
- Diet instructions.
- Selective menus.
- Patient satisfaction surveys.

The CDB and PSB personnel must be concerned and take corrective action when there is evidence of food waste or misuse. Causes of food waste, plate waste, and leftovers must be analyzed, and conservation measures established.

c. Picnic Lunches and Special Activity Meals. Picnic lunches and special activity meals requested by the nursing service or Rehabilitation Services (Physical Therapy/Occupational Therapy/Mental Health) for patients are planned by the PSB in close coordination with the CDB. All parties must share in the performance of extra duties connected with such activities to avoid overtaxing the capabilities of any one group. Accountability must be maintained for all foods consumed.

d. Meals for Patients in Transit to Other MTFs. Patients on modified diets, who are to be transferred to another MTF for outpatient treatment, may have a modified meal accompany them if they are going to miss a meal. This should be stated in locally-developed procedures, which will indicate how it is ordered, the time by which it must be ordered, and who will pick it up.

e. Holiday Meals. The procedures required for providing holiday meals are different from daily procedures. For example, special menus are printed and special subsistence rates are charged for holiday meals. Local procedures should clearly define the responsibilities of each group involved in the planning, preparation, and serving of holiday meals.

f. Standardized Recipes and Portion Control.

(1) Standardization of recipes and portion control ensure uniformity of product and cost control. The Armed Forces Recipe Service (TM 10-412), or recipes from the automated management system will be maintained for standardized recipes used in food preparation.

(2) The development and introduction of new menu items for either regular or modified diets require close coordination between CDB and PSB personnel. The number of new items introduced during any one period should not be great enough to create a workload beyond the capabilities of personnel. Detailed procedures should be established to ensure that all requirements are met, including the —

- Requisition of ingredients.
- Establishment of standard portions based on dietary requirements.
- Testing of the recipe by means of a scorecard evaluation.

g. Modified Diets for Duty Personnel. Modified diets are prepared for duty personnel on a prescription basis. Diet instructions are provided for them as needed if they are entitled to military medical care. Local procedures should include provisions for reviewing the diet prescriptions with the medical officers at specified intervals to ensure that the changing needs of personnel are met. An excessive number of modified diets for duty personnel can place a burden on all elements of the NCD, thus lessening the effectiveness of dietary treatment for hospitalized patients. Teaching nutritional awareness, portion control, and dietary guidelines to duty personnel may preclude the need for them to receive actual modified diets planned by the CDB and prepared by PTS personnel.

h. Daily Diary. A daily diary can be maintained in the NCD to record facts obtained by —

- Observations.

- Informal evaluations.
- Telephone conversations.

It serves as a valuable aid in discussing and solving daily problems and in planning for the overall improvement of the dietary treatment program. Use of a diary throughout the division is at the discretion of the Chief, NCD.

i. Daily Meetings.

(1) Representatives of CDB and PSB meet daily to —

- Plan.
- Establish goals.
- Solve problems.
- Coordinate efforts.
- Improve procedures.

Care must be taken to ensure that the meetings are productive and not complaint sessions. They should be conducted IAW a locally-established routine and be as brief as possible. The Chief, NCD determines the frequency of meetings.

(2) Daily employee meetings may be scheduled so that supervisors can disseminate information and make duty assignments. The time set aside for meetings may also be used for training employees. Local procedures should be established for daily meeting schedules.

CHAPTER 11

PRODUCTION AND SERVICE BRANCH FUNCTIONS

11-1. Introduction

The primary function of the PSB is to provide high-quality, nutritious meals to patients, staff, and personnel authorized to subsist in the MTF dining facility. Functions of the PSB as outlined in AR 40-3 include —

- Menu development.
- Ordering, receipt, storage, and issue of subsistence items.
- Food preparation and production.
- Service of food via a centralized tray service and in the dining facility.

AR 40-3 addresses specific PSB issues such as subsistence, supply, and food cost management.

11-2. Staffing

The PSB should be staffed to accommodate mission requirements specific to the type of operation and patient census. The TDA states the requirements and authorizations for the branch. Staffing of the PSB and the types of positions required depend on the size and complexity of the operation. The need for additional personnel may arise as the mission changes or the scope of care widens. Staffing is a process that determines organization manpower requirements. To assess manpower requirements, the Chief, PSB should review —

- The type of work performed.
- Operational hours.
- Average worker productivity.
- Total workload.
- Nonproductive time due to illness, annual leave, and other authorized absences.

The Chief, PSB should coordinate manpower requirements with the RMO. Responsibilities and duties are listed in the following paragraphs. In small facilities, one person may have many responsibilities.

11-3. Responsibilities

a. Chief, PSB. The Chief, PSB may be an RD, a Nutrition Care Specialist, or a civilian supervisor. This person is responsible for managing all areas of the branch. The Chief, PSB exercises control over all food service functions to include —

- Food procurement and storage.
- Meal planning.
- Meal preparation and service.

Service entails transporting meals to ward patients and operating a dining facility for other authorized patrons .

b. NCOIC. A Nutrition Care Specialist serves as the PSB NCOIC. The Chief, PSB and the NCOIC, NCD guide and supervise the PSB NCOIC. The PSB NCOIC supervises the receipt, storage, and issue of subsistence items. He oversees food preparation and service, PTS, and sanitation of the entire food service operation. He is responsible for the junior enlisted personnel in the branch, performing required counseling sessions. He is usually the primary hand receipt holder for the PSB. He acts as assistant to the Chief, PSB in administrative matters and other issues as required and is responsible for practicing fair personnel management principles .

c. Assistant PSB NCOIC. Large MEDCENs and MEDDACs may have more than one NCO in the PSB. Their rank, skill level, and the TDA will determine their use. Supervisory and administrative duties will be divided among the NCOs depending on their skill level and experience. Civilians or military, or a combination, may be used as shift leaders. One assistant may be required for each shift for each section of the branch. He receives direction and supervision from the Chief, PSB and NCOIC. He directs and coordinates the activities accomplished during the shift to which he is assigned.

d. Production Manager or Supervisor. A Nutrition Care Specialist or qualified civilian employee serves as the production manager or supervisor. Responsibilities may include —

- Ordering, receiving, and issuing food in the kitchen.
- Planning production.
- Instructing cooks.

- Overall supervision of the preparation and service of regular and modified diet foods.

The automated management system automates some of the functions. The primary responsibilities of the production manager/supervisor are to supervise the cooks and produce finished food products in a timely manner. The production manager/supervisor is responsible for enforcing departmental policies for sanitation, safety, and security. He may assist the Chief, PSB by providing feedback on the cooks' production worksheets or NMIS preparation and planning reports, developing and testing recipes, and conducting food yield studies. He enforces cost control measures by enforcing portion sizes served and the efficient use of leftovers. He documents overages and shortages and makes recommendations for forecast and/or recipe and menu changes. Each production manager/supervisor is responsible for monitoring food preparation and service in that area. He may also have a variety of personnel management responsibilities. The PSB supervisors communicate with clinical supervisors for day-to-day activities.

e. Hospital Cooks. These positions are occupied by a Nutrition Care Specialist or qualified civilian employee. Cooks work on rotating shifts under the guidance of a production manager/supervisor. They receive assignments and instructions from the production manager/supervisor. Their primary duties are cooking and preparing food for both regular and modified diets according to standardized recipes, and serving food in the dining facility and other serving areas including the PTS area. They help develop new recipes and improve old recipes. They operate specialized cooking equipment and apply portion and cost controls as directed. They are responsible for cleaning and sanitizing the equipment and work areas to which they are assigned.

f. Baker. This position is occupied by a qualified civilian employee or Nutrition Care Specialist in facilities authorized a baker. A baker is skilled in the use of standardized recipes for the preparation of breads, desserts, and other pastries as directed by the Chief, PSB or NCOIC. He uses the standardized recipes provided by the NMIS or those currently in the system. Recipes not in the system should be tested and standardized prior to incorporation into the menu. He is qualified to operate the specialized equipment in his work area and is responsible for its sanitation.

g. Patient Tray Service Personnel.

(1) *Supervisors.* These positions are usually limited to large MTFs and are occupied by civilian employees, but can also be filled by military personnel. They work under the supervision of the PSB NCOIC or civilian cook/supervisor. They train and supervise the PTS workers in the performance of their duties and may perform some of the tasks which require greater skill and accuracy. They direct the portioning of individual salads, desserts, and other items. They, or their designated assistants, check each tray for accuracy and appearance at the end of the assembly operation. They dispatch food carts to patient wards according to a predetermined time schedule. These supervisors are also responsible for

ensuring sanitary practices, including personal hygiene of PTS workers, and the cleanliness of food carts and the PTS assembly area. They also assist in performing PI studies.

(2) *PTS Workers*. The PTS worker position is a WG classification. These personnel are scheduled on rotating shifts. They receive assignments and instructions from a PTS supervisor. Their duties include —

- Portioning of food.
- Assisting in the assembly of trays as indicated on the individual menus.
- Loading the food carts.
- Delivering food carts to the wards and notifying ward personnel of delivery.
- Assembling and delivering early, late, and delayed trays and nourishments to the wards.
- Returning food carts to the dish room area.
- Cleaning and sanitizing food carts and the PTS area.

h. Food Service Worker.

(1) *Supervisors*. These are WG positions. The FSW supervisor is supervised by the PSB NCOIC. The FSW supervisor trains and supervises the FSWs in the performance of their duties.

(2) *Working leaders*. These are also WG positions. Working leaders make assignments and provide instructions to FSWs in their section based on their supervisor's guidance.

(3) *Food service workers*. These are also WG positions. The FSWs receive their assignments and instructions from a FSW supervisor or working leader. Their duties include —

- Washing dishes, pots, and pans.
- Mopping.
- Cleaning equipment and surfaces.

- Refilling condiment containers.
- Processing vegetables and fruits.
- Portioning desserts.
- Serving on the dining room line.
- Other related tasks.

The initiative and interest of FSWs are maintained by providing cross-training opportunities on a variety of tasks and types of equipment.

i. Subsistence Supply Section Personnel.

(1) *Subsistence supply section NCO/supervisor.* A Nutrition Care Specialist or qualified civilian employee serves in this position. He is responsible for the overall operation of the subsistence supply section to include—

- Advance ordering with forecast figures furnished by the Chief, PSB.
- Receipt, storage, and issue of subsistence and expendable supplies.
- Monthly inventory.
- Operation of the meat preparation unit, vegetable preparation unit, and ingredient room if collocated with the subsistence supply section.

Good communication skills are important because there is a great deal of interaction with a variety of subsistence suppliers and logistics personnel.

(2) *Warehouse personnel.* This position requires employees qualified as truck drivers and material handlers. The warehouseman loads, unloads, delivers, and stores supplies as directed. He also distributes supplies to the kitchens, using vehicles and carts. He cleans the work and storage areas, equipment, and vehicles. Personnel shortages may dictate that junior enlisted personnel fill this position. The Chief, PSB should ensure that enlisted soldiers in PSB have a military drivers license and are listed as authorized drivers for NCD vehicles.

(3) *Meat cutter.* Most facilities, if not all, have eliminated these positions or converted them to cooks or warehouse personnel. If filled, this position is occupied by a qualified civilian employee. The

meat cutter is responsible for supplying the kitchen with meat, fish, and poultry in the quantities and the types and cuts requested. He may assist the Chief, PSB and the subsistence storage specialist in preparing advance estimates for meat, fish, and poultry products. He ensures that sanitation, safety, and maintenance practices are followed. He maintains records and reports as required.

NOTE

A forecast is entered into the automated management information system. The result is a daily pre-preparation withdrawal report. The report lists the items, their quantities, and the required method of pre-preparation.

(4) *Fruit and vegetable preparation room personnel.* If filled, this position is occupied by a FSW. In smaller facilities, these duties are usually performed by FSWs or other PTS employees performing multiple tasks. The fruit and vegetable preparation room may be located near or in the subsistence supply area or it may be located near the main production area. Location will determine how it is supervised and by whom. The FSWs assigned to the fruit and vegetable room prepare raw fruits and vegetables for use by other areas. The automated management information system provides a pre-preparation and withdrawal report for this area which indicates the items, quantities, and preparation methods required. Facilities without an automated system use the cook's worksheets for identifying required pre-preparation. Fresh fruits and vegetables are prepared for the cooks and PTS personnel. The supervisor for this area is responsible for —

- Assigning FSW workload.
- Providing the necessary instructions needed for this assignment.
- Checking to ensure that the electrical equipment is functioning properly.
- Ensuring that enough ice and refrigeration are available to preserve the freshness of food items.
- Performing sanitation inspections.
- Proper use and rotation of fresh fruits and vegetables.
- Proper storage and labeling of processed items.

CHAPTER 12

SUBSISTENCE MANAGEMENT

12-1. Introduction

a. The NCD must have adequate controls over the planning, purchase, inspection, receipt, storage, and issue of subsistence items and supplies. Stock levels and reorder points for subsistence should be determined locally. Losses and discrepancies will be investigated immediately. The Chief, NCD will initiate appropriate follow-up action.

b. An essential function of the PSB is the effective management of subsistence. Food items of optimum quality must be supplied to production units in required quantities at desired times for the preparation of planned menu items. This function is the responsibility of the Subsistence Supply Section of the PSB. It requisitions, inspects, receives, stores, secures, processes, and issues subsistence items. Food costs, inventory, documentation, and maintenance of receipt and consumption records are also integral parts of food supply management. The Chief, PSB maintains operational control of subsistence management.

12-2. Placing a Subsistence Requisition

a. Procedures. Each facility will develop written procedures which detail requisition procedures and their relationship with the Troop Issue Subsistence Activity (TISA), commissary, or other authorized subsistence suppliers, such as a prime vendor. Guidelines for requisitioning subsistence through the TISA are in AR 40-3.

b. Troop Issue Subsistence Activity/Commissary.

(1) *Suppliers.* Subsistence items, including special patient feeding items, are supplied by the TISA IAW AR 30-18 and/or the installation commissary IAW Defense Commissary Agency Directive 40-1. Subsistence items may also be obtained from a commercial vendor through a prime vendor contract established by the Defense Supply Center Philadelphia (DSCP) or the Veteran's Administration. Items such as bread and milk may not be available through a prime vendor. They can be delivered directly to the dining facility. The TISA, when available, monitors the contracts. At those installations where there is a commissary but no TISA, the NCD may have the commissary provide all subsistence requirements or establish a prime vendor contract. Advance food estimates are submitted by the NCD as requested by the Troop Issue Subsistence Officer (TISO), installation commissary officer, or prime vendor. Time required for processing requests should be considered when placing orders to prevent shortages or zero balances in the inventory.

(2) *Requisitions.*

(*a*) Authorized NCD personnel will prepare and submit food requisitions such as —

- DA Form 3161 or automated equivalent.
- Forms designated by the supporting commissary.
- An approved automated equivalent.
- Other mutually agreed document.

(*b*) This requisition serves as a voucher and receiving document. "LAST ITEM" is entered in the item description column after the last entry on the DOD requisition form. The requisition form is prepared IAW local TISA/commissary policy in sufficient copies to meet NCD and TISA requirements. Requisitions (vouchers) will be serially numbered within each calendar month. A monthly transaction log will be maintained to include —

- Voucher sequence number.
- Subsistence item.
- NSN if applicable.
- Source.
- Date requested.
- Date received.
- Date costed voucher received from the TISA/commissary.
- Estimated cost.
- Actual cost.

The cost accountant maintains primary responsibility for updating and monitoring financial records.

(3) *Subsistence prime vendors.*

(*a*) Beginning in the early 1990s, the DOD began to examine costs associated with maintaining TISA operations and viable alternatives. Subsistence prime vendor contracts, administered through the DSCP were established. During the late 1990s and 2000, contracts were awarded through the Veteran's Administration. These contracts, when awarded, provide a competitive combination of price, quality, and service.

(b) It is possible for the NCD to use a subsistence prime vendor in lieu of the TISA or commissary. The Chief, NCD will contact a DSCP contracting specialist involved in subsistence prime vendor contracts and complete the required documentation, coordination, and actions to initiate a contract.

(c) Subsistence prime vendor contracts can result in significant labor and cost savings as well as providing opportunities to increase variety and quality menu items. Improved service is often a benefit. All food items ordered are normally available for delivery, and deliveries can be frequent.

(d) Subsistence prime vendor contracts may be established wherein the DSCP pays the contractor and the NCD reimburses the DSCP. The Chief, NCD must ensure that sufficient coordination is accomplished with the NCD installation billing activity, Defense Finance and Accounting Service, and DSCP to identify the DOD activity code.

(e) The Chief, NCD shall contact the Chief, NCD of the respective RMC for guidance on establishing and implementing a subsistence prime vendor contract.

(4) *Convenience foods.* These food items, used as labor-saving items, also enhance customer acceptability. In an a la carte system, the Chief, NCD should consider the effect of the surcharge on the selling price and unit cost in relation to the BDFA established for SIK soldiers when deciding on the purchase of individual convenience items.

(5) *Authorization.* If not using a prime vendor contract, the Chief, NCD will provide the TISA and commissary with one or more of the following for all personnel authorized to order subsistence.

- DD Form 577 (Signature Card).

- DA Form 1687 (Notice of Delegation of Authority--Receipt for Supplies).

- Other documentation required by the commissary officer or TISA.

12-3. Inspecting and Receiving Subsistence

Each NCD prepares a written procedure for inspecting and receiving subsistence and vehicle security. A memorandum listing specific persons authorized to order and receive will be developed and updated as changes occur.

a. Authorization. The TISA/commissary issues subsistence only to personnel authorized by the Chief, NCD IAW paragraph 12-2*b*(5) with proper identification. For appropriate control, the individual authorized to receive subsistence will not be the same person authorized to order it.

b. Receipt of Subsistence. Subsistence personnel will carefully check all subsistence items for quantity and quality (and date if applicable) upon receipt. Appropriate receipt dates assist with the first-in first-out inventory principle. Subsistence personnel will verify quantities received by actual count, weight, or specifications to ensure that they agree with those shown on the food requisition or direct delivery vendor invoice. The TISA/commissary representatives enter in the supply action column of DA Form 3161 the actual quantities of items issued. Items not available are entered as a zero. Any item not meeting NCD quality standards will be rejected. If item(s) cannot be replaced with an acceptable item, a zero must be entered on the invoice. Items received, but not ordered, should not be accepted.

c. Subsistence Pick-up. The food items listed on a single DA Form 3161 must be picked up simultaneously. The authorized NCD representative signs the request for issue to verify receipt of items. Items recorded as a zero, signifying not received, will be reordered.

d. Documentation. One signed copy of the DA Form 3161 is returned to the NCD cost accounting clerk. Remaining copies of the receiving document are retained by the TISA/commissary. The TISA/commissary personnel enter unit prices, price extensions, and total cost on the issue slips and return one completed priced copy to the Chief, NCD.

e. Vehicle Standards. Vehicles used to transport subsistence must comply with the standards established in TB Med 530.

f. Maintaining DA Form 1835. The receipt copy of DA Form 3161 or vendor invoice serves as the basis for food receipt entries on DA Form 1835 (Hospital Food Service - Food Receipt and Consumption Record) or automated equivalent. This form is maintained for all subsistence items that the NCD purchases, including fresh fruit, fresh vegetables, bread, and dairy products. DA Form 1835 aids in reconciling daily inventory balances with the end-of-month physical inventory. Additionally, by reviewing consumption factors, future requirements may be forecasted with a greater degree of accuracy.

(1) During the month, the date (column a), voucher number (column b), and quantity (column c) of each food item received is posted in ink. A running total is maintained in column d by adding each

receipt to the previous total in column d. Prices which change with the receipt of an item are updated on DA Form 1835.

(2) After the end-of-month physical inventory of food items on hand (paragraph 12-7*a*), the inventory quantity is documented in red ink on the line below the last entry in column d. The difference between this inventory figure and the preceding entry in column d is the monthly consumption to post in column e.

(3) Columns f and g are used for entry of food issues when maintaining a perpetual inventory to detect operational errors and losses, improve security, and provide daily control over food issues. Normally, a perpetual inventory is maintained for meat, fish, and poultry items. A perpetual inventory will be maintained on other high-cost inventory items as the Chief, NCD directs. The NMIS maintains a perpetual inventory on all items in the inventory on the commodity quantity and cost details printout.

g. Direct Delivery Items. Food items supplied by local vendors may be delivered directly to NCD kitchens. A designated representative in each kitchen is responsible for checking the quality and quantity of the items, and signing the vendors' sales slips. The kitchen representative determines whether or not direct delivery items (such as milk and bread) meet specified standards by inspecting delivered items for proper dates, recording, and so forth. The veterinary officer and TISO must be notified of discrepancies in the quality of directly-delivered items. The veterinary officer will make an on-site inspection and write a corroborating report. Signed invoices are forwarded to the NCD cost accounting clerk who records the items and quantities received.

12-4. Storing and Securing Subsistence and Supplies

a. Storage and Security. Storing and securing subsistence and supplies in NCD storerooms are two important functions of the Subsistence Supply Section. Procedures that detail the storage and security of subsistence and supplies will be developed.

b. Inservice Training. Inservice training should be provided to the personnel assigned to the subsistence supply section in the following subjects:

- Misuse or misappropriation of government property,
- Receipt and storage of subsistence and supplies.
- Documentation.
- Inventory management.

- Monthly inventory.

c. *Security Procedures Recommended for Subsistence.*

(1) Guidance for property accountability is in ARs 30-1, 30-18, and 735-5.

(2) Like other government property, subsistence will be safeguarded by judicious and conscientious use of measures necessary to ensure its correct requisition and subsequent issue, receipt, storage, preparation, and consumption.

(3) Subsistence security guidelines include the following:

(*a*) Persons receiving subsistence items should check to ensure they have received the exact quantity and weight for which they are signing. (These individuals should be listed on a DA Form 1687.) These items should never be left in an unattended vehicle.

(*b*) The items should be checked again for quantity, weight, and condition on delivery to the NCD.

(*c*) Storage areas should be secured against entry of unauthorized persons. These areas must be locked when unattended.

(*d*) "Off Limits to Unauthorized Personnel" signs will be posted at the entrances to subsistence storage facilities (see AR 420-70).

(*e*) Stock levels should be maintained to prevent accumulation of excess stocks, which encourages pilferage.

(*f*) Proper issue procedures should be followed, using the NMIS inventory/withdrawal and requisition lists, DA Form 2930 or an automated equivalent. Food should be issued only in the amount to be consumed within a specified time limit.

(*g*) Frequent checks, comparing the amount of food prepared against the number of servings consumed, are necessary to ensure the proper use of food in the preparation and pre-preparation areas.

(*h*) Highly pilferable items may be placed in a separate, locked cage or area.

(*i*) Adequate security should be provided for leftover foods.

(*j*) Random searches of employee lockers or carry-out items may only be conducted after prior coordination with the civilian personnel agency, JAG, and MPs, and with the commander's approval.

d. Storage.

(1) Food items not required for immediate use will be stored in secure food supply store-rooms. Shelving units should be mobile, adjustable, durable, and easily cleaned. They should be placed at least 6 inches from the wall and the bottom shelf at least 6 inches above the floor. Refrigerated store-rooms should be able to be secured after hours or during low usage times. Nonfood supplies will be stored in secure areas designated as nonfood storage.

(2) Subsistence items stored in case lots will be dated upon receipt to ensure proper rotation of stock. Nonperishable or dry stores will be placed on pallets or shelves. Items should be arranged to coincide with the inventory listing. Perishable items are stored in refrigerators or freezers equipped with accurate, numerically-scaled thermometers. Recording thermometers may be used in lieu of indicating thermometers IAW TB Med 530. Specific refrigerators should be designated and labeled for the various categories of perishable foods. Space is designated for each type of meat in the meat refrigerator and should allow for proper rotation.

(3) The temperature of each refrigerator and freezer should be checked at least three times a day and recorded on a temperature log. If refrigerators or freezers are located in a building which is locked for weekends and holidays, arrangements are made for temperature checks to be done at least once a day. Temperatures must be maintained IAW TB Med 530.

(4) Receiving and issue areas must meet the sanitation standards established by TB Med 530. Frequent inspections of these areas should be made to identify and correct discrepancies.

12-5. Subsistence Processing

In addition to ordering and receiving subsistence, the Subsistence Supply Section may have a major responsibility in the processing of foods before delivery to production units. This processing —

- Eliminates the clutter of boxes, cans, and vegetable and fruit waste from production areas.
- Minimizes wasted activity by cooks.
- Provides closer control over processing.

The three major food processing areas which may be located in the Subsistence Supply Section or away from the main production area are meat processing, vegetable preparation, and a central ingredient room.

a. Meat Processing.

(1) Meat will be processed according to locally, predetermined specifications and issued in the amounts requisitioned. A DA Form 1835 may be used as an internal control document to facilitate handling, inventory control, and economical use of meat. The automated management information system provides a food preparation and withdrawal report. This report indicates the quantities and types of meat to be pulled each day and how they are to be prepared (for example; beef cut in strips, chicken quartered).

(2) Meat is the most expensive subsistence item used in the NCD. Operating procedures specifying controls to prevent waste and loss during processing must be established and strictly enforced. Controls over storage and issue of processed meats must be established and enforced. The NMIS perpetually inventories all meat, fish, and poultry.

(3) The workload of the meat processing unit (where one exists) varies depending on the particular meat items issued. Delegation of authority over and supervision of the meat cutters will be affected by the location of their area. If it is located away from the main production area, in the subsistence supply area, the subsistence supply supervisor may have overall responsibility for managing the meat cutters as well as the subsistence personnel. If located near the main production area, the production shift leader may manage the meat shop.

(4) Meat processing areas and equipment must comply with the standards in TB Med 530. Refrigerators and freezers should be routinely emptied and thoroughly cleaned.

(5) The shift leader or supervisor is responsible for enforcing safety requirements. Refrigerators and freezers must be well lit; alarms and devices for opening doors from the inside must be in proper working order; and any liquid on floors must be cleaned up immediately. Electrical equipment, such as saws and grinders, should be set for proper cut with guards and guides in position before operation. Feeders must be used, and operators must keep their hands a safe distance from cutting instruments. Meat grinders should be stopped before removing food from the hoppers. Equipment should be disconnected from electrical outlets before cleaning. Equipment is cleaned by, or under the supervision of, an experienced meat cutter. Knives, steel saws, and other hand tools are used only for designated purposes. Meat cutters must wear safety gloves and aprons when cutting or boning meat. Power equipment is disconnected and hand tools properly stored at the end of duty.

b. Vegetable Preparation Unit.

(1) Processing vegetables and fruits for cooking and salads entails washing, paring, trimming, cutting or shaping, and soaking. Fruits and vegetables are perishable and should be refrigerated except while being processed since deterioration is rapid when removed from refrigeration. According to TB MED 530, sulfiting agents will not be used. Root vegetables require vigorous scrubbing to loosen soil and other dirt particles. Fresh fruits and vegetables shall be thoroughly washed and rinsed with potable water prior to serving. Vegetables and fruits are best washed in a colander. Vegetables and fruits in water should be removed rather than allowed to stand while the water drains. This prevents resettling of the removed soil particles.

(2) Vegetables and fruits to be cooked whole should be sorted by size during the washing process. Vegetables that require cutting should be cut into uniform sizes; this permits cooking of all pieces to the same degree. Electrical equipment used for peeling, chopping, and cutting should be set to the proper thickness to prevent loss of edible food.

(3) Greens for salads are made crisp by placing them in waterproof bags, colanders, or baskets and sprinkling them lightly with ice flakes or cold water. Greens may be cut before or after crisping.

(4) Consumption of fresh fruits and vegetables grown in areas using human fertilizer is addressed in TB MED 530.

c. Central Ingredient Room. Because of staffing, space, or need, the central ingredient-room concept is not used in all facilities. This paragraph discusses the purpose, staffing, and space requirements of an ingredient room.

(1) Use of a central ingredient room provides tighter control over the issue of subsistence. The ingredient room reduces kitchen activity by centrally weighing, measuring, and assembling menu items and ingredients. This promotes better use of time and resources, allowing the cooks to perform actual production tasks equivalent to their pay grade and skill level. The appropriate ingredients are transported to their preparation areas according to predetermined time schedules. This system ensures that cooks follow standardized recipes since they can only use the ingredients delivered to them. It also helps to control costs because known quantities of ingredients will be used. Specific kitchen work stations can be established according to products prepared and cooks assigned accordingly. Timely delivery of ingredients influences the time that meal preparation actually begins. The ingredient room should be secured when not in use.

(2) The ingredient room should be staffed by FSWs possessing the necessary skills used in weighing and measuring. They should receive periodic training on proper measurement techniques and be evaluated for accuracy as part of their performance standards. These FSWs may be supervised by a shift leader or an assistant NCOIC of the PSB. They do not need cooking experience, but potential employees

should be carefully selected. The tasks performed require persons who are alert, interested, and conscientious, as their job is critical to the production process and physical security of subsistence items.

12-6. Issuing Subsistence to Kitchen/Ingredient Room

a. Processes for Issuing Subsistence. The PSB personnel determine production requirements either manually using historical data or with the assistance of the NMIS. Written procedures for processing and issuing subsistence will be developed and enforced. Procedures will ensure that all food issued to using areas is recorded on NMIS inventory/withdrawal and requisition lists, DA Forms 2930 or an automated equivalent. Items to be turned in to the subsistence storeroom will be documented in red ink on DA Form 2930 with "Turn-in" written in red ink at the top of the page to avoid confusion during the cost accounting process.

b. Manual System. Menu items to be prepared are listed on the therapeutic worksheet. Recipes for menu items listed on the therapeutic worksheet are extended to reflect quantities required. Ingredients needed to prepare recipes are consolidated to determine total amounts of each item required, for example, lettuce requirements for a day's use. A DA Form 2930 is prepared for the types and amounts of items needed for each day and submitted to subsistence. Meat requests are listed on a separate DA Form 2930 as pounds and/or servings as indicated on the food production worksheet (FPW). Meat requisitions are filled by the meat processing unit (if one exists), and other subsistence requisitions are filled by subsistence personnel. Ingredient room personnel or designated individuals order flour, salt, sugar, spices, and other condiment items in bulk. Additional food items requested during the day by the production unit and not included in the original request are submitted on separate DA Forms 2930. These requests are dated for the day of use and numbered sequentially with the other DA Forms 2930. These items should be sent to the production unit as soon as possible. The ingredient room personnel must manage their time according to when the items are required by the production areas.

c. The Nutrition Management Information System.

(1) The NMIS provides a more rapid response to the food requisitioning process. The system maintains a recipe file, master menu, and other source documents for each facility. PSB personnel provide the system operator (individual responsible for inserting data) with a patient and dining room census for each day of the menu cycle. The system uses this data to generate —

- Recipes.
- Labels for measured ingredients.
- An ingredient summary (withdrawal and delivery list).

- A vegetable processing summary.
- A meat processing summary (pre-preparation planning report).

(2) It also has the capability of printing purchase orders based on the inventory. Upon receipt of supplies in the kitchen and/or ingredient room, personnel will verify amounts received and sign a DA Form 2930 or automated equivalent as the authorized receiving representative. The completed DA Forms 2930, or automated equivalent, are forwarded to the cost accounting section. The NMIS is discussed in greater detail in Appendix C.

d. Internal Food Requisitions. Issue of subsistence items from the NCD subsistence storerooms will be made on presentation of a DA Form 2930 with columns a through c completed and signed by both the requisitioning representative and the Chief, PSB or other authorized person. Enter "LAST ITEM" on the line following the final item ordered on the DA Form 2930. An NCD using an automated system may use a withdrawal and delivery list, properly dated and signed, in lieu of DA Form 2930.

(1) DA Forms 2930 or automated equivalent will be serially numbered within each calendar month, properly completed, and signed. A monthly transaction log of prepared DA Forms 2930 should be maintained. The log should include sequence number, using area, and date of request. Nomenclature of unit of issue on DA Forms 2930 or automated equivalent will be the same as DA Forms 3161 or automated equivalent. Accountability must be maintained for all documents on which subsistence is issued.

(2) Quantities actually issued to kitchens and/or ingredient rooms will be entered in column d, DA Form 2930 (or on the withdrawal and delivery list). It is then signed by the individual authorized to issue subsistence items and forwarded with the supplies to the kitchen. After verifying receipt of the supplies and checking column e, the recipient (authorized kitchen representative) signs the DA Form 2930 or withdrawal and delivery list.

12-7. Inventory

Inventorying and costing of subsistence are completed under the supervision of the Chief, NCD or his designated representative. The Chief, PSB must know the financial status of the operation at all times as this affects menu planning and may indicate the need for implementing additional cost controls. A written procedure on physical and perpetual inventories will be prepared by each NCD. The NMIS automatically maintains a perpetual inventory on all items in the inventory.

a. Physical Inventory. All subsistence items on hand in the central subsistence storerooms will be physically counted on the last day of each month (or the last working day if preferred). Prior to inven-

tory, unopened items stored in the ingredient room, kitchen, and freezers may be returned to the main subsistence area to maintain accountability in the inventory for these items.

(1) Two teams should be used in conducting the monthly inventory. Reconciliation of counts between the teams should not take place until all counts of a major section are completed by both teams. Final counts will be accepted only after both team counts agree. The Chief, NCD will assign personnel as necessary to assist in the physical inventory. The MTF commander or designee will appoint a disinterested officer or NCO (E-6 or above) from outside the NCD to do the inventory at least during mid-FY and at end-FY to verify the procedures IAW AR 40-3.

(2) Findings of the physical inventory will be recorded on DA Form 3234-R (Inventory Record) and DA Form 3234-1-R (Monthly Inventory Recap) or automated physical inventory worksheet. Inventories should be completed in ink. After reconciliation, a "line-through" will be made and the correct figure entered in ink. After reconciliation, all members of the inventory team will sign the statement: "Inventory completed on (date). All discrepancies were reconciled. Inventory is accurate to the best of my knowledge."

(3) Subsistence receipts and issues will not be scheduled while the inventory is in progress. Receipts during the inventory period will be added to the inventory after both teams have completed their counts. Issues on the day of inventory will note "BEFORE INVENTORY" or "AFTER INVENTORY" on the top of DA Form 2930 or automated equivalent.

(4) Prior to inventory, stocks will be aligned in a manner to expedite inventory. It is possible to preprint an automated physical inventory sheet. Inventory items can be listed by storage location order. Similar items will be stored together whenever possible.

(5) Inventories will include direct-delivery subsistence items such as ice cream, soda cylinders, fresh fruit, and vegetables.

(6) Inventory value is determined by multiplying the number of issue units on hand by the most recent price of the item.

b. Error Between Physical and Perpetual Inventory. If there are significant discrepancies, appropriate action must be taken.

c. Inventory Control. As a guideline, the value of the food inventory should normally not exceed 10 percent of the previous FY's authorized monetary value allowed for subsistence. Inventory value within this guideline reduces handling, loss through spoilage/pilferage, and misuse of space. The projected inventory (equal to opening inventory plus purchases minus net issues) represents the expected value of the inventory if no errors or losses were made. A difference between the actual and expected values

indicates possible errors in record-keeping, issuing procedures, counting during inventory, and/or theft. Because of the large number of transactions each month, some minor errors can be expected. Differences greater than 0.5 percent of the total value for all items under perpetual inventory should be investigated, explained, and corrective action taken.

12-8. Food Cost Management

a. The Chief, NCD is responsible for establishing and maintaining proper security measures and adequate controls over food supplies. Primary emphasis will be placed on food inventories, food purchases, kitchen requisitions, and food issued. The office of the Chief, NCD will maintain documents and records pertaining to food purchased, stored, and issued.

b. Food cost management procedures will be IAW AR 40-3.

c. Monthly authorized monetary value allowed for subsistence should equal monthly value of food receipts. The FY-end value of food receipts should be within one percent of the authorized monetary value allowed for subsistence.

12-9. Disposal of Subsistence

Disposal of subsistence will be IAW AR 30-18. Items disposed of as unfit for human consumption will be annotated on DA Form 1835 or automated equivalent. DA Form 3161 or automated equivalent will be completed IAW AR 30-18 and used as supporting documentation.

12-10. Special Issues of Subsistence

a. Introduction. Subsistence for experimental projects, training, or educational purposes will be used IAW AR 30-18.

b. Operational Rations.

(1) Operational rations required to support medical field training will *NOT* be charged against the MTF subsistence account.

(2) The MTF cash collection and signature head count sheets will *NOT* be used for field training exercises when operational rations are consumed. Ration accountability for field training that incorporates overnight field billeting will be IAW AR 30-21. The accounts of the field feeding operation

will *NOT* be combined with that of the fixed facility. Accountability is the responsibility of the commander conducting the exercise.

CHAPTER 13

THE A LA CARTE MEAL SERVICE

13-1. Introduction

The A La Carte Meal Service is an effective and efficient method that requires adherence to diligent food service management principles. It does not change ration accountability requirements, but will enable the Chief, NCD to more easily and accurately meet those requirements. The A La Carte Meal service is customer oriented and requires an acute awareness of the diner's desires. To be successful, all members of the NCD team must be responsive to patient/customer desires. The A La Carte Meal Service has the following advantages:

- Improved management controls.
- Increased operational costs (formerly surcharge) collections.
- Increased customer focus.
- Increased menu variety.
- Increased customer usage of the dining facility.
- Decreased food waste.

13-2. General Operating Procedures

a. Each MTF that implements or maintains the A La Carte Meal Service must conduct an extensive training program to orient personnel to the system. This training will include the following:

- Progressive cookery.
- Portion control.
- Courtesy to customers.
- Garnishing and food merchandising.
- Control and accounting for subsistence and supplies (to include policy on seconds).

- Food safety and handling.
- Nutrition Management Information System menu pricing system.
- Operation of the cash register system.
- Production planning and leftover control.
- Dining facility sanitation and maintenance.
- Adherence to recipes.
- A la carte pricing.
- Take-out policy.

b. The prerequisites for implementation of a modified A La Carte Meal Service are:

(1) Renovation of existing physical layout to include:

(*a*) Locating cash register at the end of the serving line with the cashier able to observe the entrance.

(*b*) Installing physical barriers between the dining room and serving line to direct patron flow through the cashiers and controlling access to the serving line and food items.

(*c*) Providing multiple cash register stations at larger facilities.

(*d*) Ensuring only one entrance and exit to the serving area(s).

(2) Full implementation of the NMIS including its capability to maintain current recipe prices.

(3) Cash register system including installation, training, and support.

Note

Coordination with the USAMEDCOM Dietetics Consultant is required if modifications are made that impact on cash register system support.

(*a*) The contract/purchase order will include provision for a company representative to provide start-up assistance and employee training for approximately five to seven days.

(*b*) To ensure continual service, the cash register system should be connected to a dedicated electrical circuit that is on the MTFs emergency electrical power supply or to an uninterrupted power source.

(*c*) There should be adequate hardware/software maintenance provisions.

(*d*) The system must:

1 Provide a receipt for each customer.

2 Have an electronic price display that is readable by the customer.

3 Have electronic scales for weighing/pricing selected menu items.

4 Record and summarize meal head-count data (cash and credit transactions by category).

5 Record and recapitulate menu item sales.

6 Record and verify meal card numbers. MTFs will use electronic verification (either the social security number (SSN) or meal card number) for SIK customers. However, for purposes of forecasting, establishing cost control centers, and prevention of fraud, the database should include the SSNs of SIK personnel.

7 Have adequate built-in memory with at least 130 keys to accommodate menu prices/items.

8 Compute operational costs or have the memory capability to store menu item prices, including operational costs.

9 Provide revenue reports, item sales reports, special statistical reports, and SIK status.

10 Verify up to a nine-digit number for cash customers.

(4) Visible posting of standard menu.

(5) Adequate menu pricing support.

13-3. Menu

a. Menus should be seasonal and may be a cycle-type, restaurant-type, or a combination of both. Patient/customer needs should determine the type of menu used. The A La Carte Meal Service requires the offering of a sufficient variety to provide an adequate choice for patients, enlisted soldiers not on separate rations, and paying customers.

b. Main entrees should be a cross section of low-and high-priced items. At least one low-priced entree should be available during the lunch and dinner meals, as well as one "heart healthy" entree, starch, and vegetable. Ensure that the low-priced items on the menu are not continually high fat, high sodium items (such as fried foods and preserved meats) and that selection of low-cost items results in a well-balanced diet. There must be strong consideration of customer preference and food cost.

c. Established menus should change as conditions dictate (use of leftovers, excess). The PPR will reflect what was actually served. Item sales report data should assist in determining the need for menu item changes or adjustments.

d. Local policy will determine which menu items, if any, are available to SIK customers desiring seconds. Patients and SIK customers will not be charged for seconds. Use of a "seconds" key for returning SIK customers will preclude double counting for workload or earnings. Cash customers will pay for all menu items selected.

e. Prices are based on a set serving/portion size as recorded on a computer-generated PPR. Each person serving on the cafeteria and patient tray service line will receive instructions on the proper utensils and portion size prior to the meal. Food items such as chops and fish fillets are often received from the vendor in varying portion sizes. Food serving personnel should either adjust the portion size of the item to meet that specified in the NMIS recipe or adjust the NMIS recipe price to the portion size used. Shift supervisors must strictly enforce compliance with established portion sizes to prevent hidden costs being added to recipes.

(1) *Item pricing*. Selling prices are determined by retrieving the selling price report developed by NMIS. To ensure valid pricing, an accurate recipe and commodity data base is essential. There can be manual costing of a limited number of menu items. Manual calculations for menu items should be an attachment to the NMIS printout. The NMIS printout, with attachments, must be retained for 90 days.

(2) *Selling price*. The selling price, which includes the prime vendor surcharge, consists of the recipe ingredient cost plus a 20 percent condiment factor (garnish, waste, and kitchen supplies). This

is multiplied by the DOD stated operating cost. For example, let us say that the recipe ingredient cost of beef stew is $.65 and the DOD stated operating cost is 133 percent (FY 02). To arrive at the selling price, add the $.65 (ingredient cost) and $.13 (20 percent condiment factor) and multiply the sum by 133 percent (DOD stated operating cost).

NOTE

Rounding of selling prices may be to the nearest nickel. If the selling price is less than five cents, round up to five cents.

(3) *Monthly update*. There should be monthly updating of the selling price (food cost). Price changes should occur by the 10th of the month after posting the previous month's inventory.

(4) *Price averaging*. Averaging the selling price for similar food item categories (vegetables, desserts, soups, starches, beverages) is authorized and encouraged. There should be separate pricing of items that are significantly more expensive than the average price (asparagus versus green beans). Price averaging is used to encourage the selection of a wider variety of foods and speed meal service (see Appendix B).

(5) *Salad pricing*. Pricing of salads may be by:

(*a*) Individual salad item.

(*b*) Averaging salad bar selections from the cycle menu. The cost per serving of each salad item or ingredient (including dressings) on a salad bar is used to compute an average price based on the size of the salad dish or bowl used by the patron.

NOTE

Be aware that customers can creatively "build" salads which could be much more expensive than originally computed for an average price. In such cases, take care to ensure the use of actual self-serve portion sizes in the calculation.

(*c*) Pricing selected salad items individually and offering others on the salad bar which have been price-averaged. There should be individual pricing of entree salads (large salad plates and chef's salad bowl).

(*d*) Pricing by weight. The portion is weighed on scales attached to the cash register. Based on an average price per ounce, the total price of the item is calculated by the cash register. This

option yields the highest accuracy because the customer pays only for what he or she takes. Pricing by weight is also applicable to other menu items (soft serve ice cream/yogurt, deli sandwiches).

(6) *Specials*. To promote the sale of "heart healthy" entrees, the sale of low calorie or light meals at a standard price is encouraged. For example, a daily lunch special might include soup, entree, salad (which is preplated), 1% milk, and fresh fruit. The type of soup, entree, and fruit should change daily. To calculate the standard selling price for the month, the prices of the components of the special must be averaged (see Appendix B). Total moneys collected for specials during the week must be sufficient to recover the actual cost (including the 20 percent collected for condiments) of the food sold as "specials."

(7) *Reduced price sales/leftovers.*

(*a*) The sale of an item below the normal calculated selling price is authorized only to keep the loss of subsistence (caused by discarding of leftovers or forced issues) to a minimum. Reduced selling prices are an exception and are generally a result of factors beyond the control of NCD management. For example, the failure of a large group such as a reserve unit to show up for a prearranged meal. Price reductions should not occur too often or without careful forethought.

(*b*) The price of any leftover item may be reduced up to a maximum of 50 percent of the NMIS price. The amount of the reduction is determined by the Chief, NCD (or designated supervisor) based on the circumstances (type, quality, quantity, and acceptability of the item) and the mix of SIK and cash patrons. When a price is reduced, posting of the menu price as a "special" will help to merchandise the item.

(*c*) Food production controls and progressive cooking must be used to help prevent excessive leftovers. Popular items such as roast beef, spaghetti, and desserts are not normally reduced in price because they are highly acceptable even as leftovers. There may be a reduction in the price of a leftover item if, in the opinion of the Chief, NCD (or designated supervisor), the reduction is more cost effective. For example, limited sales at the regular selling price would result in discarding a significant quantity of the item. Credit for the difference between the regular selling price and the reduced price is not authorized.

(*d*) Reduced price subsistence items are at times offered by the TISA or commissary to prevent or decrease loss to the Government. Generally, the items are perishable and in danger of spoiling. At this option, the Chief, NCD may elect to purchase these items. The selling price of the menu items using these reduced price subsistence items is based on their purchase price.

(8) *Fixed-price meals/set price meals.*

(*a*) A permanent return to the fixed-price meal system is not authorized without the approval of the Commander, USAMEDCOM, ATTN: MCHO-CL-R, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. Commanders are authorized the use of a fixed price meal for Thanksgiving, Christmas, and the Army birthday. The price charged will be the DOD published holiday meal price or the total of the prices of the individual components of the meal. Additional funds are not authorized if the DOD rate is used and it is less than the cost of the food.

(*b*) Under certain circumstances, there may be establishment of a set price meal using a total of the NMIS prices (including operational costs if appropriate) of the individual components of the meal. This may be done if a predetermined menu (or item) is served.

f. Unlike the traditional system, no specific provision is made in the A La Carte Meal Service to charge a reduced price for children's meals. However, the Chief, NCD may consider reduced portions at a reduced price to accommodate children or individuals desiring smaller portion sizes.

g. If take-out meal service is offered, adequate controls will be established to include size and availability of disposables and clear signage. Careful attention to serving sizes and proper coordination between the service and cashier areas must be observed.

13-4. Other Food Service Support

a. The A La Carte Meal Service, unlike the fixed-price system, has the capability of computing the full reimbursement value of food items (food cost plus operating cost) provided for official functions. This type of service is only authorized for official hospital and military functions that can occur without compromising patient and staff feeding (see AR 40-3). MTF commanders should be aware that NCD resources are provided to support the primary mission of feeding patients and authorized patrons. Other food service support should not be considered an additional mission, but, rather, a value-added service. If the primary mission changes, the provision of other food service support may be curtailed or eliminated if additional resources are not made available. MTF commanders will establish written policies and procedures to clearly define implementation procedures for other food service support. Policies will include measures to prevent misuse (actual or perceived) of government facilities, equipment, food, and personnel, and to provide specific guidance on internal control measures, reimbursement and accountability of funds, food, and supplies. Written policies or procedures should also address what support will be available to requesters, besides meal sales and menu item sales. For example, is other food service support at the MTF limited to sales only, or is delivery, set-up, service, and/or clean-up available. When other food service support is authorized and defined by local policies and procedures, full reimbursement (food cost plus operating costs) must be obtained and there must be adherence to the accountability procedures described in this circular. Support for private parties or for the benefit or gain of a private individual or group is prohibited. Food provided may not be resold. Support intended to result in a profit for other Gov-

ernment agencies (appropriated or nonappropriated) or private groups/organizations is prohibited. Food that is not processed, prepared, and sold through the A La Carte System will not be prepared or served using nutrition care equipment, facilities, or personnel (military or civilian).

b. Meal Sales are provided for events such as patient/company picnics, organizational day activities, and training activities in a "field" environment. Meals will be requested by memorandum (or local form) to the Chief, NCD providing complete information on the support required (time, place, menu), the number of personnel to attend, the purpose of the event, and the means of reimbursement. If the request and menu are approved, the selling price(s) will be determined using the NMIS cafeteria selling price or manual procedures described in this circular. The final selling price can be either the individual prices or total of the individual selling prices. If a total of the individual selling prices is used, the actual total must be used, not the DOD fixed-meal price. Selling prices will include operating costs.

c. Menu item sales are individual menu items such as coffee, cookies, and pastries that are approved for official hospital or military functions. Reimbursement will be obtained for all menu item sales. A request for menu item sales will be made by memorandum (or local form) to the Chief, NCD. The request must include complete information on the support required (time, place, menu items), the number of personnel to attend the event, the purpose of the event, and the method of payment. Prices charged will be determined using the NMIS cafeteria pricing report and/or manual pricing methods. All menu item sales will include operating costs. A record of all sales will be maintained. Menu item sales will be entered into the cash register system and reimbursed in the manner described in paragraph 13-4*b*. The sale, however, will be entered into the a la carte cash register system as a single purchase under the officer/civilian category. Only one headcount is entered regardless of the number of people attending the event.

d. Authorized food item sales purchased via fund cite for future reimbursement are authorized. Commanders will ensure the presence of written policies and procedures with MSAO coordination.

13-5. Identification of Personnel Authorized to Subsist

a. Persons authorized to eat in fixed MTF dining facilities are defined in AR 40-3 and local MTF policy.

b. The a la carte cash register system is designed to assist in electronically verifying the entitlement of meal card holders (SIK) to subsist.

c. A separate count of meals served will be made for the following categories of personnel:

(1) Assigned active duty Army and common service (Air Force, Navy, and Marines) not on separate rations (SIK).

(2) Transient active duty Army and common service (guests) not on separate rations (SIK).

(3) Army Reserve not on separate rations (SIK).

(4) Army National Guard not on separate rations (SIK).

(5) Other SIK categories such as Reserve Officer Training Corps cadets and Air Force Reservist as directed by higher headquarters, or determined locally.

(6) Cash customers. A positive means to readily identify other personnel routinely authorized to subsist in the NCD (meal card, identification (ID) badge or card, or magnetically coded card) will be used as prescribed by the Commander, USAMEDCOM, ATTN: MCHO-CL-P. Each MTF will establish procedures for management of the prescribed diner ID method.

(7) Patients. Patients will be identified by their wrist band (issued by PAD on admission) and entered into the cash register according to cash register procedures.

d. All SIK customers must present a valid meal card (DD Form 714), MTF ID badge, or orders that are annotated according to AR 600-38. In addition, SIK guests will also show DD Form 2(Act) (Armed Forces of the United States Geneva Convention Identification Card). SIK guests, reserves, and National Guard will sign DA Form 3032 (Signature Headcount Sheet) or the appropriate electronically generated form.

13-6. Manpower Considerations

a. Implementation of the A La Carte menu pricing system will normally be done within current manpower resources.

b. A La Carte meal services require stability of employees. For example, stability of well-trained cashiers is required because of the training necessary to operate the cash register. If permanent cashiers are hired, job descriptions could include general food service duties during slow and overlap periods. Part-time or intermittent cashiers could also be used.

c. Scheduling for employees should be reviewed and adjustments made as needed. Changes in workload requirements and longer meal hours may require modifying employee hours and break times.

d. The Chief, NCD should work closely with the servicing civilian personnel agency to ensure that policies are IAW civilian personnel regulations, policies, and procedures and that the local union is notified as appropriate.

13-7. Internal Control and Rations Earnings Management

a. *Control Of Subsistence*. Subsistence is requisitioned IAW AR 30-18, AR 40-3, and/or prime vendor specifications. The Chief, NCD must routinely compare income and expenditures to ensure that expenditures do not exceed income.

b. *Issue Of Subsistence*. Total control of the issue of all subsistence items is essential. All items of subsistence, including nourishments (but excluding supplements paid for with nonfood dollars), will be accounted for and documented on appropriate forms. For precise accountability, patient selections and nourishments, along with dining facility patron selections, may be entered in the A La Carte cash register system.

c. *Sales Processing/Reconciliation*.

(1) Change funds will be handled IAW local policies and procedures, and applicable regulatory guidance.

(2) The following guidance will be adhered to in recording sales.

(*a*) SIK personnel will show their meal card, DD Form 2, or MTF ID badge to the cashier. The cashier will then enter the SIK information into the cash register and ring the food items by individual component. A separate SIK guest key will be maintained for those soldiers not assigned to the MTF. If items selected exceed the meal authorization, SIK personnel will not be required to pay the difference. However, repeated incidents of exceeding the BDFA should be noted and investigated by the Chief, PSB. If abuse is evident, report it to the commander. Local policy should be established to address the issue.

(*b*) For patrons not required to pay the full standard meal rate, press the discount key. Operational costs will automatically be deducted from the total.

(*c*) Local policies and procedures will address erroneous cash register transactions to ensure appropriate use of Government funds.

(*d*) Cash collections will be turned in to the MSAO at least once a day (except weekends and holidays). The summarized head count data is turned in on the Daily Facility Summary or equivalent report with the cash collections.

(*e*) Signature head count sheets for US Army Reserve or US National Guard personnel, when used, are submitted to the MSAO for billing purposes.

13-8. Head Count and Cash Register Procedures

a. Head count procedures should ensure that trained cashiers are available for head count operations. Cashiers must be knowledgeable of cash register operations. Shift supervisors will ensure that the correct selling prices for menu items are programmed into the registers prior to each meal. Only designated personnel will be responsible for opening and clearing cash drawers. Cashiers are prohibited from clearing their cash register. Procedures should be written and staffed through Internal Review to ensure the security of Government funds.

(1) *Change fund*. The size of the change fund will be determined by operating experience. It is the responsibility of the Chief, NCD to obtain the change fund from the MSAO or servicing finance and accounting office and to have reasonable change for patrons purchasing meals.

(2) *Inoperative cash register*. If the cash register becomes inoperative because of power failure or other cause, one of the following procedures will be used:

(*a*) Use battery operated calculators with a paper tape to total the cost of food selected by cash customers. A computer printout of individual menu item prices will be updated and maintained, ready for the cashier's use.

(*b*) Use the traditional fixed-price system for the remainder of that meal or until the cash register system is operational. Charge the fixed-price meal rates as published in the annual DOD meal rate message.

b. The MTF will determine which option to use in the event that the cash register system becomes inoperative. Both options require adherence to the provisions in (1) through (4) below.

(1) A sealed packet containing DA Forms 3801 (Guest Log For Meals) and 3032 will be maintained in the NCD safe. Instructions and procedures to be followed in the event of a cash register system failure will be attached to this packet.

(2) Cash customers will be required to sign DA Form 3801 and indicate the amount they paid. Customers who are not required to pay cash (soldiers on separate rations) will sign DA Form 3032 and enter their SSN in the meal-card-number column. Issue, receipt, use, control, and turn-in procedures for DA Forms 3801 and 3032 will be the same as those described in AR 40-330.

(3) DA Forms 3801 and 3032 will be closed out at the end of the meal and turned into the MSAO with the cash collected and the A LA Carte Daily Facility Summary. The normal cycle of nutrition care cash turn-ins should be followed. DA Forms 3801 and 3032 will not be used for more than one meal.

(4) A method for counting and recording patients who eat in the dining facility when the cash register is inoperative will be developed locally.

13-9. Ward Meals and Nourishments

a. Meals served to patients on wards can be accounted for in one of two ways, depending on staffing, equipment capability, and the ability to meet meal deadlines.

(1) To maintain complete accountability for subsistence, meals served to patients on the wards may be entered into the A La Carte cash register system. Patient menus may be entered into the system by either the diet technicians/aides and/or dining hall cashiers prior to the beginning of meal service in the dining room. Late trays should be added prior to the close of the meal period. Immediately after the menus are entered into the register, a cash-register-generated item sales report should be generated to serve as a tally for the patient tray line.

(2) The traditional method of maintaining a tally to quantify numbers of servings needed, and noting overages/shortages on a FPW will be used.

b. Nourishments served to patients on the wards will be accounted for according to local policy.

CHAPTER 14

FOOD PRODUCTION INSTRUMENTS AND GUIDES

14-1. Introduction

The basic instruments used in food production are —

- Inventory ordering documents.
- Recipe reports and recipes.
- Production planning reports.
- Therapeutic worksheets.

The NCD may use DA forms or automated equivalents for any or all of these instruments. Proper preparation and use of these instruments ensures a systematic approach to food production for hospitalized patients and patrons authorized to subsist in the MTF dining facility. Inservice training should be conducted to ensure knowledge and understanding of production, equipment, and administrative procedures. General guides for developing procedures are provided in this chapter.

14-2. Production Planning Documents

Master menus are the basis for primary production worksheets. All purchasing decisions are based on the foods listed in the menus. Inventory ordering documents enable the supply personnel to ensure that specific food items are available. The therapeutic worksheet, PPR, and forecast planning report, or their automated equivalents, are basic planning instruments used for completing other production forms and recording information for future planning. Withdrawal delivery documents are used in determining ingredient requirements from the supply section. An ingredient delivery schedule may be developed and used as a check in the ingredient section and production unit. This assures timely delivery of menu item ingredients to the production area. A list of items not on the daily ingredient list is developed, and a standing requisition is made for these items. The PPR can contribute to the fulfillment of specific objectives. It assures optimum use of cooks, serves as a written reference for daily work assignments, and contributes to PI efforts.

14-3. Master Menus

a. Types of Menus. The master menu includes the regular and therapeutic diets. The menu is a cycle menu and may be repeated for a predetermined time. Cycle menus may be prepared with seasonal

adjustments. It is helpful to develop a calendar of the exact dates on which each week of the cycle will be repeated.

b. Dining Room Menu.

(1) The dining room master menu is the basic weekly menu designed to meet the general nutritional requirements and customer preferences of dining patrons/patients. The Chief, PSB writes it, and the Chief, NCD approves it.

(2) The dining room master menu is developed according to menu planning principles and local procedures. The weekly menu may be distributed to other departments through local distribution channels or other automated initiatives.

c. Patient Master Menu. The patient master menu prescribes the food items to be served to patients on regular and therapeutic diets. RDs write the patient master menu to ensure compliance with the requirements of the ADA, JCAHO, and other regulatory bodies. After the menu is written, the Chief, PSB reviews it for—

- Availability and cost of food items.
- Availability of recipes and equipment needed.
- Workload which the preparation of these items will impose on personnel.

Agreement to any required adjustments or changes can best be reached in a meeting where the dietitians and staff can discuss the needs and problems involved. The patient master menu in which both branches have concurred is forwarded to the Chief, NCD for review and approval.

d. Menu Meetings. This function requires the coordinated efforts of CDB and PSB personnel. Weekly menu meetings are held to review and make changes to the previous week's master menus to improve the acceptability of food items, correct errors, use seasonal foods, and provide variety. The selling price report obtained from point-of-sale systems can be used in making changes to the master menus. Changes can be made in the regular and patient master menus. Deadline dates for making changes on master menus are established in relation to the dates on which food items are requisitioned by the Subsistence Supply Section.

14-4. Menu Planning Factors

a. Dietary Requirements of Hospitalized Patients. The Manual of Clinical Dietetics specifies the daily nutritional requirements to be attained in hospital-planned menus.

b. Cost of Food. The following instruments are useful in planning menus within the authorized cost value of the daily food allowance:

(1) *Food allowance value.* Historical data can be obtained through the cost accountant to determine the monetary value of the MTF daily food allowance for each of the preceding 12 months.

(2) *Current prime vendor or TISA and commissary price lists.* These are useful in determining if a particular food item is within the cost allowance and is available and other special contracts.

(3) *Menu item costing.* This is helpful in determining if a specific menu or set of menus is within the authorized MTF meal days allowance.

(4) *Production planning worksheets.* These (paragraph 14-7*b*) show the ingredients required for the preparation of food items and so serve as guides in determining cost. Locally developed recipes may be costed at any time from development. Costed recipes are recalculated periodically through the NMIS to adjust price changes if they are to be effective in cost control.

c. Acceptability of Foods. The following instruments are designed to improve the overall quality of menu items served to patrons/patients.

(1) Local survey reports of patients' acceptance of foods. Informal suggestions from patients and staff and comment cards.

(2) Meal ward rounds that assess actual patient intakes and provide the opportunity to personally interview patients.

(3) Placement of regional foods into the menu.

d. Factors Affecting Work Distribution. The PPR is essential in planning menus that can be produced with available personnel and equipment. The report shows personnel assigned to various positions in the PSB.

e. List of Special Considerations. A locally-prepared list of special considerations, including those outlined below, can be used as a reference in planning menus.

(1) The workload that preparation of food items imposes on various cooks of different specialties.

(2) Specific days on which a particular section may be short staffed due to leave or other absences.

(3) Availability of regular and special equipment necessary for the preparation of food items.

14-5. Orders

a. General.

(1) Advance orders are estimated quantities of certain subsistence items appearing on menus for food items and ingredients.

(2) The requisitions are prepared for submission to the TISO and commissary officer or prime vendor to alert them to have specific items. A provision is usually made for increasing or decreasing the advance estimates. However, when an item is special ordered for MTF use only, the MTF is ordinarily required to accept the entire order. Local procedures should address this issue.

b. Procedural Guides for Preparing Orders.

(1) Subsistence storage personnel, the Chief, PSB (or designated representative) and the cost accountant should prepare orders jointly.

(2) The TISO, commissary officer, and prime vendor specify the subsistence items and submission dates for orders. Formats for these requisitions are determined locally.

(3) The following documents are useful in preparing orders:

- Forecast planning report.
- Master menus.
- Therapeutic worksheet.
- Production and Planning Report.
- Recipe menu items report.

- Stock record cards.
- Local TISA, prime vendor, and commissary price lists.
- Issue cost summary report.
- Receipt cost summary report.
- Cost center summary report.
- Selling price report.
- Physical inventory worksheet status.

Complete procedures for preparing orders should be developed locally.

14-6. Production Planning Report

a. PPR and Therapeutic Worksheet.

(1) The PPR is intended for all menu item preparations. This tool for production control includes--

- The menu item.
- Time of preparation.
- Quantity to be produced.
- Space provided for personnel assigned to preparation.
- Actual number of servings produced.
- Number of servings consumed/leftover/short.

(2) The therapeutic worksheet provides for all regular and modified diet menu items appearing on all daily menu patterns.

b. Guides for Preparing the Production Planning Report. The Chief, PSB is responsible for preparing and filing the PPR. Staff dietitians, PSB NCOIC, and production manager or cook/supervisor should know how to use the NMIS to prepare worksheets and, in most MTFs, actually complete them. Data should be entered five days in advance of required use; each MTF NCD determines the best time for its operation.

c. Preparation. The PPR for lunch and dinner of one day and breakfast of the following day may be assembled together since breakfast items are normally delivered the afternoon before they are used. Preparation of a PPR for each meal entails forecasting census and number of servings required.

(1) The initial forecast is based on historical amounts of both regular and modified items produced and served. Weekly menu meetings assist in keeping the census accurate. Data to be entered into the computer include the estimated census for regular and modified diets served on the wards and in the dining room and the number of servings required for each food item. The forecast of the census is based on experience, considering the factors which may influence the number of persons to be served. Historical census data in the NMIS is available for use as a basis for census forecasting. Careful study of this record should show census fluctuations due to weekends, holidays, paydays, weather, and the like.

(2) The PPR forecasts the number of servings of individual modified diet items to be prepared.

(3) If a select menu is offered, the NMIS will use historical census data to forecast the percentage of customers who will choose each menu item. Actual counts are converted to percentages and recorded for reference in forecasting the number of servings of each choice to be ordered and prepared when a particular combination of foods reappear on the menu cycle. A la carte cash register receipts provide an exact number of servings of each menu item sold.

d. Other Uses. The PPR contains valuable data for future planning. The actual census for each meal is recorded and shortages or overages of individual menu items are input. Analysis of this information shows whether shortages or overages were caused by--

- An improperly estimated census.
- Improper ratios of choice items.
- Lack of portion control.
- Inaccurate recipe yields.

- Improper cooking.

e. Disposition. At the end of each day, the PPRs are given to the individual responsible for recording the data into the actual census and actual serving areas of the NMIS.

14-7. Inventory Withdrawal and Delivery List and Production Recipes

a. Inventory Withdrawal and Delivery List (Ingredient Delivery List). This is a computerized list. It itemizes the types of ingredients and their amounts required each day of the menu cycle. These ingredients will be delivered automatically to the ingredient room. Ingredient room personnel are responsible for requisitioning any additional necessary items. This list coincides with the production recipe or recipe. In facilities that do not have an ingredient room, the ingredients are delivered to the appropriate food production area. The personnel in that area measure out the required ingredients.

b. Production Recipe. The production recipe is the basic tool of food production.

c. Instructions for Using the Pre-preparation Report.

(1) One copy of the recipe for each menu item listed is printed. The pre-preparation report will be printed two to five days in advance so that advance preparation items are received in the kitchen in time for preparation. Before they are distributed, computerized worksheets will be checked by the systems operator or person responsible for entering data.

(2) Pre-production reports are forwarded to the ingredient room according to a predetermined schedule.

(3) Upon receipt of the pre-production reports, ingredient room personnel requisition supplies and assemble ingredients.

(4) When ingredients are delivered to production units, a designated person checks the deliveries. This is done to ensure that —

- All items are received.
- Ingredients are stored as necessary in the kitchen.
- Ingredients are delivered to work stations.

(5) Production recipes accompany the delivered ingredients and are used by cooks as a guide for preparing menu items. Information regarding portion sizes, recorded on the recipe, is used as a basis for the size of servings used in the dining room and PTS.

(6) After the cook prepares the food item, he records on the PPR any suggested changes in the recipe to improve the quality of the finished product. He also records the actual quantity prepared and leftovers for the menu item. Personnel tasting the finished product should also record comments concerning quality and acceptability.

(7) After the product is prepared, the PPRs are returned to the Chief, PSB. He evaluates the information recorded by the cook and others who tasted the product and corrects recipes which are substandard. Valid data for leftovers and quantities prepared which can be used for future planning are recorded.

14-8. Requisition of Commercial/Convenience/Prepared Subsistence Items

The PSB has routine subsistence requirements that need not be supplied by the ingredient room. These subsistence items may become a standard daily order. They appear daily and are stocked routinely in the production area. Examples of these requirements are —

- Dry cereals.
- Canned and frozen juices.
- Jars of baby food.
- Regular and dietetic canned soups and fruits.
- Various frozen meats.
- Nourishments.
- Formula ingredients, if necessary.

a. Each area maintains its own stock of high use items. Supervisors inventory these items and requisition the amounts needed to maintain preestablished stock levels. The difference between the established stock level and the inventory is the quantity requisitioned.

b. The requisition is forwarded to the Subsistence Supply Section.

c. Subsistence supply personnel fill the order, record quantities issued, and sign the requisition. The requisition accompanies the ordered subsistence to the production unit where it is checked for accuracy and signed by the receiving person.

14-9. Other Useful Instruments

a. Night Supper Menu.

(1) If resources permit, a night supper meal may be served to duty personnel working the 2300 to 0700 hours shift. This meal may also be served to patients admitted to the MTF after normal NCD operations cease. The menu may be planned for a breakfast meal, secondary meal, or main meal, depending on resources available. The regular master menu for the noon meal of the following day is ordinarily used with minor changes as necessary in dessert and other items. The night meal must consist of high-quality food, not leftovers from meals served during the day.

(2) Cash charges must be consistent with the type of meal planned and accountability strictly maintained. The number of persons served the night meal is seldom adequate to compensate for the cost of NCD personnel required to prepare and serve it. If very few persons are to subsist, the serving of box meals should be considered to economize on the number of NCD personnel required for night duty. As another cost reduction measure, the NCD personnel on night duty must be used to the maximum in performing duties which will lessen the workload of the day shift. Such duties include —

- Destaining china and silver.
- Cleaning large equipment.
- Preparing vegetables for the next day.
- Preparing and portioning breakfast fruits and juices.

A call roster could be developed and used in cases where diet restrictions cannot be met by a box meal. At such time, NCD personnel could come in to prepare the special meal or tube feeding.

b. Refrigerator Temperature Logs.

(1) A temperature log must be maintained for each refrigerator. The log is used for checking and recording temperatures.

(2) Preparation of the log sheet includes entering the —

- Period for which it is to be used.
- Number and location of the refrigerator.
- Temperature at which the refrigerator is to be operated.
- Temperature of refrigerator when checked and the initials of person making the entry.
- Corrective action taken if temperature is outside specified range.

(3) The temperatures at which refrigerators are to operate are established by TB MED 530.

(4) A new log sheet is posted on each refrigerator no later than the expiration date of the existing one. All completed log sheets are reviewed, held for one month, and then destroyed unless they contain information for future use.

(5) Each supervisor is responsible for monitoring temperatures and the proper functioning of equipment in his area.

(6) Supervisors responsible for refrigeration units must take the following actions:

(*a*) Make prescribed daily thermometer readings.

(*b*) Log the reading, initial it, and draw a circle around any recorded temperature that is above or below the prescribed temperature stated on the log sheet. They must also determine whether the problem is due to personnel or mechanical failure and call in a work order if necessary.

(*c*) Ensure that the refrigerator door seals securely when closed and that the refrigerator is not overcrowded, especially around the cooling unit.

(*d*) Report unexpected deviations from the prescribed temperature to the subsistence supply NCO. The temperature is expected to rise for a short time when large quantities of food items are first placed in a refrigerator.

(*e*) Make interim checks on a refrigerator when its temperature is above or below that prescribed. If the temperature does not adjust within a reasonable time, report it to the subsistence supply NCO or PSB NCOIC.

(7) Repairs are normally made during duty hours. A request for repairs after duty hours must be justified as necessary for preventing food spoilage due to excessive temperature.

c. Standardized Food Portions. Food portion standards are quantities determined to be appropriate for small, medium, and large portions of various menu items served on regular and modified diets. The portion sizes are expressed in weights, measures, or item counts. The standards also include descriptions of the measuring instruments and utensils needed in dispensing certain food items in accurate portions. The medium portions should be used for calculating menu costs.

(1) *Uses.* CDB personnel use food portion standards in developing dietary menu plans. PSB personnel use them in determining quantity requirements for food requisitioning and production and for dispensing the proper quantities of menu items for tray and dining room services. Food portion standards are the principal guidelines used to prevent overages and shortages in menu items, thus controlling food costs. They are also used to avoid uncontrolled variations in the nutritional value of meals.

(2) *Procedural guides for preparation.*

(*a*) Preparation of food portion standards is the combined responsibility of the PSB and CDB.

(*b*) Standards must be determined for all menu items commonly used in the local master menus and therapeutic worksheets. Menu items are categorized as —

- Appetizers.
- Beverages.
- Bread and rolls.
- Cereals.
- Desserts.
- Eggs and breakfast entrees.
- Juices and fruits.
- Meats and fish and other entrees.

- Potatoes and substitutes.
- Salads.
- Salad dressings.
- Soups.
- Vegetables.
- Sandwiches.

(*c*) Standard portions for each menu item are shown on the recipe so personnel can easily refer to them. Recorded on the recipe are standard portions for medium servings in the dining room and servings for PTS.

(*d*) Suggestions for changes or improvements in food portion standards should be encouraged. Suggestions should be discussed with or submitted in writing to the Chief, PSB IAW local policy.

d. Food Cost Control Records. Controlling the cost of food requires the coordinated efforts of all NCD personnel. Each person must be fully aware of how he can prevent unnecessary food costs. Management personnel must be able to assemble, analyze, and use data to effectively control food costs. Current food costs can be compared to recorded costs of previous menu cycles for month, day, and year. The following records are especially useful in the study and management of food costs:

(1) Recipes.

(2) Reports of studies of recipe yields and cost by food portions.

(3) TISA, prime vendor, and commissary price lists.

(4) Seasonal food availability.

(5) Selling price report.

(6) Use of commercial, prepackaged items.

(7) Monthly inventories and inventory valuations by inventory item categories such as meats, produce, and dry foods.

(8) Receipt and consumption records (stock record).

(9) Meals served and meal day records (nutrition management accounting [NMA] data).

(10) Daily records of NMA data.

(11) Quarterly NMA data.

(12) Charts or graphs which depict the following:

(*a*) Cost of daily issues in relation to the daily authorized allowance.

(*b*) Cost of issues by month in relation to the authorized allowance.

(*c*) Cost overruns from the authorized MTF BDFA.

(*d*) Differences between estimated census and actual census for a period of time.

(*e*) Monthly differences in the monetary value of subsistence items on hand in the central supply storeroom for the current year and previous year.

(*f*) A la carte cash register reports.

CHAPTER 15

FOOD PREPARATION

15-1. Introduction

The food preparation functions of the PSB include –

- Hot and cold menu items of regular and modified diets for breakfast, lunch, and dinner.
- Between-meal nourishments and supplemental fluids.
- Night meals or after hours/emergency meals.

The NCD prepares special holiday meals, provides meals for patients en route to other facilities for treatment, and is involved in organizational day events. Catering for special events may be performed at certain facilities if adequate personnel are available.

15-2. Production Principles

a. Food preparation is a result of thorough planning and organization. Producing and serving safe, high-quality food are the primary goals. The palatability of menu items and their acceptance by patients depends on the production skills of the staff.

b. High-quality food preparation starts with –

- High-quality food.
- Adequate equipment and supplies.
- Skilled personnel.
- Proper supervision.
- Effective guides and controls.

The PPW, personnel assignment schedule, and recipe worksheets, or their computerized equivalents, provide guidance as well as control the production process. Local policies and procedures should be established for accomplishing food production activities.

15-3. Guides for Preparation of Meals, Between-Meal Nourishments and Supplemental Fluids, and Night/Emergency Meals

a. Breakfast, Lunch, and Dinner.

(1) All menu items listed on the FPW are prepared in the main kitchen, beginning at pre-established times shown on the PPW.

(2) Vegetables, fruits, and salads are prepared in a central vegetable preparation room. FSWs are assigned to this duty.

(3) Modified diet and regular diet food preparations are consolidated as much as practical, using recipes which have been tested and standardized for this purpose. This consolidation enhances the quality of modified diet foods and minimizes the labor cost of specialized preparation.

b. Between-Meal Nourishments and Supplemental Fluids. These items are prepared at times specified by the Chief, PSB. A list of required nourishments and supplemental fluids is forwarded from CDB. The production personnel follow recipes provided by the Chief, PSB and the food-handling precautions outlined in TB MED 530. Cooks or PTS personnel should package and label nourishments and supplemental fluids in individual containers to effectively distribute high-quality nourishments to the wards.

c. Night Meal. If warranted and cost effective, the night meal for duty personnel and designated patients is prepared by the night cook as shown on the night meal menu. The use of highly-qualified personnel in this operation is advantageous because they must work with little or no direct supervision. In addition, persons on night duty frequently have to make decisions and fill emergency requests for modified diet foods. They may also be requested to prepare a meal for a patient admitted during the night or a modified diet meal for a patient who will be en route to another MTF during meal time. They must be able to follow procedures in emergencies, such as electrical power failure. The night cook also prepares menu items for the next day that require advance preparation. Some facilities may be able to use the box-meal concept to meet limited night meal requirements.

15-4. Food Production Guidance

a. Organization and Time Management. The menu dictates the required daily production tasks. Good organizational skills and time management are critical for a cook/supervisor. The production manager or cook/supervisor should check with the NCOIC upon reporting for duty. At this time, the production and planning reports, recipes, and special instructions can be given.

b. Basic Production Guidelines. These guidelines include the following:

(1) Comparison of the recipe with the ingredients provided by the ingredient room.

(2) Check to ensure that all required utensils and equipment are available and functional. See appendix D for common measurements for utensils and equipment used in food service.

(3) Preparation of items according to the standardized recipe.

(4) Cleaning as one works.

(5) Strict observation of safety precautions.

(6) Tasting and evaluation of finished products.

(7) Comments on the worksheet/production and planning report which is returned to the NCOIC.

(8) Preparation of hot foods in batches to retain temperature and quality.

(9) Grilling of main items as needed.

(10) Maintenance of gravies at a medium consistency.

c. Nourishment Preparation. Nourishments and supplemental fluids are prepared carefully by prescribed recipes and packaged according to procedures developed locally IAW TB MED 530. Food handling precautions prescribed by TB MED 530 and outlined below must be strictly observed.

(1) Frozen foods which have been thawed are never refrozen.

(2) Ground meats, mayonnaise, eggs, cream cheese, deviled meats, and seafood are never used for box meals or any other purpose unless they are kept refrigerated at all times.

(3) Chilled sandwiches will be open dated with an expiration date and time that does not exceed 60 hours after production.

(4) Chilled sandwiches will be kept at a product temperature of 40°F or below during storage, transport, and service. Sandwiches exceeding this temperature will be discarded.

(5) Milk mixtures and egg mixtures are prepared as closely as possible to the time of consumption and are refrigerated until served.

15-5. Testing a Recipe

a. Introduction. Recipes that the PSB uses are tested, standardized, and costed. These procedures ensure cost effective, standard quantities, and high-quality items. Each nonstandard recipe is tested and standardized for use in preparing a particular menu item for both regular and modified diets. The number of recipes tested during any one period should not be great enough to create a workload exceeding the capabilities of the personnel. Emphasis should be placed on the testing of recipes for the preparation of new menu items as they are introduced on the menu. New products should also be tested to determine whether they provide equal or greater quality with better use of personnel, equipment, and money.

b. Responsibilities.

(1) The Chief, PSB, in close coordination with the CDB, selects the regular and modified diet recipes for testing, standardization, and costing. The assembled data is evaluated to determine if the recipes should become a part of the current recipe file. Any standardized recipe found incomplete or inaccurate is referred to the Chief, PSB for review as to the need for retesting.

(2) Staff dietitians and/or NCOs or dietetic interns, assisted by the production manager or cook/supervisor and cooks, are responsible for--

- Testing, standardizing, and costing recipes.
- Recording and evaluating data.
- Recommending disposition of the recipes to the Chief, PSB.

(3) Members of a selected taste panel, which may include persons from within and outside the NCD, are responsible for evaluating the food items after they are produced.

c. Guides for Testing a Recipe.

(1) Determine the availability of the ingredients required by the recipe. The ingredients used in recipes must be stocked in the Subsistence Supply Section or be approved by the Chief, PSB for requisitioning.

(2) The testing of the recipe is scheduled when the cooks' services can be used without causing a conflict in the daily production workload.

(3) If additional space is needed for the taste panel, the dining room may be used.

(4) Ensure that accurate scales and standard measures of the required sizes are available. Temperatures of ovens and other equipment are checked and needed repairs are made before testing the recipe.

(5) Prepare a recipe worksheet for the quantity to be tested. A large-quantity recipe should be tested with a yield of 25 portions. A household or family-size recipe should first be tested with no change in yield. If the product is desirable, the recipe should be retested for a yield of 25 portions. Use ingredients which will be used in large quantity, such as nonfat dry milk rather than fluid milk, in baked products. The following information should be recorded on the recipe worksheet for use in food item production:

(*a*) The ingredients should be listed in the order in which they will be combined and in a way which makes them easily identified, such as "eggs, hard boiled" or "chocolate, baking, melted and cooled."

(*b*) If as purchased and edible portion weights are the same, only the edible portion weight should be recorded.

(*c*) The unit of weight or the measure count should correspond to the purchase unit. This count is recorded when a volume measure or count is used instead of weight; for example, eggs, milk, or flavorings.

(*d*) Exact directions for preparing and combining the ingredients. The mixing speed and time, if appropriate, and pertinent precautions should be included.

(*e*) Temperature and length of time for cooking, baking, or refrigerating.

(*f*) Pan size, if appropriate, and the amount of mixture to be used per pan.

(*g*) Other information such as the name of the product, name of the person responsible for the testing process, total yield, number and size of portions, and the source of the recipe.

(6) Have the cooks produce the food item following the directions in the recipe worksheet.

(7) Following production of the food item, the labor hours required are entered on the recipe worksheet.

(8) The taste panel members may score the product on a locally-devised score sheet. The food item may be served to the taste panel in standard or small portions. Panel members should score the product when it is prepared in a family-size quantity and again when it is prepared in a larger quantity [paragraph 15-5*c*(5)]. A short presentation should be given by the tester to include the reason for testing the item, recipe source, average portion size, cost per serving, and nutritional analysis per serving.

(9) The product is evaluated for –

(*a*) Flavor, color, and consistency, using an average of the scores recorded by the taste panel.

(*b*) Labor hours required to produce.

(*c*) Suitability for production in large quantities.

(*d*) Storage and shelf-life capabilities.

(*e*) Possible dispensing difficulties.

(*f*) Cost.

(10) The evaluation data and recommendations are recorded on the recipe worksheet which is signed and forwarded with the recipe score sheets to the Chief, PSB for review.

15-6. Costing a Recipe

Recipes should be costed for 25 servings BEFORE the taste panel meets, as cost per portion is an important consideration. Also, it may be possible to substitute less expensive ingredients before the recipe is tested. The recipe is costed using NMIS or on the recipe worksheet as follows:

a. The ingredient purchase unit and the cost per unit are recorded. This information is obtained from the current TISA, commissary, or prime vendor price list, or the NCD cost accounting clerk records. Weights and measures of ingredients should be consistent with the purchase unit.

b. The total cost of each ingredient is calculated and recorded. As an example, the cost per unit is multiplied or divided, as appropriate, by the amount (weight or count) required.

c. The total cost of the total yield is determined by adding the costs of all the ingredients, and is recorded.

d. The portion cost is determined by dividing the total cost by the total yield, and is recorded.

15-7. Standardizing a Recipe

a. After a recipe for a regular menu item is tested, evaluated, and approved, it is standardized for the exact yield of 100 servings. Modified diet recipes are standardized for yields of 10, 25, and 50 servings.

b. Calculations for converting the amounts of individual ingredients listed on the recipe worksheet to the amounts required for the large yields must be made by reliable formulas and with absolute accuracy. The recipe should be retested after it is standardized. The rate of increase for all ingredients may not be the same. For example, the amount of flour, salt, and pepper used for a flouring mixture may not need to be increased for 500 servings as much as the meat or other items to be floured would increase.

c. Standardized recipe data are recorded on computer generated recipe cards. The cards are then forwarded to the appropriate offices in the PSB to be transferred to a recipe worksheet and become part of the recipe worksheet files.

d. The recipe card is filed in the office of the chief or NCOIC, PSB with the other cost study and control records.

15-8. Studies of Food Yields and Costs by Portion

a. Processing and cooking losses must be included in the calculation of quantities of food items needed to produce the specified menu items for a given number of persons. Studies of food items are necessary to determine the yield in standard portions. The nature of the studies varies with the types and uses of food items. For example, a study to determine the number of medium portion wedges which can be obtained from a lemon varies greatly from a study to determine the number of medium portions which can be obtained from 50 pounds of beef.

b. Costing food items per portion is another aspect of these studies, especially if costing has not been part of the testing and standardization of a recipe or when a recipe is not required in the preparation of menu items, for example, honeydew melon.

c. Guidance for conducting studies follows:

(1) Staff dietitians or NCOs, assisted by the production manager or cook/supervisor and cooks, are responsible for making studies to determine food yields and costs by portion.

(2) Data required for the study of a particular menu item can be obtained during normal operations.

(3) Before the weight of the food item is determined, the weight of the pan or dish holding the item must be subtracted.

(4) As the portions are dispensed, samples should occasionally be weighed to make sure the quantity for a medium portion is being maintained.

(5) The number of portions served may be obtained by use of a ticker counter or similar method.

CHAPTER 16

SANITATION

16-1. Introduction

The Chief, NCD must ensure that proper standards of sanitation, pest control, and safety are maintained in the NCD IAW AR 40-5 and TB MED 530. Veterinary food inspections are established by AR 40-657. High-quality food is not only nutritious and palatable, but also clean and microbiologically safe to eat. High-quality food is a result of effective methods of preventing or minimizing contamination. Food production is a process that starts with food procurement, storage, preparation, holding, and service. The type of food service system used has certain stages within the production process that are critical to producing safe, high-quality food. These stages are called critical control points, where a preventive or control measure should be used to eliminate, prevent, or minimize food-borne disease hazards. This prevention identification system is known as the Hazard Analysis Critical Control Point System. Preventive measures will be discussed later in this chapter. The Chief, PSB is responsible for establishing and enforcing production and service sanitation procedures which focus on high standards of sanitation and ensure that preventive measures are followed on a regular basis. These procedures should include monitoring and evaluation methods and may provide data for the PI program. Good sanitation methods are critical to employees at every level. Periodic training is provided and the principles are reinforced continuously. Supervisors should monitor employee compliance and correct mistakes immediately.

16-2. Personal Sanitation

Preemployment physical examinations are required by AR 40-5 and TB MED 530. These consist of a general physical, review and update of immunization profile, eyesight and hearing screenings, and a review of any medical history which would limit capabilities or performance. According to TB MED 530, the installation medical authority determines the extent of preemployment and periodic medical examinations. Local commands or MTFs may establish additional requirements. The NCD standards of personal hygiene for employees should be published as local procedures and be addressed during NCD employee orientation. Understanding is ensured by having employees sign a copy of the personal hygiene standards and placing it in their personnel file. Review these standards during periodic inservice training. The MTF civilian personnel officer and local union steward should be consulted for appropriateness of documentation. Personal sanitation includes personal hygiene and appearance, on-the-job sanitation, and health measures as described below.

16-3. Personal Appearance and Hygiene

a. Personal appearance includes wearing clean and appropriate clothing for the task to be performed. Employees should wear clean uniforms; type of uniform will be established by local

procedures. Low-heeled shoes are appropriate for wear in the kitchen. Open-toed sandals are a safety hazard and do not meet safety standards.

b. Persons working in the NCD should present a well-groomed appearance to patients and patrons. Employees should have clean hair that is confined by an effective hair restraint. Facial hair must also be restrained. Jewelry is restricted to plain wedding bands, emergency medical bracelets, and medical necklaces. Food service personnel cannot wear any jewelry that may come in contact with food during preparation and handling, except those previously mentioned, according to TB MED 530. Nails should be kept clean and trimmed. The use of nail polish is not permitted as it can chip and fall into the food.

c. Sunglasses are hazardous when worn inside working areas. Employees requiring dark lenses in their glasses must have a prescription describing the eye condition and the need for sunglasses.

d. Employees are expected to practice good personal hygiene which includes daily bathing, deodorant, clean underclothing, brushed teeth, and clean, short fingernails.

16-4. Preventive Measures

a. Personnel should wash their hands with soap and water often while working and always before leaving rest rooms and after smoking. Coughs and sneezes should be covered, disposable tissues should be discarded, and hands washed immediately. Hair should be combed only in rest rooms, locker rooms, or lounges. Chewing tobacco or smoking in food preparation areas is prohibited.

b. Food should not be touched by bare hands, but with proper food-handling utensils or plastic gloves. Flatware and cups are touched by the handle; glasses are touched on the bottom. Hands should not touch the part of the utensil that goes into an individual's mouth. Hands should not come in contact with the food while holding the dishes. Dishes in stacks should be carried on dish carts or lowerators, not cradled in a person's arm.

c. Food is eaten only in dining rooms and only during meal hours. Only taste testing may be done in the kitchen. No outside food or unauthorized eating is allowed in the kitchen/serving areas. Cooks and others whose assigned duties require them to taste food do so according to local policy.

16-5. Health Measures

The supervisor is told immediately of any accident or injury occurring on duty, any illness or incapacity to do work, and any cut or sore even if it is not considered incapacitating. The supervisor will send the indi-

vidual with the appropriate paperwork to the emergency room or that individual's primary care provider (see paragraph 6-7). Inoculations and other treatments or tests may be ordered by a medical officer IAW local requirements.

16-6. Preventive Maintenance and Equipment Sanitation

Sanitation and maintenance of the many pieces of equipment used in the PSB are vital to the effectiveness of the operation and the production of high-quality foods. Failure to clean and care for equipment after use can contaminate food or result in an inferior product. Lack of preventive maintenance causes equipment to break down or function poorly and possibly requires more extensive and costly maintenance or repair in the future. Poorly functioning equipment will affect the final food product. The process of operating the equipment should include its sanitation and maintenance requirements. Who, what, how, and when sanitizing and maintenance are done should be clearly stated. Operations not required daily should be written as a separate procedure. Equipment must be scheduled for routine maintenance such as lubrication and replacement of worn parts.

16-7. Sanitation and Maintenance of Facilities and Supplies

Sanitation and maintenance of the physical facilities where food is stored, prepared, and served affects the production of safe, high-quality foods. Dishes, containers, and utensils used in the preparation and service of food must also be kept clean and microbiologically safe. Waste storage areas inside and outside the facility must be cleaned frequently. The Chief, Preventive Medicine (PM) should be consulted for assistance with pest control.

16-8. Preventive Measures Suggested by the Hazard Analysis Critical Control Point System

The goal of this preventive approach is to identify stages of the food production process where food safety risks could occur (for example, stages may include food delivery, storage, preparation, holding, and service). It focuses on identified problems rather than trying to solve all possible sanitation problems. The system suggests performing the following tasks:

- Determine possible hazards and assess severity and risk.
- Work with PM personnel to identify or develop critical control points.
- Develop control criteria and preventive/control measures.

- Monitor critical control points.

- Take immediate action to correct problems when criteria are not met.

16-9. Inspections

a. Inspections are an opportunity to educate supervisors and employees, not an opportunity to alienate the staff. Inspections are performed to continuously monitor and improve NCD operations. High sanitation standards are promoted and enforced among all NCD personnel. The Chief, PSB works closely with the Chief, NCD in establishing a program of formal and informal inspections. Formal unannounced inspections will also be conducted periodically by PM. Frequency of inspections depends on PM staffing and the facility's sanitation record. Guidance for making inspections is contained in TB MED 530.

b. Continuous daily inspections are a responsibility of all supervisors and leaders. They should be taught to identify and readily correct discrepancies. During periods when the workload is at its peak or there are personnel shortages, the first discrepancies to occur are usually in sanitation. Thus, strict compliance with sanitation requirements established by TB MED 530 should be continuously emphasized.

CHAPTER 17

HOLIDAY AND SPECIAL ACTIVITY MEALS

17-1. Introduction

Thanksgiving and Christmas are the two most emphasized holidays in the military as evidenced by the elaborate meals planned for each occasion. The traditional meals are usually prepared for the lunch meal. The NCD is usually responsible for planning holiday meals, but may receive assistance from the Equal Employment Opportunity (EEO) Office in celebrating national ethnic holidays. The EEO Office is an excellent source of cultural information and frequently has decorations or items that can be used in decorating for a theme meal. Dining facility holiday decorations and patient tray favors add to the festivities and improve morale.

17-2. Planning for Holiday Meals

The Chief, PSB must consider several factors in planning for holiday meals. The MTF commander may extend guest privileges to the families of patients and duty personnel. For the traditional Thanksgiving and Christmas meals, an increased holiday allowance of 25 percent is authorized for lunch. Medical and dental officers are encouraged to liberalize patients' dietary prescriptions for that meal. Holiday menus are planned in advance. Holiday menu items tend to be higher cost items. The Chief, PSB must ensure that expenditures do not exceed the additional 25 percent allowance since a la carte operations have few opportunities to develop a surplus of funds to cover the excessive expenses of a holiday meal. Advance ticket sales may allow for more accurate production planning and can assist the Chief, PSB in minimizing over expenditures for the holiday meal. Menu items not usually carried by the TISA may have to be special ordered and will require additional time. Special holiday paper products, patient tray favors, and decorations need to be ordered in advance. Food quantities required may need to be based on smaller serving portions if the menu is expanded to serve more items to each patient. Planning guidelines for holiday meals are as follows:

a. Plan to order everything needed for the meal three months in advance. Follow up on special orders until they are received.

b. Ask for assistance from local schools or girl/boy scout troops with decorations or tray favors.

c. Test new recipes prior to the meal, following the usual taste-test procedures.

d. Develop a production schedule and holiday meal task list and distribute to all affected employees in advance.

17-3. Special Activity Meals

The NCD is frequently called upon to assist with or provide food service for special functions or activities. The NCD can sub-hand receipt out nonexpendable supplies for departmental functions or can coordinate and/or assist in planning an entire function. The NCD may assist with organizational day events. Head-count sheets can be used if it takes place during mealtime when meal card holders would normally eat.

17-4. Planning for Special Activity Meals

The function of preparing and serving picnic and special activity meals is costly in terms of man-hours expended. Local procedures should be established to ensure that the special meal is ready at the specified time and place and that all personnel involved are aware of the activity requirement. The Chief, PSB writes the local procedures to include the following:

a. A reasonable period between the date of the request and the date of the activity. A reasonable period is one that will enable PSB personnel to obtain the required quantities of desired foods and supplies.

b. A request document which includes the following:

(1) Signature of the person authorized to approve such an activity.

(2) Name of the requesting service or organization.

(3) Name and telephone number of the person who initiated the request.

(4) Type of activity for which the meal is requested.

(5) Date, time, and place of the activity and time when the meal is to be served or picked up. Service capabilities will be indicated in local procedures.

(6) Total number of persons to be served.

(7) Name and ward number of each patient to whom a regular diet is to be served.

(8) Name and ward number of each patient to whom a modified diet is to be served and the type of modified diet to be served.

(9) Names of Army enlisted personnel who are to be served a meal and are not on separate rations (no cash charge).

(10) Names and branch of service of other enlisted personnel who are to be served a meal and are not on separate rations (no cash charge).

(11) Names of enlisted personnel, officers, and guests who are to be served meals on a cash basis.

(12) Explanation of the arrangements made for collecting the cash payments and obtaining the signatures of those persons who must pay cash for meals before eating.

(13) Menu or list of food items to be served. If the cost of the menu desired by the requesting service considerably exceeds the value of the ration, the menu should be adjusted to a more moderate price that is consistent with the ration value.

(14) Equipment and supplies besides food desired by the requesting service.

(15) Name of the person who is to sign the hand receipt for NCD equipment used at the site where the meal is served and is to be held responsible for returning it to NCD.

c. Procedures to be followed to ensure accountability of and appropriate reimbursement for subsistence items under the a la carte system.

17-5. Records of Meals

The numbers, by category, of persons served at a special activity meal are recorded on the ration source data worksheet or its automated equivalent for ration accounting.

17-6. Other Special Meals for Patients

a. Requests. Patients en route to other MTFs, diabetic outpatients being seen in the emergency room or elsewhere during meal times, and patients admitted to the MTF during other than normal duty hours may require meals. Such situations may present a special problem for the PSB because of the unpredictable times when they occur. Local procedures that personnel on duty can easily follow are especially important to the effective fulfillment of this function.

b. Guides for Developing Local Procedures. Representatives from nursing service, PAD, and NCD should collaborate in developing procedures which satisfy the requirements of these organizational elements. The following information should be included in these procedures:

(1) Position title and organizational entity of the person responsible for requesting meals from NCD during other than normal duty hours.

(2) Position title of the person who can approve such requests when they are received in NCD during other than normal duty hours.

(3) Method by which the request may be made, in writing or by telephone. Also, a method by which a request may be canceled.

(4) Recommended information to be listed on the request is —

(*a*) Name and ward number of the patient, type of diet desired for the patient, and, if appropriate, the number of meals required for drivers and attendants.

(*b*) Where the meals(s) will be eaten: in the dining facility, on the ward, or en route to another MTF.

(*c*) If appropriate, special measures required, such as isolation or for a pediatric patient.

(*d*) Name of the person responsible for pickup and delivery of the meals if they are to be eaten in a place other than the dining room.

(*e*) How payment for the meals is to be made, for example, in cash or by specified authorized subsistence for meals consumed by other than inpatients.

(*f*) If appropriate, name of the person who is responsible for making cash payment to the NCD and obtaining the signatures on the head-count sheets for persons paying in cash.

c. Provision of Subsistence to Other Departments In the MTF. The NCD is not authorized to provide free snacks or food items to other departments in the MTF. Departments requiring food for blood donors must procure it themselves. Although commercially prepared baby formulas may be provided by the PSB, they are budgeted as supply items IAW OTSG policy and not as subsistence items.

CHAPTER 18

NUTRITION CARE ACTIVITIES REPORT

18-1. Introduction

a. As required by AR 40-3, each NCD will submit a MEDCOM Nutrition Care Activities Report at the end of each month. The MEDCOM Nutrition Care Activities Report is a compilation of operational costing data. This report enables the MEDCOM Chief Dietitian and senior Nutrition Care Specialist to analyze some basic cost and productivity data from a corporate perspective. It is a beneficial tool for the Chief NCD and staff. It provides hard data on current and historical staffing levels, food costs, and patient load. These statistics are vital arguments for resourcing the NCD at the MTF budget review board.

b. MEDCOM Benchmarking Activities (MBA) takes the traditional NCD Activities Report data a step further. It is the goal of benchmarking and the MBA to assist NCD chiefs in achieving efficiencies throughout their operations. Astute managers are always looking for ways to be more efficient. Benchmark programs provide information on best practices within an industry and are a helpful tool in learning from a network of experts instead of "reinventing the wheel."

c. The MBA began in 1997, which is the MEDCOM baseline study year. This is the data that will be used to analyze internal efficiency progress from year to year. In other words, FY97 is the starting point. By participating in the study, the NCD will receive quarterly feedback on facility operations in comparison to other MEDCOM and DOD MTFs. The Best Demonstrated Practices will be highlighted with the aim of stimulating communication and idea sharing. The culmination of the program is ongoing quarterly reports, corporate targets for achieving efficiencies tied to customer satisfaction, trending reports and the identity of subject matter experts to educate and assist NCD chiefs with operations

d. Above all, the program is designed to make NCDs true service organizations and to please customers, patients and commanders at every encounter. It is only a tool, but a very powerful one that highlights our expert managerial skills and creativity and establishes some real accountability for productivity and satisfaction.

e. To make it as easy as possible, the program has been combined with the MEDCOM NCD Activities Report form. Each facility will now be required to submit only one report monthly. There will be no quarterly reports. The information will be calculated at the MEDCOM and reports, with analysis, forwarded quarterly to the RMC Chief Dietitians. The new report will be in a spreadsheet format.

18-2. Data Entry Information

This paragraph describes the fields on the Nutrition Care Activities Report and the source of their data

a. Report heading.

- *FY*. Enter the current FY two-digit number.
- *Name of Facility*. Enter facility name.

b. Meal transactions. Report the number of meals served in each of the customer categories.

(1) *Patients*. The actual number of meals served to patients

NMIS Monthly Facility Summary Report, “Tally of Meals”

(2) Subsistence in kind. The number of SIK (meal card holders) transactions served to military members with meal cards as indicated on your cash register report.

- NMIS Monthly Facility Summary Report, “Tally of Meals-SIK”, Page 3
- Non a la carte facilities: Meal Days (SIK) times three

(3) Cash. The number of cash customer transactions as indicated on your cash register report.

- NMIS Monthly Facility Summary Report, “Tally of Meals-Cash”, Page 3
- Non-a la carte facilities. Meal Days (Cash) times three

(4) Total Transactions. This entry is automatically calculated (Patients plus SIK plus Cash transactions)

Cross reference NMIS Monthly Facility Summary Report, “Tally of Meals-Total, Page 3

c. Total meal days. Enter the number of meal days.

NOTE

A meal day is equivalent to the Army accounting term “ration."

- NMIS Monthly Facility Summary Report, “Total Meal Days," Page 1.
- Non a la carte manual calculation - Daily meals served cafeteria [Weighted factor for each meal period {breakfast - 20%, lunch - 40%, dinner - 40%} plus patient meal days].

d. *Patient meal days*. This is the total patient day census minus bassinets (Occupied Bed Days).

NMIS Monthly Facility Summary Report, “Tally of weighted Meal Days-Beds minus bassinets” Page 2.

e. *Meals served*. This is the total of dining room and patient meals

f. *Meal equivalent*. The cost of a predetermined standard meal. To calculate, –

(1) Use the spreadsheet format provided by the MEDCOM Nutrition Care Program Manager. The calculations on the spreadsheet, a Microsoft Word document, are automatic.

(2) Program into NMIS (see paragraph 18-4*b*(2) for instructions).

(3) Use manual calculation (See paragraph 18-4*b*(3) for instructions).

g. *Account status:*

(1) *MTF BDFA*. This is the authorized monetary value of a meal day as provided by the area TISA or Food Service Advisor. It is also available through the Internet web site at http://www.quartermaster.army.mil/ACES/bdfa/.

(2) *Patient BDFA*. The authorized monetary value of a meal day for patient meal reimbursement. This field is calculated automatically.

- Cross reference with NMIS Monthly Facility Summary Report, “Current Month - Patient BDFA”, Page 4
- Manual calculation - MTF BDFA times 1.15

(3) *Purchases*. Enter the dollar value of subsistence (food) received for the month. This number includes prime vendor contract management fees. (NMIS Monthly Facility Summary Report, " Account Status"- Purchases, Page 1).

(4) *Revenue*.

(*a*) *Total subsistence earnings (earned income).* This includes revenues earned from SIK and patient BDFA reimbursements and cash collections. (NMIS Monthly Facility Summary Report, "Account Status" Earned - Income, page 4) For manual calculation, this is (number of patient meal days times patient BDFA) plus (number of SIK meal days times BDFA) plus cash collected minus surcharge.

(*b*) *Surcharge collections*. Enter money collected in the dining facility to offset operating expenses. The surcharge rate is calculated annually by the DOD Comptroller and is used as a food cost multiplier to determine the selling price. (NMIS Monthly Facility Summary Report, "Surcharge Collections," page1).

(*c*) *Total revenues*. This entry is calculated automatically. It is the total income from subsistence earnings (paragraph 18-2*f*(4)(*a*)) and Surcharge (paragraph 18-2*f*(4)(*b*)).

(5) Amount overspent (+) or under spent (-) (purchases minus earnings): This entry calculates automatically. It is a statement of profit or loss. It is the purchases (paragraph 18-2*f*(3)) minus total revenues (paragraph 18-2*f*(4)(*c*)).

(6) *Opening inventory*. Enter the value of food held in inventory at the beginning of the reporting month. (NMIS Monthly Facility Summary Report, "Account Status"-Opening Inventory, page 4).

(7) *Closing inventory*. Enter the value of food held in inventory at the end of the reporting month. (NMIS Monthly Facility Summary Report, "Account Status"-Closing Inventory, page 4).

(8) *Amount overspent (+) or under spent (-) after inventory adjustments*. This entry is calculated automatically. It indicates the actual value of food consumed and the margin of profit or loss. The formula for this calculation is (purchases minus total revenue) plus (opening inventory minus closing inventory).

h. Labor costs.

(1) *Military - clinical*. Enter the cost of military base pay plus 24% benefits for all military dietitians and Nutrition Care Specialists, to include the Chief, CDB, who perform the following for the majority of their work day.

- Medical nutrition therapy.
- Nutrition counseling and intervention.
- Screening.

(2) *Military - nonclinical*. Enter the cost of military base pay plus 24% benefits for all military dietitians and Nutrition Care Specialists working in the NCD, but not categorized as clinical in paragraph 18-2*g*(1) above.

(3) *Civilian- clinical*. Enter the cost of pay for civilian dietitians, DTRS and Clinical Diet Technicians/Aides who perform the tasks below for the majority of their workday. This figure includes hourly wage times number of hours worked plus 24% benefits plus overtime, holiday pay, and Sunday premium. For example, $10 per hour times 80 hours per pay period.

- Medical nutrition therapy.
- Nutrition counseling and intervention.
- Screening.

(4) *Civilian - nonclinical*. Enter the cost of civilian pay as calculated above for all food service employees not categorized as clinical in paragraph 18-2*g*(3) above.

(5) *Total labor*. This is the total of military - clinical, military - nonclinical, and civilian nonclinical.

i. *Nutritional supplements*. Enter the cost of all nutritional supplements provided to inpatients. This budget line item is usually purchased through the pharmacy budget or a special budget established by the RMO for supplement purchases by the NCD.

j. *Supply costs*. Cost of all nonfood supplies less CEEP and MEDCASE items. (Facility budget tracking procedure for supplies)

k. *Contract costs*. Enter any contractual service costs or Activity Based Costing charges. Examples of this might be preventive maintenance and equipment repairs. This may not apply to all facili-

ties at this time. This information is provided by the RMO or NCD in-house budget tracking procedures for these costs.

l. Staffing. Enter the number of each personnel category that are authorized and assigned. This data field does not take military deployments into consideration. Civilian full-time equivalent (FTE) is defined as a 40-hour workweek. Part-time and intermittent employees are figured by the number of hours worked per week divided by 40 (For example, 20 hours per week equates to .5 FTE; 32 hours per week equates to .8 FTE). If calculated on a monthly basis (two pay periods), add part-time and intermittent labor hours for the month and divide by 160. All military authorizations are equated to one FTE.

(1) Officer authorizations.

(2) Officers assigned.

(3) Enlisted authorizations.

(4) Enlisted assigned.

(5) Civilian FTE authorizations.

(6) Civilian FTE assigned.

m. *Readiness*.

(1) Officer deployments. Enter the number of officers deployed (for example support and sustainment operations, rotational deployments such as Haiti and Bosnia).

(2) Enlisted deployments. Enter the number of enlisted members deployed.

(3) Officer training exercises. Enter the number of officers participating in training exercises (JROTC or two-week field training).

(4) Enlisted Training Exercises. Enter the number of enlisted members participating in training exercises.

n. Outpatient visits. Enter the total number of outpatient visits reported by the PAD on the Medical Summary Report or on the CHCS Ambulatory Data System Report.

o. Cost per clinic visit. This is the cost to operate the Nutrition Clinic obtained from the EASIV repository report from the MEPRS office.

p. *Inpatient Relative Value Unit.* Enter the number of inpatient visits reported to the RMO/MEPRS. This is calculated in the NCD and reported to RMO for the MEPRS Report.

q. Comments. List all significant events to include JCAHO inspections, explanation of unusual increases or decreases in any accounting field, initiatives, community nutrition programs, and outstanding achievements

18-3. Meal Equivalent

a. *Meal equivalent factor definition*. A meal equivalent factor is the cost of an average standardized meal served. It is used to determine cost per meal and labor cost per meal. It equates workload to a fixed value of productive food preparation. A meal equivalent equalizes sales to a set cost divisor.

b. *Meal equivalent (number of meals served).* The number of meals served or the meal equivalent is determined using the formula: total revenue divided by meal equivalent factor. Remember, total revenue equals all subsistence earnings and surcharge

c. *Transaction definition*. A transaction is a customer count. It is an indicator of customer volume. It is usually used for retail sales (cafeteria, cafe, carts) and is calculated on the cash register as each cash transaction occurs. It is not an accurate workload indicator because it assigns the same weight to the sale of a can of soda as it does to the sale of a whole meal.

d. *Meal equivalent versus transactions as workload indicators*. A transaction falsely inflates workload or productivity. The meal equivalent assigns workload to products that actually require a degree of work to be performed. The meal equivalent is widely accepted in industry benchmark programs as a sound cost indicator.

18-4. Meal Equivalent Calculations.

a. *Product definition*.

- *Chicken breast* – Five ounces of the most commonly served chicken breast.

- *Mashed potato* - This is a 4-ounce serving of mashed potatoes. If you cost average starches, input the raw food cost of the cost averaged product.

- *Green beans* – Four ounces of green beans. If you cost average vegetables, input the raw food cost of the cost averaged product.

- *Small Salad* - This should equal 4 ounces of salad if you sell it by the ounce. It would mean the small salad or side salad if they are sold by container.

- *Piece of fresh fruit* - It should be the cost of a single piece of fresh fruit. If you cost average fruits, input the raw food cost of the cost averaged product.

- *Twelve-ounce Soda* - This should be calculated based on the per ounce cost of sodas. Some facilities sell by cup size and do not have a 12-ounce serving. These sizes can easily be converted to a 12-ounce serving by creating a recipe in NMIS for that size. If you only sell canned soda then you should footnote it because it will normally cost more than fountain sodas.

b. *Calculations*. Meal equivalents may be calculated in one of three ways:

(1) *Use the spreadsheet*. Request worksheet document on disk from the MEDCOM Nutrition Program Manager. Once the program is loaded on your computer, double click on the chart. An example of the chart is depicted in Figure 18-1. The chart will convert to a spreadsheet. Input the raw food cost as defined above.

Product Name		Raw Food Cost	Selling Price			
5 oz chicken breast		$ 0.80	$ 1.30			
4 oz mashed potato		$ 0.10	$ 0.20			
4 oz green beans		$ 0.25	$ 0.40			
Small side salad		$ 0.46	$ 0.70			
Piece of fresh fruit		$ 0.29	$ 0.50			
12 oz fountain soda		$ 0.19	$ 0.30			
Meal equivalent totals		$ 2.09	$ 3.40			
Surcharge		1.33				
Condiment charge		1.20				

Figure 8-1. Meal equivalent worksheet (spreadsheet).

(2) *Use the NMIS Program.*

(*a*) Click the "Data Maintenance" button on the "Function Box" screen.

(*b*) Highlight and select the "Meals" object on the "Data Maintenance" screen.

(*c*) Click the "New" button to display the "Meal Detail" screen.

(*d*) Enter a name in the "Meal Name" field. *Do not use temporary* as the meal name.

(*e*) Select the appropriate meal period (lunch or dinner).

(*f*) Click on the "Menus" button to display the "Menus By Course Detail" screen.

(*g*) The system will default to "Dining Hall" in the "Diet Type Menu" data field.

(*h*) Click on the "?" next to "Courses," and select "Entree" (Starches, Vegetables, Salads, Fresh Fruit for the subsequent items).

(*i*) Type "Chicken" (appropriate name for subsequent items) in the "Menu Item Name" field, and click on the "?."

(*j*) The "Menu Item Query" screen will be displayed, click the "Query" button.

(*k*) The "Menu Item Summary" screen will display all of the chicken menu item names. Highlight the item (chicken recipe/food item) to add and click the "Select" button.

(*l*) On the "Menus By Course Detail," click the "Add" button and your item will be displayed.

(*m*) Follow steps (*h*) through (*l*) for all courses and assigned menu items.

(*n*) Click on the "MENU COST" button.

(*o*) Click on "Reset to Primary NMD Items."

(*p*) At the bottom of the screen will be displayed the "Per Serving Menu Totals." This is your meal equivalent price.

(*q*) Click "Close," and then click "Close" again at the "Menus By Course Detail" screen.

(*r*) Click "Save As" (for new) or "Save" (for revision). Click on "FILE," then "Close" at the "Meal Detail" screen.

(*s*) Click "Cancel" at the "Data Maintenance" screen. This step is not necessary any-more

NOTE

Prior to creating the meal, review all recipes and food items for accuracy. Ensure that all ingredi-ents have an inventory link for pricing.

(*t*) Run the "Menu Item Costing" report for all local and reference recipes and food items in the "Report Selection" prior to creating the "Meal in NMIS." It will take less than one hour to complete this report.

(3) Calculate manually. Use the worksheet in Figure 18-2 to compute meal equivalent manually.

FOOD ITEM	RAW FOOD COST	SELLING PRICE (Raw cost x 1.2 x 1.33)
Chicken Breast Entree (5oz)	____________	____________
Mashed Potato (4oz)	____________	____________
Green Beans (4 oz)	____________	____________
Small Salad (4 oz)	____________	____________
Fresh Fruit (small)	____________	____________
Fountain Soda (12 oz)	____________	____________
TOTALS	____________	____________

Figure 18-2. Meal equivalent worksheet (manual).

18-5. Spreadsheet Data Interpretation (What does it all mean?)

The MEDCOM Activities Report is linked to a benchmarking data spreadsheet. The spreadsheet is used to analyze operating efficiencies or performance indicators. Each quarter, NCD chiefs will receive feedback on each performance indicator to identify how they compare to other like-sized facilities. Operating statistics that will be reported are listed below with a definition to assist in interpreting the data. The established standards are the median values for these performance indicators based on type of facility (MEDCEN, large MEDDAC, small MEDDAC). The goal is continuous improvement.

a. Performance indicators

(1) *Total cost per meal*. Food cost plus supply cost plus labor cost plus supplement cost divided by number of meal equivalents equals the raw cost per meal. It does not account for earnings. By adjusting this cost downward, you can theoretically increase your profit if the reimbursement or selling remains constant.

(2) *Adjusted cost per meal*. Food cost plus supply cost plus labor cost plus supplement cost minus total revenues divided by number of meal equivalents equals the adjusted cost per meal. This operational statistic evaluates the cost of a meal after the revenue (earnings) has been applied against the cost.

(3) *Food cost per meal*. Food cost divided by number of meal equivalents served equals the food cost per meal. By lowering food costs, it is possible to decrease total costs to the organization.

(4) *Labor cost per meal*. Labor costs divided by number of meal equivalents served equals labor cost per meal. Since labor is the largest cost factor in any organization, this field is important to planning decreasing cost.

(5) *Supply cost per meal*. Supply cost divided by number of meal equivalents served equals supply cost per meal. Supply costs can be controlled through purchasing policies and strategies.

b. Troubleshooting. What if your numbers are higher than the performance indicators? The intent of looking at these performance indictors is to determine where costs are driven upwards and take measures to lower them or to increase revenues to offset them.

(1) *Total costs*. This can be affected by food, labor, supply and/or supplement costs.

(2) *Adjusted cost per meal equivalent*. Increase the volume of patrons. For example, –

- Open a food cart in high traffic areas.
- Extend your hours for self-serve in the dining facility.
- Solicit and implement ideas from your customers to increase patronage.

(3) *Food cost per meal equivalent*.

(*a*) *Ensure all recipes are accurate*. Cooks often add items to a recipe or increase the amounts of some recipe ingredients. That's not necessarily bad, simply adjust your recipes to accurately reflect all ingredients going into the product.

(*b*) *Practice portion control*. Make sure that servers aren't too generous with portions or adjust the charges to reflect a larger portion size.

(*c*) *Inventory control*. Make sure your facility maintains adequate security. For example, limit regular access to store rooms, refrigerators, and freezers to one or two supervisors. Pull what is needed for meal preparation and then keep food storage areas locked.

(*d*) *Update NMIS pricing*. Update NMIS pricing at least monthly to ensure that the latest prices are reflected on recipes.

(*e*) *Waste control*. Use leftovers appropriately; forecast as accurately as possible.

(*f*) *Staff meals*. Ensure that all NCD employees pay for their meals.

(*g*) *Shop around.* You are not required to purchase everything from your prime vendor. Look for other vendors with more competitive prices.

(4) *Labor cost per meal equivalent*.

(*a*) *Minimize use of overtime*. Instead of automatically paying overtime when positions are vacant due to annual or sick leave, schedule the military in shifts. This will ensure skills maintenance, and your civilians will know that the military are capable and willing to work along side them.

NOTE

This is a temporary fix and is not recommended in lieu of hiring into a required position.

(*b*) *Reevaluate the need to rehire*. Reevaluate the need to rehire into vacant positions; consider redistributing the work to other underemployed workers.

(*c*) *Ensure staff is scheduled appropriately*. For example, your site probably doesn't need two full shifts on Sundays. Patient load and dining facility patronage tends to be lower and the Sunday premium is 25%.

(*d*) *Ensure pay grades actually reflect required workload.*

(*e*) *Part time employees*. Consider hiring a part-time employee instead of full-time.

(*f*) *Crack down on sick leave abuse*. Do not allow civilians to abuse sick leave. If employees develop a pattern of abuse (call in sick the day after a weekend off, day before leave, start "using up" sick leave before retirement), ensure that supervisors counsel them appropriately. Call the CPO Management Employee Relationship Specialist.

(5) *Supply cost per meal equivalent*.

- If your facility has adequate storage, go for the volume discount.
- Shop around for the lowest cost.
- Consider using real dishes for catered events.
- Switch to lower cost items. For example, use paper plates and plastic wrap instead of clamshell containers.

NOTE

Pick up the telephone and talk to your RMC Chief and/or other Army Dietitians. They have experience and may be able to recommend ways to bring your facility's costs down.

CHAPTER 19

EMERGENCY MANAGEMENT PLAN (EMERGENCY MASS FEEDING)

19-1. Introduction

Each NCD must have a plan for feeding increased numbers of patients and duty personnel in emergency and disaster situations. Since Army MTFs vary in size, location, and capabilities, no single emergency mass feeding plan is suitable for all NCDs. The Chief, NCD must work in close coordination with chiefs of other departments in the MTF to maintain an up-to-date emergency management plan (EMP). The Chief, NCD meets with key staff to ensure that all people are informed of current EMP procedures. The Chief, PSB, working in close coordination with the Chief, NCD, therefore, must formulate an emergency mass feeding plan which is compatible with the MTF EMP. The emergency mass feeding plan is tested periodically with the EMP in a mock disaster, and modified as necessary to correct deficiencies revealed.

19-2. Joint Commission on Accreditation of Healthcare Organizations

The JCAHO requires an annual review of the MTF EMP. This plan outlines the requirements necessary to provide continued nutritional support on a limited or expanded basis and provides guidance to staff personnel during times of disaster or emergency. The NCD plans cover —

- Supply of food and nonfood items.
- Field kitchen equipment requirements.
- Procedures to notify and recall employees.
- Specific responsibilities for each functional area.
- Emergency power and/or water supplies.
- Waste disposal
- Emergency menus.
- General policies to ensure coordination with other MTF departments.
- Contingency plan for use in the event that the NCD is destroyed (bomb).

19-3. Guides for Formulation of a Plan for Emergency Mass Feeding

a. Emergency Mass Feeding Plan.

(1) The emergency mass feeding plan should not be so detailed that it is--

- Cumbersome to implement.
- Rendered useless when conditions vary from the assumptions made when the plan was formulated.

(2) The plan should provide basic directions which allow flexibility to meet any emergency.

b. Additional Workload. Directions are developed that coincide with the overall MTF plan for handling additional workloads. The plan should include the increased requirements for space, personnel, food, equipment, vehicles, and other supplies. It is expected that additional, and possibly untrained, personnel would be assigned to augment the regular staff. Productivity of untrained personnel could be enhanced by their assignment to teams with an experienced leader; a single team could be assigned to perform one activity such as cooking, serving, or cleaning.

c. Notification of Personnel. When an emergency or disaster occurs during other than normal duty hours, the first task is to notify personnel as quickly as possible to report to a designated place for duty. The Chief, NCD or a designated alternate initiates the notification system. The emergency plan must contain a notification roster which specifies by position title(s) to whom each individual relays the emergency information as soon as he receives it. A personnel roster specifies the names of persons who occupy the positions listed and their telephone numbers. This must be updated whenever changes occur. Civilian employees need to be told if they are "mission essential" and must come in during an emergency. All military personnel are considered mission essential.

d. Tours of Duty. The regular work schedule may remain in effect unless around-the-clock meals are required. If so, adjustments must be made in the tour of duty length.

e. Facilities and Equipment. Additional dining facilities should be designated in the emergency mass feeding plan. The Chief, NCD should coordinate with the chief, logistics division to survey the facility to determine how many persons could be fed by using existing equipment and utilities. This information and a list of the existing equipment and utilities for each designated facility should be an appendix to the emergency mass feeding plan.

f. Subsistence Supplies and Water. The emergency mass feeding plan must include a list of the most likely sources of subsistence items. The normal stock of food items on hand, as indicated in the

current kitchen inventory and the receipt and consumption records, may be enough to meet needs, at least in the beginning. Suitable menus from which requisitions can be made should be included as an appendix to the plan. The NCD must plan for the provision of drivers and vehicles to transport water trailers. Initially there may be no way to determine if the local water supply is contaminated. Any water known to be potable must be conserved. Instructions for emergency treatment of water should be included in the plan.

g. Menus. The Chief, NCD should plan emergency menus which can be prepared with available equipment. He must be aware of the —

(1) Equipment which will be available.

(2) Types of utilities which are likely to remain following a disaster.

(3) Food items which are considered to be safer than others. Such food items require minimum preparation time and little or no refrigeration. A list of these items and preparation instructions should be included in the appendix with the menus. Although menu items must be somewhat limited and simple to prepare, they must meet the dietary requirements and, to the extent possible, standards for good menu planning. Special consideration must be given to the feeding of infants.

h. Meal Service.

(1) Meal service will depend on the —

- Nature and volume of workload created by the particular emergency situation.
- Number of personnel available to accomplish the workload.
- Extent to which facilities, utilities, equipment, and supplies are available.

(2) Patients and staff must be fed; the staff may not be able to leave their places of duty long enough to go to another location to eat. Plans for meal service should be stated in terms of possible alternatives with the essential requirements for fulfillment of each alternative. For example,

- Bulk distribution of food by food carts to patients and staff in a multi-storied building would require electricity for operation of the elevators.
- Bulk distribution by use of stairways would require large containers in which to place the food and additional personnel to carry the containers.

- Distribution of food to other serving areas would require large containers, vehicles, and drivers.

i. Sanitation. In an emergency mass feeding operation, high standards of sanitation are very difficult to maintain. The everyday problems of sanitation increase many times because of the very nature of the mass operation. Garbage and trash far exceed the capacities of disposal facilities. The water supply and electricity required for sanitation purposes may be disrupted. The emergency mass feeding plan, therefore, must specify those measures which must be instituted immediately to prevent unsanitary conditions. As an example, if paper service is to be used, the Chief, NCD should coordinate with the Chief, logistics division for more frequent procurement and disposal. Arrangements must be made for close supervision of all NCD operations to ensure application of sanitation measures and rules.

j. Records.

(1) The emergency mass feeding plan should contain a statement to remind supervisors to place a log or diary in each work unit. The log would be used to record incoming telephone messages and other information which would be of value later. Such information includes —

- The number of meals served or the amounts of food and beverages served.
- Brief descriptions of problems encountered in performing duties.
- Statements of actions taken to solve unusual problems.

(2) An after-action review of the emergency mass feeding plan will be integrated into the MTF after-action review of the EMP. These will be used to revise and update the NCD and MTF plans.

19-4. NCD Challenges

a. Challenges. The NCD will face challenges such as —

- Damage assessment; where the NCD could move, if necessary.
- Field equipment transportation, setup, and use.
- Emergency power/light source, particularly with limited generator support.
- Continuous feeding hours, especially for staff and volunteers.

- Limited modified diet items and compromised tray delivery capabilities.
- Unknown numbers and types of casualties.
- Increased demand on the supply of paper goods and other items.
- Changes in sanitation capability (dishwashing, trash disposal).
- Uncertain deliveries from local vendors, especially bread and milk.
- Safe handling of perishable food supplies.
- Changes in ration accounting (nonfunctional cash registers, patrons with limited cash).
- Refugee feeding.

b. Operational Flexibility. During an actual emergency, the MTF must cope with many problems over which it has no control such as disrupted or nonfunctional transportation, communications, and public utility services. A continually evolving scenario will require flexibility in response. Extensive planning and continuous reviews by all NCD staff members will provide a basis for response to emergencies, with a clear understanding that adaptability will be the most important and useful response. FM 8-505 may be used as a reference when writing or carrying out an EMP.

APPENDIX A

BUSINESS PLANS

A-1. Introduction

Business and/or marketing plans have been useful in the commercial sector and are effective management tools in the field of dietetics. The military has experienced rapid changes that are expected to continue into the 21st century. Initiatives such as a la carte, subsistence prime vendors, nutrition management information systems, food service contracting, dining facility pricing, and advanced software applications are the beginning of an even a greater thrust into the future. With limited budgets and staffing, planning becomes crucial to successful operations. Nutrition care personnel must think of themselves as business people in the business world; people with a plan--a business plan. Nutrition care operations are in the business of service and sales. Patients, soldiers, professional and support staff, administrators, and dining room patrons are customers whom we must satisfy. Success comes from knowing our customers and meeting their needs. You must understand your role and be prepared to market yourself and your operation through continuous creativity, promoting packaging ideas, selling, and communicating. The business plan is a communication tool which demonstrates your skills, knowledge, and effectiveness to others. Whether you are working in clinical dietetics, production and service, administration, or staff positions, a business plan can advise and justify to administration or a higher headquarters your vision and the requirements of your department.

A-2. Development of a Business Plan

There are many references and styles for business plans. Develop one which will identify your organization's strengths, weaknesses, opportunities, and threats (SWOT). Strengths and weaknesses are generally internal organizational characteristics, while opportunities and threats generally come from external forces and environments.

A-3. Sample Generic Business Plan

The following pages present a generic business plan for the NCD. Explore various possibilities for developing an operational business plan which will be an effective management tool describing your operation. For additional information on business plans, see the following:

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SAMPLE

GENERIC BUSINESS PLAN - NUTRITION CARE DIVISION

1. EXECUTIVE SUMMARY

This is the first section, but write it last. It highlights the most significant parts of the business plan and entices the reader to read on. It should include information on your mission and objectives, your product and why it is unique and profitable, and information about the market for your product.

a. MISSION. Provide nutritional care to enhance readiness; provide accountable, accessible, preventive, and therapeutic care and services. The NCD mission must be in direct support of the MTF commander's mission.

b. OBJECTIVES. To improve business practices, to generate revenues, and to provide and continuously improve quality care and services. The NCD's objective is to improve in all areas of the tread of access, quality, and cost. Examples of appropriate objectives for this tread are:

(1) *Access*

(*a*) Specify limits on the number of patients on a waiting list.

(*b*) Set goals for limiting the number of high and moderate risk patients screened, but not treated.

(2) *Quality*

(*a*) In clinical dietetics, specify outcomes achieved.

(*b*) In production, set goals for the number of meals served or quality standards achieved.

(3) *Cost*

(*a*) Efforts directed at controlling food costs.

(*b*) Actions taken to control labor costs.

c. PRODUCT/NATURE OF BUSINESS. Our role in the military health service system (MHSS) is PREVENTION, WELLNESS, AND READINESS.

d. CURRENT STATISTICS.

________________ Patient diets served

________________ Dining hall meals served

________________ Therapeutic care visits

________________ Preventive care visits

________________ Revenue generated

e. MARKET. Decrease health care costs for MHSS beneficiaries by providing health care to prevent disease. Health care costs increase when care is delayed. We not only provide preventive care, we also provide timely therapeutic care to decrease complications during hospitalization and to facilitate healing. How do you market your plan and services? Here are some suggestions.

(1) Brief the chain of command, other department chiefs and staff, and units on post.

(2) Lobby within and outside the organization.

(3) Publish cost data and profits; report to command.

(4) Show improvements.

(5) Show comparability to civilian hospital food services or food service operators.

(6) Show revenues and surcharges generated.

(7) Publish value of nutritional intervention (outcomes versus costs avoided/costs saved).

f. MILESTONES. Describe phases and time frames of what must be done and expected completion dates to meet your goals. Discuss the unique advantages and strengths which will help the project along. Examples are as follow:

(1) Implement A La Carte Meal Service; extend dining hall hours to generate revenue and increase customer satisfaction.

(2) Nutritional screening (percent moderate and high risk treated with specific "value added" outcomes).

(3) Plan to reduce "WG" grades and salaries (if Sunset Manual permits).

2. FINANCIAL PROGRAM

a. How much money is needed; what will it be used for?

(1) *Costs.* Salaries, food, supplies, equipment.

(2) *Revenue.* Surcharge, DRGs, third party collections.

(3) *Profit/Loss*. Break-even analysis especially if investment is involved (for example, Cost minus Revenue = 0 [break-even point]). Show how the numbers are derived.

b. How will you increase your productivity?

Productivity equals *Output* divided by *Input*

(1) *Increase output.*

- Meals served.
- Timely, effective therapeutic intervention.
- Maximize third party collections from outpatient visits.

(2) *Decrease input.*

- Labor costs.
- Food waste and pilferage.

Assess the needs of your customers. Find out what patients, physicians, and commanders expect from nutritional intervention. Each NCD needs to take an objective look at whether costs of input are greater than the value added to outputs and adjust priorities based on the findings.

3. MANAGEMENT SECTION

Elaborate on SWOT. This outlines experience and past accomplishments in NCD (for example, decreased health care costs, JCAHO, surcharge revenues). The philosophy of the AMEDD is prevention, wellness, and readiness. Our management practices should reflect these goals.

a. BACKGROUND. Organizational chart with clear lines of authority and responsibility; administrative policies which specifically address goals and details of the business plan.

b. STAFFING AND SKILL LEVELS. Number of RDs (military and civilian), number of technicians (military and civilian), number of food service personnel (military and civilian; full-time and part-time). What specific skills or experiences make your staff unique in its ability to carry out the goals set forth by your business plan?

c. CURRENT TOPICS. How will your division –

(1) *Increase revenue*? (for example, surcharge collection, third party collection, DRGs)

(2) *Decrease labor cost*? (for example, increase use of part-time personnel, use appropriate skill levels, use non-select patient menus, shorten menu cycle, self-serve dining facility, bar code inventory)

(3) *Decrease food costs*? (for example, bar coding inventory to increase accountability, just-in-time inventory to decrease waste and pilferage, prime vendor supply)

(4) *Decrease health care costs*? (for example, preadmission screening with intervention to nutritionally prepare patients for surgery; conduct outcome studies to determine effectiveness of therapeutic nutritional intervention in avoidance or shortening the length of time on medications and/or length of stay in the MTF due to complications)

4. FUTURE PLANS

In order to control salary costs, NCD will consist of 50 percent military and full-time civilian staff and 50 percent part-time and when actually employed. The CDB should focus on outcomes of nutritional intervention in terms of decreasing health care costs (for example, decreased serum cholesterol by X points with nutritional intervention, thus, preventing the need for drugs which would have cost $XXXX/year).

5. APPENDIX

Incorporating into quality management plan. We need to tie this into our business plan.

a. PEER REVIEW. Focus on increasing efficiency, therefore, increasing productivity.

b. SCREENING. Focus not only on patients evaluated and recommendations made, but also on the outcomes of nutritional intervention (for example, $$$$ saved? Increased patient satisfaction?).

c. NUTRITION CARE PLANS AND GOALS. What is the outcome goal? Inpatient: weight, albumin, other laboratories, avoidance of infection. Outpatient: Assess effectiveness of nutritional counseling (for example, cholesterol and/or blood sugar reduction, weight reduction, weight gain/improved albumin levels preoperative). Follow up with questionnaires/phone calls to determine effectiveness of learning/behavior change.

d. PATIENT AND DINING HALL PATRON SATISFACTION. How have these improved with business plan implementation?

APPENDIX B

LIST OF PROCEDURES AND ILLUSTRATIVE MATERIALS

Suggest procedures and illustrative materials be developed as required locally for the following:

- Nutrition Care Division organizational chart.
- Job descriptions.
- Procedure for writing production planning documents.
- Procedure for preparing duty schedules.
- Procedure for reporting employee time and attendance.
- Schedule of meal service hours.
- A la carte procedures.
- Cash collection procedures.
- Nutrition Care Division equipment program and purchasing procedures.
- Procedures for requesting equipment repair or maintenance.
- Temperature logs for refrigerators/freezers.
- Procedures for completing kitchen requisitions.
- Procedures for direct delivery of subsistence items.
- Procedures for security of subsistence supply section.
- Vegetable preparation worksheet.
- Procedures for preparing and submitting DA Form 3161, Request for Issue or Turn-in.
- Commissary and other vendors' price lists.

- Procedures for inventory of subsistence supplies.
- Special techniques of cookery for PTS and dining hall service.
- Patient tray service procedures.
- Procedures for delivery of nourishments.
- Meal service procedures for psychiatric, pediatric, and geriatric patients.
- Nourishment and supplemental fluid procedures.
- Schedule of hours for nutrition clinic.
- Procedure for providing and recording diet instructions for inpatients and outpatients (illustrate with completed SF 513 or SF 600).
- Procedures for recording a dietary history with illustration of a completed dietary history record.
- Procedures for conducting dietary analysis.
- Procedures for feeding patients in the medical evacuation system.
- Procedures for night meal operation, if applicable.
- Requests funds for conference travel and TDY.
- NMIS food service procedures.
- Performance Improvement Program.
- Procedures to comply with the hazard communications program.
- Procedures for new employee orientations.
- Procedures for conducting and recording employee training.

APPENDIX C

NUTRITION MANAGEMENT INFORMATION SYSTEM

Section I. OVERVIEW

C-1. What is the NMIS?

a. The NMIS is a production and clinical information system that supports nutrition management operations at DOD MTFs worldwide. This DOD approved migration system replaced the legacy standalone TRIFOOD system in 1995. The Army is the Executive Agent for NMIS.

b. NMIS enables dietetics personnel in the Military Health System to accomplish the mission of providing preventive and therapeutic Medical Nutrition Therapy and Medical Food Management. It supports those functions that are calculation intense and repetitive, and through interface with the DOD Composite Health Care System (CHCS) reduces duplication of data entry.

C-2. Nutrition Management Functions Supported by NMIS

Nutrition Management consists of two major functional components, Medical Food Management and Medical Nutrition Therapy. The following lists the functional activities supported by NMIS:

a. *Medical food management functions*.

- Menu planning and production of regular and therapeutic diets.
- Forecasting the production of regular and therapeutic diets.
- Yield adjusting recipes for production.
- Recipe costing and a-la-carte pricing.
- Inventory management.
- Purchase orders.
- Inventory requisitions.
- Nutrition management accounting

b. *Medical Nutrition Therapy Functions.*

- Patient index system.
- Patient nourishment labels.

- Individualized patient menus.
- Calculation of caloric/diabetic and renal/hepatic diets.
- Monitoring of transitional diets.
- Interface with the CHCS.
- Outcomes measurement.
- Nutrition care plans.

Section II. NMIS MEDICAL FOOD MANAGEMENT

C-3. Introduction.

Medical Food Management is one of the two components of Nutrition Management. This functionality involves the production, management, and service aspects of fulfilling patient diet orders. Activities include procuring commodities and preparing, distributing and serving meals to patients and customers in an MTF.

C-4. Medical Food Management Functions

a. *Data Maintenance.* Data Maintenance contains the core data needed for food management. The five components of data maintenance are food items, ingredients, inventory items, meals, and recipes.

(1) A food Item is an edible inventory item that may be assigned to a menu. A food item contains only one ingredient, needs no preparation, and has associated costs and nutrient information.

(2) Ingredients are the individual elements used in preparing a recipe. An ingredient is usually linked to an inventory item.

(3) Inventory items include both food (edible) and supply (nonedible) items. A food inventory item is an edible or nonedible item procured for use in the NCD. A supply inventory item is a nonfood item.

(4) Meals are lists of food items and recipes served on a particular cycle day, date, and time for various diet types.

(5) Recipes are lists of ingredients with amounts and specific food preparation instructions.

b. *Inventory Management.* Inventory management manages inventory, provides commodity usage data, vendor history, and food cost data using Purchase Orders and Inventory Requisitions.

(1) Purchase Orders create purchase orders based on vendor and day of week, and adds the purchases to the NMIS inventory upon receipt. This function depends on reliable forecasting and actual data.

(2) Inventory Requisitions create four different types of requisitions based on issue destinations, menu cycle, forecasted data, day of week, and the issue transactions from inventory. This function depends on reliable forecasting and actual data.

c. *Forecasting*. Forecasting generates production reports on the amount of regular meals and therapeutic diets to produce for a specific date and meal. The forecast is based on menu cycle data, population census, preferences of the population served, acceptance of menu item combinations, and actual amount of menu items sold/served. This function affects patient menus, inventory management and dollar status. Erroneous data or lack of actual data will result in patients/patrons not receiving meals as ordered, cost overruns, underproduction and customer dissatisfaction, overproduction, and waste.

d. *Recipe Yield Adjusting.* This function calculates the amount of ingredients needed for specific servings of various recipes to be produced for a specific meal and day. It also generates reports on the amount of inventory items needed for meal production.

e. *Recipe costing and a la carte pricing.* Based on inventory prices, this function calculates the prices of over 1500 standardized Armed Forces local recipes, food items, and therapeutic recipes. It also calculates the surcharge and non-surcharge selling prices of menu items served/sold to patients and customers.

f. *Accounting.* Accounting computes the workload, weighted meals, meal equivalents, expenses, earnings, surcharge revenues, inventory values, and account status.

Section III. MEDICAL NUTRITION THERAPY

C-5. Medical Nutrition Therapy Functions.

This component has three major functions.

- Patient Index System.
- Patient Menus.
- Nutrition Outcomes Management.

C-6. Patient Index System.

Patient demographic, nutritional, and medical data can be maintained in the patient index system. Users may display and print reports, and add or modify —

- Basic patient information.
- Meal location.
- Patient location and room number/bed.
- Patient diet orders.
- Admission date.
- Discharge date.
- Patient nourishments.
- Patient preferences/allergies/remarks.

C-7. Patient Menus

A patient menu is a list of items to be served to a patient. In NMIS, a patient menu is generated using the patient's effective diet order for the date/meal, the diet type menu for the diet order (for the cycle day/meal), and the menu pattern (or menu mat) with the diet order. A patient's menu can be individualized based on a patient's preferences and allergies temporarily (good for one date/meal: for example a patient does not like shrimp) or permanently (for all meals: for example a patient does not like fruit or wants tea for breakfast every day) using a patient-specific menu pattern. In addition, the patient's name, calendar date, cycle day, and location and room number/bed is automatically printed on each patient's menu.

C-8. Nutrition Outcomes Management

a. The outcomes module is a tool that supports data collection and analysis of nutrition outcomes. It is a tool that helps provide information for decision making, quality improvement, and clinic management. The patient population report shows trends that can indicate strengths and/or possible weaknesses with the medical nutrition therapy provided.

b. A care plan is developed based on dietary intake assessments, physical and biochemical data, and the determination of nutrient needs for the disease process. Therefore, the care plan contains the data elements that pertain to each patient's laboratory results, medications, anthropometrics, and other values related to the disease process and medical condition. There are two types of care plans:

(1) *Standard care plan*.

(*a*) A standard care plan is based on a single diagnosis and may not be changed by NMIS users. The standard care plan contains data elements associated with the diagnosis that are necessary for performing a patient assessment or are a result of the patient assessment.

(*b*) The data elements apply across multiple categories; for example, demographics, clinical nutritional outcomes/goals referenced by the ADA Medical Nutrition Therapy Across the Continuum of Care. Users may not change the goals set in the standard care plan; however, they may enter intermediate outcomes/goals or change the ultimate outcomes/goals in the patient-specific care plan.

(2) *Patient-specific care plan.* A patient-specific care plan is created when the standard care plan by diagnosis is customized and saved for a patient and his medical condition(s). A patient-specific care plan is only created when it is saved with the patients' name and appointment type. Users may customize the patient-specific care plan to suit the needs of the patient. Data elements not associated with the patient's diagnoses of interest may be added, if needed. Intermediate outcomes/goals and outcome/goal dates may be set for a patient and entered in the patient-specific care plan. If the ADA ultimate outcome/goal for a patient is unrealistic, a patient-specific ultimate outcome/goal may be created.

APPENDIX D

MEASUREMENTS

Section I. COMMON MEASUREMENTS USED IN FOOD PREPARATION

D-1. Volume Measurements

1 pinch	=	1/16 teaspoon
3 teaspoons	=	1 tablespoon
16 tablespoons	=	1 cup
2 cups	=	1 pint
2 pints	=	1 quart
4 quarts	=	1 gallon
8 quarts	=	1 peck
4 pecks	=	1 bushel
8 fluid ounces	=	1 cup
16 fluid ounces	=	1 pint
1 milliliter	=	1 cubic centimeter
1 liter	=	1000 milliliters
1 liter	=	34 fluid ounces

D-2. Weight Measurements

16 ounces	=	1 pound
1 gram	=	1000 milligrams
1 ounce	=	28.35 grams
1 pound	=	454 grams
1 kilogram	=	2.2 pounds
1 kilogram	=	1000 grams

Section II. EQUIVALENT MEASURES OF COMMON EQUIPMENT USED IN FOOD SERVICE

D-3. Can Portions

Can Size		Cups
6 ounce	=	3/4
8 ounce	=	1
No. 1	=	1 1/4
No. 300	=	1 3/4
No. 303	=	2
No. 2	=	2 1/2
No. 2 1/2	=	3 1/2
No. 3 cylinder	=	5 3/4
No. 10	=	12

D-4. Using Smaller Cans to Equal No. 10 Can Size

Can Size	Number of Cans to Approximate One No. 10 Can
No. 303	7
No. 2	5
No. 2 1/2	4
No. 3 cylinder	2

D-5. Scoop Portions

Scoop Number	Level Measure
6	2/3 cup
8	1/2 cup
10	2/3 cup
12	1/3 cup
16	1/4 cup
20	3 1/5 tablespoons
24	2 2/3 tablespoons
30	2 1/5 tablespoons
40	1 3/5 tablespoons

NOTE

Scoopers are also referred to as "dippers."

D-6. Standard Serving Line Pan Sizes (Including Flanges)

Pan Size	Measurement
Full Size	12 3/4" x 20 3/4"
Two Thirds Size	13 3/4" x 12 3/4"
Half Size (short)	12 3/4" x 10 3/8"
Half Size (long)	20 3/4" x 6 3/8"
Third Size	12 3/4" x 6 7/8"
Quarter Size	10 3/8" x 6 3/8"
Sixth Size	6 7/8" x 6 1/4"
Ninth Size	6 3/4" x 4 1/4"

D-7. Pan Capacities (Usable Fluid Ounces)

Pan Depth	Full Size	2/3 Size	1/2 Size	1/3 Size	1/4 Size	1/6 Size	1/9 Size
2 1/2"	240	216	136	96	80	44	20
4"	464	320	208	140	108	64	40
6"	704	464	352	212	152	90	
8"	992		460				

" = inch(es).

NOTE

To determine the number of portions, divide total volume of pan by the number of ounces in the intended portion.

GLOSSARY

Section I. Abbreviations

ADA	American Dietetic Association
AMEDD	Army Medical Department
AMSC	Army Medical Specialist Corps
AOC	Area of Concentration
AR	Army regulation
ASMART	AMEDD Systematic Modular Approach to Realistic Training
BDFA	Basic Daily Food Allowance
CADE	Commission on Accreditation for Dietetic Education
CDB	Clinical Dietetics Branch
CDM	Certified dietary manager
CDR	Commission on Dietetic Registration
CEEP	Capital Expense Equipment Program
CHCS	Composite Health Care System
CofS	Chief of Staff
CONUS	continental United States
CPE	continuing professional education
CPT	Current procedural terminology
DA	Department of the Army
DCA	Deputy Commander for Administration
DCCS	Deputy Commander for Clinical Services
DD/DOD	Department of Defense
DPSC	Defense Personnel Support Center
DRG	diagnostic related group
DTR	dietetic technician, registered
EAS	Expense Assignment System
EEO	Equal Employment Opportunity
EMP	emergency management plan
ETB	Education and Training Branch
FM	field manual
FPW	food production worksheet
FSW	food service worker
FTE	full time equivalent
FY	fiscal year
GS	general schedule

IAW	in accordance with
ICD-9	International Classification of Diseases, 9th Revision
ID	Identification
ISSA	installation supply support activity
JAG	judge advocate general
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JROTC	Junior Reserve Officers' Training Corps
MACOM	major Army command
MEDCASE	Medical Care Support Equipment
MEDCEN	medical center
MEDCOM	medical command
MEDDAC	medical department activity
MEPRS	Medical Expense and Performance Reporting System
MHSS	military health service system
MOS	Military Occupational Specialty
MP	military police
MPT	MOS proficiency training
MSA	Medical Services Accounts
MSAO	Medical Services Accountable Officer
MSO	medical supply officer
MTF	medical treatment facility
NCD	Nutrition Care Division
NCO	noncommissioned officer
NCOIC	noncommissioned officer in charge
NMA	nutrition management accounting
NMIS	Nutrition Management Information System
NSN	National stock number
OB/GYN	obstetrics/gynecology
OCONUS	outside the continental United States
OPM	Office of Personnel Management
OTSG	Office of the Surgeon General
PAD	Patient Administration Division
PBAC	Program and Budget Advisory Committee
PBO	property book officer
PI	Performance improvement
PM	preventive medicine
PPR	Production Planning Report
PPW	Production Planning Worksheet

PSB	Production and Service Branch
PTS	Patient Tray Service
RD	registered dietitian
RMC	Regional Medical Command
RMO	Resource Management Officer
SF	Standard Form
SIK	subsistence in kind
SSN	social security number
SWOT	strengths, weaknesses, opportunities, and threats
TAADS	The Army Authorization Documents System
TAPES	Total Army Performance Evaluation System
TB Med	Technical Bulletin, Medical
TC	training circular
TDA	table of distribution and allowances
TDY	temporary duty
TISA	troop issue subsistence activity
TISO	troop issue subsistence officer
TOE	table of organization and equipment
TPCP	Third Party Collection Program
UCAPERS	Uniform Chart of Accounts Personnel Utilization System
US	United States
USAMEDCOM	United States Army Medical Command
WG	wage grade
WS	Work Supervisor

Section II. Terms

This section contains no entries.

Section III. Special Abbreviations and Terms

This section contains no entries.

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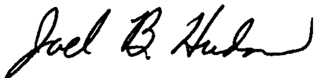

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