NJD-HCF COMMUNIQUÉ

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Articles in this newsletter are for your review and not necessarily the opinion of this editor or this practice group.

CHAIRMAN'S CORNER
By Elsie Nucum-Allen, MS RD

At this time, I present to you my final Chairman's message for 2007. Being a Chair-elect and a chairman is a very challenging task. The twentieth century has brought so much innovative techniques to our group. The coming of the Web provided our group an opportunity to look forward. The ADA as well as several National Practice Groups have been utilizing the web for newsletters, reports, meeting announcements and many other information most members find valuable, beneficial and time consuming.

It has been my goal, as well as the past chairman, Christine Colvin, RD, to maximize the use of our web by the members. We are very fortunate to obtain the service of MRN Web Designs during Christine's term and as the chairman of this group find pride in the professionalism and efficacy of this service. Based on the request of our Board members, I did a cost analysis in consolidating all services with MRN Web Designs. We are getting the best price for the quality of service to be provided.

I wanted to take this opportunity to thank all the board members for working effortlessly to serve all the members of the NJD-HCF. Your continued support and faith in me and your hard work and dedication are truly appreciated. Also, a special thanks to all the members that agreed to run for office. If you noticed, we have new names serving the board. We need more members like you in maintaining the high standard of the NJD-HCF.

The winter seminar in Cancer and Immunity was well attended and the speakers were rated high by the attendees. Our spring seminar is scheduled on April 25th. Josie Velez , MS RD, our chair-elect is planning another interesting and informative meeting on Nutrition Diagnoses, The Standardized Language of Dietetics as the component in the Nutrition Care process. The creation of the standard language will help dietetic professionals better document their nutrition care. A great seminar to attend! Please save this date.

It has been a good year! Keep the momentum going. Thank you all.

EXCITING NEWS!
Marilyn Laskowski Sachnoff: Medallion Award Nominee

NJDA is nominating Marilyn Laskowski Sachnoff for an ADA 2007 Medallion Award!

The NJD-HCF and the CD-HCF is supporting her nomination, thanks to the effort of the NJD-HCF.

As you all remember, Marilyn was our key speaker during our Fall seminar on "Sanitation and Management." It was an excellent presentation well attended by Dietitians, Food Service Managers, and front line food service workers. Our Chairman, Elsie Nucum-Allen, MS. RD., worked closely with John Krakowski, RD who is coordinating the nomination pocket. With her assistance, John was able to contact the CD-HCF who also agreed to support Marilyn for this nomination.

Elsie wrote " As the Chairman of the largest and only Practice Group in New Jersey, Marilyn has been an active participant in promoting Nutrition Education to the New Jersey Dietitians in Health Care Facility (NJD-HCF) . She had conducted several seminars on various topics of nutrition, sanitation and management, sharing her talent and knowledge which we all find very inspiring and informative to our daily practice. She is a great mentor and an inspiration to the present and future dietitians."

Wouldn't it be wonderful to have an NJDA member to receive the prestigious Medallion Award? Even more wonderful if it is awarded to someone like Marilyn!

FYI: Infection Control In-service
Submitted by Mary E. Chambers, RD

For a quick, informative and fun in-service, go to
www.coughsafe.com
You will need access to the internet on a computer or lap top to run and show your employees.

Mark Your Calendar!

May 4, 2007

NJDA ANNUAL MEETING

CRYSTAL PLAZA

Livingston, NJ

Please plan to attend and support the NJDA activities.

Deadline for the August Newsletter is July 15, 2007

Please send all articles or announcements to:

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OR

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CHAPTER 24—NJ STATE SANITATION CODE
Submitted by: Mary E. Chambers, RD

The new NJ State Sanitation Code is finally here and went into effect January 2, 2007. These regulations replace Chapter 12, and will remain in effect until January 2, 2012. Your local sanitarian, as well as our State Surveyors, will be enforcing these regulations during inspections. To obtain your copy, go to www.doh.state.nj.us

After a review of the new code, here are some of the **major changes** that stuck out in my mind.

- Refrigeration temperatures are lower at 41° F or less for new equipment, but an exception for existing equipment 45° F or lower (exception expires 1/2012)
- Assisted Living, Nursing Homes, Hospitals, Pre-schools and catering facilities are considered Type 3–High Risk due to the highly susceptible population served and held to higher standards.
- Supervision or a "person in charge" must be present during all hours of operation. The "person in charge" must have sufficient knowledge of food safety principles and preventative measures pertaining to the operation. By January 2, 2010, your facility must have at least one **certified food protection manager** (Serve Safe Certificate or CCFM from DMA).
- Safe cooking temp 135° F plant foods, 145° F fish, meat pork, 155° F raw shell eggs and ground meat, 165° F all poultry, stuffed fish and stuffed pasta. Raw or partially cooked food is not allowed to be served to our highly susceptible population. **Yes, that's right, no soft cooked, poached or sunny side up eggs unless you purchase pasteurized eggs.**
- Thin-probed thermometer must be used to monitor temps. of thin foods i.e., burgers, fish filets.
- Advanced food prep-foods must be cooled from 135° F to 70° F within 2 hours and from 70° F to "refrigeration temp" within 4 hours.
- Foods must be hot held at 135° F or above.
- Wash hands for at least 20 seconds and rub hands together vigorously with soap to a lather for at least 10 seconds. Make sure *all hand washing areas have warm water, plenty of soap and paper towels and hands free garbage.*
- Documented in-services are a must for all dietary employees.
- No bare hand contact with exposed, ready to eat foods. Single-use gloves shall be used for only one task only and discarded when damaged or soiled or when interruptions occur in the operation.
- Food employees **may drink** from a closed beverage container.

GUESS WHO'S COMING TO DINNER (AND BREAKFAST AND LUNCH)

Submitted by Liz Dunnell, M Ed, RD

It may be a big surprise for us, as dietitians, and our clients who have diabetes; unless we know about the Consistent Carbohydrate Diet. Our JADA (January 2007) featured a Perspectives in Practice: Inpatient Management of Diabetes and Hyperglycemia. From the information provided, we can extrapolate information to recommend the correct prescription in the treatment of diabetes for our out-patient/home patients to help control blood sugars and hopefully avoid side effects of uncontrolled diabetes.

Both the American Diabetes Association and the American College of Endocrinology recommend critically ill patients keep their blood glucose level as close to 110 mg/dL as possible. In the non-critically ill patient, The American Diabetes Association recommends to keep the pre-meal blood glucose as close to 90 to 130 mg/dL as possible. Both organizations agree that peak post-prandial blood glucose should be 180 mg/dL or less.

It is important that food and nutrition professionals familiarize themselves with these recommendations and implement nutrition interventions in collaboration with other members of the health care team to achieve these new glycemic control targets. Food and nutrition professionals have a key role in developing screening tools. And in implementing nutrition care guidelines, nutrition interventions, and medical treatment protocols are needed to improve inpatient glycemic control.

Recent evidence suggest that irregardless of the cause of hyperglycemia, tighter glycemic targets are necessary for individuals to achieve the best possible outcomes when hospitalized. A number of recommendations were given in the JADA article, including that all patients with diabetes admitted to the hospital should have glycosylated hemoglobin(A1c) obtained for discharge planning if the result of testing in the previous 2 to 3 months is not available; and that a diabetes education plan including "survival skills education" and follow-up should be developed for each patient. Risks and benefits of using oral diabetes medications for individuals with previously diagnosed diabetes must be assessed. Consider oral intake (ie, poor appetite) and patient's schedule (eg, frequent tests or physical therapy). Sulfonylureas (ie, glyburide glipizide, glimerpride) have a long duration of action, and thus can predispose patients to hypoglycemia if they have erratic schedules or inadequate oral intake. Caution with geriatric patients is warranted.

The consistent carbohydrate meal planning system for hospitals was developed to provide a practical way of serving food to diabetes patients in a hospital setting while improving metabolic control. This system is not based on specific calorie levels, but on the amount of carbohydrate at each meal or snack. The carbohydrate amount is consistent from meal to meal and day to day with the focus on the total amount of carbohydrate in a meal.

The primary sources of carbohydrate are fruits, vegetables, whole grains, and low-fat milk. Sucrose containing foods can also be a part of the total carbohydrate for the meal. An average hospital consistent carbohydrate daily menu provides between 1,800 to 2,000 kcal, with approximately 12 to 15 carbohydrate servings, divided between meals and snacks. A carbohydrate serving provides approximately 15 g of carbohydrate. This system focuses on the total grams of carbohydrate as a key strategy to achieving glycemic control.

Watch your mail and vote for our NJDA officers!

GUESS WHO'S COMING TO DINNER (Cont'd)

Individuals on clear or full liquid diets should receive approximately 200 g of carbohydrate throughout the day divided in equal amounts at meals and snack times to prevent starvation ketosis.

In care plan development, the nutrition intervention would be to provide a consistent carbohydrate diet so an appropriate insulin regimen can be integrated with food intake and scheduled testing and/or procedures. Consistent carbohydrate menus should be implemented and maintained for people able to consume oral intake, and clinical staff and volunteers should be educated on the rationale for a consistent carbohydrate diet. The JADA article includes consistent carbohydrate menus for progression diets. For more in depth information about these standards of care, make sure you read J Am Diet Assoc. 2007; 107:105-111.

HOW WOULD YOU APPROACH THIS NON-HEALING WOUND PROBLEM?

By Barbara S. D'Asaro, MNS, RD

A middle aged male patient had abdominal surgery for hernia repair. The incision never healed and remained an open wound; no one could figure why. Labs showed anemia and neutropenia. Iron, B12 and folate were within normal range. Other lab tests could not explain the possible cause of the problem. The patient was on more than a dozen medications but medications did not seem to be involved in poor wound healing. The patient's wife brought in a list of vitamins he had been taking. The list included iron, calcium and a multi vitamin/mineral as well as extra vitamin A and zinc. A literature search showed that vitamin A was not the culprit; however, his zinc intake was 15 times the usual dose. An RD was not consulted!

What would be your approach to this problem?

ANSWER: To test the effect of supplemental zinc, all supplements were stopped. Lab tests confirmed a copper deficiency. Copper supplements were prescribed. Within days, his white-cell count was in the normal range. The anemia resolved within the next two months and the wound finally healed.*

DISCUSSION: A very high zinc intake will depress copper because zinc and copper are in a see-saw relationship; that means that excess zinc will depress copper (and visa versa). A very high zinc intake over several months may depress immune function. A copper deficiency can cause anemia.

TAKE HOME MESSAGE: Zinc, vitamin C and protein are part of the protocol for wound healing. Dietitians should monitor total supplemental zinc and copper intake and recommend reduction of the zinc dosage when a wound is healing or healed. Often a multivitamin with minerals may be adequate. The ratio of supplemental copper to zinc should be approximately 2:15.** When wounds are slow to heal, a copper supplement may be indicated.

* The Healing Problem, New York Times Magazine, November 12, 2006
** Dietary DRI Reference Intakes 2006, Institute of Medicine of the National Academies

NEW JERSEY DIETITIANS IN HEALTH CARE FACILITIES

Presents our

SPRING SEMINAR

April 25, 2007

Princeton, NJ

"NUTRITION DIAGNOSIS AND THE NEW PROCESS FOR NUTRITIONAL CARE"

This one day program is designed to provide an understanding of the standardized, evidence-based Nutrition care Process. This program will help identify the reasons for use of a Standardized Language for Dietetics. The use of case study approach, to identify the appropriate nutrition diagnosis and utilize the nutrition care process to plan care, will be presented.

An overview of the ethical principles, description of the legal feeding cases as well as the examination of feeding as an ethical choice will be discussed.

This program will assist dietitians/diet technicians in providing a proven standard of care with defined interventions as well as improved and demonstrated clinical outcomes.

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