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 those prepared for the general population.

III. APPLICATION: Wardens/Superintendents, health care staff, chaplains, unit managers, correctional officers, TDOC food service personnel, inmates, medical contractors, food service 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 contract Dietician and prescribed by an authorized health care professional as part of the inmate's medical or dental treatment.

V. POLICY: Therapeutic diets will be prescribed by an authorized health care professional when medically/dentally indicated and will be provided by the food service staff.

VI. PROCEDURES:

A. Authorization and Indications.

1. The institutional physician/designee develops an institutional plan in cooperation with the contract Food Service Director, with the intent to minimize unnecessary therapeutic diet orders in the institution by educating the inmate in proper self-care and nutrition. The institutional plan is placed in the Health Services Unit Manual.

2. Therapeutic diets should not be ordered to accommodate an inmate's food preference or special requests.

3. Inmates requesting therapeutic diets to comply with religious beliefs are referred to the chaplain.

B. Documentation: In all cases, documentation of the condition requiring a therapeutic diet is recorded in the health record. When a therapeutic diet order is requested, a Therapeutic Diet Order, CR-1798, is initiated and signed by the physician, dentist, or mid-level provider with copies distributed as indicated on the form. Therapeutic diet orders are documented on the Physician's Orders, CR-1892.

C. Requests/Orders.

1. Therapeutic diets must 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 begins with the next scheduled meal, unless otherwise indicated. The

Therapeutic Diet Order, CR-1798, must be electronically scanned to the contract Food Service Director or designee at least two hours prior to the serving time to be effective for that meal.

3. Chronic orders, excluding allergy diets, are valid for a maximum of 180 days, or until they expire, are discontinued, a new diet order is written or changed by the authorized health care professional, or refused in writing by the inmate, in accordance with this policy. Allergy diets written during initial intake/classification or post classification and verified by lab results, are permanent and do not expire or require a renewal order.

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4. Diets other than those listed on the Therapeutic Diet Order, CR-1798, may be utilized as needed on a restricted basis and may be requested as listed in the Contractor's medical diet manual or by contacting the contract Dietitian.

5. If a required diet is not included on the Therapeutic Diet Order, CR-1798, or if other modifications are needed, the prescriber must contact the contract Food Service Director and the contract Dietitian to determine if a non-standard diet order is required.

6. If at any time the prescriber determines that there is no clinical reason to continue the therapeutic diet, he/she documents the discontinuation on the Physician's Orders, CR-1892, and notifies the Contract Food Service Director.

D. Refusal and Non-Compliance.

1. When a therapeutic diet request is refused or canceled, the food service department must be notified per the institutional procedure.

2. Health services staff document diet tray refusals in their respective infirmary.

3. Diet tray refusals or failure to pick up therapeutic meals in the living units or from food service are documented and charged $5.00 per meal. This amount will be withdrawn from the inmate's trust fund. An exception may be made if the inmate has a verifiable excuse as determined by Food Service staff in collaboration with security or behavioral health staff as applicable. If an exception is determined, the inmate is not to be charged.

4. When the health care staff encounters inmates who are non-compliant with their therapeutic diets, they must counsel the inmate regarding the importance and necessity of compliance with the diet. This counseling is documented in the health record on the Problem Oriented - Progress Record, CR-1884, and the Teaching Counseling Plan, CR-2742. Inmates may refuse medical diets by signing a Refusal of Medical Services, CR-1984. The signed Refusal of Medical Services, CR-1984, will remain in effect until the therapeutic diet order expires or until the next follow-up with the medical provider. The inmate will not be charged if the CR-1984 is in effect.

5. If an inmate signs a CR-1984 then chooses to resume their therapeutic diet more than twice in a 30-day period, then the therapeutic diet trays will continue per the original therapeutic diet order or until the next follow-up with the medical providers.

6. Inmates with an order for a therapeutic diet tray may refuse the tray in favor of a standardized diet tray. In this instance, inmates are charged $5.00 for the unused therapeutic diet tray and must see the prescribing provider before the therapeutic diet is discontinued.

7. If an inmate refuses or fails to pick-up his/her therapeutic meal for nine consecutive meals, the individual responsible for documenting the meal service notifies the health service staff by using a reproduced copy of the Therapeutic Diet Request, CR-1798, within 24 hours or

the next business day after the ninth missed meal. The inmate will have effectively demonstrated non-compliance with the therapeutic diet although a Refusal of Medical Services, CR-1984, has not been signed. The provider will have the inmate acknowledge the consequences and the act of refusal by signing the Refusal of Medical Services, CR-1984. The licensed health professional signs the CR-1984 as a witness to the refusal. This documentation demonstrates that the inmate has been advised of potential health consequences. If an inmate refuses to sign CR-1984, the health care provider writes "inmate refuses to sign" and the form must be signed by the health care professional and another staff witness. A copy will be provided to the food service department. The food service manager will be notified by phone or e-mail in addition to written documentation.

8. Inmates that receive total parenteral nutrition (TPN) or a tube feeding as a sole source of nutrition and have an order for NPO (Nothing by Mouth) may refuse the TPN or tube feeding by signing a Refusal of Medical Services, CR-1984, but will not receive a meal tray and a charge of $5.00 will be assessed. The healthcare staff will counsel the inmate regarding the importance and necessity of compliance with TPN and/or tube feeding.

E. Dietary Education: When initiating a new diet, the prescriber is responsible for educating each inmate on the clinical indication for his/her diet, 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 is documented in the inmate health record on the Teaching Counseling Plan, CR-2742. The inmate signs the Therapeutic Diet Order, CR-1798, indicating that the therapeutic diet has been fully explained.

F. Transfers.

1. When an inmate on a therapeutic diet(s) is transferred to another facility, all pertinent information regarding the diet(s) must be in the health record that accompanies the inmate.

2. Upon an inmate's transfer, the current and valid diet order(s) are forwarded to the receiving institution. The therapeutic diet must be continued until the inmate can be reevaluated by a physician, dentist, or mid-level provider at the receiving institution.

G. Special Considerations for Potential Food Allergies.

1. Clinical personnel notified of inmates with the common food allergies of shellfish, peanuts, or eggs, during initial intake/classification must have a therapeutic diet order written.

2. Inmates post intake/classification that notify clinical personnel of food allergies during sick call must be specific when identifying the food allergen and agree to food allergy testing for the specific allergen unless proof of previous testing can be verified from an outside provider. A therapeutic diet order will not be written outside of these parameters.

3. During the period awaiting the test results the inmate receives a 30-day order for a therapeutic diet that excludes the potential allergen.

4. If the test results are negative for the specific food allergen, the temporary therapeutic diet is discontinued, and a regular diet tray ordered.

5. If the test results are positive for the specific food allergen, the temporary therapeutic diet must be transitioned to a permanent therapeutic diet, void of the identified allergen.

6. All orders must be written by a physician or mid-level provider for specific food allergen testing, and arrangements will be made by the medical vendor for the allergy testing to occur.

H. Religious Diet Requests: Inmates requesting no beef, pork, poultry, and/or other specific food items for religious reasons, are referred to the chaplain.

VII. APPLICABLE FORMS: CR-1798, CR-1884, CR-1892, and CR-2742.

VIII. ACA STANDARDS: 5-ACI-5C-06, 5-ACI-5C-08, and 5-ACI-6D-06.

IX. DIVISION OF PRIMARY RESPONSIBILITY: Office of Clinical Services.

TENNESSEE DEPARTMENT OF CORRECTION

THERAPEUTIC DIET ORDER

INSTITUTION: ______________________ **LOCATION:** ______________

NAME: ______________ TDOC ID: __________ DATE OF BIRTH: __________

FOOD ALLERGIES: ______________________________

POTENTIAL FOOD/DRUG INTERACTION: ______________________

TYPE OF REQUEST: ☐ New ☐ Renewal ☐ Change ☐ Cancel

TYPE OF DIET: ☐ Allergy *(*Initial or Post-classification-Testing Completed-Allergy Verified)(Standardized/Permanent)*

☐ Clear Liquid (3 days only) ☐ Full Liquid ☐ Mechanical Soft **Renal (includes HS snack):**

☐ Pureed ☐ Finger Food ☐ Gluten Restricted ☐ Pre dialysis ☐ Post dialysis

☐ Low-fat/Low Sodium ☐ Bland ☐ Prenatal Diet (includes 3 snacks daily with meals)

☐ Moderate 2000 Calorie/Carbohydrate (ADA) (includes 3 meals and 1 snack daily)

☐ Non-Standard Diet Order (Requires Approval)

*DURATION: ________ Days START DATE: ________ STOP DATE: ________

SIGNATURE: ______________________________ DATE/TIME: ______________

Ordering Provider Signature

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

______________________________ ______________

Received: Authorized Food Services Representative/ Title **Date/Time**

DIETARY SERVICES (Comments compliance/noncompliance, i.e., failure to pick up a 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
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
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
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: ______________

Completed: Authorized Food Service Representative/Title

PHYSICIAN'S ORDERS

NAME

TDOC ID

FACILITY

PHYSICIAN

DOB

DRUG ALLERGIES

Date & Time		Nurse's Initials
	UNLESS A RED NUMBER SHOWS DO NOT USE THIS SHEET →	

CR-1892 Rev 03-23

PLEASE! USE BALL POINT PEN ONLY

PHYSICIAN'S ORDERS
RDA-1458

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

_____

INSTITUTION

INMATE NAME: _____ TDOC ID: _____

DATE	TIME	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION

TEACHING/COUNSELING PLAN

Patient's Name/TDOC ID

Subject

ELEMENT	DATES TAUGHT		
Element:			
Provider Signature:			
Patient Signature:			
Element:			
Provider Signature:			
Patient Signature:			
Element:			
Provider Signature:			
Patient Signature:			
Element:			
Provider Signature:			
Patient Signature:			
Element:			
Provider Signature:			
Patient Signature:			
Element:			
Provider Signature:			
Patient Signature:			

Note: Each entry must be signed.