



ADMINISTRATIVE POLICIES
AND PROCEDURES
State of Tennessee
Department of Correction

Index #: 113.35

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Effective Date: December 1, 2011

Distribution: A

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Approved by: Derrick D. Schofield

Subject: THERAPEUTIC DIETS

- I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.
- II. PURPOSE: To provide therapeutic diets for inmates whose health condition requires a diet other than that those prepared for the general population.
- III. APPLICATION: Wardens, health care staff, unit managers, correctional officers, food service managers, inmates, medical contractors, and privately managed facilities.
- IV. DEFINITIONS:
 - A. Authorized Health Care Professional: For purposes of this policy, a physician, dentist, mid-level provider, or registered dietitian.
 - B. Therapeutic Diet: Special meal or food combination lists developed by the TDOC Director of Food Services and prescribed by an authorized health care professional as part of the inmate's medical or dental treatment.
- V. POLICY: Therapeutic diets shall be prescribed by an authorized health care professional when medically/dentally indicated, and shall be provided by the food service staff.
- VI. PROCEDURES:
 - A. Authorization and Indications:
 1. The institutional physician/designee shall develop an institutional plan in cooperation with the food service manager, with the intent to minimize unnecessary therapeutic diet orders in the institution by educating the inmate in proper self-care and nutrition.
 2. Therapeutic diets shall not be ordered to accommodate an inmate's food preference or special requests.
 3. Inmates requesting therapeutic diets to comply with religious beliefs shall be referred to the chaplain.
 - B. Documentation: In all cases, documentation of the condition requiring a therapeutic diet shall be recorded in the health record. When a therapeutic diet order is requested, a Therapeutic Diet Request, CR-1798, shall be initiated and signed by the physician, dentist, or mid-level provide with copies distributed as indicated on the form. Therapeutic diet orders shall be documented on the Physician's Orders, CR-1892.
 - C. Requests/Orders:

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1. Therapeutic diets shall be ordered by an authorized health care professional only when a medical or dental condition precludes the inmate from eating the food prepared for the general population.
2. The therapeutic diet shall begin with the next scheduled meal, unless otherwise indicated. The Therapeutic Diet Request, CR-1798, must be delivered to the food service manager or designee at least two hours prior to the serving time in order to be effective for that meal.
3. Orders are valid for a maximum of three months, or until they expire, are discontinued, or changed by the authorized health care professional, or refused in writing by the inmate, in accordance with Section VI.(D)(5) of this policy.
4. Diets other than those listed on the Therapeutic Diet Request, CR-1798 may be utilized as needed on a restricted basis and may be requested as titled in the Nutrition Care Manual from the American Dietetic Association (ADA).
5. If a required diet is not included on form CR-1798, or if other modifications are needed, the prescriber must contact the food service manager or TDOC Director of Food Services to review these needs.
6. If at any time the prescriber determines that there is no clinical reason to continue the therapeutic diet, he/she shall document the discontinuation on the Physician's Orders, CR-1892 and notify the food service manager.

D. Refusal and Non-Compliance:

1. When a therapeutic diet request is refused or canceled, the food service department shall be notified per institutional procedure.
2. Health services staff shall document diet tray refusals in their respective infirmary wards.
3. Diet tray refusals in living units shall be documented as indicated in Policy #116.01.
4. When the health care staff encounters inmates who are non-compliant with their therapeutic diets they shall counsel the inmate regarding the importance and necessity of compliance with the diet. This counseling shall be documented in the health record on the Problem Oriented Progress Record, CR-1884, and the Teaching Counseling Plan, CR-2742. In accordance with Policy #113.51, inmates may refuse medical diets by signing a Refusal of Medical Services, CR-1984. The inmate shall also be charged for the cost of unclaimed specially prepared meals, including snacks and lunch bags.
5. Inmates with an order for a therapeutic diet tray may refuse the tray in favor of a regular diet tray. In this instance, he/she shall be charged \$5.00 for the unused therapeutic diet tray and must see the prescribing provider before the therapeutic diet is discontinued.

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E. Dietary Education: When initiating a new diet, the prescriber shall have the responsibility of educating each inmate on the clinical indication for his/her diet, and the duration, special instructions, and recommended food restrictions (including commissary items) of his/her diet. Education should include written materials with emphasis on foods to avoid, foods that are of benefit, and weight management, when appropriate. The educational intervention shall be documented in the inmate health record. The inmate shall sign the Therapeutic Diet Request, CR-1798, indicating that the therapeutic diet has been fully explained.

F. Transfers:

1. When an inmate on a therapeutic diet is transferred to another facility, all pertinent information regarding the diet shall be entered in the health record that accompanies the inmate. (See Policy #113.04)
2. Upon an inmate's transfer, the current and valid diet order shall be included in the record for transfer to the receiving institution. The therapeutic diet shall be continued until the inmate can be reevaluated by a physician, dentist, or mid-level provider at the receiving institution.

G. Food Service Responsibilities: Institutions shall follow policies #116.01, #116.03, #116.05, and #506.16, regarding menu and diet planning as well as meal service environment and sanitation

VII. ACA STANDARDS: 4-4318, 4-4320, and 4-4414.

VIII. EXPIRATION DATE: December 1, 2014.



TENNESSEE DEPARTMENT OF CORRECTION

THERAPEUTIC DIET ORDER

INSTITUTION: _____

LOCATION: _____

NAME: _____ NUMBER: _____ DATE OF BIRTH: _____

ALLERGIES: _____

POTENTIAL FOOD/DRUG INTERACTION: _____

TYPE OF REQUEST: New Renewal Change Cancel

TYPE OF DIET:

- Clear Liquid (3 days only) Full Liquid Mechanical Soft Bland Renal (includes HS snack)
- Pureed Finger Food Snacks - High-Fiber Hepatic-includes HS snack
- Low-fat/Low Cholesterol, No Added Salt AM PM HS Prenatal Diet
- Moderate Calorie/Carbohydrate (ADA) with No Added Salt (includes 3 meals with HS Snack)

DURATION: _____ Days START DATE: _____ STOP DATE: _____

SIGNATURE: _____ DATE: _____

Health Care Provider/Title

THIS SPECIAL DIET HAS BEEN EXPLAINED TO ME AND I UNDERSTAND I WILL BE CHARGED THE COST OF ANY MODIFIED MEAL I FAIL TO PICK UP.

Inmate's Signature

Date

THIS SECTION TO BE COMPLETED BY DIETARY SERVICES

DIETARY SERVICES (Comments compliance/noncompliance, i.e., failure to pick up diet, diet refusal, irregular use, etc.):

Diet Compliance/Noncompliance: (Circle Letter to Indicate Noncompliance)

B = Breakfast **L** = Lunch **D** = Dinner

MONTH _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
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MONTH _____

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B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH _____

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B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

SIGNATURE: _____

DATE: _____

Authorized Food Service Representative/Title



**TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES**

INSTITUTION _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____, _____
(Inmate's Name) (TDOC Number)
have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____
(Inmate) (TDOC number) (Date)

Witness: _____
(Signature) (Title) (Date)

Witness: _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ but has refused to sign
(Inmate's Name) (TDOC number)
the form.

Witness: _____
(Signature) (Title) (Date)

Witness: _____
(Signature) (Title) (Date)



TENNESSEE DEPARTMENT OF CORRECTION

TEACHING/COUNSELING PLAN

Patient's Name

Subject

ELEMENT	DATES TAUGHT

Note: Each entry must be signed.