EFFECT OF ABSENTEEISM AND TARDINESS ON INPATIENT MEAL SERVICE IN TWELVE MICHIGAN HOSPITALS

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ABSTRACT

EFFECT OF ABSENTEEISM AND TARDINESS ON INPATIENT MEAL SERVICE IN TWELVE MICHIGAN HOSPITALS

By

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This study consisted of an examination of hospital meal service practices with major focus on the effects of employee absenteeism and tardiness on patient meal service activities (tray assembly, tray delivery and soiled tray collection) in 12 selected Michigan hospitals. The hospitals were nonfederally operated, located within a 75-mile radius of Lansing, licensed by the Michigan Department of Public Health and had an inpatient bed capacity of not less than 125 and not more than 700.

The data for the study were obtained through on-site interviews with 18 dietary administrative/supervisory personnel from the 12 selected hospitals. The guide used during the interviews contained both highly structured and semi-structured questions.

The information from this study provides some insights as to a) the variety of techniques that are used in different size hospitals for patient meal services, b) the strategies used to maintain efficient inpatient meal delivery despite employee absenteeism and tardiness and c) the similarities and differences among personnel policies and procedures

established for handling the problems of employee absenteeism and tardiness.

Findings of the study implicate that, regardless of facility size, the policies and procedures pertaining to in-patient meal-nourishment tray assembly, tray delivery and soiled tray collection in Michigan hospitals are similar. Dietary personnel have the ultimate responsibility for all activities related to inpatient meal services. Most hospital dietary departments use the centralized method to assemble inpatient trays to enable dietary administrative personnel to minimize labor costs and to have more precise control of the personnel who participate in inpatient tray services. The only meal service activities that nondietary personnel are apt to be involved in are the delivery of service-ready foods to and collection of soiled trays from patient bedsides.

Absenteeism and tardiness among patient tray service employees are inevitable and bound to interfere with the efficiency with which inpatient meal service activities can be performed. Modifications which must be made to compensate for or cope with poor attendance among employees are daily problems that dietary administrative and supervisory personnel are forced to deal with as effectively as possible. As long as the human related problems of employee absenteeism and tardiness exist new policies, procedures and regulations will be formulated and/or existing ones revised in an effort to minimize their occurences. Of all the service responsibilities inherent in hospital dietary department operations, inpatient meal-nourishment services must be given priority.

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CHAPTER I

INTRODUCTION

The service component is a critical function of a hospital food service operation and will demand increasing emphasis as on-premise food production continues to decrease. It is estimated that, as constituents of total hospital food service, the preparation of the facilities for meal service and the portioning and assembling of service-ready foods for distribution to inpatients, hospital personnel and/or the public consume about nineteen percent of the total direct work time of dietary employees who participate in those activities [24].

As reported by Livingston [20], providing meal services in hospitals is one of the most complex areas of food service because of a) the requirement for an extensive variety of foods to satisfy short term and long term patients and b) the need to provide foods for patients on modified diets. According to Merten [24], the fact that totally automated food service systems have been tried but have been unsatisfactory because of the lack of the "human touch" shows that food service establishments cannot operate effectively without the aid of human resources. Thus, the demand for capable and available personnel who will contribute to the fulfillment of consumers' needs and the attainment of the goals of the

food service department is imperative in the provision of hospital food service. This is particularly true for hospital food service employees whose duties include patient tray assembly, tray delivery and soiled tray collection. If such services are to be rendered effectively, techniques must be developed for efficient meal delivery to all consumers and, most importantly, the required number of personnel must be present and available every day to provide patient tray services as scheduled.

Statement and Significance of the Problem

According to Castillo [4], absenteeism is one of the most serious problems facing hospital management today. On the one hand, it leads to voluntary or nonvoluntary termination of employees. On the other hand, it results in inefficient meal delivery to hospitalized patients. From this researcher's personal experience as Co-ordinator of Patient Food Service in a 565 bed metropolitan hospital, it was clearly evident that absenteeism and tardiness among dietary employees responsible for patient tray services always created severe operational problems in the service of inpatient meals.

Keiser and Kallio [17] have also stated that employee absenteeism and tardiness cause many problems in the food service industry. Since most food service operations are relatively small, the absence of even a few employees has a severe effect on work schedules, duties of other employees, volume of sales and the service efficiency of the operation.

The modifications which must be made to compensate for or to cope with the problems associated with absenteeism and tardiness among patient tray service employees become a major task for hospital food service administrators and must be given high priority. Whether the modifications made are by the development and use of human resources to meet the operational needs for efficient patient meal services or by making temporary changes in the meal service procedures themselves, the problem of choosing among the available alternatives to maintain inpatient meal services as scheduled is one of the most important continual responsibilities of every hospital food service management staff member.

The purposes of this fact-finding survey were to examine the extent to which patient tray service efficiency is affected by employee absence and tardiness in selected Michigan hospitals and how the administrative and supervisory personnel of these dietary departments deal with the problem. The researcher believed that such knowledge would provide insights concerning a) the strategies used to maintain efficient inpatient meal delivery despite service employee absenteeism and tardiness and b) the similarities and differences among the personnel policies and procedures established for handling the problems of absenteeism and tardiness of patient meal service workers.

Assumptions

The assumptions for this study were:

1. Policies and procedures used in patient tray assembly, tray delivery and soiled tray collection vary among dietary departments of Michigan hospitals.

2. Absenteeism and tardiness among employees responsible for patient tray services in selected Michigan hospitals are problems that dietary administrators are facing with increasing complexity.

Objectives

The specific objectives for this investigation were:

1. To identify the methods used in patient tray assembly, tray delivery and soiled tray collection in 12 selected Michigan hospitals with bed capacities ranging from 150 to 700 beds.

2. To examine the current job classifications and specific work assignments of dietary employees who are responsible for assisting in patient tray assembly, tray delivery and/or soiled tray collection.

3. To identify specific work assignments of nondietary department workers whose work responsibilities consist of assisting in patient tray assembly, tray delivery and/or soiled tray collection.

4. To ascertain the behavioral aspects and situational factors of dietary department employees responsible for patient tray services which may be associated with employee absenteeism and/or tardiness.

5. To compare the perceptions of hospital dietary administrative and supervisory personnel concerning the effects of worker absenteeism and tardiness on patient tray services in the hospitals selected for study.

6. To identify and compare the personnel policies concerning employee absenteeism and tardiness of the 12 dietary departments studied.

Definition of Terms

Seven definitions were adopted for use in this study:

1. Absenteeism: The failure of an individual to report as scheduled within a work day to his assigned work area.

2. Tardiness: The behavior of reporting to an assigned work area later than the time scheduled and/or reporting as scheduled but not ready to perform the assigned duties.

3. Dietary Administrative or Supervisory Personnel: The person(s) who is (are) responsible for selecting and supervising labor personnel assigned to inpatient tray assembly, tray delivery and soiled tray collection.

4. Individual who assists in Patient Tray Service: A dietary employee, or one who is employed by another department, or a volunteer worker whose work responsibilities include assisting in patient tray assembly, tray delivery and/or soiled tray collection.

5. Volunteer: An unpaid individual who works in the hospital and whose responsibilities include assisting in patient tray assembly, tray delivery and/or soiled tray collection.

6. Patient Tray Service: The meal service system for tray assembly, tray delivery and soiled tray collection for hospitalized patients.

7. Tray Service Modifications: Changes made in worker assignments and/or methods of patient meal service when absenteeism or tardiness occur among individuals responsible for assisting in patient tray services.

CHAPTER II

REVIEW OF LITERATURE

According to Doyan [8], about 14 million meals are produced, transported and served daily to hospital patients and employees by food service departments of United States hospitals. In the view of Merten [24], the hospital food service department which deals with patient menus, employees, equipment, time and capital is complex and multifaceted. All components of the hospital dietary department operate within the constraints of the colossal structure known as the health care delivery system.

The writings of Puckett [25] indicate that each hospital food service department has its own unique operation. Its policy and procedure manuals are adapted to meet the needs of the hospital as well as the department. The number of policies and the procedures differ according to the size of the hospital, the administration and the philosophy of the department. Furthermore, departmental organization, community environment and the socioeconomic system of the community also influence departmental policies and procedures.

Today, hospital food service departments along with other mass feedings operations are experiencing the effects of absenteeism and tardiness on labor cost, production and efficiency of meal services. According to Halperin [13],

absenteeism among employees is a national disgrace and is a problem that appears to be growing in intensity.

Hospital Food Service System Components

A hospital food service system is characterized by objectives, resources and operational subsystems [3]. As reported by Merten [24], all components of the food service system are critical to its effectiveness. Much difficulty would be encountered if one were to try to assign priorities or designate one component as more important than another. However, efficiency and effectiveness of the system are improved if the interactions and interrelationships of subsystems are integrated.

Of the components of a food service system, labor productivity and effective and efficient layout and design are of great importance to managers of hospital food services [3]. Managers must coordinate labor, food materials, facilities (equipment and space), information (data), energy, time and money to optimize the processing and service of high quality food. Consequently, human capability is a critical resource and an extremely variable one. In fact, Buchanan [3] has indicated that the greatest untapped resource the managers of food service departments work with may be human capability. He also advocated that the productivity of individuals depends primarily on their ability and motivation to perform and is largely influenced by their working conditions. These conditions usually fall into three general categories:

a) social conditions, b) work scheduling and c) the physical environment in the work place.

Livingston [20] stated that study of the interactions of the operational parts of a food service department requires a "system analysis" approach. The goal of such an analysis is the development of a successful "food service system." He defines this system as "an integrated program" in which the procurement, storage, preparation and service of foods and beverages, and the equipment and methods required to accomplish these objectives are fully coordinated for minimum labor and optimum customer satisfaction, quality and cost control. Bowman [2] and Donaldson [7] have emphasized that the service and distribution systems for patient meals must be based on proper inputs of patient needs. The delivery system must also be closely coordinated with the pickup of soiled trays so that mealtimes do not overlap with critical periods for other hospital services.

The system of personnel management is another one of great importance in a hospital food service department. Unionization, workman's compensation laws and regulations from governmental agencies are encroaching upon the load of administrative tasks. As the administrative tasks of dietary departments increase, the managers of these departments realize the need for an adequate impersonal system of control [9].

Although the number of individuals needed to operate a hospital food service department has never been well-defined,

Kotschevar [18, 19] reported that hospital dietary departments use too much labor in the production and service of foods. He indicated that the production efficiency rate of dietary food service labor personnel has been said to be about 47 percent compared with a desired rate of 80 to 85 percent.

Trends in the Hospital Food Service Industry

In the latter part of the 1960's numerous authors in the field were focusing upon the problems, concerns, and developing trends of the food service industry. With the rapidly rising demands for increased production, quality and quantity of service and the maintenance of an optimal balance among food cost, labor and space, Donaldson, Zolber [7] and Greenway [11] reported that the hospital food service industry was embarking on a vigorous search for methods of sharply increasing worker productivity. In some instances, labor-saving changes were proving effective in both the preparation and service of foods. However, Donaldson warned that the ability to change while achieving the objectives of the department remains a grave responsibility of managers of hospital food service departments.

In 1966 Livingston [20] cited three important emerging trends in the operation of food service systems: a) the separation of preparation from service (both in time and in place), b) the centralized mass production of food items for later reconstitution and service and c) the internal stress

for organizational change brought about by a new kind of personnel, the knowledge worker, who has goals for personnel achievement and whose social, physiological and psychological needs must be more fully understood and satisfied. Two years later (1968) Donaldson [6] further stated that certain economic, sociological and political factors in the environments in which food service operations are managed were bringing about a trend toward more precisely controlled production, processing, assembly, distribution and service of meals.

In 1970 Doyan [8] reported that major automated systems for assembly, transportation and delivery of foods in hospitals were the monorail, the automatic car system and the automatic food supply system. He defined the monorail and automatic car systems as material delivery systems that carry all kinds of supplies besides food. In contrast, the automatic food supply system is one designed especially for the transport, assembly and delivery of food. Although the systems are expensive, ranging from $1,000 to $10,000 per bed and more, they present alternatives to the antiquated delivery methods that contribute to the high cost of labor in hospitals. In the opinion of Doyan, spiraling wages have made the use of automatic food production, transport and delivery systems not only desirable but necessary.

In his 1969 review Harris [14] indicated that, in addition to concern for economic productivity, several reports from European countries emphasize improved mechanization and

automation of operations with automatic feedback. He reported that at the University of Cologne Medical Center, some of the traditional problems of food production, service and control have been solved through the use of prepared frozen foods, point-of-service finishing of foods, automatically dispatched horizontal and vertical material handling systems and combined sequential operations to reduce waste motion and time in handling and transferring products during preparation, storage, assembly, distribution and service. The Noss food service system developed by Wasserle of Hanover, Germany incorporates automatic preparation and handling of foods, continuous processing equipment, streamlined material floors, efficient distribution with electronically controlled guidance and data processing for various functions. Computer-oriented management information systems are also being designed to provide specific information for management planning, decision making and control.

Effects of Absenteeism and Tardiness on Hospital Food Services

According to Halperin [13], absenteeism causes many problems in the food service industry. The absence of even a few employees has a serious effect on work schedules, duties of other employees, service efficiency and sales volume. Generally management has a greater stake in absenteeism than labor. When employees are absent service inefficiency results, there is a delay in production schedules and subsequent grievances occur. A shortage of

help in any one area of a food service department may mean assigning inexperienced personnel to the area in order to try to keep production at its customary level or employees will have to double up on jobs. When this occurs, touchy situations may arise which can trigger many time consuming grievances. Inevitably, absenteeism reduces the efficiency of the total operation.

Smardon [26] believes that absenteeism and tardiness can be contagious. Just as any contagious disease, if absenteeism and tardiness are not checked other employees are apt to take advantage of the laissez-faire attitude of the responsible administrator and "follow suit." Hence to minimize or at best to eradicate absenteeism and tardiness, policies and guidelines relating to these problems must be established and close adherence to these policies and guidelines becomes a must.

A monthly absenteeism rate of more than 4 percent is costly to management. For every twenty-five employees, an extra employee is required to take care of the average absence. There appear to be four types of employee absenteeism that are very costly to management: a) Friday, Monday and day after payday absences, b) the absences of the employee who is not well over a relatively long time, c) the "vacationer" who takes a week off or repeated long weekends and d) the moonlighter who is too tired to come to work [26].

Causes of Absenteeism

The causes of absenteeism vary from place to place and many authorities have tried to classify them under different headings. One very simple way of classifying absence can be based on the theory reported in 1963 by Gaudet [10], which states that good attendance is found where employees are able and willing to work. However, he stated that many times this oversimplifies the case.

According to Gaudet [10], others have devised more complex classifications. One researcher at Ohio State University differentiated among types of employee absences as follows: a) absences caused by conflicting motivations of the worker, b) absences caused by physical incapability of the worker, c) absences resulting from interfering personal obligations and needs of the worker, and d) absences encouraged by wage conditions. In another method of classifying absences, those caused by conditions inherent in the job have been segregated from others. These causes include plant or departmental working conditions, methods of supervision and similar related factors, some of which are clearly under the control of management. Other conditions (external factors) may include such items as poor transportation or lack of other community facilities which top management has tried to improve. However, most of the external factors are related to the employee's ability and willingness to come to work. Management can do little about his "ability" to work, and the few research studies

which have been conducted in the area of "willingness" seem to indicate that supervisory behavior is the single greatest factor.

Many management specialists argue that illness absences are more important than other types of absences because they are likely to be preceded and/or followed by a day or two of substandard work. Because this may be true, it is necessary to check upon the productivity of workers preceding and following all types of absences.

The relationship of sickness absence to other types of employee absence varies greatly. These variations are largely accounted for by the complete lack of agreement on the definition of sickness absence. However, several other factors may also account for these variations. The type of benefit plan, or changes in an existing benefit plan, will affect the amount of the company's sickness absence as well as economic conditions, male-female ratio, age of employees and type of industry [5]. Climate will also affect statistics on sickness absence; many studies support the widespread belief that this type of absence increases in the winter months.

A significant study by Mann and Sparling [23] dealt with the relation between employee attendance and the behavior of supervisors on the job. Their findings indicated that both white and blue collar worker absences are related to how the employees felt about their supervisor and the

other people in their work group. They also found that low absenteeism was associated with better feelings toward fellow employees and in some groups toward financial and job status.

One of the few attempts to investigate the hypothesis that high absence rates are associated with a fixed group of employees was conducted by the New York telephone company [15]. The results of this 1956 investigation indicated that telephone employees who had many days of absence during their early years of service continued to be problems in this respect throughout their years with the company. Although many additional factors might also have been involved, this study does give some support to the concept of absence-proneness.

Methods Used to Control Absenteeism and Tardiness

A 1960 survey of personnel executives in 160 companies made by the Bureau of National Affairs, Inc. [27] indicated that about half of these firms try to control or reduce absenteeism and tardiness in the traditional order: warning, layoffs (sometimes) and discharge. Another approach to company disciplinary practices was found in a study made in 1957 by Malott and Hass [22] of the American Management Association in which 129 personnel officers were asked to specify the reason(s) for firing their most recently terminated employees. A surprising fact disclosed in this survey was that excessive absence had been the most common single cause

for discharge. More than half the discharges were made because the individuals "lost too much time."

Organized labor union attitudes toward employee attendance changed during World War II. Unionized companies have reported that they get help from unions. In the survey conducted by the Bureau of National Affairs [27], it was found that a vast majority of the unions actively assisted in controlling employee absence. Such assistance was in the form of admonitory talks by union representatives with chronic absentees, refusal to defend habitual offenders, investigation of the causes of absenteeism and working cooperatively with management in the formation of disciplinary procedures.

Gaudet [10] reported that in many companies, when particularly knotty problems of employee absence arise, they are settled by precedents that are legal or, in any case, well established. According to Ahern's [1] findings, in order to discharge an employee for habitual absenteeism and to have the discharge upheld (in most arbitration situations), the company may be required to supply answers to the following questions: How often has this employee been absent? What about the total number and the duration of the absences? Over how long a period have they extended? What is the overall rate of absenteeism in this company? What are the absence records of the employees having the most absences?

Besides the usual three-step procedure (warning, layoff and discharge) there is a wide variety of techniques

used to discipline employees with poor attendance records (absenteeism and tardiness). As reported by Smardon [26] methods used to control absenteeism are to confront the employee who is excessively absent and point out the expectations of the organization. Kearns [16] believes that a realistic program which deals with the problem should be developed and properly maintained. Other more specific measures used by some organizations are suspension of pay increases, decrease of seniority privileges, loss of benefits for unexcused absences, loss of overtime, placing offenders on probation, reduction of employee's paid vacation benefits and holiday pay is not granted to employees who are absent on the day before or after a holiday.

In other companies or institutions, the reward system is used to control poor attendance among employees. Rewards such as cash bonuses and/or additional paid time off for good attendance are given to employees [12]. However, the literature shows that more disadvantages have been cited for rewards than for punishments. It appears that certain built-in factors in bonus plans are responsible for some difficulties. For instance, experience has shown that the length of the period required for "good" or "perfect" attendance should not be very long. If it is too long employees tend to lose interest and resort to their past attendance habits. Another criticism of rewards is that their effects are of short duration.

Another technique, cited by Gaudet [10] and reported

with increasing frequency, is aimed at reducing off-the-job accidents. The traditional devices that have been used are posters on the company bulletin boards, prizes to school children for essays on accidents, articles in the company's paper and letters to the homes of employees. In another situation reported by Castillo [4], special programs and activities are provided to improve employee morale and attitudes and to promote physical fitness.

CHAPTER III

METHOD OF INVESTIGATION

The method used to obtain data for this descriptive study consisted of on-site interviews with dietary administrative and supervisory personnel at the hospitals selected for study. Note taking was the technique used for recording the information gathered during the interview sessions. All interviews were conducted by the investigator.

The Survey Sample

The sources used to identify the twelve Michigan hospitals chosen for study were the 1974 Directory of Hospitals, Nursing Care Facilities, Home for the Aged and the October 1974 Statistical and Directory Issue of Michigan Hospitals. Five primary selection criteria were established to identify specific hospitals for consideration: a) facility geographically located within a 75-mile radius of Lansing, b) in-patient capacity of not less than 125 and not more than 700 beds, c) a minimum average daily inpatient census of 100, d) facility provides general medical and surgical care for inpatients, and e) the hospital is nonfederally operated and licensed by the Michigan Department of Public Health only. This preliminary screening procedure identified 22 hospitals which satisfied the primary selection criteria.

In order to obtain a representative study sample with respect to hospital size, the preliminary list of 22 hospitals was subdivided into five bed capacity ranges: below 200, 200 to 399, 300 to 399, 400 to 499 and 500 to 699 beds. None of the 22 hospitals fell into the 300 to 399 bed classification. Therefore, on the basis of hospital size, three hospitals from each of the four remaining classifications were arbitrarily selected for study. Insofar as possible, consideration was given to selecting the three facilities with the same size classification from different geographical locations.

The Survey Instrument

A seventeen-page interview guide was prepared to assure collection of comparable data from the twelve hospitals selected for study. The guide contained both highly structured and semi-structured questions. In each area of inquiry one or more structured questions were introduced first. Then, in order to probe more deeply, a series of open-ended questions were used to obtain more detailed responses.

The interview guide was divided into five parts and designed to obtain data relative to a) the respondent(s); b) the operational characteristics of the dietary department; c) the manpower needed to provide patient tray services; d) the personal characteristics and job responsibilities of dietary employees who assist in patient tray service activities (tray assembly, tray delivery and soiled tray collection)

and e) the modifications made in patient tray service procedures when there is absenteeism and/or tardiness among individuals responsible for patient tray services. The format of the guide was designed to enable the interviewer to record the interviewee's responses directly on each page and to minimize the amount of recording time required. A copy of the interview guide developed for the study is included in the Appendix, page 120.

Part I. The Respondents

This part of the guide contained two items of inquiry concerning the interviewee's present position title and professional experience. The experience component elicited information pertaining to the respondent's years of employment in the food service field, length of employment in his/her current position, and his/her area of educational and/or training specialization.

Part II. Operational Characteristics-Dietary Department

The questions in this section sought to identify the general operational policies and procedures of the dietary department. The ten factors discussed with the interviewees focused on:

1. the system of management
2. employee unionization
3. average daily inpatient census
4. types of inpatient meal services provided
5. inpatient meal service patterns and schedules

6. types of menus needed for inpatient diets
7. food purchasing policies
8. method(s) of patient tray assembly
9. method(s) of service-ready food delivery and soiled tray collection
10. personnel responsible for delivering service-ready food to the patient area(s) and to the patients themselves.

Part III. Manpower Needed to Provide Patient Tray Services

The first question in this part of the interview guide concerned the total number of full-time and part-time hospital personnel needed to provide patient tray assembly, tray delivery and soiled tray collection services detailed according to worker departmental affiliation. The second question pertained only to the dietary department employees who assist in patient tray service activities and the number of hours per day each employee participates in tray assembly, tray delivery and/or soiled tray collections.

Part IV. Personal Characteristics and Job Responsibilities of Dietary Employees Assigned to Patient Tray Services

The first question in Part IV dealt with six personal characteristics of the dietary labor personnel: sex, age, marital status, number and age range of children per household and the percentage of employees who had dependents other than children at home. Information about the educational levels of the labor personnel and administrative staff

with regular patient tray service duties was also requested. The second question sought information pertaining to the major work assignments relating to patient tray service activities performed by dietary employees and by nondietary employees.

Part V. Modifications in Patient Tray Service Procedures Due to Employee Absenteeism and Tardiness

The final section of the interview guide consisted of seven questions which focused on the effects of employee absenteeism and tardiness on patient tray services, the type of procedural modifications usually made in order to cope with and/or compensate for such irregularities in employee attendance behavior, and the departmental and/or hospital policies related to employee attendance irregularities.

Pretesting the Survey Instrument

The investigator's Faculty Guidance Committee members reviewed the interview guide for clarity and completeness. Recommendations of the reviewers were incorporated into the final revision of the guide. As a pre-test, a) to determine the length of time required to complete an interview, b) to test the terminology and the logic of the sequence of questions used in the guide, and c) for the investigator to practice her interviewing technique, two professional dietitians were interviewed. At the time of the study, one was managing dietary personnel in a hospital in Cleveland, Ohio and the other was formerly employed as a managing dietitian

in a hospital in Detroit, Michigan. Both professionals had had considerable experience in the area of managing hospital dietary personnel involved in patient tray services. Each interview required approximately one hour to complete.

The Interview Procedure

The chief administrative officers of the twelve hospitals selected for study were initially contacted by telephone, informed of the nature of the research study to be undertaken and their cooperation solicited. After the initial contact by telephone, a follow-up letter detailing the objectives of the study and requesting the participation of the dietary administrative and/or supervisory staff in the interview sessions and a complete outline of the proposed project were mailed to each hospital. A week later, the hospital administrators and their respective dietary department heads were contacted by telephone to confirm their willingness to participate in the project and to schedule the interviews.

All personal interviews were conducted by the researcher between March 13 and 27, 1975. At the beginning of each interview, the interviewee was given an overview of the content of the interview guide and the approximate amount of time needed to complete it was indicated. Any questions the participants had relative to the project were discussed before the interview sessions began. At the conclusion of the interviews, the interviewees were thanked for their

willingness to assist with the project and were promised that, when available, a copy of the study results would be sent to all participating hospitals.

Analysis of the Data

The interview data from the 12 hospitals studied were hand tabulated. Factual response data were compiled and compared for similarities and differences according to hospital location, facility size and management responsibility of the dietary department. Opinions of the dietary administrators and supervisory personnel concerning the behavioral aspects and situational factors related to absenteeism and tardiness of dietary department patient tray service employees were summarized and compared within and among hospital size categories, types of management control, and organized labor status of employees. Personnel policies relating to employer disciplinary practices for worker absenteeism and tardiness were summarized and compared.

CHAPTER IV

ANALYSIS OF THE SURVEY DATA

This study concerned hospital meal service practices with major focus on the effects of employee absenteeism and tardiness on patient tray service activities (tray assembly, tray delivery and soiled tray collection). The survey sample consisted of twelve nonfederally operated hospitals, three from each of four size ranges, located geographically within a seventy-five mile radius of Lansing. Table 1 identifies the five cities in which the selected hospitals are located, the size of each hospital, and the numbers and positions of dietary personnel interviewed at each facility.

With respect to community size, ten of the twelve hospitals selected for study were located in cities with populations of 100,000 or more. Of the other two, one hospital was in a community of 45,000 and one in a community of 17,000.

At nine of the hospitals surveyed the administrator or manager of the dietary department was the only person interviewed. At the other three hospitals the administrator or manager was the primary interviewee with additional information contributed by supervisory personnel. The inclusion of supervisory personnel in these interview sessions was initiated by the respective administrators or managers and,

Table 1. Hospitals Studied: Location, Size and Dietary Personnel Interviewed

Beds	Hospital's Location	Dietary Personnel Interviewed		
		Admin./Mgr.	Supervisor	Total
		(No.)	(No.)	(No.)
Below 200	Flint	1	0	1
	Flint	1	0	1
	Grand Rapids	1	0	1
200-299	Jackson	1	0	1
	Lansing	1	0	1
	Owosso	1	3	4
400-499	Grand Rapids	1	0	1
	Flint	1	1	2
	Lansing	1	0	1
500-699	Grand Rapids	1	0	1
	Grand Rapids	1	2	3
	Flint	1	0	1
	Totals	12	6	18

in these particular cases, was indicative of the policy of team involvement in all departmental concerns and activities.

Assessment of the Responses

On-site interviews conducted with eighteen dietary administrative and supervisory personnel in the twelve hospitals studied sought information concerning selected professional characteristics of the interviewees, the policies

and procedures used in serving meals to inpatients, the classifications and duties of personnel assigned to patient tray services, and modifications made in patient tray service activities when there is absenteeism and/or tardiness among individuals responsible for patient tray services. The findings of the study are presented in the sequence used in the design of the interview guide. (See Appendix, page 120).

Part 1. The Respondents

Part 1 of the interview guide was designed to ascertain information about the respondent's administrative title and professional experience. The experience component obtained information pertaining to the respondent's years of employment in the food service field, length of employment in his/her current position and his/her educational and/or training specialization. For clarity of reporting the findings, personnel interviewed who were directing the activities of the various dietary departments are referred to as administrators and the other personnel interviewed are referred to as supervisory staff.

Administrators Interviewed.--A summary of the professional characteristics of dietary administrators interviewed is shown in Table 2.

As shown in Table 2, Director of Food Service is the title held by one half (6) of the persons who direct the activities of the departments studied. The second most frequently reported titles were Director of Dietetics and Food

Table 2. Professional Characteristics of Dietary Department Administrators Interviewed

Professional Characteristics	Hospital Size (Beds)				
	Below 200	200-299	400-499	500-699	Total
Position Title					
Director of Food Service	2	3	1	-	6
Director of Dietetics	-	-	1	1	2
Food Service Manager	-	-	1	1	2
Chief Dietitian	1	-	-	-	1
Executive Dietitian	-	-	-	1	1
Food Service Experience					
20 yrs. or more	1	1	3	2	7
15 to 19 yrs.	1	-	-	1	2
11 to 14 yrs.	1	-	-	-	1
6 to 10 yrs.	-	1	-	-	1
Less than 6 yrs.	-	1	-	-	1
Present Position					
20 yrs or more	-	-	1	-	1
15 to 19 yrs.	1	1	-	-	2
11 to 14 yrs.	-	-	-	1	1
6 to 10 yrs.	-	-	1	-	1
Less than 6 yrs.	2	2	1	2	7
Area(s) of Specialization					
On-the-job Experience	2	-	2	1	5
Military Experience	-	1	-	-	1
Dietetics-Admin.	-	-	1	1	2
Dietetics-General	-	-	-	1	1
Hotel, Rest. & Inst. Mgt.	-	1	-	-	1
Inst. Mgt. & Dietetics	1	-	-	-	1
Inst. Mgt.	-	1	-	-	1

Service Manager. The remaining titles, Chief Dietitian and Executive Dietitian, were each held by one respondent. Comparison of administrative titles of the respondents in this study revealed that the title of Director of Food Service is most often used for the person who directs the activities of the dietary department in smaller hospitals (less than 300 beds). Persons who direct the dietary department activities of larger hospitals (400 beds or more) are identified by a variety of titles.

The length of time that the dietary administrators have been in the area of food service ranged from less than 6 years to 20 years or more. Nine of the twelve administrators have 15 or more years experience in the field of food service, two have more than 6 years but less than 15 and only one has less than 6 years. These results show that considerable experience in the food service field is a major characteristic of nearly all dietary administrators interviewed.

There was an inverse relationship between the dietary administrators' years in their present positions and their total years of experience in the food service field. Nine of the administrators had been in their current positions for less than 15 years and, of these, seven for less than 6 years, whereas 9 of the 12 administrators had worked in the field of food service for more than 15 years and only 3 for less than 15 years. Four of the persons who have been in their present administrative positions for less than 6 years are employed by Contract Food Service Companies which during

the past two years have acquired contracts for managing the dietary departments of these hospitals. However, three of these four managers have ten years or more experience in the field of food service. Reasons why the three other managers have been in their present positions for less than six years were related to job promotions and/or transfers.

As shown in Table 2, one half of the dietary administrators indicated that they had acquired their specialization via on-the-job experience, either civilian or military. All others developed their specialization through formal academic training and work experience. Regardless of hospital size, the results of the inquiry revealed that on-the-job experience is a necessary route for dietary administrators to obtain their area of specialization as well as formal academic training.

Seven of the dietary administrators were males. Of this seven, six gained their specialization through on-the-job experience and only one by on-the-job experience plus formal academic training. Four of these males were employed by contract food service companies and were directing the activities of the dietary departments in smaller (less than 300 beds) hospitals.

The remaining five dietary administrators were females whose specialization developed through on-the-job training plus formal academic training. None of the females were employed by contract food service companies and three were

directing the dietary department activities in larger (more than 400 beds) hospitals and two in smaller (less than 300 beds) hospitals.

Supervisors Interviewed.--Supervisory staff members in three of the four bed size categories of hospitals established for this study were interviewed. All who participated were females and were employed in dietary departments that were hospital operated. A summary of the professional characteristics of dietary supervisory personnel is shown in Table 3.

As reported in Table 3, four different position titles were held by the six dietary supervisors interviewed. Food Service Supervisor was the title held by three and the remaining three were identified by different titles, namely Chief Dietitian, Head Dietitian and Assistant Food Service Supervisor.

One half (3) of the supervisory personnel had been in the food service field for more than 11 years and the other half less than 6 years. In contrast to dietary administrators, extensive experience in the food service field was not a major characteristic of all dietary supervisory personnel. From observation by the researcher, it was apparent that years of experience for persons in this job classification were directly related to the individual's age and background. One half of the supervisory personnel interviewed were recent college graduates and have been in the labor market for only a few years.

Table 3. Professional Characteristics of Dietary Department Supervisors Interviewed

Professional Characteristics	Hospital Size (Beds)				
	Below 200	200-299	400-499	500-699	Total
Position Title					
Chief Dietitian	-	-	1	-	1
Head Dietitian	-	-	-	1	1
Food Service Supervisor	-	2	-	1	3
Assistant Food Service Supervisor	-	1	-	-	1
Food Service Experience					
20 yrs or more	-	-	-	1	1
15 to 19 yrs.	-	-	-	-	0
11 to 14 yrs.	-	1	-	1	2
6 to 10 yrs.	-	-	-	-	0
Less than 6 yrs.	-	2	1	-	3
Present Position					
20 yrs or more	-	-	-	1	1
15 ot 19 yrs.	-	-	-	-	0
11 to 14 yrs.	-	-	-	-	0
6 to 10 yrs.	-	-	-	-	0
Less than 6 yrs.	-	3	1	1	5
Area(s) of Specialization					
Dietetics-General	-	-	1	1	2
Nutrition-General	-	1	-	-	1
Home Economic-General	-	1	-	-	1
ADA Supervisory Training	-	-	-	1	1
On-the-Job Training	-	1	-	-	1

As with years of experience in the food service field, years in their current positions were low for a majority of the supervisory personnel. Five have been in their present positions for less than six years whereas only one has had her position for more than 20 years.

A majority of the supervisory personnel had developed their specialization through formal academic training. Four were college graduates and one completed a hospital food service supervisory training program approved by a professional organization at a state university. Only one became qualified for her position solely through on-the-job experience. Findings show that formal academic training is the major route by which the supervisory staff members interviewed achieved specialization.

Part 2. Operational Characteristics-Dietary Department

Part 2 of the interview guide identified the general operational policies and procedures of the dietary department. Information pertaining to the following factors was obtained:

1. the system of management
2. employee unionization
3. average daily inpatient census
4. types of inpatient meal services provided
5. inpatient meal service patterns and schedules
6. types of menus used for inpatient diets
7. food purchasing policies
8. method(s) of patient tray assembly
9. method(s) of service-ready food delivery and soiled tray collection
10. personnel responsible for delivering service-ready food to the patient area(s) and to the patients themselves.

The information obtained is reported under three major

headings: Operational Characteristics, Menu and Food Purchasing Policies and Inpatient Tray Service Procedures.

Operational Characteristics.--Data pertaining to the operational characteristics of the hospitals studied are summarized in Table 4 according to hospital bed capacity. Comparison among hospitals indicated considerable variation within and among hospital sizes for many of the operational characteristics.

As shown in Table 4, eight of the dietary departments are hospital operated and four are managed by contract food service companies. Those dietary departments that are managed by contract food service companies are all located in smaller hospitals (299 beds or less) and each is managed by a male. These departments have been operated by outside agencies for less than three years. The dietary departments in the remaining two hospitals with 299 beds or less are hospital operated with female registered dietitians as the administrators. All six of the larger hospitals (400 beds or more) operate their own dietary departments. Three are managed by females and three by males.

Within the limits of these data it appears that, in Michigan, hospitals with 299 beds or less are more likely to employ the services of outside management companies to operate their dietary departments than are hospitals of more than 399 beds.

Table 4 shows that in seven of the twelve hospitals

Table 4. Operational Characteristics-Dietary Department

Operational Characteristics	Hospital Size (Beds)					
	Below 200	200-299	400-499	500-699	Total	Percent
	(No.)	(No.)	(No.)	(No.)	(No.)	(%)
Management Systems						
Hospital Operated	1	1	3	3	8	66.7
Contract Food Mgt. Co. (Total)	1	1	-	-	2	16.7
Contract Food Mgt. Co. (Mgt. Only)	1	1	-	-	2	16.7
Employees Unionized						
Yes	2	1	2	2	7	58.3
No	1	2	1	1	5	41.7
Average Daily Inpatient Census						
Range within classification	100-181	170-225	340-477	375-550	-	--
Percent Occupancy	64-98	74-87	85-91	71-80	-	--
Inpatient Meal Services						
Bedside trays (patient)	3	3	3	3	12	100.0
Floor trays (patient group dining)	-	-	-	1	1	8.3
Visitors trays (patient room)	-	-	1	-	1	8.3

Table 4. Continued

Operational Characteristics	Hospital Size (Beds)					
	Below 200	200-299	400-499	500-699	Total	Percent
	(No.)	(No.)	(No.)	(No.)	(No.)	(%)
Meal Service Patterns						
3 meals(3 sched. snacks for all pts. & pt. req.)	1	3	-	-	4	33.3
3 meals (3 sched. snacks on mod. diets; 1 all pts. + pt. req.)	1	-	1	1	3	25.0
3 meals (3 sched. snacks on mod. diets; 1 all pts. + pt. req.)	1	-	1	1	3	25.0
3 meals (3 sched. snacks on mod. diets; 2 all pts. + pt. req.)	-	-	-	1	1	8.3
4 meals (3 sched. snacks for all pts. + pt. req.)	-	-	1	-	1	8.3

surveyed dietary employees are unionized. Of these, four are hospitals with bed capacities of 400 or more and three are hospitals with bed capacities below 300. These data suggest only a slightly higher tendency toward unionization in larger hospitals than in smaller hospitals.

Among the hospitals participating in this study, it also follows that community size may be related to dietary employee unionization. In the two hospitals located in communities with populations of less than 45,000 the dietary employees were not unionized whereas in 7 of the 10 hospitals located in communities with populations of more than 100,000 the dietary employees were unionized.

Data pertaining to average daily inpatient census and percent occupancy are detailed by ranges within hospital size classifications (see Table 4). Among the 12 hospitals selected for this study, the average daily percent inpatient occupancy in the six larger hospitals (400 or more beds) varied less among hospitals than was true for the six smaller hospitals (less than 300 beds). Within group comparisons for the two size categories of smaller hospitals revealed far greater differences in average percent occupancy among the three facilities with less than 200 beds (34 percent) than among the three facilities with 200-299 beds (13 percent). Similar comparison between the two size categories for the larger hospitals showed less variation among the three hospitals in the 400-499 bed category (6 percent) than among the three hospitals in the 500 or more bed category (9 percent).

Tray delivery to the patient bedside was the primary type of meal service provided for inpatients in all hospitals studied. In addition, one hospital provided floor trays for group dining and, upon request, another served visitor trays at the patient bedside. Both of these hospitals are located in the same city and have bed capacities above 400. The types of meal services that are provided for patients in the hospitals studied are reflective of the many limitations imposed by facility layout and design, per patient service costs and the ratio of dietary and/or nursing personnel to the number of patients requiring service.

Five different meal-nourishment service patterns were found among the 12 hospitals surveyed. One hospital (477 beds) provides 4 meals per day for inpatients while the other 11 provide only 3 meals per day. In addition, between meal nourishments are provided for inpatients in all hospitals although the scheduled number offered per day to all patients and/or available only to patients on modified diets varies among the hospitals surveyed. However, in all hospitals studied bulk nourishments are delivered daily to the patient divisions to provide for unscheduled supplements for patients as ordered by their physicians or to accomodate permissible patient requests. The patterns used are identified in Table 4, detailed according to hospital size-categories.

In the eleven hospitals which provide 3 regular meals, the service periods begin between 7:00 - 7:30 a.m., 11 - 11:30 a.m. and 4:15 - 4:30 p.m. for the morning, noon and evening

meals respectively. In the hospital which provides 4 meals, the service period for the first meal (early breakfast) starts at 6:00 a.m. with the 3 remaining meals following the same general service schedule as found in all other hospitals studied. Time allowed for each meal service period in the 6 smaller hospitals ranges from 45 minutes to 1 hour whereas in the 6 larger hospitals meal service periods are from 1 hour 15 minutes to 2 hours.

The service time allowed for scheduled between-meal feeding is 30 to 60 minutes. In hospitals offering 3 scheduled snacks, nourishments are served at 10:00 a.m., 2:00 p.m. and 7:00 or 8:00 p.m. Hospitals offering 2 scheduled snacks serve them at 10:00 a.m. and 2:00 p.m. In the three hospitals which provide only 1 scheduled snack for all patients the service hour is 8:00 p.m.

Menu and Food Purchasing Policies.--Information regarding the menu and food purchasing policies of the dietary departments focused on two factors: a) the types of menus used for inpatient meals and between-meal nourishments and b) the percentage of 12 types of food items purchased partially and/or fully prepared. Responses to these questions are detailed according to hospital size and reported in Table 5.

Eleven (91.7 percent) of the dietary departments use selective menus for all types of inpatient meals whereas only one (8.3 percent) uses a nonselective menu. Nourishment menus are either selective or semi-selective in nine (75

Table 5. Menu and Food Purchasing Policies

Policies	Hospital Size (Beds)					
	Below 200	200-299	400-499	500-699	Total	Percent
	(No.)	(No.)	(No.)	(No.)	(No.)	(%)
Inpatient Menu Policies						
Meals - Selective	3	3	3	2	11	91.7
Nonselective	-	-	-	1	1	8.3
Nourishments						
Selective	1	-	1	-	2	16.7
Semiselective	2	1	2	2	7	58.3
Nonselective	-	2	-	1	3	25.0
Food Purchasing Policy						
Percent Service-Ready Menu Items*	1-10	0.10	0-10	4-25		
Percent Partially Prepared Menu Items*	5-20	1-10	1-20	10-65		
Percent Nonprepared Menu Items*	79-94	80-89	70-99	31-65		
Types of Fully/Partially Prepared Items	(No.)	(No.)	(No.)	(No.)	(No.)	(%)
Appetizers	3	-	2	2	7	58.3
Soups	2	2	1	1	6	50.0
Entrees	2	-	2	2	6	50.0
Potatoes	2	2	3	3	10	83.3
Vegetables	2	1	2	3	8	66.7
Salads	-	-	-	-	0	00.0
Sandwich Mixes	-	-	-	-	0	00.0
Desserts	3	1	3	3	10	83.3
Bread and/or Rolls	3	3	3	3	12	100.0
Beverages	3	3	3	3	12	100.0
Tube Feedings	2	1	3	2	8	66.7
Meal Supplements	2	3	3	3	11	91.7

*Range of percentages among three hospitals within facility size classification.

percent) of the dietary departments studied. Within the limitations of these data it appears that, irrespective of hospital size, offering patients the opportunity to choose their meals and nourishments is a relatively common practice.

Information concerning general practices with respect to the market forms of food purchased is summarized in Table 5. The extent to which service-ready (fully-prepared), partially-prepared and nonprepared items are purchased is expressed in percent of total food items needed. Percentage variability among the three hospitals within each facility size classification is reported by range. The number of hospitals in each facility size classification which purchase each of 12 types of menu items fully- or partially-prepared is indicated.

Table 5 shows that among the 12 hospitals surveyed, 100 percent purchase pre-prepared breads and/or rolls and beverages, 80-90 percent purchase prepared potatoes, desserts and meal supplements, 50-70 percent purchase prepared appetizers, soups, entrees, vegetables and tube feedings. None of the hospitals studied purchase prepared salads or sandwich mixes. Results show that there is a trend in all of the hospitals studied to purchase a variety of prepared menu items. Except for pre-prepared soups, a greater number of larger hospitals use prepared menu items than smaller hospitals. However, hospital size did not substantially influence the variety of prepared menu items used.

Inpatient Tray Service Procedures.--The data reported under this heading pertain to: a) inpatient tray assembly; b) service-ready food delivery and c) personnel responsible for delivering service-ready foods to patient areas and to patients. Table 6 identifies the procedures used for inpatient tray services in the hospitals studied.

The major procedure used in assemblying patient meal trays is the centralized method. The one dietary department that, at the time these data were gathered, was using the decentralized method for assembling patient trays will be centralized by the time this report is written. This department is in the process of centralizing its tray service procedures in an effort to reduce per patient labor and food costs. Three different methods are used in assembling nourishments. Of the twelve hospitals surveyed, 4 use the centralized method, 4 use the decentralized method and the remaining 4 use a combination of the centralized and decentralized methods.

Since a majority of the hospitals are using the centralized method for assembling meal trays, preassembled trays are delivered directly from the dietary departments to the patient areas. In only one hospital, is it necessary to send bulk food to the patient divisions.

Conversely, bulk supplies of nourishment items are sent to patient floors in all of the hospitals studied. In addition, in some cases preassembled nourishment trays and an assortment of service-ready nourishments are also

Table 6. Inpatient Tray Service Procedures

Procedures	Hospital Size (Beds)					
	Below 200	200-299	400-499	500-699	Total	Percent
	(No.)	(No.)	(No.)	(No.)	(No.)	(%)
Inpatient Tray Assembly						
Meals - Centralized	3	3	3	2	11	91.7
Decentralized	-	-	-	1	1	8.3
Nourishments						
Centralized	-	1	2	1	4	33.3
Decentralized	1	1	1	1	4	33.3
Combination	2	1	-	1	4	33.3
Service-Ready Food Delivery						
Meals						
Preassembled trays to floors for direct delivery to patients	3	3	3	2	11	91.7
Bulk-food carts to floor pantries for assembly of patient trays	-	-	-	1	1	8.3
Nourishments						
Bulk-to nursing divisions	3	3	3	3	12	100.0
Preportion to patient bedside	1	2	1	1	5	41.6
Preportion to patient area (distributed to patients upon request)	2	1	2	2	7	58.3
Service-Ready Food Delivery Personnel						
To Patient Floors						
Dietary Personnel	3	3	3	3	12	100.0
Nursing Personnel	-	-	-	-	-	
To Patients						
Dietary Personnel	1	1	1	2	5	41.6
Nursing Personnel	2	2	2	1	7	58.3

delivered to the patient division. These nourishments are then delivered directly to the patient by dietary/nursing personnel at the scheduled times, as ordered by the physicians, or if allowed, as requested by the patient.

In all 12 hospitals studied, dietary personnel are totally responsible for delivering all service-ready foods to the patient areas. The responsibility of delivering meal trays and nourishments to patient bedsides differs among hospitals. In 7 of the hospitals (4 smaller and 3 larger) nursing personnel deliver all scheduled meal trays to patient bedsides whereas in 5 of the hospitals (2 smaller and 3 larger) dietary personnel perform this duty. In all hospitals, the scheduled nourishments are delivered to patient bedsides by dietary personnel. Depending on time requested, nourishments ordered for patients on modified diets and those nourishments that are served to patients ad lib may be delivered to patient bedsides by personnel of either the dietary or nursing departments.

The policy for the delivery of assembled trays to patient bedsides (dietary versus nursing personnel) does not appear to be related to hospital size but, rather to the preferred practice of particular hospitals and/or the concern of the dietary staff for more effective control of all patient tray service activities.

Part 3. Manpower Needed to Provide Patient Tray Services

This part of the interview guide was designed to ascertain information concerning the number of manhours required to perform the duties related to patient tray services. Two questions were asked to obtain the needed data. The first pertained to the number of employees (dietary and nondietary) who participate in patient tray service activities and the second concerned the amount of time dietary employees of various job classifications spend in performing duties related to patient tray services.

Responses to the first question are summarized and presented in Tables 7 through 11. These tables show only the number of dietary manhours/100 beds required to perform patient tray service activities. The numbers of nondietary manhours required are not included because the interviewees were unable to supply definite responses relative to the number of nondietary personnel that actually participate in tray service activities. In most instances, it was found that the number of nondietary personnel who participate in patient tray service activities depends on: a) the number of available personnel on the patient division; b) other activities on the division that occur around or during meal service times; c) the time of the day that meals and nourishments are served and d) the types of patients on the division.

Dietary Manhours Required: Meals.--As shown in Table 7, the numbers of dietary manhours/100 beds required to

Table 7. Dietary Department Manhours/100 Beds: Patient Tray Assembly

Hospital Size (Beds)	Tray Assembly Method*	Manhours/100 Beds				
		Early Brft.	Reg. Brft.	Noon Meal	Even. Meal	Total Meals
Below 200						
135	C	-	2.78	4.44	4.44	11.66
182	C	-	2.75	4.12	4.12	10.99
185	C	-	3.38	4.05	3.38	10.81
200-299						
213	C	-	2.82	4.11	4.11	11.04
244	C	-	2.05	3.69	3.69	9.43
258	C	-	2.71	4.75	4.75	12.21
400-499						
400	C	-	3.44	3.66	3.66	10.76
401	C	-	3.43	4.34	4.34	12.11
477	C	0.15	4.09	4.77	4.77	13.78
500-699						
504	C	-	2.23	2.98	2.98	8.19
527	C	-	2.56	3.42	2.56	8.54
680	D	-	8.53	8.23	8.53	25.29

*Assembly Methods:
C = Centralized
D = decentralized

assemble patient trays for all meals differ somewhat within and among categories of hospitals according to maximum facility size. In the 3 hospitals with less than 200 beds, a decreasing number of manhours/100 beds per day is required as the hospital size increases. Even though this decrease is less than one, it appears that in this size category the smaller the hospital the greater the number of manhours/100 beds required per day to perform the sequential duties

involved in centralized tray assembly. In the second category of hospitals (200-299 beds), a decrease in manhours/100 beds per day is observed in the hospital with 244 beds (second largest).

In the larger hospitals (400-700 beds) manhours/100 beds per day decrease slightly as patient bed capacity reaches 500 when the centralized method of tray assembly is used. However, when the decentralized method of tray assembly is used, the requirement of manhours/100 beds per day is approximately tripled.

Among other reasons, the differences in dietary manhours/100 beds required among and within size categories of hospitals may be due to more individualized attention to each patient tray, the number of items for each tray, the condition and design of the equipment used in the patient tray assembly areas, and the employee skills and efficiencies in assembling patient trays as well as the tray assembly method.

In all hospitals using the centralized method to assemble patient trays, the manhour/100 beds required to perform this activity are less for breakfast than for the noon meal. In 2 of these 11 hospitals manhours/100 beds required are also less for the evening meal than for the noon meal because it is the policy of these hospitals to serve a larger meal at noon than in the evening. The fewer number of manhours/100 beds required to assemble breakfast trays is due to the smaller number and the types

of breakfast food items served. In the one hospital using the decentralized method to assemble patient trays, the number of manhours/100 beds required for the noon meal is reduced slightly because for this meal tray assembly for two patient divisions are combined, thereby requiring fewer dietary employees overall.

Table 8 shows the increase in the number of dietary manhours/100 beds required when dietary rather than non-dietary employees deliver the trays to patient bedsides. Among the 4 hospitals of 200 or more beds in which dietary employees deliver service-ready trays to patient bedsides, manhours/100 beds required to perform this service appear to increase as hospital size increases. Another factor that may influence the number of dietary manhours/100 beds required to deliver trays to patient bedsides is the amount of indirect assistance provided dietary employees by non-dietary floor personnel. Such assistance may consist of readying the patient for eating, clearing bedstands, and notifying the dietary department in advance of patient trays that are to be delayed or cancelled. Tray delivery service is also affected by the structural design of the patient floor areas and whether the rooms are arranged for single or multiple occupancy.

The dietary manhours/100 beds required daily to collect soiled meal trays from patient bedsides and patient areas are summarized in Table 9. In the 5 hospitals where dietary employees deliver the meal trays to patient bedsides

Table 8. Dietary Manhours/100 Beds: Patient Tray Delivery to Patient Floors and to Patient Bedsides

Hospital	Tray Assembly Method*	Tray Delivery to Floors Manhours/100 Beds				Tray Delivery to Bedsides Manhours/100 Beds				Total Manhours/ 100 Beds
		Early Brft.	Reg. Brft.	Noon Meal	Even. Meal	Early Brft.	Reg. Brft.	Noon Meal	Even. Meal	
Below 200										
135	C	-	0.43	0.43	0.43	-	-	-	-	1.29
182	C	-	-	-	-	-	1.74	1.74	1.74	5.22
185	C	-	0.40	0.40	0.40	-	-	-	-	1.20
200-299										
213	C	-	-	-	-	-	1.06	1.06	1.06	3.18
244	C	-	0.32	0.32	0.32	-	-	-	-	0.96
258	C	-	0.78	0.78	0.78	-	-	-	-	2.34
400-499										
400	C	-	0.31	0.31	0.31	-	-	-	-	.93
401	C	-	0.37	0.37	0.37	-	-	-	-	1.11
477	C	-	-	-	-	0.26	1.26	1.26	1.26	4.04
500-699										
504	C	-	-	-	-	-	1.79	1.79	1.79	5.37
527	C	-	0.28	0.28	0.28	-	-	-	-	0.84
680	D	-	-	-	-	-	2.94	2.94	2.94	8.82

*Assembly Methods:
C = Centralized
D = Decentralized

they are also responsible for removing the soiled trays from patient rooms and returning them to the dishwashing area in the dietary department. In the 7 hospitals where dietary personnel only deliver meal trays to patient floor areas for distribution to patient by nondietary personnel their responsibility is limited to transporting the soiled trays collected by nondietary personnel from the patient floor areas to the dishwashing area in the dietary department. In these latter situations the numbers of dietary manhours/100 beds required for soiled tray return to the dishwashing area are the same as the numbers of dietary manhours/100 beds required to deliver service-ready meal trays to the patient areas (see Tables 8 and 9).

For each of the 5 hospitals where dietary employees are totally responsible for patient tray delivery, distribution and collection, comparison of the dietary manhours/100 beds required daily for all meals reveal that in all cases the return of soiled meal trays to the dietary dishwashing area (Table 9) requires fewer manhours/100 beds than does the distribution of service-ready meal trays (Table 8). In the 4 hospitals using the centralized tray assembly system, reductions in dietary manhours/100 beds required for soiled tray collection and transport to the dishwashing area range from 37.6 to 55.7 percent. In the hospital using the decentralized tray assembly system the reduction in dietary manhours/100 beds required is somewhat less (24.8 percent).

Table 9. Dietary Manhours/100 Beds: Soiled Tray Collection From Patient Floors to Kitchen and From Patient Bedsides to Kitchen

Hospital Size (Beds)	Tray Assembly Method*	Soiled Tray Collection From Patient Floors Manhours/100 Beds				Soiled Tray Collection From Patient Bedsides Manhours/100 Beds				Total Manhours/ 100 Beds
		Early Brft.	Reg. Brft.	Noon Meal	Even. Meal	Early Brft.	Reg. Brft.	Noon Meal	Even. Meal	
Below 200										
135	C	-	0.43	0.43	0.43	-	-	-	-	1.29
182	C	-	-	-	-	-	0.98	0.98	0.98	2.94
185	C	-	0.40	0.40	0.40	-	-	-	-	1.20
200-299										
213	C	-	-	-	-	-	0.47	0.47	0.47	1.41
244	C	-	0.32	0.32	0.32	-	-	-	-	0.96
258	C	-	0.78	0.78	0.78	-	-	-	-	2.34
400-499										
400	C	-	0.31	0.31	0.31	-	-	-	-	0.93
401	C	-	0.37	0.37	0.37	-	-	-	-	1.11
477	C	-	-	-	-	-	0.84	0.84	0.84	2.52
500-699										
504	C	-	-	-	-	-	0.89	0.89	0.89	2.67
527	C	-	0.28	0.28	0.28	-	-	-	-	0.84
680	D	-	-	-	-	-	2.21	2.21	2.21	6.63

*Assembly Methods:
C = Centralized
D = Decentralized

Within and among the hospital size categories, differences in the dietary manhours/100 beds required to collect soiled trays from patient bedsides and/or patient floor areas may be due to several factors: a) the time required for all patients on a floor to complete a given meal; b) the collection and transportation systems used in returning the trays to the dishwashing area; c) the soiled tray capacity of the carts used; d) the number of dietary and/or nondietary employees involved in the collection and/or transportation of the soiled trays and equipment to be returned to the dietary kitchen; and e) the location of the dishwashing area(s) in relation to the patient areas of the hospital.

Of the total number of dietary manhours/100 beds required daily to perform the duties related to patient meal tray services, a greater number of dietary manhours/100 beds is required per day in those hospitals in which dietary employees are responsible for all 3 steps (tray assembly, tray delivery to patient bedsides and soiled tray collection from patient bedsides) in the patient meal tray service system (see Table 10).

Among the patient tray service activities, tray assembly requires 50 percent or more of the total dietary manhours/100 beds in all hospitals studied. This activity requires from 50.5 to 70.6 percent of the total dietary manhours/100 beds in the 5 hospitals in which dietary employees are responsible for delivering service-ready meal trays to patient bedsides and collecting soiled trays from

Table 10. Dietary Department Manhours/100 beds: All Patient Meal Tray Services Per Day

Hospital Size (Beds)	Tray Assembly Method*	Dietary Manhours/100 Beds - For Meal Tray Services			
		Assembly	Delivery to Patient Division	Return to Dietary Department	Daily Total All Meals
Below 200					
135	C	11.66	1.29	1.29	14.24
182	C**	10.99	5.22	2.94	19.15
185	C	10.81	1.20	1.20	13.21
200-299					
213	C**	11.04	3.18	1.41	15.63
244	C	9.43	0.96	0.96	11.35
258	C	12.21	2.34	2.34	16.89
400-499					
400	C	10.76	0.93	0.93	12.62
401	C	12.11	1.11	1.11	14.33
477	C**	13.78	4.04	2.52	20.34
500-699					
504	C**	8.19	5.37	2.67	16.23
527	C	8.54	0.84	0.84	10.22
680	D**	25.29	8.82	6.63	40.74

*Assembly methods:
C = Centralized
D = Decentralized
**Tray transport to and from patient floor areas and to and from patient bedsides by dietary department personnel.

patient bedsides. In the 7 hospitals in which dietary employees only deliver service-ready trays to and collect soiled trays from patient areas the comparable manhour percentages are even higher (from 72.3 to 87.5 percent).

The centralized method of tray assembly is used in all 7 of the hospitals in which dietary personnel only deliver service-ready meal trays to and collect soiled trays from

patient floors. Among 6 of these hospitals (all less than 500 beds) differences in total dietary manhours/100 beds required for tray assembly, and delivery to and from patient floors appear to be due to variations in employee productivity rather than to differences in the actual bed capacities of the hospitals studied. In the 1 hospital with over 500 beds it appears that employee productivity (10.22 manhours/ 100 beds) is greater than is true for any of the other 6 smaller hospitals.

When dietary department personnel are responsible for all meal service steps (tray assembly, tray deliver to patient floors and bedsides and soiled tray collection from patient bedsides and floors), the difference in the total daily dietary manhours/100 beds required for patient meal tray service (irrespective of hospital size) appears to be due primarily to the method used for patient tray assembly. In the 1 hospital using the decentralized tray assembly method more than twice as many total dietary manhours/100 beds are required daily than for any of the 4 hospitals which centrally assemble their patient meal trays. Among these 4 hospitals which use the centralized method of patient tray assembly differences in the total dietary manhours/100 beds appear to be due more to variations in dietary employee productivity rather than to hospital size.

Dietary Manhours Required: Nourishments.--Table 11 shows that the numbers of total dietary manhours/100 beds

Table 11. Dietary Manhours/100 Beds: Nourishments

Hospital Size (Beds)	Assembly Method*	Nourishment Schedule**	Nourishment Assembly and Delivery Manhours/100 Beds			Total Dietary Manhours/ 100 Beds
			Assembly	Delivery To Patient Areas	Delivery To Patient Bedsides	
Below 200						
135	C+D	3SM+PR	.74	1.11	--	1.85
182	C+D	3SAP+PR	.82	.41	.55	1.78
185	D	3SM+1SAP+PR	.81	.41	.54	1.76
200-299						
213	C+D	3SAP+PR	.82	1.17	--	1.99
244	D	3SAP+PR	.94	1.02	--	1.96
258	C	3SAP+PR	.91	1.45	--	2.36
400-499						
400	D	3SM+PR	.88	.25	.56	1.69
401	C	3SM+1SAP+PR	.75	1.06	--	1.81
477	C	3SAP+PR	.88	.42	.63	1.93
500-699						
504	C	3SM+PR	.79	.30	.79	1.88
527	C+D	3SM+1SAP+PR	.85	1.19	--	1.74
680	D	3SM+2SAP+PR	.74	.37	.74	1.85

*Assembly Methods
C = Centralized
D = Decentralized

**Nourishment Schedule
SM = Scheduled Modified Diets
SAP = Scheduled all Patients
PR = Patient Request

required to assemble and deliver nourishments to patient areas and to patient bedsides vary very little within and among hospital size categories regardless of the number of times nourishments are offered to all patients per day, whether the nourishments are delivered to patient bedsides by members of the dietary or nursing departments or the method(s) used to assemble nourishments for distribution.

In all hospitals approximately 2 dietary manhours/100 beds are required per day just to assemble and deliver nourishments topatient floor areas and/or bedsides. Since these data do not include the dietary manhours/100 beds required for the preparation of nourishment food items to make them service-ready, the number of additional dietary manhours/100 beds required to provide these supplemental feedings in each hospital depends upon hospital policy regarding the degree of pre-prepared convenience purchased (fully-prepared, partially prepared, or basic ingredients).

No dietary manhours are required for collecting soiled dishes that have been used for nourishments because all hospitals studied use disposable ware for this service and the removal of refuse from nourishment service is the assigned responsibility of nondietary floor personnel only.

It is recognized that, if available, the total number of manhours/100 beds (dietary and nondietary) required for (a) the delivery of supplemental feedings and (b) the collection and disposal of refuse from this service would be higher and more factually accurate than only the dietary

manhours/100 beds reported. However, because in all 12 hospitals studied the responsibility of delivering nourishments to patient bedside areas are shared between dietary and nondietary personnel and the collection and disposal of refuse from nourishment service is done only by nondietary personnel, and since all interviewees were unable to indicate the number of nondietary manhours involved, the assessment of manhours/100 beds required for nourishment service is, admittedly, incomplete.

It is interesting to note that despite the interdependence of dietary and nondietary personnel and the necessity of team effort between the dietary department and the nursing department in the service of meals and nourishments to inpatients, the administrators of the 12 dietary departments of the hospitals studied, by their own admission, did not know the additional manhours required by nondietary personnel to provide these essential services to inpatients in their respective institutions.

Job Classifications: Dietary Employees.--The job classifications and variety of position titles used for the dietary employees (labor and supervisory) who participate in patient tray services are detailed according to hospital size in Tables 12 and 13. Even though many of the labor personnel who participate in tray service activities are from employee groups of similar status (level of difficulty and work responsibility), fourteen different job titles

Table 12. Small Hospitals*: Job Classifications, Position Titles and Patient Meal Service Duties of Dietary Employees

Hospital Size (Beds)	No. of Hosp.	Job Class**	Position Title	Patient Meal Service Duties				
				Tray Assembly	Tray Delivery		Tray Collection	
					Patient Floor	Patient Bedside	Patient Bedside	Patient Floor
Below 200	1	L	Dietary Aide	X	-	-	-	-
	2	L	Dietary Porter	-	X	-	-	X
	1	L	Breakfast Cook	X	-	-	-	-
	1	L	Therapeutic Aide	X	-	-	-	-
	1	L	Gen. Dietary Utility Personnel	X	-	-	-	-
	1	L	Food Service Worker	X	X	X	X	X
	1	S	Food Service Supervisor	X	-	-	-	-
200-299	1	L	Dietary Aide	X	-	-	-	-
	2	L	Dietary Porter	-	X	-	-	X
	1	L	Vegetable Cook	X	-	-	-	-
	1	L	Kitchen Assistant	X	X	X	X	X
	1	L	Dietary Technician	X	-	-	-	-
	3	S	Food Service Supervisor	X	-	-	-	-
	1	S	Asst. Food Service Supervisor	X	-	-	-	-

*Small Hospitals = less than 300 beds.
**Job Classification: L = Labor personnel; S = Supervisory personnel.

Table 13. Large Hospitals*: Job Classifications, Position Titles and Patient Meal Service Duties of Dietary Employees

Hospital Size (Beds)	No. of Hosp.	Job Class**	Position Title	Patient Meal Service Duties				
				Tray Assembly	Tray Delivery		Tray Collection	
					Patient Floor	Patient Bedside	Patient Bedside	Patient Floor
400-499	1	L	Dietary Aide	X	X	-	-	X
	1	L	Dietary Porter	-	X	-	-	X
	1	L	Main Course Cook	X	-	-	-	-
	1	L	Salad Cook	X	-	-	-	-
	1	L	General Dietary Personnel	X	-	-	-	-
	1	L	Food Handler	X	X	X	X	X
	3	S	Food Service Supervisor	X	-	-	-	-
	1	S	Dietary Technician	X	-	-	-	-
	2	S	Professional Dietitian	X	-	-	-	-
500-699	1	L	Dietary Aide	X	X	X	X	X
	1	L	Dietary Porter	-	X	-	-	X
	1	L	Food Service Worker	X	X	X	X	X
	1	L	Senior Food Service Worker	X	X	X	X	X
	1	L	Patient Food Service Worker	X	X	X	X	X
	3	S	Food Service Supervisor	X	-	-	-	-
	1	S	Assistant Dietitian	X	-	-	-	-
	1	S	Prof. Dietitian	X	-	-	-	-

*Large Hospitals = 400-699 beds; **Job Classifications: L = Labor personnel; S = Supervisory personnel

were identified among and within the four size categories of the 12 hospitals studied. The job titles established are either reflective of the accepted distinguishing terminology denoting general skill levels for employees in all areas of a particular hospital or the title describes the area the employee is assigned to and/or the types of work responsibilities the employee has. The job classifications and position titles may also be related to hospital or departmental organizational policies and/or management/union agreements.

The job titles of similar terminology used for dietary labor personnel in at least 1 hospital within each category of hospitals studied are dietary aides and dietary porters. Other job titles used for labor personnel which carry comparable job status in the smaller hospitals are general dietary personnel, kitchen assistant, dietary technician and therapeutic aide. Other titles used to describe similar dietary labor personnel in the larger hospitals are food handler, general dietary personnel and food service worker. The title senior food service worker is used to describe one of the labor personnel positions in 1 of the larger hospitals. This title denotes a position which is one step above the entry level position, food service worker. With the exceptions of dietary porters, all of these labor personnel participate in patient tray assembly activities. Tables 12 and 13 also show that another group of labor personnel participate only in patient tray assembly. This group consists

of 4 types of cooks (main course, vegetable, salad and breakfast).

As hospital size increases, more members of the supervisory staff with a variety of position titles participate in tray service activities. In all twelve hospitals, professional dietitians, dietary technicians and/or food service supervisors participate in patient tray service activities. These supervisory personnel primarily participate in patient tray assembly (checking trays for menu accuracy, tray appearance, food quality, etc.), although in some cases their duties may also include the supervision of tray delivery and soiled tray collection. In the larger hospitals there are more vocationally and professionally trained supervisory staff members, therefore many of the duties relating to patient tray service supervision are delegated to them by their respective dietary department administrators.

In the smaller hospitals, food service supervisor and assistant food service supervisor are the titles given to supervisory staff who participate in patient tray service activities. In 2 of the smaller hospitals, the professional dietitians are only employed on a consulting basis, in 2 others the professional dietitians are also the department administrators and in the 2 remaining hospitals, the professional dietitians are mainly responsible for therapeutic rather than production and service assignments.

The amount of time each day that dietary personnel from each of the job classifications spend in performing

duties related to patient tray services depends on whether they are full-time or part-time employees and the specific meal service duties assigned to them. Full-time personnel usually participate in the tray service activities for 2 meals (Breakfast and Noon) and 2 nourishments (midmorning and afternoon). Part-time personnel are usually involved in 1 meal and 1 nourishment (midmorning or night).

Part 4. Personal Characteristics and Educational Background of Dietary Employees Who Assist in Patient Tray Services

The fourth part of the interview guide sought information pertaining to a) six personal characteristics of dietary employees who participate in patient tray services: sex, age, marital status, number of children in each household, age ranges of children and the number or percentage of employees with dependents other than children and b) the educational background of the dietary administrative staff and labor personnel.

Personal Characteristics.--The responses to the inquiry pertaining to the personal characteristics of sex, age and marital status of the labor personnel assigned to patient tray services are summarized according to hospital size and reported in Table 14. In all hospitals studied except 1 (244 beds), 62 percent or more of the employees who participate in patient tray services are females. Fifty percent or more of the patient tray service employees are married in 11 of the 12 hospitals studied. With the exception of 1

Table 14. Dietary Labor Personnel: Personal Characteristics

Hospital Size	Personal Characteristics				
	Sex		Marital Status		Age Range
	Male (%)	Female (%)	Single (%)	Married (%)	(Years)
Below 200					
135	5	95	50	50	40-45
182	6	94	11	89	21-60
185	12	88	50	50	17-55
200-299					
213	0	100	50	50	17-64
244	61	39	50	50	17-40
258	10	90	400	60	19-50
400-499					
400	12	88	50	50	16-65
401	38	62	50	50	18-70
477	10	90	85	15	16-55
500-699					
504	17	83	50	50	18-55
527	17	83	30	70	18-54
680	22	88	38	62	18-58

hospital (135 beds), a wide range of ages exists among employees who participate in patient tray services. These ages are from 16 to 70.

From the data gathered, it appears that hospital size is not related to the employee personal characteristics of age, sex and martial status. In both the larger and smaller hospitals, a majority of the patient tray service employees are females and married.

Data relating to the number of children in each household and their ages, and the percentage of employees with

dependents other than children are not reported because most of the interviewees were unable to provide the information requested.

Educational Background.--As indicated in Part 4, 15e and 15f of guide (see Appendix) the responses to the question concerning the highest educational level of dietary labor and administrative personnel were placed in one of five percentage (proportion) categories: 100% (all), 80% (nearly all), 60% (more than half), 50% (half), 30% (less than half), less than 30% (few) and 0% (none). The estimates obtained from the interviewees were used to calculate the approximate percentage of patient tray service workers who have completed each of the educational levels listed in the interview guide. The results are detailed in Tables 15 and 16 respectively.

As shown in Table 15, a higher percentage of the labor personnel in larger hospitals have college level educations than in smaller hospitals. The highest percentage (10%) of the labor personnel with Bachelor Degrees are employed in one of the larger hospitals. In this hospital, a majority of the employees with the degrees are working under the provisions of the Comprehensive Employment and Training Act of 1973 (C.E.T.A.). This act provides job training and employment for economically disadvantaged, unemployed and underemployed persons. In order to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency, a flexible and decentralized

Table 15. Highest Educational Level Attained: Percent of Dietary Labor Personnel

Hospital Size (Beds)	Highest Educational Level Attained									
	College Level			Public School Level						Other*
	Bach. Degree	Assoc. Degree	Total	High Sch.+	High Sch.	Total	Voc. Sch.	Jr. High Sch.	Elem. Sch.	
Below 200										
135	-	-	-	10	50	60	-	35	-	5
182	4	4	8	-	75	75	-	13	-	4
185	-	-	-	-	73	73	-	13	8	6
200-299										
213	-	-	-	-	20	20	-	75	-	5
244	-	8	8	-	60	60	-	16	-	16
258	-	-	-	-	85	85	-	-	-	15
400-499										
400	-	-	-	-	80	80	-	-	-	20
401	-	-	-	-	80	80	-	-	-	20
477	-	-	-	-	70	70	-	-	-	30
500-699										
504	-	-	-	-	85	85	-	10	-	5
527	3	7	10	10	60	70	10	-	-	10
680	10	15	25	25	30	55	10	5	5	-

*Others = Part-time employees who are attending public school or college.

system of federal, state and local programs was established. Under this provision, employment opportunities were offered to those employees in the dietary department with a Bachelor Degree who would otherwise have been unemployed.

Fifty-five percent or more of the labor personnel in 11 of the 12 hospitals studied have completed high school or high school plus vocational school. In the 1 remaining hospital (213 beds), only 20 percent of the labor personnel have completed high school. Some part-time employees from each hospital who participate in patient tray services are students, either in college or high school (4-30 percent).

The presence of well educated dietary labor personnel within all categories of hospitals studied may be attributed, in part, to the changing standards of employment and the unavailability of jobs in the Michigan labor market. The scarcity of employment opportunities allows employers to select highly qualified individuals even for entry level positions. This could account for the fact that people with college training and those who have completed high school plus vocational school have accepted jobs that heretofore have not required such high educational qualifications.

Table 16 shows that of the 12 hospitals studied only 4 have administrative and supervisory staff members with Masters Degrees who participate in patient meal service activities. The percentages of staff with these degrees do not appear to be related to hospital size as indicated by the 20 percent in 1 of the smaller hospitals and 5, 8 and

Table 16. Highest Educational Level Attained: Percent of Administrative and Supervisory Personnel

Hospital Size (Beds)	Highest Educational Level Attained							
	College Level					Public School Level		
	Masters Degree	Bach. Degree + Diet. Intern.	Bach. Degree (4 Yrs)	Assoc. Degree (2 Yrs)	Total	High Sch.+ Voc. Sch.	High Sch.	Total
Below 200								
135	-	-	-	33	33	67	-	67
182	-	17	33	17	67	33	-	33
185	-	17	-	-	17	-	83	83
200-299								
213	-	25	25	-	50	-	50	50
244	-	33	-	33	66	-	33	33
258	20	-	60	-	80	-	20	20
400-499								
400	5	42	5	-	52	10	37	47
401	8	33	8	-	49	25	25	50
477	-	-	-	-	-	-	100	100
500-699								
504	-	-	14	-	14	86	-	86
527	-	-	25	50	75	25	-	25
680	25	38	19	6	88	12	-	12

25 percent in 3 of the larger hospitals. In 7 of the 12 hospitals studied from 17 to 42 percent of the members of the administrative/supervisory staff have completed a dietetic internship.

A wide range in the percentages of administrative staff members with Bachelor Degrees and Associate Degrees exists among the hospitals studied. The range of the percentages of staff members with Bachelor Degrees varies from 5 to 60 percent with all size categories of hospitals represented and from 6 to 50 percent with Associate degrees with only 3 of the size categories represented.

The remaining members of the administrative/supervisory staff assigned to patient tray service duties from each of the hospitals studied have only completed high school or high school plus vocational school. Of these individuals, more who have completed both high school and a post-high school vocational training program work in the larger hospitals (400 to 700 beds) than in the smaller hospitals (less than 300 beds). Among the 12 facilities studied, 1 large facility has no member of the administrative/supervisory staff assigned to patient tray services who has completed formal education or training beyond the high school level.

Part 5. Absenteeism and Tardiness Among Patient Meal Service Employees

Part 5 of the interview guide was designed to identify a) the seasons and specific times of the year when absenteeism

and tardiness occur more frequently among patient tray service employees, b) the number of individuals that can be absent or tardy before inpatient meal service efficiency is affected, c) the patient tray service activities that are most affected by employee absenteeism and tardiness, d) the types of procedural modifications usually made in order to cope with and/or compensate for absenteeism and tardiness among patient tray service employees, e) the assignment of tardy employees upon their arrival, f) the effects of absenteeism and tardiness among patient tray service employees on the duties of other personnel and the patient's meal and g) the departmental and/or hospital policies concerning employee absenteeism and/or tardiness.

Seasons and Times When Absenteeism and Tardiness Occur More Frequently.--Three seasons of the year (winter, spring and summer) are identified by some administrators as being particularly associated with absenteeism among dietary employees who participate in patient tray services. In 4 of the smaller hospitals (less than 300 beds) and in 2 of the larger hospitals (400 beds or more) absenteeism is encountered more frequently among dietary tray service employees during the winter season. According to the dietary administrators of these hospitals, absenteeism in this season is primarily due to illness, especially colds and the flu.

Prevalence of absenteeism among patient tray service employees during the spring was also reported by dietary

administrators of 2 of the larger and 2 of the smaller hospitals. Dietary administrators of these hospitals associated absenteeism among the older employees during this season with more pleasant weather conditions and among the younger (high school age) employees with the many extracurricular school activities that are scheduled during this time of the year. Summer was reported as a season in which absenteeism occurs more frequently in only 1 of the larger hospitals. The reason offered by the dietary administrator was that summer is the time of the year when employees like to be outside enjoying themselves.

Monday, Friday, Saturday and Sunday were cited as the days of the week patient tray service employees are absent more frequently. Monday and Friday are the days of the week indicated as being related to absenteeism in some hospitals with bed capacities below 200 and in some hospitals with bed capacities above 500. Saturday and Sunday are the days when more absenteeism is encountered among patient tray service employees in 2 of the hospitals with bed capacities above 500 and in at least 1 hospital from each of the other size categories of hospitals established for this study.

Three other times when there is increased absenteeism among patient tray service employees in the larger hospitals are: a) the day before and/or the day after an employee's regular day off, b) around but not on specific holidays and c) the day after payday. In one smaller hospital, a time

when absenteeism occurs more often among patient tray service employees is the day after payday. It is evident from these data that in most of the hospitals studied, frequency of absenteeism among patient tray service employees is associated with particular seasons and/or times of the year and are usually due to personal causes rather than to on-the-job causes.

With further questioning, additional data were obtained for the calculation of the rate of absenteeism per week among employees who participate in patient tray services for each hospital. The formula[1] used to calculate the rate of absenteeism is as follows:

$$\text{Rate (\%) of Absenteeism} = \frac{\text{No. of absentees during period X 100}}{\text{Avg. no. employees X no. working days}}$$

Comparisons among the percentages calculated revealed that the rate of absenteeism among employees who participate in patient tray service activities is low (3 percent or less) in the six smaller hospitals studied. Of these 2 have an absenteeism rate of 3 percent, 2 have an absenteeism rate of 2 percent and 2 have an absenteeism rate of 1 percent. Among the six larger hospitals, a wider range is found in the rates of absenteeism per week among patient tray service employees than is true for the six smaller hospitals. Three of these hospitals have absenteeism rates of only 1, 2 and 4 percent, respectively, but 2 have absenteeism rates of 10 percent and 1 has an absenteeism rate of 12 percent.

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[1] J. Keiser and E. Kallio. Controlling and Analyzing Costs in Food Service Operations. (New York: John Wiley and Sons, Inc., 1974), p. 40.

Neither marital status nor age of the employees were found to be related to absenteeism in 10 of the hospitals studied. However, in 1 of the smaller hospitals (182 beds) married employees were found to be absent more frequently and in 1 of the larger hospitals (527 beds), employees in the age group of 18-21 were found to be absent more often.

It is evident from the results obtained that absenteeism among patient tray service employees exists in varying degrees among and within the categories of hospitals studied and that higher rates of absenteeism are more apt to occur in larger than in smaller hospitals.

The dietary administrators of the hospitals studied do not consider tardiness a serious problem among the employees who participate in patient tray services. Tardiness was associated with the seasons of winter and spring in only five hospitals. Of these five, three dietary administrators from the larger hospitals associated winter with employee tardiness and two from the smaller hospitals associated tardiness with spring. Administrators from the other seven hospitals responded to the inquiry relating to the seasons and times of more frequent tardiness among patient tray service employees in the following ways: a) tardiness is not really a problem and it can occur any time of the year, b) there is very little tardiness and c) it is not really a problem and when it occurs it is usually related to transportation methods.

Employee Absences and/or Tardiness Versus Meal Service Efficiency.--Responses pertaining to the number of employees assigned to patient tray service duties that can be absent before the efficiency of the meal service is seriously affected were summarized according to hospital size. The results show that in 1 of the smaller (less than 300 beds) and in 5 of the larger (400 beds or more) hospitals, the specific number of dietary employees assigned to inpatient tray services for a particular meal must be present or the meal service efficiency will be measurably affected. One of the larger and 5 of the smaller hospitals can, if necessary, function adequately with one or two fewer employees than are usually assigned duties related to inpatient tray services.

In each of the hospitals studied, the number of employees that can be tardy before inpatient meal service is seriously affected is the same as the number of absentees. However, the more tardy employees are the greater the effects are on meal service efficiency.

Within the limits of this small study it is apparent that the number of dietary employees that can be absent or tardy before inpatient meal service efficiency is seriously impaired depends upon three interrelated factors:

1. the specific steps in the inpatient meal service process for which dietary department employees have major responsibility (tray assembly, tray delivery to floors and/or patient bedsides, soiled

tray collection from patient bedsides and/or floors).

2. the relationship between the number of patient trays to be processed per meal and the number of available dietary personnel employed to provide the required services as scheduled.
3. the expected productivity levels of dietary employees assigned to patient meal service duties under normal full-time conditions.

Inpatient Meals and Tray Service Activities Most Affected by Absenteeism and/or Tardiness.--Breakfast is the meal most affected by absenteeism among patient tray service employees in 7 (3 larger and 4 smaller) of the hospitals studied. Absenteeism during this meal usually results in an insufficient number of employees who are familiar with tray service procedures. Workers who substitute for the absent employees may be less skilled in performing the duties related to patient tray service activities. Combining the duties of the patient tray service employees may lead to a delay in starting the meal service period and/or require a longer time to complete all services for all inpatients.

In 2 of the other larger hospitals, the evening meal is the meal affected most by absenteeism among patient tray service employees because these particular hospitals are more dependent upon part-time workers for the service of

the evening meal. Of the three remaining hospitals, in 2 (1 smaller and 1 larger) no meal service is seriously affected by limited absenteeism among patient tray service employees because an absent employee is immediately replaced by an employee from another area of the dietary department. In 1 of the smaller hospitals, the service efficiency of all three regular meals is usually affected by absenteeism among patient tray service employees. Neither the noon meal nor any of the in-between meals (nourishments) are seriously affected by absenteeism among the patient tray service employees in the 12 hospitals studied.

Of the 10 hospitals in which absenteeism among patient tray service employees does affect meal service efficiency, the specific tray service activities affected are either tray assembly or all activities related to patient tray services. Tray assembly is affected most by absenteeism in 2 of the smaller and in 1 of the larger hospitals. In 3 of the smaller and in 4 of the larger hospitals all tray service activities are equally affected.

Tardiness affects patient tray assembly for the first regular meal (Breakfast) in 2 of the smaller hospitals and all activities pertaining to patient tray services in 3 of the larger hospitals during the evening meals. None of the tray service activities are measurably affected by some tardiness among patient tray service employees in the remaining hospitals studied.

Types of Procedural Modifications Usually Made to Cope with Employee Absenteeism.--A number of modifications are made in patient tray service procedures among the 12 hospitals studied to compensate for unexpected and/or long-term departmental absences and for extensive absenteeism due to emergency situations.

The eight different ways the dietary departments surveyed cope with unexpected dietary tray service employee absences are reported in Table 17 according to hospital size and rank order of frequency among all hospitals studied. From these limited data it is clear that, irrespective of hospital size, the dietary administrators attempt to compensate for missing workers by first utilizing the skills and services of other on-duty dietary workers to maintain patient meal services as scheduled without increasing payroll costs. When the number of available workers is deemed inadequate the next options pursued are a) to obtain the necessary workers on a paid overtime basis (time and a half), b) divide the duties of the absentees among the regular patient tray service workers present and/or c) modify the patient menus to simplify the meal service procedures required. The dietary administrators of all hospitals indicated that, although some unexpected absences are inevitable, every effort is made to maintain both the quality of patient meal service and the tray delivery schedules expected from the department. The effects of unexpected absenteeism on patient meal services ultimately

Table 17. Modifications Made to Compensate for Absences of Dietary Employees Normally Assigned to Patient Tray Service Duties

Modifications	Hospital Size (Bed Capacity)				
	Below 200	200-299	400-499	500-699	Total
On-duty dietary employees from other work areas substitute for absent employees	3	3	3	3	12
Dietary administrative/supervisory staff substitute for absent employees	2	3	2	3	10
Off-duty regular tray service employees are asked to report for duty	3	2	2	2	9
Dietary employees are asked to work overtime if the absences occur on a meal other than the first meal (Breakfast)	2	2	2	2	8
Duties of the absent employees are divided among on-duty tray service employees	1	1	2	3	7
Employees who work for the dietary department on an "on-call" basis are asked to report on duty	2	-	1	1	4
Menus are modified to simplify tray service procedures	2	-	1	1	4
Dietary employees scheduled for later shifts are asked to report earlier	1	1	1	-	3

depend on the resources available to management (human, material, financial) and the ability of management to use them to operational advantage to meet temporary worker shortage.

The types of procedural modifications used to compensate for long-term absenteeism among departmental patient tray service employees are necessarily governed by a) the accepted definition of "long-term absenteeism" and the established rules for such absences in each operation, and b) the availability of sufficiently skilled individuals to permit work schedule adjustment for extended periods of time. Among the 12 hospitals studied the type of dietary department management (hospital operated versus outside contracted services) appeared to be less of a determinant in the worker replacement strategies used than the status of the dietary department employees with respect to unionization.

In the 7 hospitals where the dietary employees were unionized four options appeared generally available to management: a) hiring an additional worker as a temporary replacement for the long-term absentee, b) temporarily assigning a regular relief person to the position for the period needed, c) increasing the number of working hours of regular qualified part-time employee schedules temporarily to provide adequate daily patient meal service coverage for all scheduled meals. In nearly all cases the modifications favor employees rather than management.

In the 5 nonunionized departments there appears to be greater flexibility in making adjustments which favor management by minimizing increases in labor costs during periods of employee long-term absenteeism. The three types of modifications generally used in these departments are a) dividing the duties of the absent worker among the other regular patient tray service workers, b) temporarily assigning a regular relief worker to the vacant position for the period needed, and c) arranging with regular employees for overtime work on a preplanned basis to provide adequate coverage for the duration of the worker shortage.

In emergency situations such as walkouts, strikes and disastrous weather and/or community situations the modifications made to compensate for absenteeism among patient tray service workers are somewhat different from those used to cope with unexpected and/or long-term departmental absenteeism. When these extreme conditions occur absenteeism usually becomes a hospital-wide problem and disrupts nearly all patient services. Under such circumstances all hospital and dietary administrative personnel work together and give high priority to the provision of essential meal services for inpatients and hospital personnel.

Even though not all of the dietary departments studied had actually experienced the emergency situations noted above, the concensus of the interviewees was that in addition to their usual strategies more extreme actions would be undertaken immediately. Depending on the severity and the

duration of the emergency, one or more of the following adjustments would be made:

a. All available hospital personnel (dietary, non-dietary and volunteers) would work together to see that all essential duties related to inpatient and personnel meal services were completed.

b. Menu modifications would be made to simplify the service of all general and special diets. Non-selective menus would be used.

c. More pre-prepared food items would be used.

d. Insofar as possible disposable service items would be used.

e. Public food service units of the hospital (cafeteria, snack shops, vending machines, etc.) for which the dietary department regularly provides food and services would be closed.

Types of Procedural Modifications Usually Made to Cope with Employee Tardiness.--In all hopsitals studied, the types of changes made when tardiness occurs among patient tray service employees depends, in large measure, upon the anticipated extent of tardiness and the usual assignment of the missing employee. All interviewees reported that, irrespective of employee tardiness, patient tray service activities are started as scheduled. In general the temporary adjustments made include one or more of the following in rank order of their practicability:

a. Dietary employees who may be somewhat less familiar with the tardy employee's duties are asked to substitute.

b. Members of the dietary administrative/supervisory staff fill-in for the missing employee.

c. The duties of the missing employee are temporarily divided among the employees who are present.

Insofar as practical, in all hospitals tardy employees are allowed to report to their regular positions upon arrival. Situational factors which must be assessed at the time the employee arrives in the work area include how late the employee is in relation to his/her specific assign duties, how advanced the patient meal service activities are and if the additional shifting in personnel assignments will increase or decrease meal service efficiency.

Effects of Employee Absenteeism and Tardiness on Other Personnel and on the Quality of Patient Meal Services.-- Among the four size categories of hospitals studied, the effects of absenteeism among patient tray service employees on the duties of dietary administrative/supervisory staff differ slightly according to hospital size. In the larger hospitals (400 beds or more) one or more of the following results occur: a) less supervision is given to department employees who do not participate in patient tray service activities, b) diet consultation with patients is limited, and c) staff members must either work overtime to complete their daily duties or work more rapidly and effectively to complete their daily assignments in a shorter period of time. With the exception of working overtime, the same results occur when administrative/supervisory staff members from hospitals with 200-299 beds substitute for absent employees assigned to patient tray service activities. The daily duties of the dietary administrative/supervisory staff

members in hospitals with less than 200 beds are not measurably affected when staff members must substitute for absent employees. Because of the smaller number of inpatients requiring tray service per meal, there appears to be greater flexibility in the use of administrative/supervisory work time in smaller hospitals than is true in the larger hospitals.

When other on-duty dietary employees substitute for absent patient tray service employees adjustments often must be made to compensate temporarily for their absence from their regular duties. In most cases the job responsibilities of employees who are substituting for absent patient tray service employees are either a) divided among the other employees in the work units, or b) performance of less essential duties of employees substituting in patient tray service activities is delayed until the patient meal service duties are completed or c) the least essential duties are omitted entirely to permit the employee to complete his/her work day as scheduled. Only when absolutely necessary are employees asked to work overtime to complete all of their regularly assigned duties.

Usually tardiness among patient tray service employees does not measurably affect the daily duties and responsibilities of other on-duty dietary employees or administrative/supervisory staff members unless the employee is very late in arriving. When extreme tardiness does occur, the effects on other dietary personnel parallel those resulting from absenteeism.

The effects of absenteeism among dietary patient tray service employees on the quality of inpatient meal services are usually more varied and often more severe in smaller hospitals (300 beds or less) than in larger hospitals (400 beds or more). According to those interviewed, in the 6 smaller hospitals delivery of patient trays may be delayed because of worker shortage with the result that some tray items are undesirably warm or cold, some patients do not receive all menu items as ordered because of last minute changes in food items available for service and/or temporary procedural changes are made to simplify the ways in which particular items are served. In the 6 larger hospitals surveyed the usual effect of absenteeism on the quality of inpatient meal services reported by the interviewees is generally limited to delayed or "behind-schedule" delivery of meal trays to patients. Only under very extreme circumstances are menu items or service procedures modified to compensate for absences among patient tray service workers.

In each of the hospitals studied tardiness among regular patient tray service employees results in the same problems for management as does absenteeism. The severity and duration of the effects depend upon the number of employees tardy during a particular meal service period and how late each one is in reporting for work.

Absences and tardinesses among patient tray service workers which cause substantial delays in the delivery of meal trays to patients also often upset other scheduled

essential inpatient services for which other departments of the hospital (nursing, x-ray, physical therapy, diagnostic testing laboratories etc.) have primary responsibility. Because of the possible undesirable multiple effects in the provision of total health care for inpatients all persons interviewed indicated that strict adherence to patient meal service schedules must be maintained.

Personnel Policies Concerning Dietary Employee Absenteeism and Tardiness.--In the 12 hospitals studied policies pertaining to absenteeism and tardiness for dietary employees appear to be well-defined. In every case the departmental regulations conform to the general policies of the hospital, and, where applicable, to specific union contract conditions covering dietary workers and/or to hospital-management company contractural agreements. In some cases departments have additional procedural rules regarding employee responsibilities for reporting and justifying deviations in their attendance behavior.

The conditions under which dietary employees may be absent without loss of pay vary somewhat among the 12 hospitals surveyed according to the particular regulations established in each facility. From the data obtained it is apparent that all departments annually provide a stipulated number of paid leave days for regular full-time employees. The apparent differences among hospitals are due to categorical variances in the number of paid leave days that employees are allowed

per year and the extent of payment permitted. In some cases all paid absences are credited against personal leave days whether such absences are due to illness or to other personal needs. In other facilities payment for days off due to personal illness are differentiated from days off for other reasons such as a death in the immediate family, illness of a family member or other types of personal matters. If an employee has used all his/her earned personal leave days or personal leave and sick days and is absent for an extended period of time, he/she may be entitled to a percentage of his/her regular wages if the employer feels the employee's circumstances merit such consideration. Such cases are individually considered and, if awarded, the reduced remuneration may range from 50 to 60 percent of the employee's regular pay in some of these hospitals. If the employee is absent for a long period of time due to work-related circumstances, in some situations, he/she may qualify for workmen's compensation benefits.

Conditions under which part-time employees may be absent without loss of pay also vary among the 12 hospitals studied. In 4 of the hospitals, regular part-time employees receive no pay for absence due to illness whereas in the other 8 hospitals paid sick leave is awarded according to the number of scheduled work hours missed. In each of these latter hospitals the qualifying conditions for paid sick leave for part-time employees are the same as for full-time employees.

According to the dietary administrators interviewed, many of the restrictions concerning employee absences such as no pay for the first day off, no pay if absent the day before and/or the day after a regular scheduled day off or a holiday, and no pay for a designated number of consecutive days absent without proof of illness resulted from employee abuse of these benefits.

Procedures pertaining to paid compensation for time lost due to employee tardiness are generally the same in all of the dietary departments studied. Decisions as to whether tardy employees are allowed to make up for the time lost by a) working later than usually scheduled, b) reporting earlier on another day or, c) having the tardy time deducted from personal or sick leave allowance rest with the dietary administrative/supervisory personnel. Factors which influence the actions taken usually include a) the amount of time involved, b) the reasons for the employee's failure to report as scheduled, and c) the tardiness frequency of the employee.

In all dietary departments the interviewees indicated that the reasons employees usually give for their absences are those for which they are most apt to receive pay for their lost time. Only on rare occasions do employees indicate reasons for absence which they know will result in loss of pay. Although all hospitals studied require all employees to notify the dietary department when they are unable to report to work as scheduled, only 2 of the 12 hospitals require that the call must be made by the employee himself to qualify for paid absent time.

In a majority of the hospitals studied all employees (full-time and part-time) can accumulate unused sick days up to stipulated maximum. Among the hospitals studied this maximum varies from 5 days to 180 days. In one small nonunionized dietary department employees are paid for unused earned sick time at the end of each operating year. In one of the other hospitals when the maximum number of earned sick days is reached a portion of the time is converted to additional vacation time at a rate of 2 hours of earned sick time equals 1 hour of extra vacation time.

When employment is terminated (voluntarily or nonvoluntarily) the procedures for accrued sick time compensation differ among the 12 hospitals surveyed. In 7 hospitals departing employees do not receive additional pay for unused sick time; in 4 hospitals employees are paid in full for all unused sick time; and in 1 hospital only retirees are compensated for accrued sick time and then for only half of the time they have accumulated. In the 4 hospitals where the job termination policy includes full monetary compensation for unused sick time the administrators indicated that, as a general rule, employees in the 3 smaller hospitals (less than 300 beds) tend to take time off equal to their accrued sick days before departing whereas in the 1 larger hospital employees are more apt to ask for the additional pay at the time they leave their job.

The steps taken when an employee returns after an extended period of absence are principally the same among

the 12 hospitals surveyed. In all hospitals if an employee's absence exceeds a designated number of consecutive days (as few as 3 days in some hospitals) proof of the reason stated for the absence must be provided before the individual can return to his/her assigned work area. Such proof may be a signed statement from the employee's personal physician or from a physician who provides medical services for employees of the hospital. In some situations the hospital physician must also render judgment as to whether the employee is sufficiently recovered to be permitted to return to his/her assigned work area and resume his/her normal duties. In all dietary departments employees are expected to call in advance to inform the manager or their supervisor of the anticipated day of their return so that work assignments and schedules may be readjusted accordingly.

When the tolerance level for patient tray service employee absenteeism is reached, the number of disciplinary steps taken by the management staff differ somewhat among the particular hospitals surveyed. In all hospitals the first two steps are the same. Employees are first given a verbal warning and if the employee's attendance record does not improve the second step is to give the employee a written warning.

Third step actions are the most varied. Among the 12 hospitals, failure to improve attendance behavior results in dismissal in 3 hospitals, in suspension without pay for a specific number of days in 5 hospitals, in a change in work

assignment and/or conditional probation for a designated period of time in 3 hospitals and a written final reprimand in 1 hospital.

In the 9 hospitals who do not terminate employment at the third step, the next or fourth step taken in 6 of the hospitals is dismissal. In the 3 remaining hospitals the employee is suspended from work without pay for a stipulated period of time and if upon return the individual's attendance record does not show marked improvement he/she is then discharged.

The particular disciplinary procedures used for excessive absence in each dietary department are also used for controlling excessive tardiness among dietary employees. However, in the opinion of most of the dietary administrators interviewed, excessive employee absenteeism and tardiness can usually be corrected by verbal and written reprimand. Only rarely must they resort to the more severe penalties of unpaid suspension and/or dismissal.

When asked what the usual disciplinary actions are for absenteeism and tardiness among supervisory personnel, six dietary administrators indicated that the procedures are the same for dietary employees of all levels. Among the six remaining administrators five stated that they first attempt to counsel a supervisory staff member as to the attendance behavior they expect from them as a member of the management team. If such efforts fail to correct the situation then the ensuing procedures parallel those used

for employees. One administrator indicated that he is less lenient with supervisory personnel than with employees because of their leadership roles and their responsibility to set a positive example as a standard for employees to follow.

CHAPTER V

SUMMARY, CONCLUSION AND IMPLICATIONS

This study pertained to hospital meal service practices with major focus on the effects of employee absenteeism and tardiness on patient meal service activities (tray assembly, tray delivery and soiled tray collection). The 12 Michigan hospitals selected for study were a) nonfederally operated, b) located within a 75-mile radius of Lansing, c) licensed by the Michigan Department of Public Health and d) had an inpatient bed capacity of not less than 125 and not more than 700.

The data for the study were obtained through on-site interviews with 18 dietary administrative/supervisory personnel from the 12 selected hospitals. The guide used during the interviews contained both highly structured and semi-structured questions (see Appendix, p. 120).

It was believed that the information obtained from this study would provide some insight as to a) the variety of techniques that are used in different size hospitals for patient meal delivery, b) the procedural modifications that are made when there is absenteeism and/or tardiness among patient tray service employees and c) the variety of hospital personnel policies and procedures that have been established

to deal with the problems of absenteeism and tardiness among dietary employees assigned patient meal service duties.

The summarized findings are presented in the same sequence as the major sections appear in the interview guide.

Summary of Findings

The Respondents

Of the 18 persons interviewed, twelve are dietary administrators (those who manage the activities of the dietary department), and six are supervisory members of the department staff. Five different position titles were identified among the dietary administrators and four were identified among the supervisory personnel. Director of Food Service is the title most frequently held by administrators and the title of Food Service Supervisor is the most common one used for supervisory personnel.

Nine of the dietary administrators interviewed have considerable experience (15 years or more) in the area of food service, 2 have less than 15 but more than 6 years and only 1 administrator has less than 6 years experience. In contrast, extensive experience in the food service field is not as characteristic of the 6 supervisors interviewed. Three have been in the field for less than 6 years, 2 for more than 10 years but less than 15 years and only 1 for more than 20 years. Employment in their present positions for both dietary administrators and supervisory personnel was less than 6 years for the majority from both position levels.

On-the-job experience or formal academic training plus on-the-job experience are the major ways the administrators surveyed prepared themselves for their present positions; 6 by experience only and 6 by a combination of academic study and work experience. For the supervisory personnel, preparation for their current positions was primarily through formal academic training and, for the most part, they are younger and have had relatively few years of on-the-job work experience in the food service field.

Of the 12 hospitals surveyed, 5 of the dietary department administrators are female and 7 are male. Four of the 7 male administrators are employed by contract food management companies and assigned to hospitals of less than 300 beds. Of the 8 dietary departments which are hospital-operated, 5 are managed by women and 3 by men.

Operational Characteristics: Dietary Department

The dietary departments of 8 of the 12 facilities studied (6 with more than 400 and 2 with less than 300 beds) are hospital operated. The remaining 4 (all with less than 300 beds) are managed by contract food service companies. All of the hospitals in the latter category have been operated by an outside agency for less than 3 years. The labor personnel in 7 of the 12 dietary departments are unionized. All of the hospitals with unionized labor personnel are located in communities with populations of more than 100,000.

Greater differences in the average daily percent

inpatient occupancy were found among the three smaller hospitals with less than 200 beds (34 percent) than among the three facilities with 200-299 beds (13 percent). Similar comparison between the two size categories of larger hospitals showed less variation among the three hospitals in the 400-499 bed category (6 percent) than among the three hospitals in the 500-699 bed category (9 percent).

Delivery of trays to patient bedsides is the only type of meal service regularly provided for inpatients in the 12 hospitals studied. However, two additional types of meal service are provided in 2 of the larger hospitals. In one floor trays for inpatient group dining are provided and in the other, upon request, visitor trays are delivered to patient rooms.

Five different meal-nourishment service patterns were found among the 12 hospitals surveyed. All of the patterns consist of 3 or 4 regularly scheduled meals plus one of 4 nourishment schedules. Regular meal services in all of the hospitals begin between 7:00 - 7:30 a.m., 11:00 - 11:30 a.m. and 4:15 - 4:30 p.m. for the morning (regular breakfast), noon and evening meals, respectively and at 10:00 a.m., 2:00 p.m. and 7:00 or 8:00 p.m., respectively for the 3 regularly scheduled nourishments. In the one hospital which provides 4 meals, the service of the first (early breakfast) begins at 6:00 a.m. Approximately 45 to 60 minutes are allowed for the service of each meal in the smaller hospitals whereas 60 to 95 minutes are allowed for this function in

the larger hospitals. The service time required for each of the scheduled nourishments ranges from 45 to 60 minutes in all 12 hospitals. Patient meal menus are selective in 11 of the 12 hospitals surveyed and nonselective in only one. Nourishment menus are either selective or semi-selective in 9 of the hospitals and nonselective in only 3.

With the exception of soups, a greater number of larger hospitals (more than 400 beds) than smaller hospitals (less than 300 beds) purchase a wide variety of prepared menu items. Of the 12 hospitals studied, 100 percent purchased prepared breads and/or rolls and beverages, 80-90 percent purchased prepared appetizers, soups, entrees, vegetables and tube feedings. None of the hospitals purchased prepared salads or sandwich mixes.

Two methods (centralized and decentralized) are used in the 12 hospitals to assemble patient meal trays and 3 methods (centralized, decentralized and a combination of centralized and decentralized) are used to assemble nourishments. Of the two methods used for tray assembly, 11 of the hospitals use the centralized method and only 1 uses the decentralized method. When assembling nourishments, 4 of the hospitals use the centralized method, 4 use the decentralized method and the remaining 4 use a combination of the centralized and decentralized methods.

In the 11 hospitals where the centralized method is used to assemble patient meal trays, preassembled trays are delivered directly from the dietary department to the

patient areas. Bulk food (to be used in tray assembly) is sent to the patient division in the one large hopsital in which the decentralized method is used to assemble inpatient trays. In some of the hospitals preassembled nourishment trays are delivered to patient divisions and in some an assortment of service-ready nourishments are also delivered to patient divisions. In addition, bulk supplies of nourishment items are delivered to the patient divisions in all hospitals. The responsibility of delivering service-ready foods to patient areas (meals and nourishments) is that of dietary labor personnel in all 12 of the hospitals studied. Delivery of assembled meal trays and nourishments to patient bedsides may be the responsibility of either dietary labor personnel or personnel of the nursing department and varies among hospitals according to the individually established work assignment policies of the hospitals surveyed. Among the 12 hospitals studied, facility size did not appear to be a factor of influence in this regard.

Manpower Needed to Provide Patient Tray Services

The number of dietary manhours/100 beds required to assemble inpatient trays varies within and among the 4 categories of hospitals studied. In the category of smaller hospitals with less than 200 beds, a decreasing number of manhours/100 beds is required per day as hospital bed capacity increases. Among the 3 hospitals with 200-299 beds, fewer manhours/100 beds are required per day in the hospital with

244 beds (second largest) than in the other two hospitals. When considering the daily manhours/100 beds required for tray assembly in the 2 categories of larger hospitals (more than 400 beds), a slight decrease is found as hospital bed capacity reaches 500 and the centralized method of tray assembly is used. When the decentralized method is used, the manhours/100 beds required per day triple. In all hospitals in which the centralized method is used to assemble inpatient trays, the manhours/100 beds required to assemble trays for breakfast (first regular meal) are less than for the noon and evening meals. In the one hospital in which the decentralized method of tray assembly is used, the manhours/100 beds required per day for the noon meal are less than for breakfast or for the evening meal.

Dietary manhours/100 beds required per day in the 5 hospitals where dietary employees deliver service-ready trays to patient bedsides increase as hospital size increases. In these 5 hospitals, the return of soiled trays to the dishwashing area requires fewer manhours/100 beds than the distribution of the service-ready meals. In the 7 hospitals where dietary employees only deliver trays to and collect them from patient areas, the return of soiled trays to the dishwashing area from the patient area requires the same number of dietary manhours/100 beds daily as required to deliver the service-ready meal trays to the patient areas.

A greater number of dietary manhours/100 beds is required per day in those 5 hospitals where dietary employees

are responsible for all tray service activities; tray assembly, tray delivery to patient bedsides and soiled tray collection from patient bedsides. Of the tray service activities, tray assembly requires 50 percent or more of the total dietary manhours/100 beds per day.

The differences in the total dietary manhours/100 beds required for all meal service activities appear to be due primarily to the method of patient tray assembly used. More than twice as many total dietary manhours/100 beds are required daily for tray service activities in the one hospital using the decentralized method of tray assembly than in any of the 11 hospitals using the centralized method.

Regardless of the number of scheduled nourishments per day, the personnel (dietary or nursing) responsible for delivering nourishments to patient bedsides or the method used to assemble nourishments for distribution, the total number of dietary manhours/100 beds required to assemble and deliver nourishments to patient bedsides and areas is approximately 2 per day. Because all hospitals studied use disposable ware for nourishment services and the removal of refuse from nourishment services is the responsibility of nondietary personnel, no additional dietary manhours are required in this part of the service procedure.

Fourteen different job titles were identified among the dietary workers assigned to patient tray service activities in the 12 hospitals studied. The job titles of similar terminology used for dietary labor personnel in at least one

hospital within each hospital size-category are dietary aide and dietary porter. Other job titles used for labor personnel which carry comparable job status in the smaller hospitals are general dietary personnel, kitchen assistant, dietary technician and therapeutic aide. Other titles used to describe similar positions in larger hospitals are food handler, general dietary personnel and food service worker. In one of the larger hospitals, senior food service worker is a title given to a dietary employee to denote a position one step above the entry level.

In all 12 hospitals, professional dietitians, dietary technicians and/or food service supervisors or assistant food service supervisors participate in patient meal service activities. Of these position titles, professional dietitian, dietary technician and food service supervisor are the ones given to the supervisory personnel who participate in patient tray service activities in larger hospitals. In the smaller hospitals supervisory staff who participate in patient tray service activities have the title of either food service supervisor or assistant food service supervisor.

Personal Characteristics and Educational Background of Employees who Assist in Patient Tray Services

In general, the majority of the dietary labor personnel in 11 of the 12 hospitals studied are female (62 percent or more), married (50 percent or more) and vary widely in age (16 to 70 years). Exceptions among hospitals include 1 smaller hospital (244 beds) which has 61 percent male employees,

1 larger hosptial (477 beds) in which 85 percent of the dietary employees are single and 1 smaller hospital (135 beds) in which all dietary employees are between 40 and 45 years of age.

The presence of well-educated dietary labor personnel was found within all size categories of hospitals studied. In 11 of the 12 hospitals studied, 55 percent or more of the labor personnel have completed high school or high school plus vocational school. In the 1 remaining hospital (213 beds) only 20 percent of the labor personnel have completed high school.

Among the hospitals studied, a higher percentage of the dietary labor personnel in the larger hospitals have a college level education than is true in the smaller hospitals. The highest percentage of the labor personnel with bachelor degrees (10 percent) was found in one of the larger hospitals. In this hospital, a majority of the employees with these degrees are working under the provisions of the Comprehensive Employment and Training Act of 1973.

Irrespective of hospital size, both college and high school level education are characteristic of the dietary administrative/supervisory staff members in the 12 hospitals studied. In only one hospital all administrative/supervisory staff members who participate in patient tray service activities have only a high school education. Among the 12 hospitals studied, the percentage of administrative/supervisory staff members regularly participating in patient meal

service activities who have completed college range from 17 to 88. Percentages for those who have only completed high school range from 12 to 100. The higher percentages of persons who had not completed a college degree were found in smaller hospitals (less than 300 beds) rather than in larger hospitals (400 beds or more).

Absenteeism and Tardiness Among Patient Meal Service Employees

The dietary administrative/supervisory personnel interviewed associated the seasons of winter, spring and summer with frequent absenteeism among dietary employees who participate in patient tray service activities. According to these staff members, absenteeism during the winter is primarily due to illness (colds and flu) and in the spring, absenteeism among the older employees (those who are not of high school age) is related to their practice of taking time off to enjoy the pleasant weather conditions and among the younger employees (those who are attending high school) with their desire to participate in the extracurricular school activities. Absenteeism during the summer is related to the employee's desire to be outside enjoying themselves.

Monday, Friday, Saturday and Sunday are the days of the week associated with absenteeism among patient tray service employees by the personnel interviewed. According to these staff members three specific times when there is more absenteeism among patient tray service employees in the larger hospitals are: a) the day before and/or the day after an

employee's regular day off, b) around but not on specific holidays and c) the day after pay day. The specific time when absenteeism among patient tray service employees occurs more frequently in smaller hospitals is the day after pay day.

The rate of absenteeism per week among employees who participate in patient tray service activities showed less variation (1-3 percent) among the 6 smaller hospitals (less than 300 beds) than among the 6 larger hospitals (1-12 percent). Of the smaller hospitals, 2 have an absentee rate of 3 percent, 2 have an absentee rate of 2 percent and 2 have an absentee rate of 1 percent. Among the larger hospitals (more than 400 beds), 3 have absentee rates of 1, 2 and 4 percent, respectively, but 2 have absentee rates of 10 percent and 1 has an absentee rate of 12 percent. Neither marital status nor age of the employees were found to be related to absenteeism in 10 of the hospitals studied. Of the other 2, in 1 smaller hospital (182 beds) married employees are absent more frequently than single persons and in 1 larger hospital (527 beds) employees in the age group of 18-21 are absent more often than those over 21 years of age.

Tardiness is associated with specific seasons of the year in only 5 hospitals. Of these five, the three dietary administrative/supervisory members from the larger hospitals associated winter with employee tardiness and the two from the smaller hospitals associated tardiness with spring. Administrative/supervisory personnel from the other 7

hospitals stated that tardiness is not really a serious problem. There is very little tardiness and when it occurs it is usually related to transportation methods.

The number (1 or 2) of patient tray service employees that can be absent or tardy before inpatient meal service efficiency is seriously impaired depends on: a) the specific meal service activity for which dietary employees have major responsibility (tray assembly, tray delivery to patient floors and/or patient bedsides, soiled tray collection from patient bedsides and/or floors), b) the relationship between the number of patient trays to be processed per meal and the number of dietary workers normally available to provide the required services as scheduled and c) the expected productivity levels of dietary employees assigned to patient meal service duties under normal full-time conditions.

Absenteeism affects breakfast (first regular meal) service most in 10 hospitals (5 larger and 5 smaller) and tardiness seriously affects this meal service in only 5 hospitals (2 smaller and 3 larger). The specific meal service activity affected most by absenteeism and/or tardiness in these hospitals is patient tray assembly. In some of these hospitals, however, all activities related to patient tray services are impaired when employees are absent or tardy.

Of the different adjustments made to cope with unexpected absenteeism, irrespective of their size, in all hospitals the first adjustments consist of attempts by the dietary

administrative/supervisory staff to compensate for the missing worker(s) by first utilizing the skills and services of other on-duty dietary workers to maintain patient meal services as scheduled without increasing payroll costs. If this type of adjustment is deemed inadequate the next options are: a) to obtain the necessary workers on a paid overtime basis (time and a half), b) divide the duties of the absentees among the regular patient tray service employees present and/or c) modify the patient menus to simplify the meal service procedures required. The effect of unexpected absenteeism on patient services ultimately depends on the resources available to management (human, material, financial) and the ability of management to use them to operational advantage to meet worker shortage.

Among the 12 hospitals studied, the types of procedural modifications used to compensate for long-term absenteeism among patient tray service employees depend on the prevailing definition of "long-term absenteeism" and the availability of sufficiently skilled individuals to permit work schedule adjustments for extended periods of time. The options usually available in unionized hospitals are: a) hiring an additional worker as a temporary replacement for the long-term absentee, b) temporarily assigning a regular relief person to the position for the period needed, c) increasing the number of working hours of regular qualified part-time employees temporarily to provide adequate daily

patient meal service coverage for all scheduled meals. Modifications generally used in nonunionized hospitals generally are: a) dividing the duties of the absent worker among the other regular patient tray service workers, b) temporarily assigning a regular relief worker to the vacant position for the period needed and c) arranging with regular employees for overtime work on a preplanned basis to provide adequate coverage for the duration of the worker shortage.

Absenteeism caused by emergency situations such as walkouts, strikes and disastrous weather and/or community situations are cooperatively handled by both dietary and hospital administrative personnel. Even though not all of the hospitals studied have actually experienced an emergency situation, the concensus of the interviewees was that in addition to their usual strategies one or more of the following adjustments would be made: a) all available hospital personnel (dietary and nondietary) would work together to see that all essential duties related to inpatient and personnel meal services are completed, b) menu modifications would be made to simplify the service of all general and special diets, c) nonselective menus would be used, d) more pre-prepared food items would be used and e) insofar as possible disposable service items would be used.

The daily duties of dietary administrative/supervisory staff members are measurably affected by absenteeism among patient meal service workers in 3 of the 4 size categories of hospitals studied. In the two categories of hospitals

with more than 400 beds, one or more of the following results occur: a) less supervision is given to department employees who do not participate in patient meal services, b) diet consultation with patients is limited and c) staff members either work overtime to complete their daily duties or work more rapidly to complete their duties in a shorter period of time. In the 1 remaining category of hospitals (200-299 beds) in which absenteeism among patient meal service employees affects the duties of dietary administrative/ supervisory personnel, except for working overtime, the same results occur as stated for the two categories of larger hospitals.

When other on-duty dietary labor personnel substitute for absent patient tray service employees, dietary administrative/supervisory personnel must make adjustments to compensate for their absence from their regular duties. The adjustments usually made are: a) to divide the regular duties of the employee who is substituting for an absent or tardy employee among other employees in that work unit, b) to delay the performance of less essential regular duties of the employee substituting in patient tray service activities or c) omit the least essential duties of the employee who is substituting in order to permit the employee to complete his/her work day as scheduled.

Unless an employee is very late in arriving, tardiness does not measurably affect the duties of other dietary personnel. When extreme tardiness does occur, the effects

on dietary personnel parallel those resulting from absenteeism.

According to those interviewed, the effects of absenteeism among dietary patient tray service employees on the quality of inpatient meal services are usually more varied and more severe in smaller hospitals (less than 300 beds) than in larger hospitals (more than 400 beds). The effects that result in smaller hospitals are a) patient trays may be delayed because of worker shortage with the result that some tray items are undesirably warm or cold, b) some patients may not receive all menu items as ordered because of last minute changes in foods available for service and/or c) temporary procedural changes are made to simplify the ways in which particular items are served. In the larger hospitals surveyed the usual effect of absenteeism on the quality of inpatient meal services is generally limited to delayed or "behind schedule" delivery of meal trays to patients.

Tardiness among patient tray service employees usually causes the same types of problems as absenteeism. However, the severity and duration of the effects of tardiness depend upon the number of employees tardy during a particular meal service period and how late each one is in reporting to work.

Scheduled essential inpatient services for which other departments of the hospital (nursing, x-ray, physical therapy, diagnostic testing laboratories, etc.) have primary responsibility are often upset if absenteeism and/or tardiness

among patient tray service employees cause substantial delays in the delivery of meals to patients. All persons interviewed indicated that strict adherence to inpatient meal service schedules is maintained as much as possible because of the compounding effects resulting from off-scheduled patient meals.

In all 12 hospitals, policies pertaining to absenteeism among dietary patient tray service employees were well-defined. These regulations conform to the general policies of the hospital and, where applicable, to specific union contract conditions covering dietary workers and/or hospital-management contractural agreements. Additional procedural rules regarding employee responsibilities for reporting and justifying deviations in their attendance records were found in some hospitals. All 12 hospitals annually provide a stipulated number of paid leave days for regular full-time employees, however, the situation for part-time employees differs among hospitals.

The differences among hospitals in relation to policies regarding absenteeism among full-time employees are due to categorical variances in the number of paid leave days that employees are allowed per year and the extent of payment permitted. In some cases all paid absences are credited against personal leave days whether such absences are due to illness or to other personal needs. In other hospitals, payment for days off due to personal illness are

differentiated from days off for other reasons such as a death in the immediate family, illness of a family member or other types of personal affairs. If an employee who has used all of his/her sick time is absent for an extended period of time, in some of the hospitals studied he/she may be able to collect a percentage (50-60 percent) of his/her regular pay. In other hospitals, employees who are absent for a long period of time due to work-related circumstances, may qualify for workman's compensation.

For part-time employees, conditions under which they can be absent with pay vary among the 12 hospitals studied. In 4 of the hospitals, regular part-time employees receive no pay for absence due to illness whereas in the other 8 hospitals paid sick leave is awarded according to the number of scheduled work hours. In these latter hospitals the qualifying conditions are the same as for full-time employees.

Decisions as to whether tardy employees are allowed to make up for the time lost by a) working later than usually scheduled, b) reporting earlier on another day or c) having the tardy time deducted from personal or sick leave time allowance rest with the dietary administrative/supervisory personnel of the particular hospital.

The reasons that employees usually give for their absences are those for which they are most apt to receive pay for their lost time. Seldom do employees indicate reasons for absence which they know will result in loss of pay. Even though all hospitals require that employees

notify the department when they are unable to report to work as scheduled, only 2 of the 12 hospitals require that the call reporting the absence be made by the absent employee.

Employees can accumulate unused sick days up to a stipulated maximum in a majority of the hospitals studied. This maximum varies from 5 days to 180 days. In one of the small nonunionized hospitals, dietary patient tray service employees are paid for unused earned sick time at the end of each operating year. In one of the larger hospitals when the maximum number of earned sick days is reached a portion is converted to additional vacation time at a rate of 2 hours of earned sick time for 1 hour of extra vacation time.

The procedures for accrued sick time compensation also differ when an employee is terminated (voluntarily or nonvoluntarily). In 7 hospitals departing employees do not receive additional pay for unused sick time; in 4 hospitals employees are paid in full for all unused sick time; and in 1 hospital only retirees are compensated for accrued sick time and then for only half of the time they have accumulated. In the 4 hospitals where the job termination policy includes full monetary compenstaion for unused sick time the administrators indicated that, as a general rule, employees in the 3 smaller hospitals (less than 300 beds) tend to take time off equal to their accrued sick days before departing whereas in the 1 larger hospital employees are more apt to ask for the additional pay at the time they leave.

In all hospitals if an employee's absence exceeds a designated number of consecutive days (as few as 3 days in some hospitals) proof of the reason stated for the absence must be provided before the individual can return to his/her assigned work area. Such proof may be a signed statement from the employee's personal physician or from a physician who provides medical services for employees of the hospital. Along with the proof of illness, in some facilities the hospital physician must also render judgment as to whether the employee is sufficiently recovered to be permitted to return to his assigned work area and resume his/her normal duties. In all dietary departments employees are expected to call in advance to inform the manager or their supervisor of the anticipated day of their return.

When the tolerance level for absenteeism is reached among patient tray service employees, the disciplinary steps taken by management vary from 3 to 5 in the 12 hospitals studied. The steps are as follows:

a) The first two steps are the same in all hospitals. First employees are given a verbal warning and if the employee's attendance record does not improve the second step is to give the employee a written warning.

b) Third step actions vary considerably among the 12 hospitals studied. Failure to improve attendance results in dismissal in 3 hospitals, in suspension in 5 hospitals, in a change in work assignment and/or

conditional probation for a designated period of time in 3 hospitals and a written final reprimand in 1 hospital.

c) In the 9 hospitals where employees are not terminated at the third step, the next or fourth step taken in 6 of these hospitals is dismissal. In the 3 remaining hospitals the employee is suspended from work for a stipulated period of time, and if upon return the individual's attendance record does not show marked improvement, the fifth step taken is dismissal.

The particular disciplinary procedures used for excessive absence in each dietary department are also used for controlling excessive tardiness among dietary employees. However, in the opinion of most of the dietary administrators interviewed, excessive employee absenteeism and tardiness can usually be corrected through verbal and written warnings.

Six dietary administrators indicated that they follow the same procedures for supervisory personnel as for labor personnel when the tolerance level of absenteeism and tardiness is reached. Among the 6 remaining administrators, five stated that they first attempt to counsel a supervisory staff member as to the attendance behavior they expect from them as a member of the management team. One administrator indicated that he is less lenient with supervisory personnel than with labor personnel because of their leadership roles

and their responsibility to set a positive example as a standard for employees to follow.

Conclusions and Implications

Although it is acknowledged that the scope of this investigation is quite limited, the findings from the study lend credence to eight general conclusions regarding the operational aspects of dietary departments and the procedural elements involved in the provision of inpatient meal services in nonfederally operated hospitals in Michigan.

1. Irrespective of facility size, community size, type of dietary department management or employee unionization status, the operational characteristics and inpatient meal service procedures of hospital dietary departments are generally similar. Each department is obliged to service the individual needs of patients, personnel and visitors within the constraints imposed by the policies and practices of the hospital of which it is an essential part. Differences in departmentally established procedures for inpatient meal-nourishment services (tray assembly, tray delivery and soiled tray collection) are due, primarily, to variations in the extent of responsibility assigned to the respective dietary departments to provide for the dietary needs of inpatients throughout their periods of confinement.

2. Hospital dietary departments are managed by personnel with various levels of academic training and/or experience in the food service field. Employment of a contract food management firm to operate the dietary department is practiced more by smaller hospitals (300 beds or less) than larger hospitals (400 beds or more).

3. The majority of dietary labor personnel who participate in patient meal service activities in Michigan hospitals are married females from a wide range of ages (16-70 years). More than half of these employees have completed high school. Positions of dietary labor personnel regularly assigned to patient meal service activities are described by many different titles whereas the positions of

of dietary administrative/supervisory personnel regularly involved in patient meal services are identified by relatively few different titles. Unionization among dietary labor personnel is related to and influenced more by community size than by hospital size or type of dietary department management.

4. In nearly all hospitals dietary employees are responsible for all functions related to the preparation of service-ready meal trays and nourishments (assembly and/or delivery to patient areas) and the collection of soiled meal trays from the patient areas. Responsibility for meal tray and nourishment distribution to patients and the collection of soiled meal trays from patients varies according to hospital policy and may be assigned to either dietary or nondietary personnel.

5. In the provision of inpatient meal-nourishment services the two major determinants of dietary manpower needs and the associated labor costs are the extent of service responsibility assigned to the dietary department and the method(s) used to assemble meal trays and nourishments for distribution.

6. Higher rates of absenteeism among patient tray service employees in Michigan hospitals are more prevalent in larger hospitals than in smaller hospitals. Absenteeism among patient tray service employees is more likely to be associated with particular seasons of the year, days of the week and specific times of the week and of the year than tardiness. In most instances employee absences are due to personal needs and situational factors rather than to on-the-job causes. Tardiness among patient tray service employees is neither frequent nor a problem of great concern to dietary administrative/supervisory personnel.

7. Modifications made to compensate for absences (unexpected, long-term and those cause by emergency situations) and tardinesses among patient tray service employees are similar in Michigan hospitals. Regardless of the number of employees absent or tardy or the situations which cause the absences, all dietary administrative/supervisory personnel work together to see that meal service schedules, the quality of patient meals, and the adequacy of patient meal service are maintained. In addition, when excessive absences occur, such as those caused by extreme situations, hospital nondietary personnel

also participate in patient meal-nourishment service activities to see that meal services for patients are adequately maintained for the duration of the emergency.

8. Hospital and dietary department policies and practices pertaining to employee absenteeism and tardiness are well-defined and designed both to treat all employees fairly and to assist management in the control of operational procedures essential for success. When employees abuse or fail to follow the established rules regarding work attendance, the number and successive severity of the mandatory steps for management before an employee can be discharged are specifically detailed in the regulatory practices established by each hospital. In general, the more steps required the more chances the employee has to correct his/her attendance behavior.

From this study it is apparent that, regardless of facility size, the policies and procedures pertaining to inpatient meal-nourishment tray assembly, tray delivery and soiled tray collection in Michigan hospitals are similar. Dietary personnel will continue to have ultimate responsibility for all activities related to patient meal services.

Dietary departments use the centralized method for assembling inpatient trays to minimize labor costs and enable managers of dietary departments to have more precise control of the personnel who participate in patient tray services, the assembly of prescribed food items and the system used for patient food distribution. The only meal service activities that nondietary personnel are apt to be involved in are the delivery of service-ready foods to and the collection of soiled trays from patient bedsides.

Absenteeism and tardiness among patient tray service employees are inevitable and bound to interfere with the

efficiency with which patient meal service activities can be performed. The number and types of modifications that need to be made to cope with or compensate for poor attendance among employees are daily problems dietary administrative/supervisory personnel are forced to deal with as effectively as possible. As long as the human related problems of employee absenteeism and tardiness persist, new policies, procedures and regulations will be formulated and/or existing ones revised in an effort to minimize their occurences. Of all the service responsibilities inherent in hospital dietary department operation, inpatient meal-nourishment services must be given priority.

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APPENDIX

INTERVIEW GUIDE

SURVEY: EFFECTS OF ABSENTEEISM & TARDINESS ON PATIENT MEAL SERVICE IN MICHIGAN HOSPITALS

INTERVIEWEE(S)

#1. Mr, Mrs, Ms, _____

#2. Mr, Mrs, Ms, _____

#3 Mr, Mrs, Ms, _____

DATE OF INTERVIEW_____ TIME_____

HOSPITAL_____

SIZE-RANGE_____ (beds)

PART I: THE RESPONDENT(S)

1. ADMINISTRATIVE TITLE

#1	#2	#3		TITLE
				Director of Food Service
				Director of Dietetics
				Chief Administrative Dietitian
				Chief Therapeutic Dietitian
				Administrative Dietitian
				Therapeutic Dietitian
				Food Service Manager
				Dietary Technician
				Food Service Supervisor
				Chief, Head, or Charge Nurse
				Staff Nurse
				Other_____

2. PROFESSIONAL EXPERIENCE

a) Years in area of food service #1____ #2____ #3____
b) Years in present position #1____ #2____ #3____
c) Area(s) of Specialization

#1	#2	#3		AREA
				Hotel & Restaurant Management
				Institution Management(Admin.)
				Food Service Management(Admin.)
				Dietetic-Administrative
				Dietetic-Therapeutic
				Dietetic-General
				Dietary Technician
				Business Administration
				Home Economics(identify area)
				Fd. Ser. Supervisory Training
				Other_____
				None-Experience only

PART II: OPERATIONAL CHARACTERISTICS--DIETARY DEPARTMENT

3. MANAGEMENT OF THE DIETARY DEPARTMENT:
___Hospital operated
___Contract Fd. Co. (Total)
___Contract Fd. Co. (Mgt. only)

4. ARE THE EMPLOYEES OF THE DIETARY DEPARTMENT UNIONIZED? ___yes ___no

5. AVERAGE DAILY IN-PATIENT CENSUS. _____

6. WHAT TYPES OF PATIENT MEAL SERVICES ARE PROVIDED?
___patient tray (bedside)
___cafeteria (on patient division or in another area)
___family style (patient division or in another area)
___other (identify)_____

7. WHAT MEAL SERVICE PATTERN(S) ARE USED? WHAT TIME IS EACH MEAL SERVED?

	Pattern(s)						
a)	___3 meals	_____	_____	_____			
b)	___5 meals	_____	_____	_____	_____	_____	
c)	___3 meals + 2 snacks	_____	_____	_____	_____	_____	
d)	___3 meals + 3 snacks	_____	_____	_____	_____	_____	_____
e)	___other (describe)	_____	_____	_____	_____	_____	_____

8. WHAT TYPES OF MENUS ARE USED FOR PATIENT DIETS?

a)

Types	selective	semi-selective	non-selective
General Diets			
Special Diets			
Nourishments			

b) Are the same policies used on holidays? ___yes ___no
weekends? ___yes ___no

c) If not, what types are used on:

Holidays?_____

_____

Weekends?_____

_____

9. FOOD PURCHASING POLICIES

a) What percentage of the menu items you serve are purchased:
_____% fully prepared (service-ready or reconstitute and serve)
_____% partially prepared (additional preparation required)

b) What types of prepared foods do you buy?

_____appetizers
_____soups
_____entrees
_____potatoes
_____vegetables
_____salads
_____sandwich mixes
_____desserts
_____bread and/or rolls
_____beverages
_____tube feedings
_____special nourishments
_____meal supplements
_____other (identify)

_____

10. WHAT METHOD(S) OF PATIENT TRAY ASSEMBLY ARE USED?

ASSEMBLY METHOD	MEALS	NOURISHMENTS
centralized		
de-centralized		
combination: centralized and de-centralized		

11. HOW IS THE SERVICE-READY FOOD DELIVERED FROM THE MAIN KITCHEN TO THE PATIENT AREA?

____Bulk-Food carts to pantries on each floor
____Bulk-Food carts to pantries in one central area for tray assembly and distribution to patients on more than one floor
____Preassembled trays sent to each floor for direct delivery to patients
____Other (describe)_____

_____

12. WHO IS RESPONSIBLE FOR DELIVERING SERVICE-READY FOOD?

a) To patient areas	b) To patients
_____Patient Fd. Ser. Aides	_____
_____Dietary Aides (kitchen helper)	_____
_____Dietary Porters	_____
_____Dishroom Aides	_____
_____Nurses (charge, staff, aide)	_____
_____Volunteers	_____
_____Others (specify)	_____

_____

PART III--MANPOWER NEEDED TO PROVIDE PATIENT TRAY SERVICES

13. HOW MANY FULL-TIME AND PART-TIME PERSONNEL ARE NEEDED EACH MEAL TO PROVIDE: a) TRAY ASSEMBLY, b) TRAY DELIVERY and c) SOILED TRAY COLLECTION? (INCLUDE WORKERS INVOLVED IN ALL LOCATIONS WITHIN THE SYSTEM.)

MEAL SERVICE STEPS

MEALS SERVED [1]	(a) TRAY ASSEMBLY [2]				(b) TRAY DELIVERY				(c) SOILED TRAY COLLECTION				TOTAL
	T	DE	ND	V	T	DE	ND	V	T	DE	ND	V	
#1 Full Time													
Part Time													
Total													
#2 Full Time													
Part Time													
Total													
#3 Full Time													
Part Time													
Total													
#4 Full Time													
Part Time													
Total													
#5 Full Time													
Part Time													
Total													
#6 Full Time													
Part Time													
Total													
Total Meals 1-6													GRAND TOTAL

[1] #1-6=consecutive meals from 12:01 am - 12:00 pm
Full time=30 or more hours/day
Part time=less than 30 hours/week

[2] T=total number
DE=dietary dept. employees
ND=non-dietary dept. employees
V=volunteers

14. WHAT EMPLOYEE JOB CLASSIFICATIONS ARE REPRESENTED AMONG THE DIETARY DEPT. PERSONNEL WHO ASSIST IN PATIENT TRAY SERVICES? HOW MANY IN EACH CLASSIFICATION? HOW MANY HRS/DAY IS REQUIRED OF EACH PERSON?

DIETARY JOB CLASSIFICATION	TRAY ASSEMBLY					TRAY DELIVERY					SOILED TRAY COLLECTION					TOTAL BY CLASS
	No.	Hours/day				No.	Hours/day				No.	Hours/day				
Dietitian(s) (Professional)																
Main Course Cook(s)																
Vegetable Cook(s)																
Salad Cook(s)																
Bakery Cook(s)																
Other																

14. JOB CLASSIFICATIONS (continued)

DIETARY JOB CLASSIFICATION	TRAY ASSEMBLY					TRAY DELIVERY					SOILED TRAY COLLECTION					TOTAL TIME	
	No.	Hours/day				No.	Hours/day				No.	Hours/day				Sub T	GT
Dietary Technician(s) Interns																	
Patient Food Service Worker(s)																	
Kitchen Assistant(s)																	

PART IV--PERSONAL CHARACTERISTICS AND JOB RESPONSIBILITIES OF DIETARY EMPLOYEES WHO ASSIST IN PATIENT TRAY SERVICES

15. EMPLOYEE CHARACTERISTICS

a) Of the Dietary Dept. Labor Personnel assigned to patient tray services, how many are males? How many are females? How many are under 18? 18-25? 26-55? 41-55? over 55? How many are married? How many are single? (Record according to sex.)

SEX	TOTAL	AGE RANGES					MARITAL STATUS	
		under 18	18-25	26-40	41-55	over 55	married	single
Male								
Female								
Total Labor								

b) On the average, how many children do these employees have living at home? _____

c) What is the general range of children's ages per household? _____

d) What proportion of these employees have other dependents at home? (Spouses, parents, other relatives, friends.)

_____

15. EMPLOYEE CHARACTERISTICS (continued)

e) Among the Labor Personnel of the Dietary Department assigned patient tray service duties, what proportion (or percentage) have completed the following levels of education?

EDUCATIONAL LEVEL	PROPORTION OR % OF EMPLOYEES						
	All 100%	Nearly All 80%	More Than Half 60%	Half 50%	Less Than Half 30%	Few -30%	None 0%
Bachelor Degree (4 yrs. College)							
Associate Degree (2 yrs. College)							
High School + Vocational School							
High School							
Vocational School							
Jr. High School (Middle School)							
Elementary School							
Other							

16. WHAT ARE THE MAJOR WORK ASSIGNMENTS PERTAINING TO PATIENT TRAY SERVICE ACTIVITIES PERFORMED BY DIETARY DEPT. EMPLOYEES? NON-DIETARY EMPLOYEES?

WORK ASSIGNMENTS	DIETARY DEPT. EMPLOYEES				NON-DIETARY EMPLOYEES	
	Admin. Staff	Ther. Staff	Pt. Fd. Serv. Emp.	Main Kitchen Emp.	Nurses (aides, staff, charge)	Volun-teer
Tray assembly-main Kitchen						
Tray assembly-patient area						
Deliver bulk food--pt. area						
Deliver service-ready food (pt. area)						
Deliver service-ready food (pts.)						
Deliver nour. + snacks (pt. area)						
Deliver nour. + snacks (pt.)						
Check trays before serv. (pt.)						
Collect soiled trays (pt. bedside)						
Collect soiled trays (pt. area)						
Return soiled trays (dishwashing area)						
Isolation tray assembly						
Deliver + Collect Isolation trays						
Other						

PART V--MODIFICATIONS MADE IN PATIENT TRAY SERVICE PROCEDURES WHEN THERE IS ABSENTEEISM AND/OR TARDINESS AMONG INDIVIDUALS RESPONSIBLE FOR PATIENT TRAY SERVICES

17. DURING WHICH SEASON OR TIMES OF THE YEAR DO YOU ENCOUNTER MORE ABSENTEEISM AND TARDINESS FROM PATIENT TRAY SERVICE EMPLOYEES?

SEASONS & TIMES	ABSENTEEISM	TARDINESS
Fall		
Winter		
Spring		
Summer		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Around and on specific holidays		
Day before employee's regular day off		
Day after employee's regular day off		
Other		

18. HOW MANY INDIVIDUALS CAN BE ABSENT(?), (TARDY), FROM PATIENT TRAY ASSEMBLY, TRAY DELIVERY AND SOILED TRAY COLLECTION BEFORE THE EFFICIENCY OF MEAL SERVICE IS AFFECTED? (give the number for each meal)

	TRAY ASSEMBLY						TRAY DELIVERY						SOILED TRAY COLLECTION					
	Meals*						Meals						Meals					
	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
ABSENT																		
TARDY																		

*1-6 No. of meals served

19. WHICH MEAL(S) AND WHICH TRAY SERVICE ACTIVITY(ES) ARE MOST AFFECTED BY ABSENTEEISM AND/OR TARDINESS? (dietary employees)

	TRAY SERVICE ACTIVITIES					
	ASSEMBLY		DELIVERY		COLLECTION	
MEALS	ABS.	TARD.	ABS.	TARD.	ABS.	TARD.
1st						
2nd						
3rd						
4th						
5th						
6th						
Other						

20. WHAT ARE THE ADJUSTMENTS MADE IN PATIENT TRAY SERVICE ACTIVITIES IN ORDER TO COMPENSATE FOR UNEXPECTED ABSENTEEISM AND TARDINESS?

TYPE OF ADJUSTMENT	TRAY ASSEMBLY		TRAY DELIVERY		SOILED TRAY COLLECTION	
	ABS.	TARD.	ABS.	TARD.	ABS.	TARD.
Dietary workers who are less familiar with tray service activities are assigned to area						
Obtain help from non-dietary department emp.						
Menu modifications made to simplify service requirements						
Admin. and/or Supv. Staff substitute for missing emp.						
Vol. are asked to work in service area						
Pt. tray serv. emp. who are on-call are asked to report on duty						
Pt. tray serv. emp. who are scheduled-off are asked to come in						
Emp. are asked to work overtime if abs. or tard. is on a shift later than the first						
Work is divided among ind. present						
Emp. is assigned to check trays						
Other						

b) IN THE CASE OF TARDINESS, HOW LONG DO YOU WAIT BEFORE YOU MAKE ADJUSTMENTS IN THE WORK SCHEDULED?

_____

20. (continued)

c) ARE THE SAME ADJUSTMENTS MADE FOR LONG TERM ABSENTEEISM?

_____yes _____no

IF NOT, WHAT ADJUSTMENTS ARE MADE TO COVER LONG TERM ABSENTEEISM?

_____Relief person is placed in position
_____A replacement is hired to cover schedule
_____Employees are asked to work overtime in advanced
_____Work is divided among present employees
_____Other

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d) DO THESE SAME ADJUSTMENTS APPLY TO ABSENTEEISM IN SITUATIONS SUCH AS STRIKES, WALKOUTS, AND DISASTROUS WEATHER WHEN MORE THAN HALF OF THE EMPLOYEES MAY BE ABSENT OR TARDY?

_____yes _____no

IF NOT, WHAT HAPPENS UNDER THOSE CONDITIONS?

_____Hospital Administrative Staff is in charge of making adjustments
_____Additional public volunteers are called in (Red Cross)
_____Other

---

e) WHAT IS THE COMPENSATION POLICY FOR EMPLOYEES WHO ARE ASKED TO WORK OVERTIME?

_____regular rate
_____regular plus 1/2
_____double
_____equal time-off
_____other

---

f) IS THE TARDY EMPLOYEE GIVEN A NEW WORK ASSIGNMENT WHEN HE REPORTS ON DUTY OR IS HE GIVEN HIS REGULAR ASSIGNMENT?

_____yes _____no
_____depends on employee's regular assignment
_____depends on employee's seniority
_____according to statement in union contract or to a departmental policy
_____other

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20. (continued)

g) WHEN ADMINISTRATIVE OR SUPERVISORY PERSONNEL SUBSTITUTE IN TRAY SERVICE ACTIVITIES, WHAT ARE THE EFFECTS ON THEIR DAILY ACTIVITIES?

_____None
_____Less supervision is given to employees who do not participate in tray service activities
_____Patient diet consultation and dietary education limited because of time shortage
_____Others

_____

21. WHAT ARE THE EFFECTS OF PATIENT TRAY SERVICE EMPLOYEES ABSTENEEISM AND TARDINESS ON THE PATIENTS' MEAL?

_____none
_____meal served later than usual
_____food not received as ordered
_____food slightly cold
_____other

_____

b) WHAT SPECIFIC AREA(S) OF THE HOSPITAL IS/ARE AFFECTED BY OFF-SCHEDULED MEALS? HOW IS/ARE THE AREA(S) AFFECTED?

	EFFECTS
Housekeeping	
Nursing	
X-Ray	
Laboratory _____ (specific lab)	
Other	

22. WHO OR WHAT ESTABLISHES THE EMPLOYMENT RULES REGARDING ABSENTEEISM AND TARDINESS AMONG PATIENT TRAY SERVICE EMPLOYEES?

	ABSENTEEISM	TARDINESS
Written Hospital Policy		
Written Departmental Policy		
Admin. Personnel Dietary Department _____ position		
Other		

b) UNDER WHAT CIRCUMSTANCES ARE ABSENT AND TARDY EMPLOYEES PAID?
(Include part-time, full-time and Administrative and Supervisory Staff-Dietary Department Employees)

22. (continued)

c) ARE THE REASONS EMPLOYEES STATE FOR ABSENTEEISM AND TARDINESS USUALLY THOSE WHICH ARE COMPENSATED WITH PAY

_____yes _____no

THEN, WHAT ARE THE REASONS?

_____

_____

d) DOES PAY FOR ABSENTEEISM OR TARDINESS DEPEND ON WHETHER THE CALL THAT REPORTED THE ABSENTEEISM OR TARDINESS IS MADE BY THE ABSENT OR TARDY EMPLOYEE?

_____yes _____no

e) CAN AN EMPLOYEE ACCUMULATE PAID SICK LEAVE? _____yes _____no

f) WHAT IS THE MAXIMUM AMOUNT OF PAID SICK LEAVE TIME THAT EMPLOYEES CAN ACCUMULATE?

_____

g) IF THE SICK LEAVE IS NOT TAKEN BEFORE THE EMPLOYEE RETIRES OR LEAVES THE DEPARTMENT FOR OTHER REASONS, IS HE COMPENSATED WITH PAY FOR

_____none
_____1/2
_____all
_____other

_____

DO YOU OFTEN FIND EMPLOYEES USING ALL OR SOME OF THEIR SICK TIME WHEN ANTICIPATING A LEAVE OR RETIREMENT?

_____yes _____no

h) WHEN AN EMPLOYEE IS ABSENT FOR AN EXTENDED PERIOD, DOES HE

_____call the day before he returns and notify supervisory personnel of his anticipated return
_____if out for illness of others, report to physician and bring in a statement of validation
_____if out for personal illness, report to his physician and bring a statement of validation plus report to employee's health clinic in order to obtain a work clearance
_____other

_____

23. WHAT ACTION IS TAKEN WHEN THE LEVEL OF DEPARTMENTAL TOLERANCE IS REACHED FOR ABSENTEEISM AND TARDINESS? (dietary employees)

ACTIONS	ABSENTEEISM	TARDINESS
Change shift if person has problems in reporting on duty at his scheduled time		
Re-assign person to another area of hospital if it is found that absenteeism or tardiness is due to lack of job satisfaction		
oral warning		
written warning		
suspension _____ length		
dismissal		
others		

b) IS THE SAME TYPE OF ACTION TAKEN FOR DEPARTMENTAL ADMINISTRATIVE AND/OR SUPERVISORY PERSONNEL?

_____yes _____no

IF NO, WHAT ACTION IS TAKEN FOR ADMINISTRATIVE OR SUPERVISORY PERSONNEL?

_____

_____

COMMENTS: