MARYLAND Department of Juvenile Services

Successful Youth • Strong Leaders • Safer Communities

POLICY

SUBJECT: Therapeutic Modified Diets and Food Allergies
NUMBER: HC-327-18
APPLICABLE TO: Residential, Food Service and Somatic Health Services Staff

APPROVED: /s/ signature on original
Sam Abed, Secretary
DATE: 2/27/18

I. POLICY

The Department of Juvenile Services (DJS) will administer therapeutic modified diets as directed by a physician.

II. AUTHORITY

A. Md. Code Ann., Human Services, §§9-203 and 9-204
B. COMAR 10.15.03
C. American Correctional Association (ACA) Standards, 4-JCF-4A-06 and 4-JCF-4C-18

III. DIRECTIVES/POLICIES RESCINDED

None

IV. FAILURE TO COMPLY

Failure to comply with the Department's Policy and Procedures shall be grounds for disciplinary action up to and including termination of employment.

V. STANDARD OPERATING PROCEDURES

Standard operating procedures have been developed.

VI. REVISION HISTORY

DESCRIPTION OF REVISION	DATE OF REVISION
New policy issued.	February 27, 2018
Revised Nutrition Service Referral Form	May 26, 2020

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PROCEDURES

SUBJECT: Therapeutic Modified Diets and Food Allergies
NUMBER: HC-327-18
APPLICABLE TO: Residential, Food Service and Somatic Health Services Staff

APPROVED: /s/ signature on original
Linda McWilliams, Deputy Secretary
DATE: 2/23/18

I. PURPOSE

To ensure that therapeutic modified diets are appropriately administered pursuant to the directions of a physician and to define the responsibilities of the DJS Registered Dietitian Nutritionist (RDN), medical and food service staff.

II. DEFINITIONS

Registered Dietitian Nutritionist (RDN) means a licensed food and nutrition expert who has a college degree and has completed course work accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics.

III. PROCEDURES

A. A physician shall prescribe all therapeutic modified diets, nutrition consults and food allergy substitutions for youth. All therapeutic diets shall be ordered according to the name of the diet as listed in the approved Therapeutic Diet Manual. A copy of the approved Therapeutic Diet Manual shall be maintained in both the nursing and dietary areas.

B. The nurse shall complete and send the Director of Food and Nutrition Services or designee the **Nutrition Service Referral Form (Appendix 1)** and the **Health Status Alert (HSA) Form (Appendix 2)** as applicable**.**

C. The nurse shall immediately submit the **HSA Form (Appendix 2)** to the food services staff and the off-site vendor providing food services, Shift Commander

and appropriate facility staff who have a need to know as specified on the **HSA Form (Appendix 2).**

D. The Registered Dietitian Nutritionist (RDN) shall review and sign the **Nutrition Service Referral Form (Appendix 1)** and schedule a nutritional assessment/consultation, as required. Therapeutic diets shall conform as closely as possible to the foods served to other youth in the facility.

E. A copy of the completed nutritional assessment/consultation and diet plan shall be sent to the food service staff and the nursing department.

F. The nurse shall place documentation of the nutritional assessment/consultation in the youth's health record for review and signature by the medical doctor or nurse practitioner.

G. The Food Administrator or Food Service Manager shall provide menu substitutions for all youth with food allergies.

H. The Food Administrator or Food Service Manager shall keep an updated list of all therapeutic diets and food allergy substitutions currently ordered for youth. The list shall be made available to all food service staff.

I. All dietary orders must be **rewritten quarterly** by the physician.

J. If an off-site vendor is providing food service to the facility, the vendor shall be assigned the Food Administrator duties as noted in this Policy and Procedures.

IV. RESPONSIBILITY

The Medical Director and the Health Administrator are responsible for ensuring implementation of this policy and procedures.

V. INTERPRETATION

The Deputy Secretary for Operations shall be responsible for interpreting and granting any exceptions to these procedures.

VI. LOCAL OPERATING PROCEDURES REQUIRED

No

VII. DIRECTIVES/POLICIES REFERENCED

No policies referenced.

VIII. APPENDICES

1. Nutrition Service Referral Form
2. Health Status Alert Form

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DJS POLICY AND STANDARD OPERATING PROCEDURES

Statement of Receipt and Acknowledgment of Review and Understanding

SUBJECT: Therapeutic Modified Diets and Food Allergies
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I have received and reviewed a copy (electronic or paper) of the above titled policy and procedures. I understand the contents of the policy and procedures.

I understand that failure to sign this acknowledgment form within five working days of receipt of the policy shall be grounds for disciplinary action up to and including termination of employment.

I understand that I will be held accountable for implementing this policy even if I fail to sign this acknowledgment form.

_____ _____

SIGNATURE PRINT FULL NAME

_____ _____

DATE WORK LOCATION

SEND THE ORIGINAL, SIGNED COPY TO THE DIRECTOR OF THE OFFICE OF HUMAN RESOURCES FOR PLACEMENT IN YOUR PERSONNEL FILE.

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Nutrition Service Referral Form

TO: Dietary and Nutrition Services		Date:
Sending Facility:		
Youth's Name:	Date Of Birth:	Race:
Reason For Referral:		
MD/NP Order For Referral Written By:		
Allergies:		
Current Medications: _____ _____ _____ _____ _____ _____ _____ _____ _____		
Current Diagnosis: _____		
Date Of Admission:	Weight Upon Admission:	Height Upon Admission:
	Referral Date **Current Weight:**	Referral Date **Current Height:**
Please attach any available labs (Hematology, Chemistry, Cardiovascular/Lipids, Miscellaneous, etc.)		
Medical Staff Signature:	Title:	
RDN Signature:	Date Received:	
Consultation Date:		

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HEALTH STATUS ALERT

All information contained on this form must be kept confidential in accordance with federal laws, Maryland laws and regulations, and DJS policy and procedures.

Date: _____

Name: _____ DOB: _____ Facility: _____ Unit: _____

HEALTH CONDITIONS

☐ Allergic To: _____ Reaction: _____

☐ Diabetes ☐ Sickle Cell ☐ Asthma ☐ Seizure Disorder ☐ Heart Condition

☐ Injury: Type/Location: _____

☐ Dental Appliance: Type: _____ ☐ Vision Impairment ☐ Contact Lenses ☐ Eyeglasses

☐ Hearing Deficit ☐ Speech Impairment

☐ Other Disabilities/Health Concerns: _____

RESTRICTIONS & INSTRUCTIONS

From: _____ To: _____ ☐ No Sports ☐ No Lifting ☐ Bedrest ☐ Medical Isolation

☐ No Kitchen Detail (*Youth Centers Only*) ☐ Other: _____

Comments:

DIETARY ORDERS

☐ Food Allergy: _____

☐ Lactose Intolerance Dietary Substitutions: _____

☐ Special Diet Ordered Type: _____ From: _____ To: _____

☐ Other Dietary Orders: _____

☐ Registered Dietitian Notified: ☐ Telephone ☐ Fax From: _____ To: _____

☐ Facility Food Service Department Notified: Date: _____ Time: _____ Via: _____

Comments:

SELF ADMINISTERED MEDICATIONS

Please use with the Self-Administered Medication/Treatment Record form and must have a current physician's order.

From: _____ To: _____ Medication/Treatment: _____

Directions: _____

NOTIFICATION OF HEALTH STAFF

Notify Health Services if:

DISTRIBUTION

☐ Unit ☐ Control Center ☐ Registered Dietitian ☐ Food Service

☐ Recreation ☐ School ☐ Shift Commander ☐ Other: _____

Nurse's Signature: _____ Date: _____ Time: _____