

	<b>DEPARTMENT OF PUBLIC SAFETY</b>  <b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>EFFECTIVE DATE:</b> 10/29/07	<b>POLICY NO.:</b> COR.10.1F.02
		<b>SUPERSEDES (Policy No. &amp; Date):</b> COR.10D.17 (09/18/96) COR.10D.39 (03/04/93)	
<b>SUBJECT:</b> <b>NUTRITION AND MEDICAL DIETS</b>		Page 1 of 3	

PSD NO. 2007-3004

## 1.0 PURPOSE

The purpose of this policy is to ensure that nutrition is adequate and that diets are modified when necessary to meet specific requirements related to medical conditions.

## 2.0 REFERENCES AND DEFINITIONS

### .1 References

- a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails, (2003).
- c. Hawaii Dietetic Association, Hawaii Diet Manual, 7th Ed., (1997).
- d. United States Departments of Agriculture and Health and Human Services, Food Guide Pyramid (2005).

### .2 Definitions

- a. Medical Diet: Special diets ordered for temporary or permanent health conditions that is different from the norm by type, preparation and/or amounts of food an individual may eat in an attempt to provide optimum health.

## 3.0 POLICY

- .1 All inmates will be provided a diet that incorporates the principals expressed in the United States Departments of Agriculture (USDA) and Health and Human Services (DHHS) the Food Guide Pyramid and the current recommended dietary allowances for appropriate age groups.
- .2 Religious diets are not classified as medical diets. Food Service may offer an alternative vegetarian meal for all three meals for the entire population in addition to the regular menu to decrease requests for special diets.

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- .3 Inmates shall be provided with a medical diet when ordered by the physician or dentist. Diet orders shall be clear and specific and shall include type of diet, duration of the diet and any special instructions to the kitchen if necessary.
- .4 A registered or licensed dietitian will review regular and alternative diets for nutritional adequacy at least every 6 months and whenever a substantial change in menus is made. The review may take place through a documented on-sit visit or by written consultation. Written documentation of menu reviews shall include the date, signature and title of the consulting dietitian.
- .5 Workers who prepare medical diets shall be trained in preparing appropriate substitutions and portions or shall be required to reference documents approved by the nutritionist that details allowable substitutions and portions.

#### 4.0 PROCEDURES

- .1 The food service manager shall be notified of prescribed medical diets, diet changes, renewals, cancellations and required in between meal feedings on Form DOC 0426, Special Medical Diet (Attachment A).
- .2 Inmates who refuse a medical diet shall sign the refusal of treatment Form DOC 0417 (Attachment B). Follow up nutritional counseling will be conducted if clinically indicated.
- .3 For emergencies or changes in diets after business hours, or on weekends and holidays, the medical section shall call the food service manager or designee with a telephone diet request. The food service manager or designee shall document the telephone diet request on Form DOC 0509, Special Diet Telephone Order Log (Attachment C). Health Care Services shall develop a procedure that shall ensure that Form DOC 0426 is signed by a physician and forwarded to the kitchen as soon as possible but no later than seventy-two (72) hours after the telephone request.
- .4 On transfer to another facility inmates on special diets shall show their copy of Form DOC 0426 to their facility social worker or case manager. The kitchen shall honor the special diet until confirmed or deleted by medical staff, whichever is sooner.



STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

SPECIAL MEDICAL DIET

\_\_\_\_\_  
Facility \_\_\_\_\_  
Date

TO: Food Services - Dietitian

FROM: Medical Unit

\_\_\_\_\_  
(Physician's Name)

RE: \_\_\_\_\_  
(Inmate's Last Name, First Name, MI)      SSN      Housing

Is to be placed on:

\_\_\_\_\_ Diabetic Diet      \_\_\_\_\_ Prune Juice \_\_\_\_\_ time(s) a day

\_\_\_\_\_ Low Sodium      \_\_\_\_\_ Snack: A.M., P.M., or H.S.

\_\_\_\_\_ Low Fat and/or Low Cholesterol      \_\_\_\_\_ Other \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Start Date: \_\_\_\_\_

Stop Date: \_\_\_\_\_

Review Date: \_\_\_\_\_

\_\_\_\_\_  
Health Care Staff's Signature

Original: Medical Record  
Yellow: Dietitian  
Pink: Food Service  
Golden Rod: Housing

**REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION**

NAME: \_\_\_\_\_ SID: \_\_\_\_\_ DOB: \_\_\_\_\_

FACILITY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

I, the undersigned patient, refuse the following treatment and/or medication: \_\_\_\_\_

\_\_\_\_\_  
(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

A referral has been made to a provider:      YES                      NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

\_\_\_\_\_  
(Print Name of Provider)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

*\* If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

\_\_\_\_\_  
(Print Name & Title)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

