Principles of Nursing Care in the Correctional Setting

16

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Scope and Standards of Professional Practice

Nurses are the primary healthcare provider for the population of justice-involved persons detained in correctional facilities. In 2017, the Health Resources and Services Administration (HRSA) reported that 29,461 registered nurses identified their primary practice location as a correctional facility (Smiley et al., 2018). An additional 20,009 licensed practical or vocational nurses work in these settings. The number of advanced practice nurses is unknown. These data do not reflect nurses who have another primary employer and work part-time in correctional facilities, nor does it count nurses who are employed by hospitals, universities, or public health departments to deliver health care to persons who are incarcerated.

Correctional nurses share the same ethical principles and practices that are universal to the profession. It is the population served, role of the nurse, the setting, and context in which care is delivered that distinguish the specialty from other areas of nursing practice (Schoenly, 2013). The American Nurses Association (ANA) recognized correctional nursing as a specialty area of practice in 1974 and established the first standards for the scope and practice of the specialty. Currently there are 17 standards with corresponding competencies for correctional nursing practice. There are 17 standards. The first six correspond to the nursing process; the others concern aspects of professional performance (ANA, 2020).

Conflict Between Organization Mission and Professional Practice Values

Human-to-human caring is the moral foundation of nursing practice (ANA, 2015). The profession's code of ethics calls for nurses to practice with compassion and respect for the individual; the nurse's primary commitment is to the patient (ANA, 2020). The purpose of the carceral environment and culture in correctional organizations is to maintain safety and security, accomplished by removing justice-involved persons from society and then de facto submitting them to depersonalization, loss of

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autonomy, and degradation in all aspects of daily life. The environment and culture are antithetical to the core of nursing and the source of considerable cognitive dissonance (Choudhry et al., 2017).

Nurses who stay in the field of correctional health care must do considerable work to resolve or mitigate the conflict between the correctional organization's environment and culture and caring in their pattern of practice. This work includes learning to express caring for individuals in ways that do not rely on casual touch and personal disclosure, recognizing and addressing personal biases and negative narratives about stigmatized people that impede the development of a therapeutic relationship and cloud clinical judgment, and developing superior skills in communication and collaboration to negotiate and advocate in harsh conditions (Dhaliwal & Hirst, 2016; Solell & Smith, 2019). When this conflict is not resolved, nurses either leave correctional nursing or adopt the beliefs and values of the dominant organizational culture and find their practice compromised in ways which puts patient outcomes at risk (Chafin & Biddle, 2013; Choudhry et al., 2017; Venters, 2016).

Correctional healthcare programs with a strong commitment to excellence are able to recruit and retain nursing professionals who excel. This is accomplished, among other things, when recruits are provided with realistic information about the setting. Orientation, clinical supervision, coaching, and a lengthy mentoring period are recommended so that nurses have time and guidance to adjust their professional practice to be effective in the correctional environment (Chafin & Biddle, 2013; Hale et al., 2015; Choudhry et al., 2017; Venters, 2016).

Access to Care

Annually, given the flow of people in and out of correctional settings in the United States, health care reaches 1 out of every 30 adults living in the United States (Rich et al., 2014). Nurses have primary responsibility for facilitating access to this care through health screening, initial and periodic health appraisals, and response to requests for healthcare attention.

Receiving Health Screening

Receiving health screening is the first encounter detained persons experience with a healthcare professional. It may be the only healthcare encounter during the person's detention. The purpose of screening is to identify disease that must be treated immediately and to prioritize access for evaluation and treatment of other identified health needs. Receiving health screening should take place as soon as possible after admission but no more than 2–4 hours later (Titus, 2019).

The major risk with receiving screening is under-identification of medical or mental health conditions which delays timely access to necessary care. Inquiries about health status and history can be annoying, especially if the person has other concerns or does not believe they will be detained long. Nurses who are skilled in establishing rapport, eliciting information, and observing nonverbal behavior are better able to obtain information at receiving screening (Knox, 2013).

Factors that contribute to the failure to identify someone who has healthcare needs include:

- Insufficient inquiry when the patient reports a medical or mental health condition.
- Failure to collect serial assessment data (vital signs, peak flow, etc.) when abnormal results are found.
- Faulty communication, especially with language differences, disability, or with individuals who respond minimally to inquiry about their health status at intake (who should then be scheduled as a priority for an initial health assessment and to check on their condition).

- Deficient follow-up on urgent referrals to a provider or requests for bridge orders for medication.
- Failure to access health records of recent treatment from providers in the community or in the facility itself. Making advance agreements for the transfer of information with providers who care for the same population, but elsewhere, reduces time and effort obtaining records. Examples of major providers are the state prison system, other jails, major providers of indigent care in the community, and the mental health system in the state or county (Knox, 2016a).

The priorities for this encounter are to ensure that medical support for detoxification is in place, orders for continuing medication and other treatment obtained, trauma and injury are addressed, transmission of contagious disease prevented, and the person informed about how to access care for any subsequent needs. The volume and quality of health information obtained at intake can be improved by looking critically at the process from the perspective of those who have been detained to identify and mitigate barriers.

Performance monitoring for receiving health screening includes timeliness of screening, referral completion, carrying out a withdrawal protocol, and receipt of the first dose of critically important medication (e.g., anticoagulants, psychotropics, HIV medication, insulin, detox medication). Monitoring should also evaluate the thoroughness and accuracy of screening, the quality of the clinical assessment, and the appropriateness of decisions made about immediate need for treatment, referrals for higher-level care, housing restrictions, and diet.

Health Assessment

The initial health assessment (NCCHC, 2018) is more comprehensive and includes elaboration of the patient's health history, vital signs, laboratory work, and physical examination. The purpose of the health assessment is to provide a basis for a treatment plan. Individuals who have chronic disease, acute illness, or injury should be scheduled for an initial health assessment with a physician, nurse practitioner, or physician's assistant as soon after admission as possible to avoid discontinuity or deterioration of function. At better performing facilities, this assessment takes place within hours of receiving health screening.

Persons without acute or chronic illness or injury at intake can have the initial health assessment completed by a registered nurse who has received appropriate training. It should take place only a few days after admission to a correctional facility. This is a good time to ensure the person understands the instructions provided at intake about how to access care, refill medications, obtain self-care items, and make complaints. Periodic health assessments are completed throughout a person's incarceration at intervals established by the facility medical authority.

The health assessment should take place in a clinical setting with supplies and equipment sufficient to take a health history and perform an examination. Auditory and visual privacy should be sufficient for the patient to feel comfortable and safe. Language assistance and the presence of a chaperone need to be available, when necessary. A health assessment should take on average 40 minutes to complete including documentation, testing, vaccination, and referral.

Because the justice-involved population has more limited access to healthcare resources when in the community, preventive care and screening for early identification of treatable disease should be available (Kinner & Young, 2018; Strugar-Fritsch & Follenweider, 2016; Massoglia & Remster, 2019; Rich et al., 2014). The A and B recommendations of the U.S. Preventive Services Task Force, the immunization schedules recommended by the Centers for Disease Control and Prevention, and chronic disease guidelines developed by the facility, based on nationally accepted guidelines, should be used to guide decisions about diagnostic screening and vaccinations offered. These recommenda-

tions should be incorporated into written guidelines and treatment protocol so that nurses can initiate orders for diagnostic work, address infectious disease, identify persons at risk of poor health outcomes, and establish an individualized plan to reduce the risk of harm.

Recording vital signs, including height and weight, and calculation of BMI, vision, hearing, and an oral health assessment establish a baseline of the patient's health status against which to measure change in condition at subsequent healthcare visits. The health assessment is also a time to evaluate progress accomplishing wellness goals, identify new targets (weight control, exercise, substance misuse treatment, coping skills, etc.) with the patient, and evaluate their readiness to engage in learning more, referral, or make a self-care plan. Referrals for follow-up on newly identified medical, mental health, and dental concerns or wellness goals need to indicate urgency and their completion monitored. The benefits of these encounters are early identification of disease, development of rapport, and patient engagement in managing their health (Gorbenko et al., 2017).

Performance monitoring for health assessment includes timeliness of the appraisal and referral completion, the thoroughness of the history and physical exam, compliance with preventive care protocols, appropriateness of clinical decision-making, and attention to wellness targets. People who are at risk of adverse health outcomes (e.g., acute and chronic disease, elderly, infirm or disabled, etc.) should be targeted for inclusion in sample selection.

Requests for Healthcare Attention

The ability to request healthcare attention and receive timely and appropriate care, to obtain a professional clinical judgment, and to receive care that is ordered are civil rights for patients in custody. Neither correctional nor healthcare staff can limit requests for healthcare attention. At correctional facilities with timely, responsive healthcare programs 3–5% of the population request healthcare attention each day. In healthcare programs that are operating effectively 60–80% of patient-initiated requests can be resolved by nurses with simple first aid, over-the-counter medication or other self-care products, and health education or advice about self-care. Nurses experienced performing sick call should see on average seven patients per hour (Knox, 2014b).

When justice-involved persons are received at a correctional facility, they must be informed about how to request healthcare attention before leaving the booking area. Common methods to request healthcare attention are by filling out a request, signing up on a list, or showing up at a particular time. Pitfalls to an effective request process are listed in Table 16.1.

Nursing staff must investigate any indication of a breakdown in the process to request health care and resolve it promptly or report the problem to a responsible supervisor for further action. Each request received, each sign-up sheet, or each walk-in encounter should be dated, and the record retained to provide evidence of unencumbered access.

Table 16.1 Pitfalls in the process to request healthcare attention

Failure to provide instructions on how to make a request for healthcare attention	Misunderstanding instructions about how to make a request
Not having a secure or confidential way to make a request	Staff not picking up or receiving requests every day
Request forms that are too complicated	Not having enough request forms
Not having access to devices used to request care	Intimidation or dismissal by others

Each request for healthcare attention is assessed by a licensed nurse within 24 hours of receipt to determine when and how each request will be handled. Requests that are not symptomatic, such as information, refills of medications or supplies, an appointment to use the nail clippers, etc., can be handled administratively with a written response to the person. However, simply reading the request is not sufficient when it involves any description of a symptom-based complaint. Emergent requests such as chest pain or suicidal thoughts are seen immediately. Urgent requests such as abdominal pain, headache, or mental deterioration should be seen the same day the request is received. Routine requests such as muscle ache, minor infection, or back pain should be seen no later than the next day. Documentation includes the results of the assessment with the date and time the patient was seen. Screening requests for care less than 7 days a week, staff practicing outside their legal scope, clinically inadequate assessment, and minimizing patient complaints are risk factors for harm to patients.

It is important for the patient to know what to expect and when. This is accomplished when the nurse discusses their recommendations with the patient and a care plan is developed. The plan includes treatment, referral, patient education, and advice about self-care. Pitfalls in the assessment include poor clinical decisions, inadequate follow through or handoffs, fragmented implementation of the plan of care, and patient misunderstanding or disagreement with the plan of care.

Sick call is a barometer for the quality of the entire healthcare program in a correctional facility. When requests for healthcare attention are not received and acted upon in a timely, responsive, and clinically appropriate manner, the efficient operation of the healthcare program is in serious jeopardy. Effects of insufficient access include increased number of grievances, increased requests for emergent healthcare attention, and multiple requests for the same problem (Knox, 2014a, b, c; Murphy, 2015). Healthcare programs should track the timeliness, completeness, and clinical appropriateness of the assessment of healthcare requests and resulting care plans. The types of requests being made and frequency of multiple requests should also be tracked.

A recent study using the 2004 Survey of Inmates in State Correctional Facilities found black men more likely to access health care compared to white or Latino men. The author suggests that racial disparities in access to health care are reduced because of the availability of health care during incarceration (Nowotny, 2016). Similarly, others have suggested that incarceration provides low-threshold access to health care for those who face substantial barriers in healthcare access when in the community (Kinner & Young, 2018; Massoglia & Remster, 2019; Matz, 2018).

There are, however, barriers to care in prisons and jails. These may include dysfunctional methods to request healthcare attention, untimely delays seeing those who have a healthcare request or those who have been referred to a provider, offering sick call at unreasonable times of day, excessive fees such as co-pays, language or other difficulty with communication, and culturally discriminatory practices. Incarcerated persons report reluctance to access health care because of distrust in healthcare staff, not having a choice of provider, being disbelieved, loss of wages from missing work, isolation from general population if admitted to the medical unit, and logistical challenges in obtaining care. A last reason given for reluctance to access care is being treated like everyone else rather than having unique needs addressed, and is an example of the depersonalization that characterizes correctional settings (Heidari et al., 2017).

Telehealth nursing has been in place in primary care settings since the 1970s and is very similar to the assessment of healthcare requests in correctional settings (Mataxen & Webb, 2019; Neville, 2018). However, the application of telehealth technology in correctional health care has been primarily limited to specialty care. Advantages of telehealth technology are eliminating the need to transport, reducing wait times, and reducing the costs of higher-level care (Young & Badowski, 2017). Telehealth is considered as effective as face-to-face interventions and patient satisfaction with telehealth encounters is equal to or better than a face-to-face encounter (Schuelke et al., 2019; Finley & Shea, 2019; Speyer et al., 2018). It is estimated that half of all ambulatory care visits in the community can be

accomplished safely in a telehealth encounter (Deloitte, 2014). Increased use of telehealth technology to address requests for attention in correctional settings mitigates some of the barriers described earlier; missed appointments are reduced and is a more efficient way to make use of nursing personnel (Peck, 2005; Cady & Finkelstein, 2014).

Getting Work Done: Communication, Advocacy, and Collaboration

Communication

Healthcare delivery in the correctional setting takes place within hierarchal and rule-driven organizations, emphasizing command and control of detained people. Nurses must communicate with personnel throughout the organization to ensure that timely, necessary, and appropriate health care is provided. Communicating effectively requires nurses to understand the language, culture, norms, and values of the organization and to establish relationships. Positive work relationships are not among the characteristics that nurses use to describe the correctional setting. Correctional nurses report custody staff are most often the source of emotional abuse, conflict, and bullying (Solell & Smith, 2019; Almost et al., 2013; Maroney, 2005; Weiskopf, 2005).

Communication between nurses and custody staff is facilitated when clear expectations are established for a respectful workplace, staff are educated about the roles of the various professional disciplines, interdisciplinary training is conducted, and joint meetings are held to monitor services and address problems. Correctional nurses benefit from developing conflict resolution skills, given their prominent role negotiating coordination of patient care with custody operations (Knox & Pinney, 2017; Schoenly, 2014; Weiskopf, 2005).

Nurses also communicate with other healthcare professionals. Communication in health care is often fragmented and does not provide pertinent information, causing delays in patient care. Communication failures are widely recognized as contributing to the majority of adverse events in health care (Schoenly, 2014; O'Keeffe & Saver, 2014; Institute for Healthcare Communication, 2011). Correctional health care does not differ from the community in error caused by fragmented, incomplete communication.

Communication failures take place when work rules are not followed, such as when staff take shortcuts or develop workarounds. Another situation in which communication failure is likely is when there is poor oversight of clinical judgments resulting in a patient care mistake. Lack of support from colleagues who are reluctant or refuse to help also can contribute to communication failure. The failure to communicate concerns about a provider's competence is another example. Poor teamwork resulting from divisiveness, disrespect among coworkers, and managers who abuse their authority who threaten, bully, and force their own viewpoint on subordinates are also situations when communication failure is likely to take place (O'Keeffe & Saver, 2014). There are two types of communication breakdowns in health care. The first occurs as a result of mistakes or misunderstandings which are accidental and unintentional (misplacing the report from the specialist, giving the wrong medication, drug-drug interactions). Interventions to correct the first type of communication failure include structured handoff protocols (e.g., SBAR), checklists and whiteboards, standardized procedures (e.g., read back verbal orders, check backs, approved abbreviations), and automation (Schoenly, 2014; Maxfield et al., 2011).

The second type of communication failure is intentional and takes place because an individual knows or suspects something is wrong (work shortcuts, incompetence, disrespect) but chooses to ignore or avoid it. Addressing these errors requires an organizational culture that enables people to speak up. Since the magnitude of mistakes made in healthcare delivery and risk to the patient has been

recognized, several organizations such as the ANA Magnet Program and the Institute for Healthcare Improvement (IHI) have developed training and tools to improve communication about these kinds of problems in healthcare programs (Maxfield et al., 2011).

Delegation and supervision of subordinate personnel is an inherent nursing responsibility and, in correctional settings, may also include inmate or detainee workers. Communication with subordinate personnel should be respectful, timely, with a rationale that gives the delegated task meaning (Anthony & Vidal, 2010). Better performance on quality measures in patient care has been consistently reported when communication between nurses and subordinate personnel is more frequent (Knox & Pinney, 2017).

Most importantly, communication skill is considered essential to correctional nursing practice because it is how caring, the moral foundation of the profession, is demonstrated (ANA, 2020). Similarly, justice-involved persons also identify good communication by healthcare providers as indicative of caring. Reaching out to inquire about the person rather than waiting to receive a request for healthcare attention is one example of caring. Another is spending time listening and getting to know the patient (Walsh-Fez et al., 2019; Kanbergs & Durfey, 2019).

A nurse providing in-reach services at the jail in Camden County, New Jersey described her clients as being "in a more contemplative state, so it's a little easier to get down to what is important to them and learn what has been going on…" (Wiest & Kuruna, 2019 page 14). Failure to provide appropriate communication aids for persons for whom English is not their primary language or who have hearing or speech difficulty is a significant barrier and cause for healthcare error (Watt et al., 2018; Knox, 2014a, b, c). The use of nonjudgmental inquiry and active listening improve accuracy and understanding when people from different cultures, ages, and gender communicate. Effective communication helps patients participate in their care, adhere to the treatment plan, and improve self-management; these contribute to better health outcomes (Institute for Healthcare Communication, 2011).

Grievances are a primary means of communicating dissatisfaction with health care and the source of valuable information about patient perceptions of the program. The subject areas being grieved should be tracked to identify trends with results discussed by the healthcare team. Ways to improve patient perceptions about specific subjects (e.g., missing medication, delays in care, disagreement with the treatment plan, etc.) should be identified and acted upon.

Individual grievances should be investigated so problems are resolved promptly. Meeting with the patient to discuss the problem and options for resolution has been found especially helpful with complex patients. Table 16.2 lists recommendations to effectively respond to healthcare grievances.

Table 16.2 Practices for an effective response to grievances

1. Write in a simple, conversational manner easily understood by the reader. Avoid medical and correctional terminology
2. Be professional and polite, regardless of what was written in the complaint
3. Respond in person-first language, not a third party such as the grievance coordinator or ombudsman
4. Thoroughly address each of the issues being grieved. Do not add irrelevant material or blame the writer
5. Let the person know what steps were taken or what action will be taken in the future to resolve the complaint
6. If a problem is identified and needs correction, let the person know the information was appreciated, for example, "Thank you for bringing this problem to my attention…." If an apology is due, include it in the response
7. Keep the response informative; avoid abrupt or legalistic answers

Source: Knox (2014c)

Advocacy

Advocacy is closely aligned with communication. For nurses in correctional settings, advocacy for patient needs is a fundamental area of responsibility (ANA, 2020). The dehumanizing nature of the correctional setting requires nurses to speak out regularly on behalf of the patient to ensure their health and well-being are not compromised (Solell & Smith, 2019). Advocacy by nurses takes place on behalf of individuals and for groups at the organizational and policy level. Examples for patients include: ensuring medically necessary assistive devices are provided (e.g., C-PAP machines, hearing aids, eyeglasses, etc.), protecting patients from deterioration if segregated, and arranging extended family visitation for ill patients. Examples of nursing advocacy at the organization and policy level include: establishing a heart healthy diet, increasing the number of healthy items in the commissary, and requesting the local hospital incorporate the NCCHC position statement on Restraint of Pregnant Inmates into their policy and practices. Correctional nurses also work cooperatively with community-based advocacy groups to improve conditions within correctional facilities (ANA, 2020).

The characteristics of successful advocates include the following practices:

- A calm and thoughtful approach
- Raises relevant issues in a fair manner
- Builds on relationships
- Incorporates the views of the patient
- Facilitates others' understanding of the problem
- Is succinct, articulate, and offers alternatives (Stewart & Macintyre, 2013)

Advocacy is the most direct way to bring about needed change; it also improves confidence and self-esteem and brings the attention of other stakeholders to the issue (Disability Rights Wisconsin, 2008). The result of advocacy is illustrated in this description by one person who was incarcerated: "They showed that they wasn't just doing their job, which was enough. Just doing their job was enough. But they genuinely cared. They genuinely put forth an effort and got other people to understand my point of view. My lawyer stepped in then. The judge started listening. Now everybody's paying attention. And this is what I needed. I needed this. So, it's a great blessing for me" (Wiest & Kuruna, 2019).

Collaboration

Correctional facilities are complex organizations with many parts (e.g., central control, facility maintenance, ambulatory care clinics, food service, commissary), intertwined and connected. Collaboration is a means for complex organizations to address a problem, increase efficiency, or improve patient outcomes (O'Keeffe & Saver, 2014; Grafton & Erickson, 2007). An example of collaboration is meeting with the Captain to determine how to complete a series of radiation treatments for a patient with cancer without delaying other off-site appointments.

Collaboration is predicated upon relationships and communication among the participants. Team members must be able to articulate their own role in achieving a shared outcome and differentiate it from others (Haas et al., 2016; McGarry & Ney, 2006; Grafton & Erickson, 2007; Ashkenas, 2015; Schoenly, 2014). In health care, collaboration is associated with improved patient outcomes and decreased mortality. It is also associated with improved patient satisfaction and decreased staff turnover (Knox & Pinney, 2017; Schoenly, 2014; O'Keeffe & Saver, 2014).

Table 16.3 Behaviors to facilitate collaboration

1. Listening instead of talking or thinking about what to say next
2. Demonstrating empathy—imagine yourself in another's place—to see another person's viewpoint
3. Being comfortable with feedback; soliciting feedback
4. Flexibility, both leading and following
5. Clearly, plainly speaking and avoiding abstraction
6. Identifying shared goals

Source: Gino (2019)

Other examples of collaboration in the correctional setting include multidisciplinary treatment planning, safety and sanitation monitoring, and responding to communicable disease clusters. Nursing collaboration on committees such as pharmacy and therapeutics, medical administration, morbidity, and mortality is mandatory so that barriers in delivery of care are identified and resolved. Table 16.3 lists behaviors that facilitate collaboration.

Collaboration does not happen without leadership and support to overcome barriers in the correctional setting. These include staff turnover, lack of trust, diverse opinions, lack of a shared mission or values, authority imbalance, and time (Schoenly, 2014). In organizations that support collaboration, leaders create opportunities for staff from various areas to work together on problems. Leaders model collaborative behaviors; they are open to diverse viewpoints and share power. Leaders provide time away from distraction for staff to align interests and bring resources to problem-solving or completing a project. Collaboration is both the grease that keeps the organization running smoothly and also the brakes that keep it from crashing.

Care Coordination

The coordination of patient care is a major role of correctional nurses. For example, a person who has a history of seizures should not be assigned to a top bunk. This can only be prevented if the housing officer is informed. Nurses are responsible for managing the delivery of care and maintaining care continuity (ANA, 2020).

Other examples of care coordination are transferring information about health status and prescribed medication when someone is transferred from jail to prison, administering medication and other treatment, performing diagnostic procedures and obtaining results, and explaining or teaching the patient about their care.

Care coordination is a concept that has received a great deal of attention in the last 20 years, as a way to improve the experience of health care, improve the health of populations, and reduce costs. This is known as the Triple Aim (Berwick et al., 2008). Care coordination specifically targets defects in the continuum of care. An example of a defect in the continuum of care is when a patient returns to the correctional facility after hospitalization and the discharge recommendations are not acted upon. Care coordination involves identifying patients at risk of poor outcomes, communication of accurate and meaningful information, managing the delivery of care, and managing transitions.

Identifying Patients at Risk

Certain patients or situations in the continuum of care present a significant risk of harm or an adverse event. These are times when nurses are most vigilant coordinating care. In correctional settings, people with the following conditions benefit from care coordination:

- Newly diagnosed chronic condition or major medical disorder
- Poorly controlled chronic condition
- Deteriorating or unstable medical disorder
- Multiple comorbidities, especially psychiatric conditions

Nurses in the community found that the need for care coordination increased when language was a barrier or cultural beliefs diverse, when family and financial resources were limited, and physical and social problems complex (Vanderboom et al., 2015). These factors should be considered when identifying patients needing closer monitoring and early intervention.

Communicating Accurate and Meaningful Information

Care coordination does not happen without timely flow of accurate and meaningful information. Nurses are referred to as the "switchboard" of health care. This is because nurses make sure that each person has the information needed to carry out their role in the delivery of care. The use of a standardized script, like the huddle agenda, ensures that pertinent information is not left out of important communication within the care team. The daily huddle prioritizes the issues to be addressed that day and assigns responsibility among members of the care team. Subjects reviewed in the daily huddle include:

- Patients who required attention from the on-call provider
- Patients returning from a higher level of care
- Patients with significant lab or diagnostic results
- New patients who are at high risk
- Patients who have medication due to expire
- Patients scheduled to be seen that day
- Scheduling issues or backlog
- Barriers to care
- Insufficient available resources (Dunlap et al., 2016)

Another form of scripted communication is known as SBAR, a tool used to convey information, especially in critical situations that require a clinician's immediate attention. This tool is especially useful in communicating with on-call providers. SBAR is an acronym that corresponds to the order of subjects to be communicated.

- **S** is for Situation and includes the person's identity, location, and reason for the communication, the identity of the patient and a brief description of the problem, when it happened, and the urgency that needs to be addressed.
- **B** indicates the Background information pertinent to the situation. Information should include the presenting complaint, relevant past medical history, vital signs, and relevant lab or other diagnostic results.
- **A** is your Assessment and clinical impression of what the problem is.
- **R** is your Recommendation and should clearly state what action you want the other person to take and how quickly (Schoenly, 2014; Institute for Healthcare Improvement, n.d.).

Seeing complex patients more frequently to review health status and address concerns improves patient engagement and outcomes (Cryer, 2018; Strugar-Fritsch & Follenweider, 2016). Patients are more engaged when nurses inquire about side effects or improvement in symptoms, answer questions,

Table 16.4 Techniques to promote accurate and meaningful communication with patients

Simplicity	1. Explore simple concepts before moving to complex areas 2. Avoid medical terminology 3. Use words that are meaningful to the general public 4. Be concrete—state what you want the other person to do
Reinforcement	1. Discuss the most important subject first and come back to it at the end 2. Ask the person to restate what you said to check for understanding 3. Use visual aids 4. Provide written follow-up material

Source: Burrow et al. (2006)

teach, and support their commitment to the treatment plan. Techniques recommended for accurate and meaningful communication with patients are listed in Table 16.4.

Managing the Delivery of Care

The central work of care coordination is translating the plan of care into action. A typical plan of care is an interplay of various providers and intended actions related to diagnostic work and follow-up care, medication administration and management, treatment procedures, patient education, and referrals. Nurses are responsible for coordinating the staff and resources to implement the plan and then monitoring completion of these activities. In correctional facilities, this will also involve custody staff to ensure that people arrive on time for scheduled appointments.

Traditionally, health care in correctional settings has been delivered as a series of discreet tasks; nurse sick call is separate from practitioner clinic, labs require a separate appointment, tuberculosis screening is handled apart from any other encounter. This requires the patient to make multiple trips to the healthcare area. Some information gathered at the encounter is redundant, other pertinent information may not be available or missed, and care is delivered by multiple people impeding the development of a helping relationship between the patient and caregivers.

Some state and county correctional healthcare programs have adopted team-based care where a primary care team shares responsibility for a panel of patients. The team convenes daily to prioritize needs for care, reviews the schedule of activities, and allocates responsibility among team members with a particular focus on high-risk patients. Staff work collaboratively to address patient care needs comprehensively (Strugar-Fritsch & Follenweider, 2016). Tips for running a primary care clinic in the correctional setting are listed in Table 16.5.

Strategies for more comprehensive care management include periodic team conferences. An example is for the team to review care of patients whose chronic disease is not well controlled. The purpose of the review is to identify contributing factors and develop strategies to influence better disease control. Team conferences with difficult patients are also effective because all members of the team hear out the patient's concerns and collaboratively arrive at a treatment plan that is acceptable.

Shared visits are another care management strategy. These are appointments that take place with a group of patients who share the same diagnosis. The educational portion of the encounter takes place in a group setting and then individuals are seen individually for a shorter, focused visit. While individual visits take place, other members of the group are coached in self-management and lifestyle modification. Shared appointments have the additional advantage of peer support and advice. Patients

Table 16.5 Ten ways to run clinics smoothly

1. Monitor and continuously improve the quality, effectiveness, and efficiency of clinics: Data collected should include the number of people seen timely, the number of no-shows by reason, diagnostic tests not available, number of patients whose condition improved since last visit, the number of patients in fair or poor condition, and patient satisfaction
2. Protect the provider from interruptions: Interruptions are potential causes for error. Discuss with the provider in advance what interruptions are necessary
3. Plan how to manage time when patients are late or miss their appointment: Avoid overscheduling because it increases no-show rates; instead correct the root cause
4. Keep the provider running on time: Discuss with the provider how this is accomplished
5. Gather information the provider should review in advance: This includes medication adherence, blood pressure or blood glucose readings, canteen purchases, and adherence with diet and any exercise, sleep, or food diaries
6. Schedule all routine diagnostic work and consults to be completed before the appointment.
7. Update the chronic disease flowsheet or record for each visit: Review the record to identify clinical variables that determine the status of the patient's condition (e.g., number of seizures, etc.) and summarize these for the provider
8. Take vital signs, including weight. Record them on the encounter record: Taking vital signs before the visit saves time for the provider to focus on the patient
9. Summarize the reason for the visit on the encounter record and list any questions or issues the patients want to have addressed: This helps focus the patient and gives the provider a quick reference to begin the encounter
10. Promptly follow up after the visit to remove paperwork and process orders: Schedule diagnostic and treatment procedures to take place while the patient is still in the clinic to avoid return appointments

Source: Burrow et al. (2006)

who participate in shared appointments have more knowledge about disease and self-care strategies, quality of life, and problem-solving skills than those enrolled in usual care (Ridge, 2012; Strugar-Fritsch & Follenweider, 2016). With shared appointments, nurses are a resource because of their knowledge and expertise in health education and coaching.

Maintaining medication continuity is a fundamental aspect in managing the delivery of care. Negotiation and collaboration with custody staff on an ongoing basis are required to ensure that medication is administered as ordered and diversion is prevented.

Medication reconciliation needs to take place upon arrival after patients return from off-site care and at each primary care encounter. Nurses educate the patient about their medications and role in reconciliation. Any inconsistency between recommended doses and what is ordered, especially high-risk medications, needs to be resolved by a clinician promptly (Knox, 2016b). Nurses also monitor patient symptoms to evaluate the effectiveness of treatment and work with patients to improve adherence, if necessary. Patients likely to be nonadherent should be identified early and monitored closely for early intervention, if necessary (Mills et al., 2011; Ehret et al., 2013). The following is a list of strategies to improve medication adherence:

Symptom and side effect monitoring

- Increase frequency of contact
- Address side effects promptly
- Consider how distressing the side effect is for the patient
- Provide information about how to manage side effects
- Simplify the medication regime
- Consider the patient's preference for dosing regime
- Monitor closely for symptom response using a daily checklist or chart

Medication monitoring and environmental supports

- Institute directly observed therapy
- Provide reminders to take medication
- Provide reminders to get medication refills
- Target support to address barriers
- Increase visit frequency to monitor for relapse
- Involve family or other social support
- Use motivational interviewing to prompt patients to adopt behavior consistent with their goals

(Sources: Velligan et al., 2010; Palacio et al., 2016)

Typically monitoring of care is done by maintaining a log of scheduled care by type (e.g., dental, medical, mental health, episodic care, wound care, lab, radiology, referrals) with notation of the date the request, order, or referral was received, the date scheduled, the date it occurred, and, if different than the date scheduled, the reason why. Keeping the log is not enough; they need review to identify delayed care and action taken to provide the needed service. Recurring delays in care need to be discussed by the care team, corrective action taken, and performance improvement monitored. As electronic health records make their way into the correctional setting, logs are replaced with automated reports greatly facilitating the availability of information for patient management.

Monitoring performance of the healthcare program identifies areas of discontinuity in patient care. Examples of monitoring measures that detect discontinuity include:

- Were discharge recommendations implemented within a day of the patient's return from the hospital?
- In the last 6 months, have any prescribed medications expired without notification of the prescribing clinician?
- Were CIWA-R assessments completed as scheduled?
- Were labs obtained within the timeframe specified in the order?
- Did the specialty consult take place within the timeframe ordered?

Managing Transitions

All nurses have had experience with that patient who "fell through the crack." Anytime the responsibility for a patient's plan of care moves from one clinician to another, there is risk that important aspects of care will be disrupted, misunderstood, or forgotten.

During incarceration, people experience many transitions including intake, health care at a hospital or from a specialist, transfers within the correctional facility or to another, and release.

Whenever a patient is hospitalized or referred to see a specialist, there is a need to send and receive information about the patient to facilitate care. Nurses are responsible for preparation of the patient and assembly of pertinent information to inform providers at the hospital or specialists office of the assistance needed. They are also responsible for obtaining information about the care the patient received in the community, implementing a plan of care which includes collaboration with the primary care provider to incorporate the recommendations from the off-site visit, and scheduling future appointments.

Steps to improve the quality of care during these transitions include targeting patients at high risk of avoidable hospitalization, proactive intervention, increased timeliness accessing care, and patient education. The likelihood of future hospitalization is reduced when the nurse provides the patient with an explanation about their condition, how to take medications and why, what to expect about their progress, self-management, and then answers questions and listens to concerns (Cryer, 2018).

Steps to improve the quality of specialty care include:

- Build a relationship with high referral specialists.
- Establish expectations with each about when to refer, prior diagnostic work desired, pertinent information, type of recommendations sought, and future care.
- Logging and tracking referrals, addressing barriers and following up on missed appointments.
- Use information technology to improve timeliness and flow of information (Wagner & Thomas-Hemak, 2013).

Continuity of care is at risk with transfer. Any time a person is transferred, nurses prepare information and supplies, as necessary, to continue care. Steps to improve continuity of care on transfer are to establish a relationship with the most frequent transfer locations and agree on what information needs to be communicated and how it will be conveyed. Provide feedback to the transferring party about the adequacy of transfer arrangements and develop backup mechanisms to ensure that information vital to continuing care is communicated. For persons with complex care needs, consideration should be given to putting a hold on the patient's transfer. If transfer is unavoidable, confer with the receiving party before the transfer, so they are prepared; follow up afterward to address any questions or concerns.

Discharge or release from incarceration is the most important transition. People are most vulnerable to deterioration in their health and at increased risk of mortality during the first 2 weeks after release from incarceration (Costa et al., 2018; Harzke & Pruitt, 2018). Bureaucratic hurdles within the healthcare program and differing goals for care during and after incarceration are cited as the main challenges in effective care coordination at discharge (Wiest & Kuruna, 2019).

Nurses assist in identifying patients who need services after release, linking patients to community providers, obtaining a prescription or supply of necessary medication, preparing a summary of the patient's health status and need for ongoing health care, and communicating with the patient about these arrangements.

Performance monitoring should track counts of how many people are released, how many are identified as needing discharge planning, receive discharge planning, are enrolled in benefit programs, provided health summaries and medication or a prescription at release, and attend their first appointment in the community. Connecting releases to health care in the community reduces disease burden and the associated costs of deteriorating health status, as well as suppressing communicable disease transmission in the community (Costa et al., 2018). The reason correctional nurses persist in caring for incarcerated population is the committment that every person transitions back to their community in better health, with more knowledge about health and with increased ability to care for themselves.

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