In this era of downsizing, mergers and cost containment, clinical positions in health care facilities are far less secure than ever before. To maintain a desirable dietitian-to-patient ratio of 1:50 to 60, the clinical nutrition manager must closely monitor patient care activities as well as continuously track environmental trends. Whenever negotiating with administrators over departmental positions, it behooves the manager to present meaningful statistics which substantiate and further strengthen his/her argument for maintaining adequate staffing patterns.

Unfortunately, not all facilities have favorable patient care loads. In fact, a number of institutions have dietitian-to-patient ratios exceeding 1 to 100 (Schiller, et al., 1991; Edelstein, 1991; Simmons, 1997); a ratio suggested over 60 years ago (McEachern, 1930)!

Dietitians in Nutrition Support (DNS), a dietetic practice group of the American Dietetic Association (ADA), constructed a questionnaire with the intent of evaluating staffing trends among nutrition support dietitians (Compher and Colaizo, 1992). The same survey tool was mailed to the membership in 1986 and then again in 1989. Over this time period, staffing had declined from 1.4 full-time equivalents (FTEs) per 100 patients to 1.0 FTE per 100 patients. Coincidentally, the average length of stay (ALOS) decreased, patient turnover increased and patient acuity had only intensified.
Published staffing ratios do not necessarily represent the “ideal” situation but rather identify prevailing trends (Schiller, et al., 1991). It is difficult to apply one universal ratio that will meet every institution’s needs, largely due to the fact that health care systems differ greatly in relation to facility design, employee pool, staff responsibilities, and standards of practice (Simmons, Future Dimensions, 1997). Nonetheless, staffing ratios are one simple way to measure equity in workloads.

With high staffing ratios becoming commonplace, clinical nutrition managers must also establish alternative systems for the delivery of quality nutritional care. They can begin by asking a few simple questions: What duties can only be completed by the Registered Dietitian? What tasks could be delegated to the Dietetic Technician? Could other staff be used to augment services?

Increased patient acuity has dictated more intensive nutritional care, resulting in a greater demand for dietitian involvement (Lafferty and Dowling, 1993). Hence, the clinician of the 21st century is caught in a proverbial “catch 22.” With an increased demand for comprehensive nutritional care, coupled with larger patient case loads, practitioners are still expected to maintain the highest quality care but to provide it at the lowest possible cost. More care for more people at lower cost — a nice package if you can deliver it!

In addition to patient acuity, there are several other factors which largely impact the staffing needs of clinical nutrition services (Schiller, et al., 1991):

- changes in bed capacity;
- changes in meal delivery and service;
- changes in regulations;
- decreases in length of stay (LOS) and increases in patient turnover;
- increases in community services; and
- increases in research activities.

Since labor costs comprise approximately 60 to 70 percent of the overall departmental budget (Lafferty and Dowling, 1993), the clinical manager must judiciously determine personnel needs and constantly defend such resources through the routine collection, compilation and interpretation of timely data; such as patient acuity, staffing patterns and productivity statistics.

**Patient Acuity and Staffing Models**

Patient acuity, which can be easily described as “the time and expertise required to deliver quality care to patients with varying medical conditions” (Escott-Stump, 1997), has increased dramatically over the last two decades. Estimates indicate that 40 to 50 percent of all patients admitted to the hospital are at risk for malnutrition (Sproat and Russell, 1993; Byham-Gray, 1999). Other sources believe the incidence to be greater than 50 percent (Coates, 1993; Chima, et al., 1997; Byham-Gray, 1997).

In light of these reported changes in patient mix, clinical nutrition managers have consistently tried to find the best possible method for determining adequate staffing patterns. There are a number of staffing models that the clinical nutrition manager may explore, such as the Alford-Powers, the Veterans Administration Clinical Nutrition Services Staffing Model, Patient Acuity Staffing, and the Premier Clinical Benchmark Tool; all are described fully in the book by Biesemeier (2004). A few staffing models will be discussed in the following sections. To address these concerns, the Clinical Nutrition Management dietetic practice group of the ADA initiated the Patient Acuity Staffing (PAS) Study (Simmons, Future Dimensions, 1997).

The intent was twofold: 1) to ascertain whether a relationship exists between a patient’s acuity and the time required to deliver nutritional care and 2) to develop a formula which is capable of projecting staffing hours needed for medical nutrition therapy (MNT) activities (Simmons, 1998; Simmons, 1997; Simmons and Vaughn, 1999).
The PAS Study was composed of two phases. Phase I defined the “unit constant tasks”; i.e. activities carried out for all patients, such as menu distribution, food preferences, tray delivery and meal rounds. Phase II specified patient demographics and MNT services, and provided estimates on the amount of time expected to complete these services.

Ninety-three facilities, ranging from university teaching hospitals to skilled rehabilitation clinics, participated in the collection of data. The median facility had 395 licensed beds with a daily census of 271 patients. The chart below shows staffing ratios.

### Staffing Ratios

<table>
<thead>
<tr>
<th></th>
<th>FTEs</th>
<th>Full capacity Patients/FTE</th>
<th>Average Census Patients/FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical nutrition manager</td>
<td>1</td>
<td>395</td>
<td>271</td>
</tr>
<tr>
<td>Dietitians</td>
<td>4.5</td>
<td>88</td>
<td>60</td>
</tr>
<tr>
<td>Dietetic technicians</td>
<td>1.8</td>
<td>219</td>
<td>151</td>
</tr>
<tr>
<td>Diet Clerks/Aides</td>
<td>5</td>
<td>79</td>
<td>54</td>
</tr>
</tbody>
</table>

**Patient Acuity Tool and Medical Nutrition Therapy Time Staffing Model**

One of the major outcomes of the PAS was the validation of the Patient Acuity Tool (PAT) (Simmons, 1997). Its purpose was to categorize patients according to 21 acuity statements. In order to determine who was eligible to receive nutrition care; i.e. it identified who is at nutritional risk using predetermined criteria. Interestingly enough, the original study tool contained 27 acuity factors, but parameters such as age or weight history were dropped since they were not found to be powerful predictors of Medical Nutrition Therapy Time (MNTT).

By using the patient acuity ranking, the MNTT model was then able to forecast the number of FTEs required to provide high-quality, appropriate MNTT (Simmons, 1998). Total time spent on MNT was the focus of this project, not on who was actively doing these tasks; e.g. dietitian versus dietetic technician. Thus, this method for analyzing staffing patterns should not replace the more conventional means, described later in the chapter. Rather, it should be used in conjunction with such processes.

The MNTT activities give standardized definition to all nutrition care functions performed. There were large discrepancies among the participants in some of the time allocated for the completion of tasks. This can be partly explained by the broad categories established for the MNT activities. Despite these variances, such values were plugged into the MNTT staffing model, which in turn converted raw data into projected FTEs for delivering nutritional care (Simmons and Vaughn, 1999).

Worksheets and examples applying the PAT and MNTT models have been reserved for publication in the references cited by Simmons at the end of this chapter. The complexity and intensive nature of these mathematical equations are beyond the scope of this course. (It should be noted that at the time of this publication, only preliminary information and data can be accessed).

Nonetheless, the Clinical Nutrition Management dietetic practice group of The American Dietetic Association is considering the development of computer software in order to simplify the application and use of the MNTT model. The chart on the next page demonstrate the usefulness of such research by providing examples of
FTE calculations. Additional sources for developing and utilizing a Patient Acuity Staff Model can be obtained by contacting the Veterans Administration:

VA Health Services Research & Development
P.O. Box 13070
Ann Arbor, MI 48113-0170
Phone: (734) 930-5118
Fax: (734) 930-5159

A comprehensive discussion and examples using a patient acuity staffing model are also available at Shavink-Dillerud, Lowery & Striplin (1999).

<table>
<thead>
<tr>
<th>Facility situation</th>
<th>Sample facility</th>
<th>Same facility: Reduced census increased acuity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Census</td>
<td>271</td>
<td>225</td>
</tr>
<tr>
<td>ALOS</td>
<td>4.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Total Annual patients</td>
<td>24,729</td>
<td>23,464</td>
</tr>
<tr>
<td>45% eligible for MNTT*</td>
<td>11,128</td>
<td>10,559</td>
</tr>
<tr>
<td>AT*</td>
<td>25</td>
<td>32</td>
</tr>
<tr>
<td>Total MNTT hours</td>
<td>4,637</td>
<td>5,631</td>
</tr>
<tr>
<td>FTEs to provide MNTT#</td>
<td>2.23</td>
<td>2.71</td>
</tr>
</tbody>
</table>

Key:

MNTT=Medical nutrition therapy time; this percentage is derived from a series of equations provided by Simmons, 1997.

AT=Acuity tool indicator, given in minutes; this is calculated from standard coefficients for the acuity tool (Simmons, 1997).

ALOS=Average length of stay, given in days.

FTE=One full-time equivalent is equal to 2080 hours of work Adapted from Simmons, Future Dimensions, 1998.

Queueing Theory

Queueing theory is another method available to the manager; this can assist with making decisions about staffing needs (Miller-Kovach, 1992). Although it has been widely used in business management, it can have real application for the field of dietetics.

The formula used in queueing theory has four variables (Miller-Kovach, 1992):

• Arrival rate (A) is the average rate at which demand for service comes in, expressed as a number per unit of time; e.g. nutrition consultations per month, meals per week, diet changes per month, etc.;

• Service rate (S) is the average rate at which the service is performed, expressed in the same unit of time as the arrival rate; i.e. per day, week, or month;

• Channels (m) are the number of people or machines needed to do the work. As a rule, channels are expressed as a whole number and rounded up if needed; and

• Utilization Ratio (U) is the arrival rate in relation to the total amount of service that can be provided. Mathematically, the utilization ratio is \[ U = \frac{A}{m(S)} \].
(Without getting into the statistical basis of the equation, a U equaling 0.80 maximizes productivity with very little idle or waiting time. Using the equation $U = \frac{A}{m(S)}$, where $U = 0.80$, it is possible to predict the number of personnel required to perform a job. See examples below.)

### Example: Problem #1

Based on statistics reported to you from your dietitians, you would like to determine whether the number of dietitians devoted to acute care reflects current trends. This will be a three-phase calculation since you have statistics gathered for three primary job functions; a) comprehensive assessments b) reassessments and c) consultations.

#### a) comprehensive assessments

- $A = 12$ comprehensive assessments done per day
- $S = 8$ hours devoted to inpatient acute care per day x 1.33 comprehensive assessments done in one hour (estimated that one assessment takes 45 minutes). Service rate done in one work day = 10.64 comprehensive assessments

$U = 0.80$ for maximum productivity

$U = \frac{A}{m(S)}$

$0.80 = \frac{12}{m(10.64)}$

$m = 0.90$ dietitians needed for comprehensive assessments

#### b) reassessments

- $A = 15$ reassessments are done per day
- $S = 8$ hours devoted to inpatient care per day x 2 reassessments done per hour (estimated that one reassessment takes 30 minutes)

Service rate = 16

$m = \ ?$

$U = 0.80$

$U = \frac{A}{m(S)}$

$0.80 = \frac{15}{m(16)}$

$m = 0.75$ dietitian needed for reassessments

#### c) consultations

- $A = 3$ consultations received per day
- $S = 8$ hours devoted to inpatient care per day x 1.5 consults completed per hour (estimated that one consult takes 40 minutes)

Service rate = 12

$m = \ ?$

$U = 0.80$

$U = \frac{A}{m(S)}$

$0.80 = \frac{3}{m(12)}$

$m = 0.74$ dietitians needed for consultations

**Total dietitians needed for accomplishing acute care job functions on any given day = 2.39 dietitians.**
Queueing theory is only as reliable as the data utilized (Miller-Kovach, 1992) — in other words, “garbage in = garbage out.” If the arrival and service rates are incorrect, the decisions made about staffing could be detrimental.

One disadvantage of the queueing theory is that it does not measure efficiency or effectiveness of care provided. Rather, it measures the amount of resources needed to maximize productivity for primary job functions, like screening, passing trays, completing assessments, etc. It does not account for non-productive tasks or down time either.

Since queueing theory is grounded deeply in business statistics and management principles, one strong advantage in applying it is so the clinical manager will be able to speak the same language as administrators and budget directors when discussing staffing needs. Instead of trying to identify the number of staff persons needed to complete specific job duties, you can switch your formula around and do simple predictions on productivity.

To summarize, both the MNTT model and the queueing theory simply predict a total number of FTEs needed for the delivery of MNT activities. They do not differentiate between levels of expertise. It is for the clinical manager to decide who is to accomplish which tasks and how many FTEs are assigned to complete these duties. A Staffing Needs Assessment (SNA) can easily address this dilemma.

### Example: Problem #2

You hear complaints from patients that food is cold, and it takes a long time for them to be served. You wish to determine whether the nutrition care assistants are efficient in passing patient trays, or whether adjustments need to be made.

- \( A = \) Average meals served/day is 450 (150 X 3 meals)
- \( S = ? \)
- \( M = 3.0 \) nutrition care assistants scheduled each day
- \( U = 0.80 \)

\[
U = \frac{A}{m(S)}
\]
\[
0.80 = \frac{450}{3(S)}
\]

\[
S = 120 \text{ trays per day for 3 meals or 40 trays passed per nutrition care assistant at each meal. If they are given 1.25 hours to pass trays per each meal, that relates to 1 meal passed every 2 min.}
\]

### Staffing Needs Assessment

Prior to the availability of the PAT and MNTT, the clinical nutrition manager traditionally determined human resource needs by conducting a staffing needs assessment. This method still remains valid today. It does, however, insist on a comprehensive analysis of departmental systems (Biesemeier, 2004). In order to begin the needs assessment, Schiller and associates (1991) suggest the following questions for the manager to consider:

- How are diet orders transmitted to the department?
- What records are maintained by the department?
- Do the records have to be transposed or are they computerized?
• How are the menus processed?
• Are systems sufficiently standardized so that dietetic assistants or computers can process new diet orders into meals?
• Who delivers menus and food to the patient?
• Who monitors food intake of low-, moderate- or high-risk patients?
• Who collects and corrects menus with the client?
• Who checks menus for accuracy?
• Who provides nutrition screening?
• Who documents and where?
• Who provides basic nutrition assessments?
• Who provides assessments to those at moderate or high nutritional risk?
• Who provides the follow-up monitoring to each level of client?
• Who provides nutrition supplements?
• How is client acceptance of supplements evaluated?
• Who monitors the tube-fed patients?
• Who monitors parenteral nutrition patients?
• How are procedures different by service or disease entity?
• What is the patient turnover rate?

Flowcharting the process of a patient’s hospitalization from admission to discharge can visually assist the manager in combining or eliminating steps. One example of flowcharting is presented below.

The main impetus for changing or analyzing staffing patterns is, typically, cost-containment. Thus, the clinical manager may want to take a closer look at current labor expenditures and strategize how to possibly lower them (Schiller, et al., 1991):

• Can lower level personnel perform the task?
• Can the task be subdivided, with certain portions delegated to lower level personnel?
• Can middle-management positions be reduced?
• Can the dietitian or technician or dietetic assistant spend more time in direct patient care?
• Can the time per procedure decrease?
• Can the level of procedure decrease?
• Can the number of procedures decrease?
• Can the use of supplies or enteral products decrease?
• What types of technology can save time or money?

Besides analyzing departmental systems, the staffing needs assessment should gather statistics on patient acuity, clinical activities and productivity, using the form at the end of this module.
Staff Productivity

The following equation is frequently cited as the definition of productivity (Alford, 1994):

\[ \text{Productivity} = \frac{\text{output}}{\text{input}} \]

- \( \text{output} = \) patient care or outcomes
- \( \text{input} = \) clinician time or resources consumed

Whenever measuring productivity, CUTS is a useful acronym to remember (Schiller, et al., 1991):
- \( \text{C} = \) Collect meaningful data;
- \( \text{U} = \) Utilize data effectively;
- \( \text{T} = \) subsequently compare Time and Task productivity; and
- \( \text{S} = \) Standardize the assessment (quantity and quality) of care provided.
The first data collected should be the actual time spent in clinical activities. For a predetermined length of time; e.g. 2 to 3 weeks, staff should record their activities as well as the actual time to accomplish these tasks. All activities are monitored; direct and indirect patient care, nonproductive tasks, clerical duties, as well as downtime. A useful Clinical Staffing Needs and Assessment form is added at the end of this module.

Once gathered, it can provide a plethora of information for establishing staffing patterns and goals. Besides ascertaining the average time spent in activities, staff reports must be obtained on the volume of duties performed, both daily and monthly. Useful forms for this purpose are provided at the end of this module.

Measuring productivity not only helps to assess staffing needs and contain labor costs, but may also serve to evaluate job performance. The manager, however, should not hastily judge performance strictly on the quantity of work completed. Greater volume may indicate substandard quality of care and/or a lowered patient acuity.

Alford (1994) recommends using three productivity values for objectively measuring job performance:

- The first productivity value is Percentage of Direct Patient Care Time (% PC Time), calculated as:

\[
\text{% PC Time} = \frac{\text{# hours worked} - (\text{administrative + project hours})}{\text{# hours worked}}
\]

Direct patient care hours are computed in order to separate out administrative time, and to default the time spent waiting for charts, conferring with staff, and walking to nursing units as patient care time (Alford, 1994). The following indirect patient care activities are also considered as direct patient care: charting, patient care meetings (i.e. rounds, discharge planning), cardex review, etc. Administrative tasks or projects include department meetings, productivity reporting, quality improvement (QI) monitoring, and so forth. The expected %PC Time can be outlined in the job description, thereby setting limits to the amount of time the employee should be spending in administrative tasks.

Illustration: If it is expected that only four hours per week are spent doing projects, then 10 percent of the work week should reflect time completing administrative tasks. The rest of the time (90 percent) should be devoted to direct patient care activities.

- The second productivity value is Average Time Spent per Activity (PC Hr/Act) calculated as

\[
\text{PC Hr / Act} = \frac{\text{# hours direct patient care hours}}{\text{# of direct patient care activities}}
\]

The PC Hr/Act value does not differentiate between the various types of activities completed, but instead considers all data collectively (Alford, 1994). If activities are balanced between the simple to the complex, the PC HR/Act ranges from 0.7 to 0.8 hours or approximately 40 to 50 minutes per activity for the dietitian, and 0.3 to 0.5 hours or approximately 18 to 30 min. per activity for the dietetic technician. The ranges could be closer to 1.0 if the dietitian was assigned to critically ill patients; e.g. nutrition support, multiple organ system failure, etc.
The third productivity value is Weighted Activity Value per Hour (W Act/Hr), calculated as:

\[
W\text{ Act/Hr} = \frac{\text{time value of each activity } \times \# \text{ of each activity}}{\# \text{ direct patient care hours}}
\]

The (W Act/Hr) does take into account the diverse types of activities performed (Alford, 1994). Department standards for average time spent completing each activity are used for comparison. If the staff performs activities ranging from the basic to the comprehensive, the (W Act/Hr) should be 0.68 to 0.89. Lower results may indicate too few tasks completed or a focus on one type of task (such as screening or follow-up) rather than assessments. Higher values may identify a staff member who is completing comprehensive tasks faster than established.

Illustration:

\[
\text{PC Hr/Act} = \frac{\# \text{ of direct patient care hours}}{\# \text{ direct patient care activities}} = 7.5 \text{ hours}
\]

11 activities (ranging from counseling, consults, assessments, reassessments and calorie counts)

\[
= 0.68
\]

Illustration:

\[
W\text{ Act/Hr} = \frac{\text{time value of each activity } \times \# \text{ of each activity}}{\# \text{ direct patient care hours}}
\]

\[
a). \quad \text{assessments (45 minutes or 0.75 hr) } \times 5 \quad = \frac{0.75 \times 5}{7.5} = 0.50
\]

\[
b). \quad \text{reassessments (30 min. or 0.5 hr) } \times 2 \quad = \frac{0.5 \times 2}{7.5} = 0.13
\]

\[
c). \quad \text{calorie counts (20 min. or 0.33 hr) } \times 2 \quad = \frac{0.33 \times 2}{7.5} = 0.09
\]

\[
d). \quad \text{consult (50 min. or 0.83 hr) } \times 1 \quad = \frac{0.83 \times 1}{7.5} = 0.11
\]

Total (W Act/Hr) = (a + b + c + d) = 0.83
When used together (W Act/Hr) and (PC Hr/Act) can identify weaknesses in job performance. Guidelines for evaluating these calculations is provided as a chart at the end of this module.

In closing this discussion on productivity, Maillet (1993) has suggested monitoring job performance by setting an “entrepreneurial mindset.” The first step in this method requires the assignment of a cost value to all MNT services performed — *e.g.* basic assessment = $15; comprehensive assessment = $45; counseling session = $60, etc. Practitioners are then evaluated on whether they were producing sufficient income for the department — are they earning 50 percent of their salary, or 150 percent?

Besides providing a means for motivating staff to remain productive, this arbitrary system for revenue generation can become the basis for deciding upon merit increases.

**Employee Recruitment and Selection**

As quintessential as determining appropriate staffing levels, so is the recruitment and selection of quality personnel. High employee turnover creates much dissension and discord within the department. For every professional staff member replaced, it is estimated that more than $16,000 is lost by the organization (Bisonnette, 1988). In 2009 dollars, that could be more than $40,000. Thus, it is paramount that the manager recruit and then select candidates who are the “best overall fit.”

Seventy-five percent of all vacant positions are filled by word-of-mouth (Ross Professional Series, 1989). This statistic is staggering! It just emphasizes the old adage, “it’s not what you know, but who you know.” Needless to say, the clinical manager should remain active in local dietetic associations, community organizations and other professional societies. Having such a broad network of contacts will only enhance the manager’s ability to recruit potential candidates for future job vacancies. Maintaining open lines of communication between academic institutions will also afford the manager with great opportunities to precept students, as well as possibly train them as prospective employees.

When networking fails to bear fruit, the traditional approach of posting jobs in the classified ads still remains an effective method. Posting a job opening on the internet can reach thousands of prospective candidates within days; whereas placing it with a recruiter, in the newspaper or a trade journal, may take weeks or even several months to reach the target audience. The urgency for filling the position will determine the medium with which to advertise.

Once a pool of eligible candidates has been received, the manager should compare each applicant’s abilities and skills to the qualifications of the job; only the top five candidates should be interviewed. The goal of the interview is for the manager to retrieve more information about the candidate that will assist in the selection process as well as provide an opportunity to evaluate his/her interpersonal skills. Some candidates may look good on paper, but are less than average when interviewed.

In preparation for the interview, it is imperative that the manager familiarize himself/herself with the candidate:

- Review the resume, application and/or curriculum vitae closely for education and employment history;
- Investigate for gaps in employment;
- Evaluate prior positions — examine job duties and responsibilities; and
- Analyze for stability in employment; *i.e.* have they held one job for a number of years, or have they jumped from job to job?

When interviewing the applicant, use an open-ended, nondirective style of questioning (Schiller, *et al.*, 1991). This will not only enable the candidate to openly express ideas but will also give the manager a good picture of his/her oral communication skills. Sample questions are provided on the following page.
### Clinical Dietitian Interview Select Questions

**Background:**
1. What were some rewarding areas of practice for you? What were some frustrating ones?
2. Which clinical areas do you prefer?
3. As it relates to clinical practice, what are some of your strengths? Weaknesses?

**Special Skills:**
1. What are special skills you possess that would make you a unique candidate?
2. What are some skills you would like to acquire?
3. Do you have any unique qualifications or experiences?

**Professional Goals & Objectives:**
1. What would be an “ideal” job for you now, based on your qualifications and experience?
2. What do you hope to accomplish in the field of dietetics within the next 5 years? 10 years?
3. What do you hope to accomplish personally?

**1st Interview Goals:** General information regarding educational experiences and employment history.

**2nd Interview Goals:** More in-depth review of skills; tour of facility; meet other clinicians; references requested.

Besides the customary interview questions, some managers prefer to administer a written and/or oral examination at the time of the first interview in order to ascertain training needs and clinical knowledge base. This can be utilized as an objective measure for selection. Other techniques may include the use of a checklist based on the job description. The manager simply questions the individual about his/her experiences, and then records such responses. A handy worksheet is included at the end of this module.

At the close of the first interview, the manager must clearly communicate the process for selection. For professional positions, generally there is a two-phase interview process. The second interview may include further questioning by the primary manager and/or higher level administrator, an introduction to other staff members, and possibly a tour of the facility. The more input the manager receives from others concerning an applicant, the easier it may be to narrow down the selection.

Offering the job and conducting salary negotiations are usually handled by the human resources department; if so, work closely with them. Any candidate, however, that was not chosen should be contacted regardless. If s/he were second or third choices for the position, convey his/her strengths as a candidate. Also, communicate to him/her that should another position come available, s/he would seriously be considered for it. This technique leaves the individual with a positive impression, and may lead to his/her eventual hire when other job opportunities present themselves.
Nontraditional Approaches to Scheduling

In the interest of controlling labor costs, the employee schedule should reflect appropriate staffing levels with minimal incidences of overtime. To remain cost-effective, the traditional method of scheduling full-time employees to work five (8-hour) shifts is becoming far less common in today’s workplace. Managers are using more creative approaches, like introducing flexible work shifts, hiring PRN (as needed) or temporary employees, or even permitting the job-sharing of positions.

The main forces driving these nontraditional strategies include patient census and shortened length of stay. The patient census and the volume of patient care activities completed are directly proportional — i.e. as the census increases, so does the amount of work. Tracking the daily census allows the manager to predict the number of employees to schedule for any given day. However, it does not provide the whole picture. The manager should also monitor shifts in patient activity.

An example can be illustrated using data collected from the Patient Acuity Staffing (PAS) study (Simmons, 1997):

A peak of new admissions occurred on Tuesday and Wednesday of each week, while most of the discharges happened on Saturday and Sunday. Thus, it was concluded that the staffing for nutrition screening needed to be greater midweek than on the weekend. From this information, a creative work week was extrapolated. If a nutrition screening takes an average 15 min. to complete, and there are 15 due on Sunday and 30 due on Wednesday, the hours devoted towards screening on Sundays could be shortened to 3.75 hours whereas the hours on Wednesdays would be maintained at 7.5 hours.

From the years 1985 to 1995, the LOS decreased by 12 percent (Simmons, 1997). It is estimated that the average length of stay (ALOS) in an acute-care facility is less than 5 days. In light of these trends, a 10- or 12-hour extended workshift can be instituted for days when there is greater volume. Conversely, a shortened work shift can be scheduled when there is less projected activity.

Besides making more flexible workshifts to accommodate changes in census, the hiring of PRN or temporary employees can also help on days when patient activity is expected to be higher. Colovos (2001) conducted a survey to identify the main reasons for the hiring of PRN dietetic professionals, and lists the following additional considerations:

- vacancies during staff recruitment
- vacation/holiday coverage especially in the summer months
- maternity/medical leaves
- seminar or professional meetings attendance

Usrey (1992) has been very successful in using temporary professionals, and has found it to be of great benefit to the department as well as the employee. The flexible work hours provide relief to the full-time employees when the census is higher and the workload is increased. It also allows for adequate staff coverage during vacations, holidays, or extended family/medical leaves. The employees who like being hired on a PRN basis are typically working mothers, clinicians close to retirement age, or professionals needing additional time to investigate other opportunities (Usrey, 1992).

In order to keep the PRN staffing hours within budget, the manager should project the number of hours needed versus the number of hours available, and then fill in as necessary with any PRN positions. For the PRN pool to be successful, the manager must have a network of practitioners who are able to work on short notice. In fact, the PRN employees should select specific days that they can work in advance. The manager can then place them on call for the agreed-upon dates.
Generally, the PRN employees are paid commensurate with experience. They may also receive a higher pay rate in comparison to the FTEs, simply because the organization is not paying for any additional benefits; e.g. health care, paid-time away, etc. Thus, having a PRN employee pool can assist with reducing labor costs.

Another alternative for scheduling staff is sharing positions. Job-sharing has become a more popular choice for replacing a full-time position, largely due to the greater cost savings realized. For example, if a full-time position with benefits becomes available, two employees can “share the hours” of the position without earning the full benefits package. Some managers have found this to be a “win-win” solution for both the employees and the department — less call-outs, greater teamwork, and improved employee morale. Others have been less than enthusiastic about the outcomes, citing poor communication between the employees sharing the position, scheduling nightmares for the manager, and less cooperation among the staff (Clinical Nutrition Management, 1992). One frustration for the clinical nutrition manager is finding a reliable source of PRN employees. There are contract services, mostly owned and operated by dietetic professionals, that can assist with such endeavors (Colovos, 2001).

Nonetheless, arranging the schedule using nontraditional approaches does result in less downtime, greater efficiency, and produces an overall reduction in labor hours. As mentioned earlier, the routine collection of productivity statistics is necessary for such predictions as well as to determine the most appropriate and adequate human resource levels for the department.
Clinical Staffing Needs & Assessment

ENVIRONMENT

<table>
<thead>
<tr>
<th>Type of Institution:</th>
<th>Average Number of Daily Admissions: ( \frac{\text{________}/\text{mo}}{\text{= ________/day}} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Daily Admissions: ( \text{______ Sun} \</td>
<td>\ \text{Mon} \</td>
</tr>
<tr>
<td>Number of beds: ( \text{______} )</td>
<td>Percent Occupancy: ( \text{______%} )</td>
</tr>
</tbody>
</table>

HOURS AVAILABLE (1 FTE = 40 hours worked per week)

<table>
<thead>
<tr>
<th>Position</th>
<th>Number Currently Available</th>
<th>Break Time</th>
<th>Sick</th>
<th>Holidays</th>
<th>Vacation</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS</td>
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</tbody>
</table>

ADMINISTRATIVE TIME (average per person)

<table>
<thead>
<tr>
<th>Position</th>
<th>Total Hr/wk</th>
<th>Staff Meetings</th>
<th>CE activities</th>
<th>Rounds</th>
<th>Precepting</th>
<th>Inservicing</th>
<th>Supervising</th>
<th>Billing</th>
<th>Project Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS</td>
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</tbody>
</table>

HOURS AVAILABLE PER WEEK

Days/Year: 260 days - (Sick) (Holiday) (Vacations) (Other) = ________ days/year

Days x (hrs/wk - break time) = ________ hrs/year divided by 52 weeks/year = ________ hrs/wk

Number of RD ________ x hrs/wk = ________ hours available for patient care

Number of DTR ________ x hrs/wk = ________ hours available for patient care

Number of NCA ________ x hrs/wk = ________ hours available for patient care

TIME UTILIZATION STUDY RESULTS (List in minutes per task)

<table>
<thead>
<tr>
<th>Tasks: Direct Clinical</th>
<th>Total Time Spent</th>
<th>Dietitian</th>
<th>Dietetic Technician</th>
<th>Nutrition Care Asst.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Screening</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Basic Assessments</td>
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<tr>
<td>Comprehensive Assessments</td>
<td></td>
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</tr>
<tr>
<td>Reassessments</td>
<td></td>
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<tr>
<td>Calorie Counts</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Consultations</td>
<td></td>
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</tr>
<tr>
<td>Nutrition Counseling</td>
<td></td>
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</tr>
<tr>
<td>Meal Rounds</td>
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<tr>
<td>Patient Visits/Interviews</td>
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</tbody>
</table>

Acreity: \( \text{______ low risk} \ | \ \text{______ moderate risk} \ | \ \text{______ high risk} \)

Mode of feeding: \( \text{______ oral} \ | \ \text{______ TF} \ | \ \text{______ PN} \ | \ \text{______ NPO} \)

Average Minutes per Person each Day:

<table>
<thead>
<tr>
<th>Position</th>
<th>Menu/Pattern Changes</th>
<th>Diet Changes</th>
<th>Cardex Updates</th>
<th>Charting</th>
<th>Care Conferences</th>
<th>Clerical Duties</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS</td>
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</tbody>
</table>

Tasks

<table>
<thead>
<tr>
<th>Nutrition Screening</th>
<th>Estimated # needed/day</th>
<th>( \times ) time needed</th>
<th>Equal time/activity</th>
<th>Hours/week</th>
<th>RD</th>
<th>DTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic assessment</td>
<td></td>
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<tr>
<td>Comprehensive assessment</td>
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<tr>
<td>Reassessment</td>
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<tr>
<td>Calorie counts</td>
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<tr>
<td>Consultations</td>
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<td>Nutrition counseling</td>
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<td>Meal rounds</td>
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<tr>
<td>Patient visits/Interviews</td>
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</tr>
</tbody>
</table>

Number of Staff Needed

\[ \frac{\text{(Hours Needed)}}{\text{(Hours Available)}}: \]

\[ = \text{_____ \text{CDS}} \ | \ \text{_____ \text{RD}} \ | \ \text{_____ \text{DTR}} \ | \ \text{_____ \text{NCA}} \]

Adapted from Schiller, Gilbride & Maillet, 1991.
From ___________ to ___________, the clinical nutrition services staff will record all activities completed as well as indicate the amount of time it took to accomplish such tasks. A worksheet will be completed for each day worked during the study period and then forwarded to the clinical nutrition manager.

1. **COMPLETE SCHEDULE FOR THE DAY:**

<table>
<thead>
<tr>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00</td>
<td>12:00</td>
<td>5:00</td>
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<td>7:15</td>
<td>12:15</td>
<td>5:15</td>
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<tr>
<td>7:30</td>
<td>12:30</td>
<td>5:30</td>
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<tr>
<td>7:45</td>
<td>12:45</td>
<td>5:45</td>
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<td>8:00</td>
<td>1:00</td>
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<tr>
<td>11:30</td>
<td>4:30</td>
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</tbody>
</table>

2. **INDICATE THE AMOUNT OF TIME AND/OR THE NUMBER OF EACH ACTIVITY LISTED**

   **Direct Patient Care Functions:**
   - Nutrition screening
   - Basic assessments
   - Comprehensive assessments
   - Reassessments
   - Calorie counts
   - Consultations
   - Nutrition counseling
   - Meal rounds
   - **Total Number**
   - **Total Time Spent (minutes)**

   **Indirect Patient Care Functions:**
   - Menu or pattern changes
   - Diet changes
   - Charting
   - Cardex updates
   - Menu delivery and retrieval
   - Menu correction
   - Patient care conferences
   - Clerical duties
   - **Total Number**
   - **Total Time Spent (minutes)**

   **Administrative functions:**
   - Staff meetings
   - CE activities
   - Rounds
   - Precepting
   - Inservicing
   - Supervising
   - Billing
   - **Total Number**
   - **Total Time Spent (minutes)**

   Date: ____________________
   Employee Name: ____________________
   Position: ____________________

Adapted from Schiller, Gilbride & Maillet, 1991.
# Monthly Staff Reports

## DIRECT PATIENT CARE FUNCTIONS:
Record total number of direct patient care activities completed each day:

<table>
<thead>
<tr>
<th>Date</th>
<th>Screening</th>
<th>Basic Assessments</th>
<th>Comprehensive Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Record the amount of time and/or the number of each activity listed:

## INDIRECT PATIENT CARE ACTIVITIES:

Menu/Pattern changes: ____________________

Diet Changes: __________________________

Cardex Updates: _________________________

Menu Correction: _______________________

Care Conferences: ______________________

Clerical Duties: ________________________

Other: _________________________________

## ADMINISTRATIVE FUNCTIONS:

Staff Meetings: ________________________

CE Activities: ________________________

Rounds: ______________________________

Precepting: _________________________

Inservicing: _________________________

Supervising: _______________________

Billing: _____________________________

Projects: ___________________________

MONTH: ______________________________

SUBMITTED BY: ______________________
Productivity Monitors & Staff Performance

1. PC Hr/Act = 0.7-0.8 (normal)  
   W Act/Hr > 0.89 (high)  
   (Completing comprehensive tasks faster than average). Either the staff member has found a more efficient way of completing comprehensive or time-consuming activities or s/he is not performing comprehensive tasks according to established standards.

2. PC Hr/Act = 0.7-0.8 (normal)  
   W Act/Hr < 0.68  
   (Concentrating on brief tasks; completing brief tasks slower than normal). The staff member is recording comprehensive or time-consuming activities as brief activities or s/he is spending longer than average completing brief activities or she is losing time to tasks which are not counted as direct patient care activities or administrative activities. This is often the case of someone who spends much time in patient review meetings. If the time spent is judged to be useful for building rapport or maintaining effective communications, than a specified amount of time is allotted each week as meeting time and classified as administrative time. This then would lower the direct patient care time and increase productivity.

3. PC Hr/Act < 0.7 (low)  
   W Act/Hr > 0.89 (high)  
   (Completing tasks faster than average). Either the staff member has found a more efficient way to complete all tasks or she is not performing tasks according to established standards or spends little time building rapport or maintaining communications.

4. PC Hr/Act < 0.7 (low)  
   W Act/Hr < 0.68 (low)  
   (Concentrating on brief tasks; completing brief tasks slower than average). The staff member has many more brief tasks (follow-up, screening, monitoring) than comprehensive tasks (full assessments, detailed counselings). This might be appropriate if the tasks completed match the job description but in such a case the staff member is taking longer than average to complete tasks.

5. PC Hr/Act < 0.7 (low)  
   W Act/Hr = 0.68-0.89 (normal)  
   (Concentrating on brief tasks). The staff member is concentrating on brief tasks. This might be appropriate if the tasks completed match the job description but in the case of the PC Hr/Act should approximate the average time allotted for completing brief tasks.

6. PC Hr/Act > 0.8 (high)  
   W Act/Hr > 0.89 (high)  
   (Concentrating on comprehensive tasks; possibly taking longer than average on brief tasks). The staff member is concentrating on comprehensive tasks with little follow-up or monitoring. If the staff member is performing brief tasks, then she is taking longer than average on each.

7. PC Hr/Act > 0.8 (high)  
   W Act/Hr < 0.69 (low)  
   (Taking too long on tasks; too few tasks). The staff member is spending more time on activities not counted as direct patient care activities or administrative time. See example 2.

8. PC Hr/Act > 0.8 (high)  
   W Act/Hr = 0.69-0.89 (normal)  
   (Taking longer than average on comprehensive activities; too few brief activities). The staff member is concentrating on comprehensive tasks but is taking longer than the established standard to complete these tasks. There is also a lack of follow-up or brief activities.

**Checklist for Recruitment & Interviewing**

Clinical Dietitian ______________________________________________________
Name of Applicant: ____________________________________________________

<table>
<thead>
<tr>
<th>Requirement for the job?</th>
<th><strong>Extent of Experience</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mode of Feeding</strong></td>
<td></td>
</tr>
<tr>
<td>Oral</td>
<td></td>
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<tr>
<td>Enteral Supplements</td>
<td></td>
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<tr>
<td>Tube Feedings</td>
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<tr>
<td>Parenteral Feedings</td>
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<tr>
<td><strong>Area of Experience</strong></td>
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<tr>
<td>Medical Services</td>
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<td>Surgical Services</td>
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<td>Obstetrics</td>
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<td>Pediatrics</td>
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<td>Orthopedics</td>
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<td>Geriatrics</td>
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<tr>
<td>Intensive Care</td>
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<td>Specialty</td>
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<td><strong>Level of Care</strong></td>
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<td>Quantity of Care</td>
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<td>Depth of Care</td>
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<tr>
<td><strong>Type of Communication Skills</strong></td>
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<td>Group teaching: clients</td>
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<td>Group teaching: professionals</td>
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<tr>
<td>Individual interviewing</td>
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<td>Individual counseling</td>
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<td>Material development</td>
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<td>Written documentation</td>
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<tr>
<td><strong>Nutrition Care Process</strong></td>
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<td>Data Collection</td>
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<td>Assessment</td>
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<td>Plan</td>
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<td>Implementation</td>
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<td>Evaluation</td>
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<td><strong>Leadership Abilities</strong></td>
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<td>Independence</td>
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<tr>
<td>Resourcefulness</td>
<td></td>
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<tr>
<td>Other traits</td>
<td></td>
</tr>
</tbody>
</table>

References


Bisonnette C. A study to determine the cost of employee replacement in the clinical laboratories at Ohio State University Hospitals. Master’s thesis. Columbus, OH: Ohio State University, 1988.


MacEachern MT. Factors that influence ratio of personnel to patients. Modern Hospital, 35(5): 59-61, 1930.


Simmons ML and Vaughn LA. Patient nutrition acuity as a predictor of the time required to perform medical nutrition therapy. JADA, 99(11): 1367-72, 1999.


Examination for MHR09

1) What is the desirable dietitian to patient ratio?
   a) 1:50 to 60
   b) 1:60 to 70
   c) 1:70 to 80
   d) 1:80 to 90

2) What factors into the determination of staffing rations of an institution?
   a) facility design
   b) standards of practice
   c) staff responsibilities
   d) all of the above

3) Labor costs comprise what percentage of departmental budgets?
   a) 40 to 50%
   b) 25 to 30%
   c) 60 to 70%
   d) 80%

4) Using the patient acuity tools (PAT) the following can be determined:
   a) a forecast of FTEs required to provide appropriate MNTT
   b) level of skills needed for diet assessment
   c) specific dietary needs of the patient
   d) none of the above

5) The formula used in queueing theory has four variables. Which of the below is NOT one of these?
   a) Channels
   b) Utilization Ratio
   c) Efficiency
   d) Arrival rate

6) The various theories and formulas used to determine staffing needs can be adjusted to take into account varying levels of expertise.
   a) True
   b) False

7) Among the questions to ask in determining human resource needs are the following:
   a) Who provides nutrition supplements?
   b) What records does the department maintain?
   c) Who monitors tube-fed patients?
   d) All of the above
8) Flowcharting has been largely discredited as a means of helping managers combine or eliminate duplications or extraneous functions because it is so complicated.
   a) True
   b) False

9) Generally, the main impetus for changing staffing patterns is to provide variety for employees:
   a) True
   b) False

10) Measuring productivity of employees serves to:
    a) assess staffing needs
    b) determine quality of work accomplished
    c) contain labor costs
    d) a and b above
    e) a and c above

11) Which of the following are NOT considered Direct Patient Care time:
    a) charting
    b) patient care meetings
    c) discharge planning
    d) cardex review
    e) all are considered Direct Patient Care time

12) When measuring job performance the following should be considered:
    a) exclusion of administrative duties
    b) time of day that tasks are performed
    c) nonproductive tasks
    d) to whom duties are reported
    e) all of the above

13) A low result on the W Act/Hr may indicate:
    a) too many tasks completed
    b) focus on one type of task
    c) completion of comprehensive tasks faster than established
    d) all of the above

14) Assessing an “entrepreneurial mindset” can:
    a) provide a means for motivating staff to remain productive
    b) become the basis for deciding upon merit increases
    c) evaluate whether practitioners are producing sufficient income for the department
    d) all of the above
15) The highest percentage of vacant positions are filled by:
   a) responses to professional journal advertisements
   b) online submission of resumes
   c) word-of-mouth
   d) job fairs

16) Using professional and community groups to aid in recruiting employees:
   a) punishes potential employees who do not belong to those groups
   b) risks violating ethical standards
   c) can result in legal action
   d) can destroy a manager’s credibility
   e) enhances a manager’s ability to recruit potential candidates

17) When reviewing submitted resumes the manager should:
   a) consider all applicants for interview
   b) compare applicant’s skills to job qualifications
   c) assume that applicant who looks good “on paper” will be a good fit
   d) call for interviews in alphabetical order
   e) interview older applicants first, because they are more mature

18) The best interview will:
   a) identify interpersonal skills
   b) assess whether candidate is appropriate fit for position
   c) include trick questions to reveal psychological problems
   d) include surreptitious video/audio surveillance
   e) a and b above

19) Contacting candidates who were not hired for a position will:
   a) alienate the candidate and call attention to his/her failure
   b) leave the candidate with a positive impression
   c) violate confidentiality rules
   d) undermine the candidate who was hired
   e) none of the above

20) Nontraditional approaches to staffing:
   a) always result in higher staffing costs
   b) result in more downtime
   c) usually require a network of practitioners with flexible schedules
   d) eliminate the need for routine collection of productivity statistics
   e) lower employee morale
Continuing Education credit

is available for this module for the following professions:
  Registered Dietitians/Dietetic Technicians: 3 CPEUs
  Certified Dietary Managers: 3 Clock Hours

To earn credit, you must complete the examination on the preceding pages, by purchasing access to our Interactive OnLine Testing System at:
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Begin by writing down your answer choices, then visit our website:
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