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An evaluability assessment to develop a restaurant health promotion program in Canada

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SUMMARY

An evaluability assessment was conducted to develop a standard, provincial restaurant health promotion program that public health units across Ontario can adopt. This assessment focused on extensive stakeholder consultation to develop a program logic model to diagrammatically describe the assumptions underlying the program. First, details about existing restaurant health promotion programs were analyzed to assist in planning the program. Based on this review, a provincial steering committee recommended that restaurants must meet minimum requirements for nutrition, food safety and non-smoking seating standards to qualify for recognition. Second, stakeholders were consulted about the program goal, target groups, and these and other possible standards. This entailed conducting focus groups with restaurant patrons and interviewing public health unit staff, restaurateurs and food service suppliers. A workgroup developed a draft logic model based on the results of the consultation. Third, community focus groups, public health unit surveys and expert reviews were conducted to assess the plausibility of the logic model. The workgroup revised the logic model based on the results of this consultation. The final logic model conceptualizes the program as: (i) three program standards for restaurateurs; (ii) social marketing activities targeted to consumers and restaurateurs; (iii) education and skill development activities targeted to restaurant managers and staff, public health unit staff and volunteers; and (iv) environmental support activities targeted to restaurateurs, public health unit staff and volunteers. The logic model shows the relationship between long-term, intermediate and short-term desired outcomes and program activities that need to be implemented provincially and locally to achieve the desired outcomes. The final logic model was subsequently communicated to various stakeholders. It is apparent that the evaluability assessment involved considerable stakeholder participation to develop the program. Thus, they should be more likely to agree with the program design and participate in the restaurant program in their community.

Key words: food safety; nutrition; restaurant; smoking

INTRODUCTION

Eating establishments are a practical channel for health promotion activities because they enable health promoters to reach a large number of people and to satisfy consumers' desire for information in a potentially cost-effective manner (Glanz *et al*., 1992). Point-of-purchase interventions, e.g. menu inserts and labels, table tents and posters have been used to influence consumer selection of targeted food items in restaurants and cafeterias, but they have had mixed success (Hooper and Evers, 1997). In Ontario, a restaurant award or promotion scheme to recognize eating establishments that provide healthier choices to their patrons is a

more popular strategy. Examples include the Lifestyle Approved Award Program, Bon Appétit Restaurant Program, and Heart Smart Restaurant Program. Specifically, restaurants that meet certain health promotion standards receive an award and free promotion in the community for providing a healthier environment. Currently, these programs in Ontario are sporadic and vary in complexity. Some programs only focus on nutrition, whereas multifaceted programs address additional criteria, e.g. tobacco use prevention, food safety, injury prevention, breast-feeding acceptance, allergy awareness, alcohol server training, and wheelchair accessibility.

This article describes an initiative to develop a standard, provincial restaurant health promotion program that public health units, in conjunction with community partners, can adopt. The program was subsequently named 'Eat Smart! Ontario's Healthy Restaurant Program'. A provincial program is appealing for various reasons. First, public health units would be more likely to adopt a provincial program, as opposed to expending considerable human and financial resources to develop and implement their own programs. Second, the food service industry, consumers and the media would recognize a standard provincial program more than many different locally developed and delivered programs. Third, a provincial program can be linked with and promoted through other provincially supported programs, e.g. Heart Health, the Community Food Advisor Program, the Healthy Eating Manual, and Ontario Tobacco Strategy.

An evaluability assessment, which is a formative evaluation strategy that links program planning, development and evaluation (Fisher and Peters, 1985), was undertaken. This assessment focuses on the development of a program logic model to diagrammatically describe the program and to determine whether the program is ready for evaluation. A logic model shows the assumptions underlying the program by linking the objectives of the program and program activities (Rutman, 1980; Wholey, 1987; Smith, 1989; Rush and Ogborne, 1991).

METHODOLOGY

Figure 1 shows the steps taken to conduct the evaluability assessment over an 8-month period.

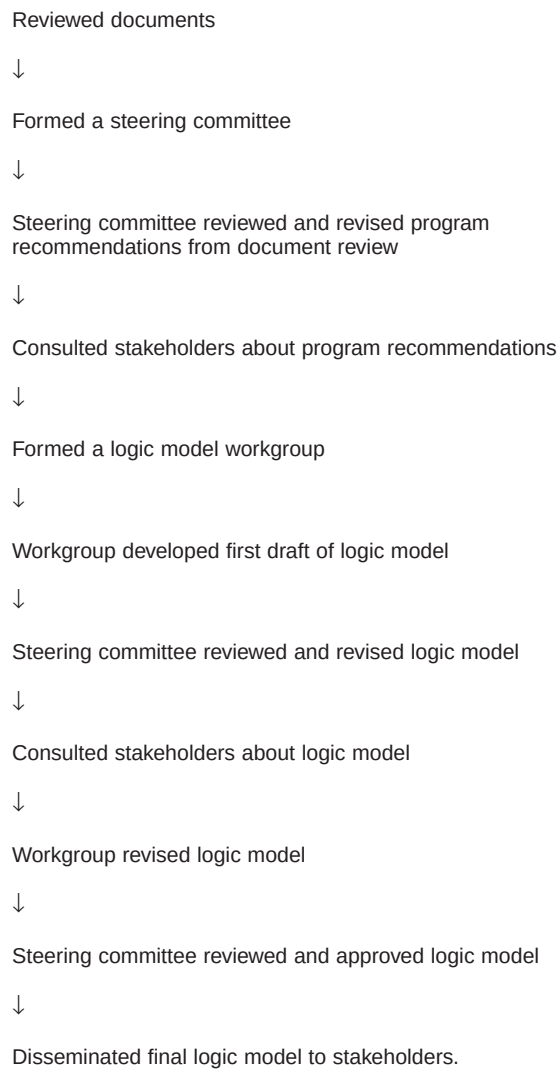


Fig. 1: Steps taken to conduct evaluability assessment.

Document review

Details about existing restaurant health promotion programs in Ontario and elsewhere and their evaluations were reviewed to assist in the development of a provincial program. Programs were deemed potentially suitable if they targeted or involved consumers and restaurateurs, were simple to implement, required little effort from participants, and used strategies that did not interfere with profit goals (Hooper and Evers, 1997). Some programs that were reviewed are as follows.

- Lifestyle Approved Award Program. Restaurants must meet nutrition, food safety and non-smoking seating criteria. Also, information about accessibility, alcohol serving practices, breast-feeding and allergy awareness is given to restaurants.
- Bon Appétit Restaurant Program. Restaurants must provide healthy food choices on request and meet standards for one of the following components: healthy kids' menu; food safety; alcohol awareness; 100% smoke-free; choking prevention; fall prevention; and accessibility for customers with physical disabilities.
- Heart Smart Restaurant Program. Restaurants must provide healthy food choices on request and have non-smoking seating.
- Restaurant Recognition Program. Restaurants must meet criteria for all of the components: nutrition, food safety, non-smoking, healthy food choices for kids, wheelchair accessibility, fall prevention, breast-feeding friendly, child safety, alcohol and environmental practices.

On the basis of this review, the program coordinator (L. M.) made recommendations to the steering committee. The recommendations pertained to the program goal, target groups, program standards, minimum requirements for standards, and possible ways to implement the program. In particular, she recommended three provincial program standards: nutrition, food safety and non-smoking seating. To receive an award, a restaurant must have a menu that has healthy food choices and customers must be able to request certain food or preparation methods when ordering. A restaurant must have a clean inspection record and the public health unit must have certified at least one staff member as a safe food handler. A restaurant must provide more non-smoking seating than is required in the local community.

Steering committee's review of program recommendations

A provincial steering committee comprised of people with expertise in restaurant health promotion and representatives of key stakeholders was established. Committee members had expertise in nutrition, food safety, tobacco use prevention, marketing and program evaluation. There was representation from public health units; health agencies, e.g. Heart and Stroke Foundation of Ontario, Ontario division of Canadian Cancer Society, and Ontario Public Health Association; Ontario Ministry of Health; Ontario Ministry of Agriculture, Food and Rural Affairs; and restaurant chefs. The committee reviewed program recommendations from the document analysis and subsequently revised them.

Stakeholder consultation about program recommendations

Focus groups and telephone interviews with various stakeholders were conducted to obtain input on the revised program recommendations. Six 2-h consumer focus groups were held in diverse Ontario communities. A market research company recruited 'eating out consumers', defined as those who ate at restaurants a minimum of three times per week. Each group of ~10 participants included both smokers and non-smokers, and had a mix of demographics. Participants were asked questions about their 'eating out experiences' and the three proposed program standards.

Managers and front line staff involved in nutrition, food safety, tobacco use prevention and heart health programs in 28 out of the 37 public health units in Ontario participated in 30-min telephone interviews. They were asked questions about the three program standards and implementation issues for the program, and provided collective responses after internal consultation. Also, interviewees were asked to provide names of family-style or quick-service restaurants in their community for province-wide restaurant consultation. Convenient interview times could not be arranged for staff in nine public health units.

Sixteen out of 39 contacted owners or managers from family-style and quick-service restaurants across Ontario were interviewed on the telephone for 15 min. Convenient interview times could not be arranged for 21 restaurateurs and two restaurateurs were not interested in being interviewed. Restaurateurs were asked questions about the three program standards and incentives to participate in the program.

Six out of 13 contacted food service suppliers across Ontario were interviewed on the telephone for 15 min. Convenient interview times could not be arranged for seven suppliers. Suppliers were asked about customer trends, strategies to promote food products and strategies to communicate about food safety.

Development of initial draft of logic model

A logic model workgroup was formed. This group was comprised of members from various disciplines and geographical regions. A program evaluator (J. D.) facilitated sessions to: (i) identify the program goal, program strategies or components, and target groups; and (ii) show the relationship between desired outcomes and program activities. A logic model framework that positions long-term desired outcomes near the top of the diagram, as opposed to at the bottom, was used to emphasize that desired outcomes should determine program activities (Dwyer, 1996). The workgroup developed a draft of the logic model based on the steering committee's review of program recommendations and results of stakeholder consultation. The steering committee subsequently reviewed the logic model and its feedback was incorporated into a revised logic model.

Stakeholder consultation about logic model

Focus groups, surveys and expert reviews with various stakeholders were conducted to assess the plausibility of the logic model. Five 2-h focus groups were held in diverse Ontario communities. Each group of five–nine participants represented public health units, restaurants and community partners. Participants were presented details of the logic model. They were asked: whether the desired outcomes and program activities were clear, realistic and measurable; which outcomes and activities should be omitted or added; and to identify which activities should be implemented provincially and which activities should be implemented locally. A survey was mailed to key contact persons in all public health units to obtain collective unit responses to details of the logic model. Staff involved in nutrition, food safety, tobacco use prevention and heart health programs in 21 public health units contributed to the responses. They were asked questions about monitoring the program standards, feasibility of the desired outcomes and program activities, and implementation issues, e.g. provincial and local implementation of activities. Four public health nutritionists, four public health inspectors and four tobacco use prevention officers across Ontario reviewed and critiqued the minimum requirements for the program standards. The logic model workgroup revised the logic model based on the results of the stakeholder consultation.

The steering committee's review of the logic model

The steering committee reviewed and approved the logic model. Then, the final logic model was communicated to various stakeholders in Ontario.

RESULTS AND DISCUSSION

More than 300 stakeholders were consulted in the evaluability assessment to develop the logic model for a provincial program.

Initial stakeholder consultation

Some key findings that were considered in developing the logic model are summarized below.

Consumer focus groups

Participants' main criterion for selecting a restaurant was to obtain quality food at a reasonable price. They also mentioned location, service, cleanliness, variety of food choices and non-smoking seating. They have requested substitutions or made special preparation requests, e.g. salad dressing on the side and salad instead of french fries. The main barriers to asking for special requests were not wanting to slow down the order and a poor attitude among servers. Consumers were annoyed with extra charges for equivalent substitutions and with the lack of choice of a healthier beverage in fixed priced meals. They suggested that restaurants voluntarily indicate that they respond to substitution requests by noting this on the menu. Some participants preferred smaller portion sizes at a lower price. Participants patronized restaurants that were responsive to their special requests.

Participants felt that children's menus have limited variety, offer minimal nutritional value and consist of too much fried food. Some participants were concerned about restaurant promotional offers that encourage children to order unhealthy meals to obtain a prize. They suggested that children's menus should offer healthier food, e.g. fruit, vegetables and pasta.

Participants felt that the cleanliness of a restaurant is a good indicator of food being 'safe'. They viewed the recognition program as a type of assurance that specific restaurants are 'safe'. They were interested in knowing a restaurant's food safety record. Participants did not find the notion of a program standard for a certain percent of non-smoking seating above the legal requirement

meaningful. They felt that the standard was meaningless if you walked in the restaurant and there was second-hand smoke. Suggested standards ranged from a minimum percent of non-smoking seating to an entirely smoke-free restaurant. They offered suggestions to promote the program.

Public health unit interviews

Health unit staff said that public health units require the following support to ensure that the nutrition standard is met: a centrally developed standard; specific and well-defined criteria for menu assessment; centrally developed, comprehensive bilingual resources; and training and skill development for promotional activities. They felt that restaurants require the following support: assessment, consultation, training and feedback from public health units; a widely publicized program; consumer demand for healthier food choices; low-cost adaptations for restaurants to qualify for the award; and recognition of participating restaurants.

Health unit staff contended that, as part of the food safety criteria, restaurant supervisors should be trained in food handling so that there is at least one supervisor certified in food handling on-site at all times. Also, they believed that more restaurant personnel should be trained in safe food handling. They wanted a food handler certification program that is standardized across Ontario. They wanted standardized information and resources but the flexibility to deliver the program according to local needs. They suggested that there be flexibility in how and when training is given to encourage more restaurants to participate, and that restaurants completing training receive recognition in the community.

Health unit staff had different views on the percent of non-smoking seating above the local smoking by-law that a restaurant should provide in order to qualify for the program. The average response was 15% above the by-law. Some participants said that there should be 70–75% non-smoking seating to reflect the proportion of the population that does not smoke, whereas others stated that the criterion should be entirely smoke-free. They suggested various incentives for restaurants to provide non-smoking seating, e.g. providing recognition in the community, allowing them to gradually increase non-smoking seating over time, providing evidence that a smoke-free restaurant yields economic benefits, and subsidizing the installation of proper ventilation. They felt that public health units require more inspectors to ensure that this standard is met.

It was felt that local public health units could co-ordinate the program by establishing a steering committee with representatives from all stakeholders. Support from the medical officer of health, senior managers, front line staff, heart health planning committee and other stakeholders was deemed important. They suggested that provincial restaurant recognition include: a standard logo, slogan and certificate; a province-wide media campaign; and tourism-related promotion. The most preferred methods of local restaurant recognition were media coverage, an awards ceremony with local dignitaries, a dining guide, advertising, certificates and promotional materials, e.g. door decals.

Interviews with restaurateurs

Restaurateurs reported that they can accommodate most customer requests for healthy choices, e.g. milk as an alternative to cream for tea or coffee; lower-fat milk as a beverage; lower-fat cooking techniques, e.g. baking, broiling and steaming; menu substitutions, e.g. salad for french fries; and butter/margarine, sauces, gravy and salad dressings served on the side. They had more difficulty offering calorie-reduced salad dressings, preparing food with no salt or providing low-sodium choices, and offering smaller portion sizes.

Most restaurateurs knew that public health units offered training and resource materials in food safety. Most restaurants had all of their kitchen supervisors trained in safe food handling, whereas approximately two-thirds of restaurants had trained all of their kitchen staff. Half of the restaurateurs did not know the non-smoking seating requirement for restaurants in their community. Several restaurateurs who exceeded the minimum requirement reported that they did not lose business over time. On average, the restaurateurs stated that restaurants in communities that have a minimum requirement should be 75–80% smoke-free to be recognized in an awards program. In contrast, they said that restaurants in communities that do not have a smoking by-law should provide 50% non-smoking seating to be recognized as promoting the health of their customers.

They were interested in participating in the program, mainly because it provided free publicity. They felt that cost was a barrier and

expressed concern about available time, possibly being charged for materials or program administration, and costs associated with becoming 100% smoke-free.

Interviews with food service suppliers

Suppliers reported that their customers are ordering more pre-cooked and convenience products, particularly food in single-serve packaging. They indicated that the demands of restaurants, patrons and their own competitors prompt them to provide new products. They felt that their healthy choice product line is successful and that their customers are demanding more low-fat products. However, the higher cost of healthy choice products is a barrier. They believed that providing consistent, accurate nutrition information to the public would increase customer demand for healthier choices in restaurants. Also, suppliers reported that they communicate proper food handling practices to customers primarily by educating their sales representatives and providing point-of-sale literature to customers.

Subsequent stakeholder consultation

Some key findings that were considered in revising the logic model are summarized below.

Community stakeholder focus groups

Community stakeholders supported the three program standards, and felt that both public health units and restaurateurs can manage a small number of core standards better than many standards. Some suggestions about the posting of restaurant inspection reports were offered. Also, stakeholders advised that restaurateurs serve on local program planning committees, and emphasized that both dieticians and public health inspectors should be involved in assessing whether restaurants meet the standards. They suggested that some of the desired outcomes, particularly consumer-related ones, would require considerable resources to monitor. These desired outcomes were subsequently omitted from the logic model. Stakeholders felt that there were adequate provincial and local program activities to achieve the desired outcomes.

Public health unit surveys

Health unit staff suggested that public health inspectors could monitor the food safety and non-smoking seating standards during routine inspections, whereas dieticians or trained volunteers could monitor the nutrition standard, once per year. They preferred a simple checklist to assess compliance. They suggested a focus on a smaller number of key desired outcomes, particularly outcomes for which public health units already collect data. They felt that public health units would not have adequate resources to assess consumers' awareness, knowledge, attitudes and practices. They deleted some program activities that were listed and suggested additional activities. Finally, they identified each activity as a provincial or local activity.

Expert review of standards

The content experts supported the detailed requirements for the standards and provided some minor wording changes for clarification.

Final logic model

Figure 2 shows the final logic model. The program was conceptualized as: (i) three program standards for restaurateurs (refer to Appendix); (ii) social marketing activities targeted to consumers and restaurateurs; (iii) education and skill development activities targeted to restaurant managers and staff, public health unit staff and volunteers; and (iv) environmental support activities targeted to restaurateurs, public health unit staff and volunteers. The stakeholders' views of the assumptions underlying the program are shown. Availability of healthier food choices in restaurants and requests for healthy food choices from consumers are depicted as longer-term desired outcomes, whereas knowledge about the program within various target groups is shown as a shorter-term desired outcome. For illustration, some underlying assumptions of the program are as follows (Figure 2).

- In order to have more consumers making healthy requests, restaurateurs need to make healthier food choices available.
- In order to have more restaurateurs making safe, healthier food choices available, there needs to be more restaurants that have received the award and more kitchen staff certified in safe food handling.
- In order to have more restaurants receiving the award and more kitchen staff certified in food handling, servers need to be more knowledgeable about the program standards, and chefs need to be more knowledgeable and skilled in preparing healthy foods.

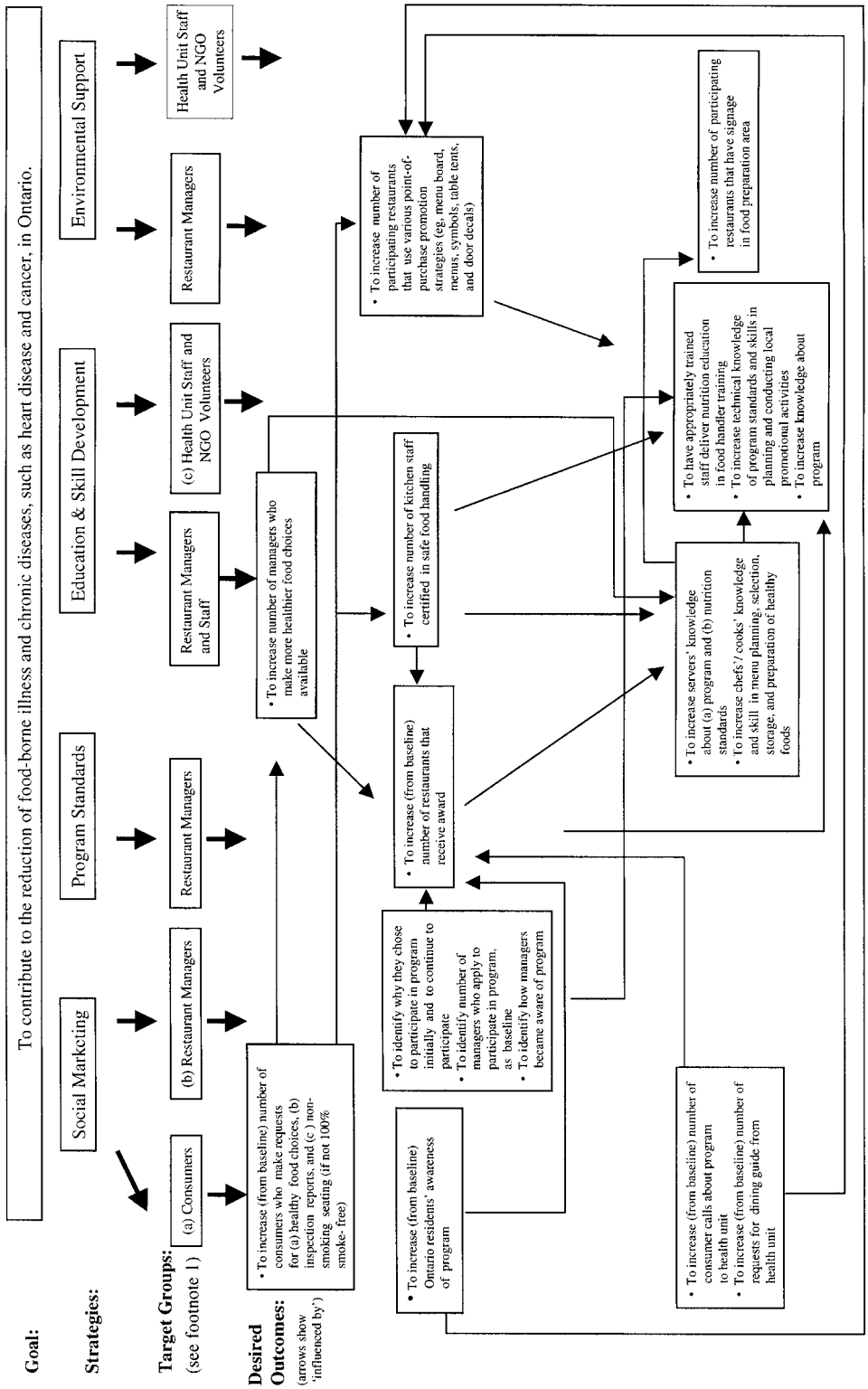


Fig. 2: Logic model for 'Eat Smart! Ontario's Healthy Restaurant Program'.

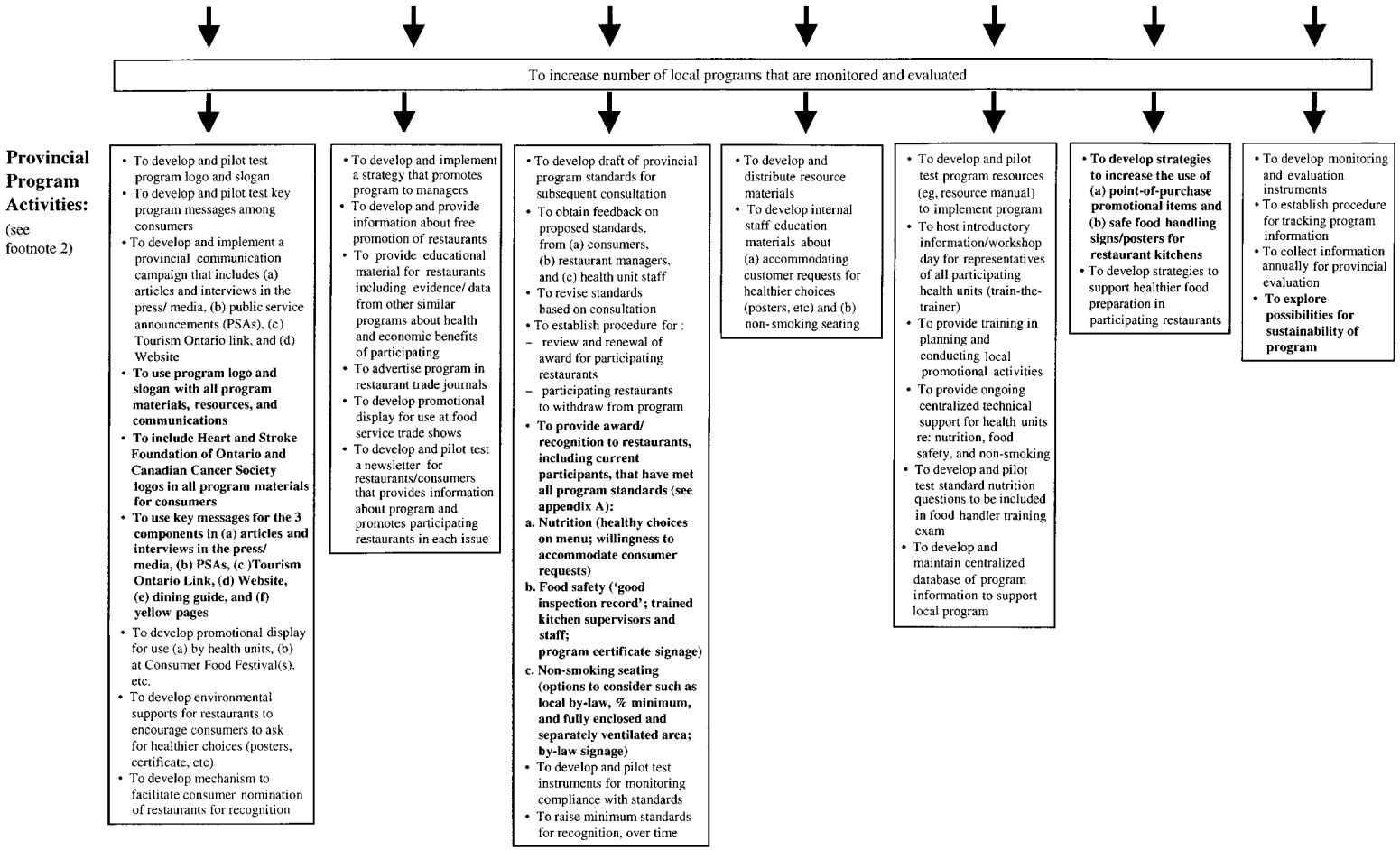
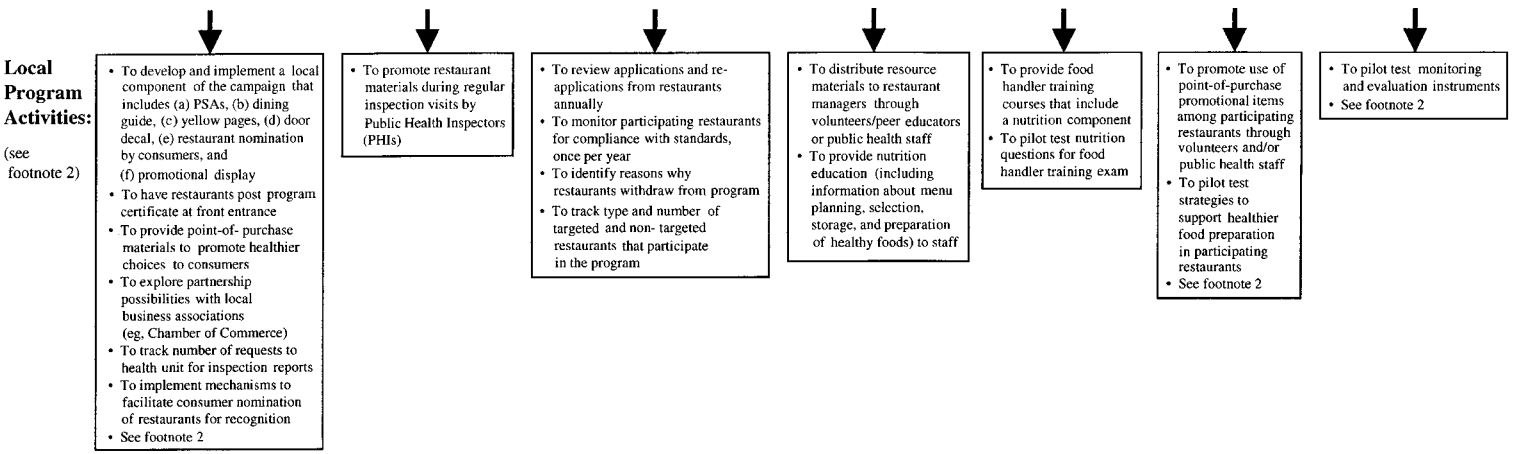


Fig. 2: Continued.



Footnote 1: (a) Ontario consumers who eat out at quick-service/ family restaurants 3 or more times per week. (b) Managers of quick-service and family restaurants. (c) Public health unit staff and volunteers in non-governmental organizations (NGOs).
Footnote 2: Bolded provincial activities are also local activities.

Fig. 2: Continued.

- In order to have more knowledgeable servers and chefs, public health unit staff must have sufficient knowledge and skills to implement the program and to support restaurant managers and staff.

Finally, program activities that need to be implemented provincially and locally to achieve the desired outcomes are listed in the logic model.

Gaining regional support

Ontario is a vast and diverse province with large multi-cultural urban centres in the south, French-Canadian areas in the North and East, and isolated regions throughout the far north and west. Including all regions in the consultation ensured that the logic model did not become 'Toronto-centric' but addressed issues and concerns from areas across the province. For example, very little non-smoking seating is available in communities without legislation requiring non-smoking seating in restaurants. A 100% smoke-free requirement would be unfair to these regions as very few restaurants would qualify. Instead, local standards for non-smoking seating were permitted to reflect the current political climate and recognize restaurants that were leaders in promoting health in their communities.

All public health units are considered equal

Public health units across Ontario vary widely in size, staffing, programming and resources. In the initial consultation, some staff reported that their participation in the program would be unlikely because of limited resources. Instead of eliminating them from further consultation, they were asked what they would need to implement the program. For example, several public health units were concerned about not having staff expertise to conduct local promotional activities. To address this need, regional workshops to train public health unit staff in promotional activities were included in the logic model.

Involving the food service industry

The opinions and values of food service industry representatives were considered. Restaurateurs were consulted because they are gatekeepers to activities and promotions within their establishments. Obtaining their input about program development makes it more likely that they will perceive that the benefits of participating outweigh any costs. Trying to harmonize their goal of increasing profits while implementing health promotion activities was challenging. For example, restaurateurs from all regions expressed concern about the possibility of having an entry standard of 100% smoke-free and said that it would deter participation. To encourage restaurant participation, a more moderate non-smoking requirement was established, with the intent to increase the requirement to 100% smoke-free in later years. Restaurateurs said that they value free promotion and thus, public recognition of participating restaurants was incorporated in the logic model.

Discussions with suppliers helped the program planners understand the factors that influence food supply to the restaurant industry. Consumer demand determines suppliers' product offerings, and therefore, promotional activities targeted to restaurant patrons were planned. Trying to affect consumer demand for healthier choices at restaurants would likely encourage suppliers to make this food more readily available.

Recognizing content experts

Content experts were consulted throughout the planning of the program. The logic model workgroup included content experts from various disciplines. Also, content experts in nutrition, food safety and tobacco use prevention provided input on program recommendations. Further, public health unit staff involved in similar programs reviewed and commented on the logic model. These consultations identified regional differences relevant to the three program standards. Municipal non-smoking by-laws for restaurants differ across the province. Public health units vary in the resources available for food safety and restaurant inspections. Also, nutritionists reported that restaurant menu choices and consumer food preferences differ from region to region. This consultation underscored the need for regional differences to be considered when developing the program standards.

Workgroups working in tandem

The logic model workgroup and other workgroups were involved in different aspects of program development but complemented each other's work. For example, a workgroup provided

assistance with the development of focus group interview guides and surveys that were used in the stakeholder consultation. This support ensured that the evaluability assessment was completed in a timely manner. Further, a communication workgroup determined the desired outcomes and program activities for a social marketing campaign which, in turn, were incorporated into the logic model. The project co-ordinator was a liaison between the different groups to co-ordinate the efforts of the workgroups.

Best possible solution

As more consultation was completed, it became apparent that no single logic model would meet all the needs of all stakeholders. A lot of dialogue, evidence-based information sharing and communication were required to educate stakeholders and encourage them to compromise on some issues. The non-smoking requirement was the most contentious program standard. Health promoters, community stakeholders and the steering committee were evenly split on whether to uphold the health standard of requiring 100% smoke-free restaurants or to lower the non-smoking standard to encourage more restaurant participation. Consumers and restaurateurs expressed that a 100% smoke-free standard was too much too soon in some communities and that other factors, e.g. the local political climate and restaurants' profitability, have to be considered. Arguments for both sides can be made. It was decided that 100% smoke-free dining is a long-term objective of the program. There was consensus for a lower program standard during the first year and a gradually increased non-smoking seating standard in later years.

CONCLUSION

A document review and extensive stakeholder consultation were performed to develop a provincial restaurant health promotion program. A logic model that diagrammatically describes the program was developed. It would be an easier task for health promotion practitioners to develop a logic model that is based on their own priorities. For this project, the challenge was reaching a compromise between public health goals and the realities of consumer behavior, the food service industry, and regional differences. Investing time to consult program partners and to incorporate their priorities is likely to yield a more comprehensive logic model that various stakeholders will embrace. It is expected that this logic model provides a realistic program plan that is feasible to implement and evaluate in communities across the province.

ACKNOWLEDGEMENTS

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APPENDIX: PROGRAM STANDARDS FOR RESTAURANT HEALTH PROMOTION PROGRAM

Nutrition standard

You offer:

(Circle one)

(1) Grain products from at least **two of the following**: (excluding croissants, danishes, donuts, muffins or banana bread-like products).

YES NO

Check all that apply.
- — *Whole grain* breads/rolls, pita, bagels, pizza crust or lower-fat muffins, etc.
- — *White* breads/rolls, bagels, chapati, flour tortillas, naan, pita, pizza crust or roti shell.
- — Hot or cold cereal.
- — Pasta, noodles, couscous or wrap made with dough, e.g. perogi, Chinese dumpling.
- — Rice, barley, baked corn tortillas, polenta, bulgur, millet or other grain products.

(2) At least **four choices of vegetables and fruit**: (excluding deep fried vegetables, vegetables in cream/cheese/peanut/coconut sauce, caesar salad and garnishes).

YES NO
- — Fruit (one piece) or fruit salad (1/2 cup/125 ml minimum).
- — 100% fruit or vegetable juice (4 oz/125 ml minimum).
- — Leafy green salad (1 cup/250 ml minimum).
- — Baked potato.
- — Tomato sauce, e.g. on pasta (1/2 cup/125 ml minimum).
- — Stir-fried vegetables (1/2 cup/125 ml minimum).
- — Other vegetables (1/2 cup/125 ml minimum). Please list.

(3) Either 2%, 1%, or skim milk, if milk is served as a beverage (2%, 1% or skim chocolate milk is acceptable).

YES NO N/A

(4) At least one meat, fish, poultry or alternative prepared using a lower fat cooking method, e.g. steaming, poaching, broiling, roasting, baking, barbecuing, if meat or alternatives are served as entrées.

YES NO N/A

(5) At least one lower-fat dessert choice, e.g. fresh fruit, fruit salad, angel food cake, gelatin, lower fat frozen yogurt, sherbet or milk pudding, if dessert is served.

YES NO N/A

(6) Milk or 100% fruit juice with children's meals, if a children's menu is offered.

YES NO N/A

Upon request, your restaurant provides at no extra cost to the customer:

(Circle one)

(1) Milk as an alternate to cream for tea or coffee.

YES NO N/A

(2) Gravies, sauces and salad dressings served on-the-side whenever possible.

YES NO N/A

(3) A substitute for french fries if they are served as part of an entrée. The substitute could be baked potato, rice, vegetables or salad.

YES NO N/A

(4) Calorie-reduced or fat-free salad dressings, if salad is served.

YES NO N/A

(5) Butter, margarine, sour cream or mayonnaise served on-the-side or not used on entrées, side dishes, vegetables or sandwiches.

YES NO N/A

(6) Removal of visible fat from meat and skin from poultry before serving.

YES NO N/A

(7) Information about recipe ingredients, whenever possible.

YES NO N/A

(8) A 'menu for smaller appetites' and/or serve half-size portions of regular menu items.

YES NO N/A

(9) Vegetable sticks, salad, potato or rice instead of french fries in a child's meal.

YES NO N/A

Food safety standard

Food safety standards must be demonstrated and maintained at all times, not only at the time the award/recognition is given.

Your establishment must adopt safe practices in the areas of storage, preparation and sale of food. The food safety assessment will focus on the following critical items:

- cooling and refrigerated storage of hazardous food;
- cooking/hot holding/re-heating of hazardous food;
- protection from contamination by food handlers;

- protection from cross-contamination of ready-to-eat hazardous foods by raw foods or preparation surfaces;
- protection from contamination from other sources.

Non-critical items, e.g. equipment and utensils, pest control, general sanitation and sanitary facilities will also be evaluated for compliance with the Food Premises Regulation.

Compliance with the Ontario Food Premises Regulation 562/90 is required. Please note that a restaurant which has received a closure or conviction under the Health Protection and Promotion Act 1990 and the Ontario Food Premises Regulation 562/90 within the 12 months proceeding the (month, year) inspection will not qualify for the award/recognition.

Food handlers must be knowledgeable in the care and handling of food. Participating restaurants must have:

- a minimum of one full-time kitchen employee certified in safe food handling by the Public Health Unit/Department.

Your restaurant:

(Circle one)

(1) Complies with the Ontario Food Premises Regulation 562/90 on the date of inspection. **YES NO**

(2) Has a history of compliance with the Ontario Food Premises Regulation 562/90 for a minimum of 12 months prior to the inspection date. **YES NO**

(3) Has not been convicted of an offence for non-compliance with the Food Premises Regulation 562/90 during the past 12 months. **YES NO**

(4) Has not been confirmed as the source of food-borne illness during the past 12 months. **YES NO**

(5) Has a minimum of one full-time kitchen employee certified in safe food handling by the Health Unit/Department (as per the Food Handler Training Protocol, 1 January 1998). **YES NO**

(6) Consents to the sharing of its most recent inspection report with customers through the Public Health Unit/Department upon request. **YES NO**

*Can be shared on-site at restaurant if operator prefers.

Non-smoking seating standard

(1) Participating restaurants must meet one of the following four criteria (A, B, C or D), depending upon local by-laws.
Your restaurant must meet the requirement in statement _____ to be eligible to participate.

(A) For those communities with a by-law requiring restaurants to provide up to 75% non-smoking seating:
Your restaurant provides a minimum of 15% more non-smoking seating than the by-law requires (or 50% non-smoking seating, whichever is greater).
(Circle one) **YES NO**

OR

(B) For those communities with a by-law requiring 80–90% non-smoking seating in restaurants:
Your restaurant provides a minimum of 90% non-smoking seating.
(Circle one) **YES NO**

OR

(C) For those communities with no by-law:
Your restaurant provides a minimum of 50% non-smoking seating.
(Circle one) **YES NO**

OR

(D) Your restaurant's smoking area is a separately enclosed and separately ventilated area, comprising not more than 25% of the total seating in the establishment.
(Circle one) **YES NO**

(2) In addition, the smoking area:

(Circle one)

- is one contiguous area (connected without a break) **YES NO**
- is not located in the centre of the establishment **YES NO**

(3) A sign indicating that smoking is not permitted except in the designated smoking area is posted at each entrance (or signs are posted according to local by-law). **YES NO**

(4) The establishment has a policy of asking customers if they wish to be seated in the smoking or non-smoking area. **YES NO**