

**Optimized Prescribing in Correctional Psychiatry: A Quality Improvement Policy**

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NURS 703B: DNP Project Planning

Winter Term, 2026

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This paper is submitted in partial fulfillment of the requirements for

the Doctor of Nursing Practice degree.

### **Abstract**

Psychiatric prescribing in the corrections context is complicated by many factors. Incarcerated individuals have poorer mental health on average compared to the general population, with homelessness, adverse childhood experiences, trauma exposure, and socioeconomic instability increasing their susceptibility to poor health outcomes (Cloud et al., 2023; Favril et al., 2024). Beyond the complex health needs of the incarcerated population, psychiatric prescribers face multiple barriers practicing in the corrections setting, particularly in county corrections. Unlike prisons, county correctional facilities have fewer resources and often have to contract with outside organizations to provide care to adults in custody (AIC) (Oregon Court Records, n.d.; Brinkley-Rubinstein et al., 2025). This can lead to a disconnect between providers, unclear roles and responsibilities, miscommunications, and process inefficiencies, especially when facility policies are not established to standardize care (Bicknell et al., 2024; Butler, 2018; Collins et al., 2017; U.S. Department of Justice, 2023). At one county correctional facility in rural Oregon, a prescribing policy for contracted psychiatric prescribers was developed to address these problems. While data samples were small, quantitative and qualitative feedback from stakeholders found the policy improved multidisciplinary collaboration, clarified roles and responsibilities, and improved the efficiency of psychiatric medication management at the facility.

*Keywords:* prescribing policy, corrections prescribing, correctional psychiatry, quality improvement

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## **Optimized Prescribing in Correctional Psychiatry: A Quality Improvement Policy**

### **Problem Description**

### **History and Background**

Psychiatric prescribing in the corrections environment is complicated by many factors. People who are incarcerated have poorer mental health on average compared to the general population, with most mental illnesses two to four times more prevalent in incarcerated persons (Cloud et al., 2023; Favril et al., 2024). Additionally, 58% of incarcerated persons have substance use disorders, and persons who have been incarcerated have a 62% increased risk of suicide compared to those who have not (Cloud et al., 2023; Morgan et al., 2022). Homelessness, economic instability, trauma history, and adverse childhood experiences are also more common in this population, further increasing their susceptibility to poor health outcomes (Cloud et al., 2023; Favril et al., 2024). Not only do people come into correctional facilities with poorer mental health on average, but the corrections environment itself contributes to psychological decompensation in various ways (Cloud et al., 2023; Favril et al., 2024). Overcrowding, exploitation and victimization by other incarcerated persons and corrections staff, exposure to solitary confinement and social isolation, and limited access to health resources are a few of the mechanisms perpetuating poor health in this population (Cloud et al., 2023).

Beyond navigating the complex health needs of this population, psychiatric providers face additional challenges prescribing in the corrections context. Financial and formulary constraints, facility restrictions, unclear roles and responsibilities, differing perspectives between corrections and healthcare staff, and disconnection between psychiatric and medical providers all complicate the process of providing high quality, evidence-based care (Bicknell et al., 2024; Butler, 2018; Collins et al., 2017; U.S. Department of Justice, 2023).

### **Purpose of Policy Project**

The purpose of the project is to develop an organizational policy on psychiatric medication management to promote standardized, collaborative, efficient, and safe care. The project site is a county correctional facility located in rural Oregon, which houses a maximum of 37 individuals at a time with a yearly average of 1,200 bookings. In contrast to state and federal prisons, county jails house individuals for shorter periods of time while they either await sentencing, or serve sentences of one year or less (Oregon Court Records, n.d.; Brinkley-Rubinstein et al., 2025). Because of this, county correctional facilities are typically less developed than prisons, and offer fewer services to those who are incarcerated (Oregon Court Records, n.d.; Brinkley-Rubinstein et al., 2025). For example, prisons have their own full-time medical staff, on-site pharmacies, psychiatric providers, dentists, and other services, whereas jails are more limited (Oregon Department of Corrections, n.d.; Brinkley-Rubinstein et al., 2025). Individuals lose their health insurance once they become incarcerated; as such, all medical and psychiatric services are paid through the facility's budget. The facility's budget for all medical and psychiatric services, including medication, totals \$50,000 for the year and fluctuates annually based on available funding.

The project site employs a part-time medical staff, including one family nurse practitioner (FNP) and two medical assistants (MAs), who are available during limited hours each week. AICs seeking medical or psychiatric care must submit their requests in writing; these written requests are known as 'kites' in the corrections setting, and are used to communicate all non-emergent needs. The medical team is in charge of managing medications for physical health conditions, including prescribing and submitting refill requests for prescriptions. Of note, the facility utilizes a paper medical record system, rather than electronic. The corrections officers are in charge of administering medications, which are delivered by an external institutional pharmacy and tracked in a paper medication administration record. For psychiatric medication management, the facility contracts with a local community mental health organization, which employs three psychiatric mental health nurse practitioners (PMHNPs). The PMHNPs

manage the prescribing and ordering of psychiatric medication at the facility, independent of the medical team.

### **Available Knowledge**

There is a gap in research related to quality improvement in the corrections healthcare setting, and there are no general guidelines specific to corrections prescribing despite the unique needs of this population (Tamburello et al., 2018). Additionally, corrections healthcare settings are not subjected to the same oversight as traditional healthcare settings, and care provided is often inadequate as a result (Brinkley-Rubinstein et al., 2025). Research has suggested health policy as an avenue to improve corrections healthcare, especially at the systems-level, and healthcare providers serve a critical role in the development of these policies (Brinkley-Rubinstein et al., 2025). What is clear in the research is the importance of multidisciplinary collaboration and process standardization in corrections healthcare (Magola-Makina et al., 2022).

Multidisciplinary collaboration in the care of AICs is frequently cited in the research (Bicknell et al., 2024; Magola-Makina et al., 2022; Tamburello et al., 2018). In the corrections setting, the multidisciplinary team typically includes psychiatric providers, medical providers, nursing staff, pharmacists, and corrections officers (Butler, 2018; Magola-Makina et al., 2022). The benefits of multidisciplinary collaboration include reduced medication prescribing errors, supported decision making for complex cases, identification of safety risks, assurance that prescribing practices align with facility guidelines, and enhanced monitoring of medication responses (Bicknell et al., 2024; Magola-Makina et al., 2022; Tamburello et al., 2018). One method for enhancing multidisciplinary collaboration is through regular prescribing meetings, where complex prescribing decisions are discussed amongst the multidisciplinary team (Magola-Makina et al., 2022).

Process standardization is another recommendation from the research (Magola-Makina et al., 2022; Rosen et al., 2023). As described by the Centers for Medicare and Medicaid Services (2024), the primary mechanism of quality improvement is standardization, as it allows for predictable and consistent outcomes. Healthcare providers in the county corrections setting are often contracted from outside organizations, which can further complicate prescribing processes if there are no standards in place (Magola-Makina et al., 2022). Standardization of prescribing processes may be achieved through the development of medication management policies (Magola-Makina et al., 2022).

### **Rationale**

The Institute for Healthcare Improvement's (IHI) cause and effect diagram (Appendix H) was used to identify problem areas specific to medication management at the facility. Through this process, the need for a psychiatric medication management policy was discovered. The U.S. Centers for Disease Control and Prevention's (CDC) Policy Process framework (Appendix A) was utilized to develop the policy (Appendix E) at the project site. The policy was intended to standardize the psychiatric prescribing process at the facility, and outline facility-specific guidelines for the multidisciplinary team.

### **Objectives**

The objective of this project was to develop an organizational psychiatric medication management policy for contracted psychiatric providers based on qualitative feedback from stakeholders by September 1, 2025.

### **Implementation**

The policy was developed collaboratively with the multidisciplinary team during a stakeholder meeting. The facility's commanding officer, one institutional pharmacist, two PMHNPs, one FNP, two MAs, and the project leader were in attendance and contributed to the development of the policy. The

policy outlined who is responsible for submitting new prescriptions to the pharmacy, who is responsible for tracking prescription refills, how medication changes are communicated to the multidisciplinary team, and dictated facility-specific prescribing guidelines. For example, regulations on prescribing controlled drugs, cost limits, and medication administration times were included in the policy. Throughout the project implementation period, adjustments to the process were communicated to the project leader and updates were made to the policy.

### **Feasibility and Utility**

Key stakeholders for the policy project included the commanding officers and corrections staff, psychiatry team, medical team, and the institutional pharmacy. The policy was developed with the input of stakeholders to increase the likelihood that it would be utilized. Because the policy was written based on the current resources available at the facility, there would be no additional costs or resources needed to implement it. The proposed benefits of the policy were that it would increase multidisciplinary team knowledge of facility regulations, improve multidisciplinary communication, standardize the prescribing process for contracted psychiatric prescribers, and, overall, promote safe, efficient, and evidence-based practices.

### **Measures**

The outcome of the policy was initially intended to be evaluated through pre and post intervention surveys administered to stakeholders, which would collect quantitative and qualitative data. However, the pre-survey (Appendix B) was administered after the stakeholder meeting, which caused confusion and led to a mix of pre- and post-intervention responses, rather than the intended pre-intervention responses. As such, quantitative baseline data could not be extrapolated. In retrospect, administering the pre-survey prior to the stakeholder meeting may have yielded intended results.

Despite the lack of usable quantitative data, the pre-survey offered valuable qualitative data which assisted in the development of the policy and, later, was compared to post-survey data.

Qualitative data was analyzed through extraction of themes from free-text survey responses (Appendix C), measuring the following: efficiency of the prescribing process, risk of prescription errors, and knowledge regarding roles and facility regulations.

Five months after the stakeholder meeting and subsequent implementation of the policy, a follow up survey (Appendix F) was sent to stakeholders to evaluate the policy and its impact on process standardization, multidisciplinary communication and collaboration, process efficiency, knowledge of facility guidelines, and knowledge of roles and responsibilities. Given the small sample size, descriptive statistics were used to analyze the data. Survey results found 100% (n=4) of respondents agreed these measures had been improved since the implementation of the policy. Post-survey qualitative data was analyzed through extraction of themes from free-text survey responses (Appendix G). Overall, the qualitative responses showed process improvement through enhanced multidisciplinary communication and decreased medication mistakes and miscommunications.

### **Ethical Considerations**

Protected health information was not collected for this project and all identifying data from the project site was de-identified. Participation in this project by the site and stakeholders was voluntary and could have been withdrawn at any time. Prior to implementation, this project was determined not to be human subjects research by the Oregon Health & Science University Institutional Review Board. Further, developing a policy aimed at providing evidence-based care to incarcerated persons is the ethical approach to corrections psychiatry.

### **Achievements and Challenges**

#### **Achievements**

The new process outlined in the policy was implemented at the facility in September as planned. One major achievement was the improved efficiency of submitting prescriptions to the pharmacy. Prior to the policy, psychiatric providers would call the pharmacy and verbally submit prescriptions, which was time consuming and often occurred later in the day. These late calls prevented the pharmacy from delivering new prescriptions to the facility in time for nighttime administration. In order to address this part of the process, a fax form (Appendix D) was created and a timeframe for prescriptions to be faxed to the pharmacy was noted in the policy. Another achievement of the policy was that it outlined clear roles and responsibilities, as well as facility guidelines related to psychiatric medication management, which were primary concerns brought up in the stakeholder meeting and survey. Additionally, the development phase of the project facilitated enhanced communication among the multidisciplinary team overall.

### **Challenges**

Challenges unrelated to the policy itself occurred at the same time as the project's development. For example, the facility had recently hired a new medical team, who were still in the process of orienting at the time. Additionally, the psychiatric providers were working to gain approval from the community mental health organization to submit prescriptions through their electronic system; however, after several meetings, the organization was unable to grant this access due to their own regulations. This led to additional footwork to create and utilize the fax order form (Appendix D). While the fax order form received positive feedback from stakeholders, there were instances where the faxes were not transmitted, leading to missing prescription orders. This is a challenge inherent in using a paper fax system, but was mitigated through enhanced communication between prescribers and the pharmacy.

### **Recommendations and Conclusions**

Process standardization and multidisciplinary collaboration are research-based methods for healthcare quality improvement (Magola-Makina et al., 2022; Rosen et al., 2023). This project

incorporated both process standardization and multidisciplinary collaboration in the development of a psychiatric prescribing policy (Appendix E), which ultimately improved process efficiency and safety, clarified roles and responsibilities, and outlined facility regulations as intended. Moving forward, it is recommended that the facility continues to utilize the policy, with the understanding that it may be adapted using the CDC's Policy Process Framework (Appendix A) when new problems are identified. The key project stakeholders include the corrections officers, psychiatric and medical providers, and institutional pharmacist, who also make up the multidisciplinary team. Each provided a different perspective from which to write the policy, and together negotiated a process that is suitable for the corrections environment while prioritizing evidence-based healthcare.

Patient advocacy is challenging in the corrections environment, which is inherently punitive. Healthcare is a constitutional right of all persons who are incarcerated in the United States; however, corrections healthcare settings are not subjected to the same regulatory oversight as traditional healthcare settings, and the populations served are especially vulnerable (Brinkley-Rubinstein et al., 2025). Healthcare providers have a unique opportunity to address quality issues and improve health outcomes for persons who are incarcerated, and policy development is just one mechanism that may be used to effect change.

### References

- Bicknell, M., Glover, C. and Wright, N. (2024). Prescribing in prisons and other secure settings. *Prescriber*, 35, 10-14. <https://doi.org/10.1002/psb.2116>
- Brinkley-Rubinstein, L., Berk, J., & Williams, B. A. (2025). Carceral health care. *New England Journal of Medicine*, 392, 892-901. <https://doi.org/10.1056/nejmra2212149>
- Butler, B. (2018). *Prescribing and dispensing medications within correctional environments: The role of health information technology* [PDF]. Community Oriented Correctional Health Services. <https://cochs.org/files/health-it-hie/cochs-emar.pdf>
- Centers for Medicare and Medicaid Services. (2024). *Quality measurement and quality improvement*. <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/mms/quality-measure-and-quality-improvement-#:~:text=The%20mechanism%20of%20quality%20improvement,to%20select%20high%2Dperforming%20clinicians>
- Cloud, D. H., Garcia-Grossman, I. R., Armstrong, A., & Williams, B. (2023). Public health and prisons: Priorities in the age of mass incarceration. *Annual Review of Public Health*, 44, 407-428. <https://doi.org/10.1146/annurev-publhealth-071521-034016>
- Collins, T. N., Avondoglio, J. B., & Terry, L. M. (2017). Correctional psychopharmacology: Pitfalls, challenges, and victories of prescribing in a correctional setting. *International Review of Psychiatry*, 29(1), 34-44. <https://doi.org/10.1080/09540261.2016.1235017>
- Favril, L., Rich, J. D., Hard, J., & Fazel, S. (2024). Mental and physical health morbidity among people in prisons: An umbrella review. *The Lancet Public Health*, 9(4), e250–e260. [https://doi.org/10.1016/S2468-2667\(24\)00023-9](https://doi.org/10.1016/S2468-2667(24)00023-9)

Magola-Makina, E., Abuzour, A. S., Ashcroft, D. M., Dunlop, J., Brown, P., & Keers, R. N. (2022). Exploring the challenges to safer prescribing and medication monitoring in prisons: A qualitative study with health care staff. *PloS One*, *17*(11), e0275907.

<https://doi.org/10.1371/journal.pone.0275907>

Morgan, E. R., Rivara, F. P., Ta, M., Grossman, D. C., Jones, K., & Rowhani-Rahbar, A. (2022). Incarceration and subsequent risk of suicide: A statewide cohort study. *Suicide and Life-Threatening Behavior*, *52*, 467–477. <https://doi.org/10.1111/sltb.12834>

Oregon Court Records. (n.d.). *The Oregon state prison system*. <https://oregoncourtreports.us/criminal-court-records/inmate/prison-system/#:~:text=What%20is%20the%20Difference%20Between,State%2D%20run%20correctional%20institutions>

Oregon Department of Corrections. (n.d.). Adult in custody services: health and wellness. <https://www.oregon.gov/doc/inmate-services/pages/health-and-wellness.aspx>

Rosen, D. L., Blue, C., Brown, M., Bradley-Bull, S., DiRosa, E. A., & Carda-Auten, J. (2023). The role of detention officers in the provision of jail healthcare in the Southeastern United States. *Social Science & Medicine*, *330*, 116065. <https://doi.org/10.1016/j.socscimed.2023.116065>

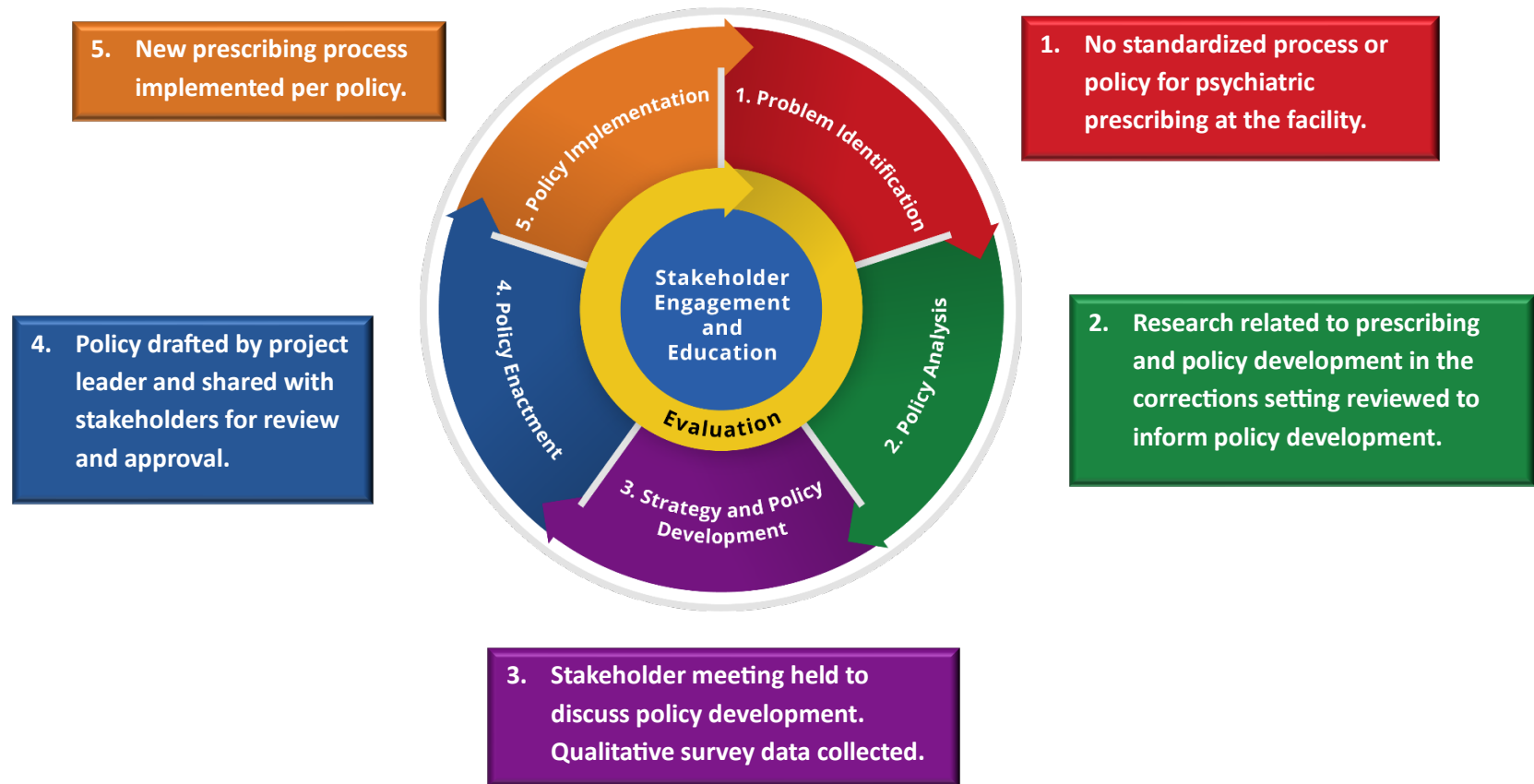
Tamburello, A., Metzner, J., Ferguson, E., Champion, M., Ford, E., Glancy, G., Appelbaum, K., Penn, J., Burns, K., & Ourada, J. (2018). The American Academy of Psychiatry and the Law practice resource for prescribing in corrections. *The Journal of the American Academy of Psychiatry and the Law*, *46*(2), 242–243. <https://www.aapl.org/docs/pdf/Corrections-Resource-Document.pdf>

U.S. Department of Justice. (2023). *Guidelines for managing substance withdrawal in jails: A tool for local government officials, jail administrators, correctional officers, and health care professionals*

[PDF]. [https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/guidelines\\_for\\_managing\\_substance\\_withdrawal\\_in\\_jails\\_6-6-23\\_508.pdf?sfvrsn=f25be919\\_1](https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/guidelines_for_managing_substance_withdrawal_in_jails_6-6-23_508.pdf?sfvrsn=f25be919_1)

Appendix A

CDC Policy Process Framework



Centers for Disease Control and Prevention. (2024). *CDC policy process* [Infographic]. <https://www.cdc.gov/polaris/php/cdc-policy-process/index.html>

Appendix B

Pre-Survey

Facility  
Psychiatric Medication Management  
Survey

This survey is intended to evaluate the effectiveness of the psychiatric medication management process at [redacted] which includes prescribing, ordering psychiatric medications, and submitting refills, and to assess the team's knowledge about facility-specific policies. This initial survey is asking about your experience with the process before the implementation of a new policy, which we hope will standardize our process, create a more efficient workflow, ensure we are following jail and pharmacy guidelines, and, of course, ensure the safety of the inmates receiving the medications. There will be a follow up survey in the future to evaluate the effects of the new policy. We value your feedback, thank you so much!

The "multidisciplinary team" includes mental health and medical prescribers, medical assistants, nurses, pharmacists, corrections officers, and corrections supervisors.

\* Indicates required question

1. 1. My role at [redacted] is... \*

Mark only one oval.

- Mental health prescriber
- Medical prescriber
- Medical assistant
- Nurse
- Pharmacist
- Commanding officer/Jail supervisor
- Correctional officer/Jail staff
- Other: \_\_\_\_\_

2. 2. There is consistent communication between the multidisciplinary team with regards to psychiatric medication management at [redacted] \*

Mark only one oval.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

3. Please elaborate on the reasoning for your answer to question 2. (Optional)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. 3. The current process for prescribing, ordering, and refilling psychiatric medications at [redacted] runs smoothly. \*

Mark only one oval.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

5. Please elaborate on the reasoning for your answer to question 3. (Optional)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. 4. The current process for prescribing, ordering, and refilling psychiatric medications at [redacted] is prone to errors. \*

Mark only one oval.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

7. Please elaborate on the reasoning for your answer to question 4. (Optional)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Appendix B

Pre-Survey, continued

8. 5. I am aware of [redacted]'s guidelines regarding psychiatric medication management \*  
(i.e. restricted medications, cost limits, scheduled administration times).

Mark only one oval.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

9. Please elaborate on the reasoning for your answer to question 5. (Optional)

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10. 6. I am aware of each person's role in the management of psychiatric medications \*  
at [redacted] (i.e. who is responsible for prescribing, submitting orders to the  
pharmacy, tracking refills, and submitting refill requests).

Mark only one oval.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

11. Please elaborate on the reasoning for your answer to question 6. (Optional)

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12. 7. If I have questions about [redacted]'s psychiatric medication management \*  
policy/process, I know where to find the answers.

Mark only one oval.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

13. Please elaborate on the reasoning for your answer to question 7. (Optional)

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14. Any other concerns or feedback on how the process of psychiatric medication  
management could be improved at [redacted]? (Optional)

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## Appendix C


## Stakeholder Qualitative Pre-Survey Data

Measure	Stakeholder Survey Responses
Efficiency	<ul style="list-style-type: none"> <li>“...timeline of when [prescription telephone orders] are received can conflict with when refills are made.”</li> </ul>
Errors	<ul style="list-style-type: none"> <li>“There are always potential errors when giving verbal orders to the pharmacy.”</li> </ul>
Knowledge of Facility Guidelines	<ul style="list-style-type: none"> <li>“[Project Facility’s] guidelines are often communicated verbally by officers as case by case issues arise and may vary depending on the specific circumstances in some cases.”</li> </ul>
Roles & Responsibilities	<ul style="list-style-type: none"> <li>“I am not fully aware of the roles of the medical providers. Do they watch for medications in need of refills, do they do any refills on psychiatric medication and if so how does the PMHNP get notified that a refill has been done?”</li> </ul>



## Appendix E

## De-Identified Prescribing Policy



**Psychiatric Medication Management Policy**

**Effective Date**

September 1, 2025

**Responsible Party**

Jail

Phone:

Fax:

**Scope and Audience**

psychiatric providers, institutional pharmacist, medical providers, and correctional officers

**Contact Information**

, Commanding Officer

Commanding Officer

PMHNP

FNP

Medical Assistant

Pharmacist

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When inmates are released, all prescriptions through the institutional pharmacy, including refills, are automatically cancelled. Any remaining medication that has already been dispensed to the jail will be sent with the inmate when they are released, except for controlled substances. *Release of controlled substances must be coordinated between the prescriber and commanding officers.*

## 2.2 New Prescriptions & Refills

### 2.2.1. Pharmacy Hours

Prescriptions should be submitted by 1100 for same-day delivery. Deliveries begin at noon on business days, with deliveries to the jail occurring between 1700 and 1730. For emergent needs, the PMHNP may coordinate with the pharmacy, jail staff, and medical team to arrange an urgent fill.

### 2.2.2. New prescriptions

New prescriptions will be submitted by the PMHNP to the pharmacy using the 'Prescription Order Form.' *Completed forms should be signed by the prescriber, dated, and FAXED to Institutional Pharmacy at*

### 2.2.3. Prescription refills

Standard long-term prescriptions should include a 30-day supply with refills. When refills are due, the medical team will submit the refill request to the pharmacy. *If there are no remaining refills, the medical team will notify the prescriber.*

## 2.3 Changes to existing prescriptions

Some changes to prescriptions do not require a new fill from the pharmacy, but the changes should still be communicated to the pharmacy and documented in the MAR and on the bubble packs.

### 2.3.1. Changes to administration time

If only the administration time is changed, the PMHNP should write the new administration time in the MAR and on the bubble pack, then the corresponding sticker should be placed on the bubble pack, and the bubble pack should be placed in the corresponding time slot in the cabinet. The pharmacy should be notified of the change, along with a note stating, "administration time change only, no fill required."

### 2.3.2. Changes in dose

If a change in dose is prescribed, the PMHNP should write "CANCEL" on the MAR and bubble pack of the old prescription along with their signature and date. The PMHNP should then pull the bubble pack from the cabinet and notify the commanding officer. Note: dose changes cannot be written on the bubble packs; they must be submitted to the pharmacy and new bubble packs will be delivered.

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## Policy Purpose

The purpose of this policy is to standardize the prescribing process at for contracted psychiatric providers, and outline facility guidelines related to psychiatric prescribing.

## Definitions

AM = morning, PM = evening, HS = bedtime, PRN = as needed, MAR = medication administration record, kite = written request

## Procedures

### 1. Psychiatry Consult Requests

Inmates who wish to be evaluated by the PMHNP for medication management will submit a kite that includes: Inmate name, date, and their specific complaint or request. Requests that are non-specific (i.e. "see mental health") should be returned to the inmate and clarification should be requested. Kites will be reviewed and triaged on a weekly basis by the PMHNP, and acute psychiatric needs will be prioritized. Urgent requests may be communicated by officers directly to the PMHNP or mental health agency. Note: outside agencies/contracted providers do not have access to digital kites, so hand-written kites must be utilized for psychiatry consult requests.

### 2. Medication Management & Prescribing

#### 2.1 Medication Administration

##### 2.1.1. Medication administration record

Medications are tracked in a paper MAR and medications are dispensed in bubble packs. Each bubble pack has a sticker corresponding to the time of day it is ordered to be administered ('AM,' 'NOON,' 'PM,' 'HS,' and 'PRN').

##### 2.1.2. Administration times

Medication administration times at the facility are limited to: 0500 (AM), noon (1200), PM (1800), and HS (2200).

##### 2.1.3. PRN administration

Medications ordered as 'PRN' must be offered each time indicated in the order and the outcome must be documented in the MAR.

##### 2.1.4. Prescription status upon release

##### 2.3.3. Discontinuing a prescription

If a prescription is discontinued by the PMHNP, the PMHNP should write "CANCEL" on the MAR and bubble pack along with their signature and date. The PMHNP should then pull the bubble pack from the cabinet and notify the commanding officer and pharmacy. \*Discontinued medications are returned to the pharmacy for reuse, and the cost is credited back to the jail.

### 3. Facility Guidelines

#### 3.1 Controlled medications

Controlled medications should be prescribed with caution due to their high risk of diversion in the jail. The multidisciplinary team may wish to have a treatment team meeting to discuss controlled medication prescribing on a case-by-case basis.

#### 3.2 High risk medications

Other non-controlled medications identified to be high risk for diversion and should be prescribed with caution. These include, but are not limited to: quetiapine (Seroquel), gabapentin (Neurontin), and bupropion (Wellbutrin).

\*Individuals who are found to be diverting or misusing their medications may no longer be allowed those medications. These will be discussed amongst the multidisciplinary team on a case-by-case basis.

#### 3.3 Cost restrictions

Inmates lose their insurance coverage when they are incarcerated, so all medical and mental healthcare is paid out of's annual budget. Psychiatry is included in the overall healthcare budget for the jail. Budget restrictions should be considered carefully when prescribing. Any medication that is expected to exceed \$1,000 must be approved by the commanding officer.

### 4. Medication for Addiction Treatment

The Sublocade program is managed separately from the general psychiatric medication management program and is not included in this policy.

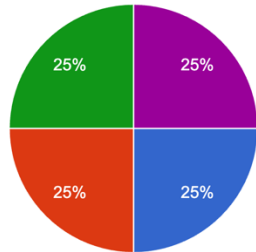
## Revision History

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Appendix F

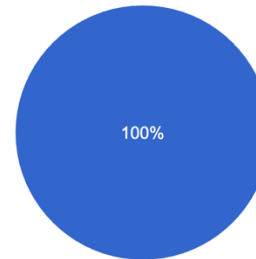
Post-Survey Quantitative Data

My role at [redacted] is...  
4 responses



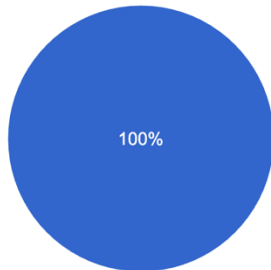
- Psychiatric Prescriber
- Medical Assistant
- Medical Prescriber
- Pharmacist
- Commanding Officer/Supervising Officer
- Corrections Officer/Corrections Staff

The new policy has led to increased efficiency with psychiatric med management overall  
4 responses



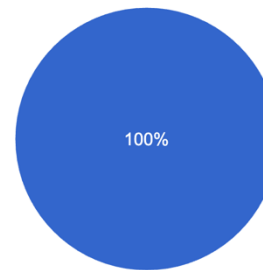
- Agree
- Neutral
- Disagree

The new policy has standardized the psychiatric med management process at [redacted]  
4 responses



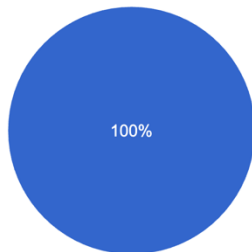
- Agree
- Neutral
- Disagree

The policy clearly outlines [redacted] guidelines related to psychiatric med management  
4 responses



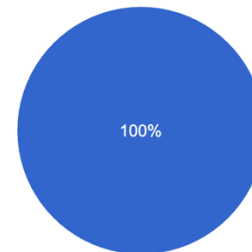
- Agree
- Neutral
- Disagree

The new policy has enhanced communication and collaboration among jail, pharmacy, medical, and mental health team members  
4 responses



- Agree
- Neutral
- Disagree

The policy clearly outlines the roles and responsibilities of each member of the multidisciplinary team  
4 responses



- Agree
- Neutral
- Disagree

**Appendix G****Stakeholder Qualitative Post-Survey Data**

<b>Measure</b>	<b>Stakeholder Survey Responses</b>
Communication	<ul style="list-style-type: none"><li data-bbox="575 418 1688 451">• “[The policy] has made communication efficient between medical and psychiatric staff.”</li></ul>
Errors	<ul style="list-style-type: none"><li data-bbox="575 506 2037 613">• “Medication mistakes and miscommunications decreased significantly once the policy was implemented. In an otherwise digital era of medicine it was a great job working in an archaic paper charted environment such as a small rural jail.”</li></ul>
General	<ul style="list-style-type: none"><li data-bbox="575 636 1839 669">• “The process has been greatly improved since the policy was discussed, planned and implemented.”</li><li data-bbox="575 675 1243 708">• “Thank you for your time on this. We are grateful!”</li></ul>

Appendix H

IHI Cause and Effect Diagram

QI ESSENTIALS TOOLKIT: Cause and Effect Diagram

Before filling out this template, first save the file on your computer. Then open and use that version of the tool. Otherwise, your changes will not be saved.

Template: Cause and Effect Diagram

Team: Jessica Norton Project: DNP Project

- 1) Input the effect you'd like to influence.
- 2) Input categories of causes for the effect (or keep the classic five).
- 3) Input causes within each category.

