REAL CASE · STRUCTURAL DIAGNOSIS

Training without a system isn't food safety.

Social care catering
Structural diagnosis and design of an applied HACCP system.

JIWA BIRU CONSULTORA

THE CONTEXT — SOCIAL CARE CATERING

Social care catering, not commercial hospitality. The brief wasn't to improve a service: it was to establish whether what existed amounted to a control system or to a collection of good practices sitting next to each other.

THE CENTRE

A catering operation serving people who live there permanently. Social care catering, not commercial hospitality.

THE SERVICE

Breakfast, lunch and dinner every day, with no possibility of stopping. There's no day on which the system can afford not to work.

THE CRITICAL DIFFERENCE

The diner doesn't choose where to eat. He depends entirely on the centre's system to be fed safely.

In social care catering the margin for error isn't absorbed by a customer. It's absorbed by a person who can't go anywhere else.

THE STARTING DATA — WHAT THIS RESTS ON

WHAT WAS ALREADY THERE

- Dishes identified by colour according to allergy
- Trays and containers assigned by diner
- Documented records
- Knowledge of the main allergens
- Staff with valid food handler training
- A genuine will to get it right

LEVEL OF INFORMATION ON ENTRY

Partial records. The documentation existed, but it wasn't joined up: each piece was kept separately and there was no traceability between stages.

WHAT WAS OBSERVED

The route of a special meal from kitchen to diner, during live service. Goods-in and spec sheet checks. What happens when service gets overloaded.

The problem wasn't that they were doing nothing. It was that what they did wasn't connected to anything else.

THE DIAGNOSIS — WHAT WAS ACTUALLY GOING ON

NO SYSTEM · ONLY LOOSE PROCEDURES

Isolated procedures, not integrated ones

Colour identification, separate containers and record-keeping each worked on their own account. None of them was linked to the next one, and none depended on the previous one having been done.

OPEN CONTRADICTION · CONTROL IN THE KITCHEN ↔ CONTROL AT HANDOVER

Traceability that breaks between kitchen and delivery

The special meal is identified and stays identified inside the kitchen. Between the moment it leaves and the moment it reaches the diner, there's no point where anyone checks it again.

STRUCTURAL RISK · NO VERIFICATION BARRIER

Allergens identified, with no risk management procedure

Each diner's allergens are identified and the team knows them. What doesn't exist is a procedure that turns that knowledge into a compulsory check before serving.

TENSION · TRAINING ↔ REAL OPERATION

Valid training, with no process to carry it

Food handler training is in date. What's missing is a written process setting out what gets verified, who verifies it and where it gets recorded.

ROCAMORA METHOD

Every finding is classified as Aligned, Tension or Open contradiction.

Where there's documentation but no system, the documentation isn't control. It's paper.

Most expensive contradiction: control existed in the kitchen and disappeared at handover, which is exactly where the error reaches the person.

THE STRUCTURAL RISK — WHERE THE CHAIN BREAKS

Technical scenario: a supplier changes a product's formulation and doesn't say so. What happens in each case.

WITHOUT A SYSTEM

- The change of spec sheet isn't picked up at goods-in
- The allergen record isn't updated
- The team applies the previous procedure, which no longer matches the product
- No later stage checks anything
- The error would only become visible through its consequences

WITH A SYSTEM

- Goods-in checks labelling and spec sheet on every delivery
- The change is picked up and flagged
- The spec sheet and the allergen record are updated
- Affected dishes and diners are reviewed
- The system absorbs the change without creating risk

The supplier changes the formulation and doesn't warn anyone. A well-designed system doesn't depend on being warned.

THE INTERVENTION — THE SYSTEM THAT WAS DESIGNED

1 Documented operating flow

From goods-in to handover to the diner: who does what, in what order, and what gets verified at each stage. It goes first because until the flow is drawn, the critical points can't be placed.

2 Critical control points

Goods-in and spec sheet verification, preparation of special meals, plating and distribution, and the arrival of a new diner or a change to an existing diner's file.

3 A verification barrier at handover

A double check at the exact point where traceability was breaking: the special meal is confirmed against the diner's file before it's served. This corrects the most expensive contradiction.

4 Control of product changes

Spec sheet verification on every delivery, linked to each diner's allergen record.

5 Incident protocol

What gets done, who acts, within what time, how it's recorded and how it's kept from happening again.

6 Periodic verification, actually carried out

The system was checked against the real operation over twelve months: regular review that what had been designed was being applied in daily service, not just that it was written down.

SCOPE **Design and implementation of the full system, with compliance monitoring over twelve months.**

THE RESULT — CONTROL, RISK AND COST

EFFECTS OBSERVED DURING THE MONITORING PERIOD. THERE IS NO NUMERICAL BEFORE-AND-AFTER: NO PRIOR RECORDS EXISTED TO BUILD ONE FROM.

CONTROL AND RISK

- A verification barrier at the point where there had been none
- Full traceability of the special meal, from goods-in to handover
- Demonstrable compliance under inspection, with records that match the real operation
- The system stops depending on nobody making a mistake in a moment of pressure
- Twelve months of compliance verification: the system was tested in the real operation, not only on paper

COST AND OPERATIONS

- Less waste: control at goods-in, storage and rotation cuts losses from expiry and misuse
- Less food thrown away: control of deliveries, spec sheets and menu planning improve how product gets used
- Faster onboarding: with written procedures, training someone new stops depending on a colleague having a spare moment
- Visibility for management: you see where the process fails before there's an incident, not after

Food safety gets sold as a legal obligation. What it actually does is throw away less food and keep a grip on spending.

WHAT THIS CASE TEACHES

1

Food handler training is compulsory and necessary. Without a system that turns it into a verifiable process, it doesn't protect anyone.

2

The human factor fails at some point, always. The system doesn't exist to stop it failing, but to stop the failure reaching the end of the chain.

3

A system with no periodic verification goes back to being paper within months. What holds up a HACCP system isn't the design, it's checking that it's being applied.

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Rocamora Method · Structural diagnosis