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The Lived Experience Of Correctional Nurses Working In Two Ontario Detention Centres : A Descriptive Phenomenological Study

Sheleza Latif
Ryerson University

THE LIVED EXPERIENCE OF CORRECTIONAL NURSES WORKING IN TWO ONTARIO DETENTION CENTRES: A DESCRIPTIVE PHENOMENOLOGICAL STUDY

by

Sheleza Latif

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Abstract

This thesis presents a descriptive phenomenological inquiry of the lived experience of correctional nurses working in Ontario detention centres. Correctional nursing is an area of nursing that remains understudied in Canada. The purpose of this study was to describe the experience of correctional nursing in a Canadian context. Seven in-depth interviews with correctional nurses were conducted. Data analysis was guided by Giorgi's description of the descriptive phenomenological psychological method. Fourteen essential structures were identified. These essential structures described participants' experiences related to: discovering correctional nursing; their physical workspaces; their working relationships; and caring for inmate clients. Implications for policy and administration include suggestions for reviewing the service delivery model of healthcare services within corrections and improving the recruitment and retention of correctional nurses. Implications for nursing practice, education, and research are also discussed

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"WHOEVER IS NOT GRATEFUL TO HIS FELLOW HUMANS CANNOT BE GRATEFUL TO GOD"

- Prophet Mohammad (peace be upon him)

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Dedication

This thesis is dedicated to all those who strive to make corrections a healthier place for all those who work there and who are incarcerated therein for an appointed time.

TABLE OF CONTENTS

LIST OF APPENDICES

CHAPTER 1.0 – OVERVIEW OF THE STUDY

INTRODUCTION

Correctional facilities - jails, prisons, and detention centres are hardly places of employment most people would consider at first, if at all, when talking about the work environments of nurses. It may be counter-intuitive to think that nurses could work in a place that is socially constructed as a place of punishment and confinement. For the most part nursing is viewed as a caring, nurturing profession, which would appear to be inconsistent with the perceived purposes of correctional facilities. Yet for many nurses in Ontario, correctional facilities are their places of employment and incarcerated individuals are their clients. This study was designed to describe and gain insights into the lived experiences of correctional nurses working in two Ontario detention centres.

This chapter is divided into the following five sections: the problem statement (section 1.1); the study purpose (section 1.2); the research question (section 1.3); the significance of the study (section 1.4); and the outline of the thesis (section 1.5). The problem statement (section 1.1) will discuss the need for this study. The study purpose (section 1.2) will discuss the nature of this study. The research question (section 1.3) will present the overarching question used to guide this study. The significance of this study (section 1.4) will describe the objectives of this study. Lastly, the outline of the thesis (section 1.5) will outline the upcoming chapters of this dissertation.

1.1 Statement of the Problem

Although correctional facilities have existed since the sixteenth century, the use of professional nurses within these institutions has only become common within the past 20-30 years (Hufft, 2006). A search of the literature indicates that the specialties of forensic nursing

and more particularly, forensic psychiatric nursing, have received more scholarly attention and research over the years. While forensic nursing involves caring for and perhaps working in secure or correctional facilities, the nurses' role is not confined to the correctional setting. As well, the scope of practice for forensic nurses varies widely within this specialty and includes caring for victims of violent crimes and presenting evidence and expert testimonials in court. While correctional nurses may also be required to present evidence in court, they do not generally present expert testimonials (Hammer, Moynihan, & Pagliaro, 2006). Additionally, correctional nurses care for individuals incarcerated and housed within a correctional facility.

In Ontario, there are twenty-six adult correctional facilities: five shared adult and youth facilities; five stand-alone youth facilities; and the remaining sixteen facilities are adult institutions. The census estimations indicate that during the 2004/ 2005 fiscal year, approximately 64,632 individuals were admitted into the custody of the Ministry of Community Safety and Correctional Services (MCSCS). During this time, the average daily census was 7,773 incarcerated adults. Women represented 11.5% of the annual admissions and 6.2% of the daily adult population. Inmates 55 years old and older represented 3% of the annual admissions and 3.1 % of the average daily census. (December 2005, Personal Communication, Joanne Shaw, Manager of Health Care Services, MCSCS).

There are approximately 132 full-time nurses employed with MCSCS. Although there is at least one nurse on site at every institution, staffing numbers and hours are minimal. Five institutions have nursing care on site, twenty-four hours a day, seven days per week. Five other institutions offer nursing care five days per week. Physicians and psychiatrists are available daily for limited periods. As a result, nurses are the primary health care providers for all health

care matters on site (December 2005, Personal Communication, Joanne Shaw, Manager of Health Care Services, MCSCS).

The above statistics provide a sense of the volume of the clients that are cared for annually in Ontario correctional facilities by a small group of nurses. In addition to caring for a large volume of clients annually, correctional nurses also care for a population that has been identified as being socially excluded with significant health needs (Prison Health Research Network: PHRN, 2007). A national survey of the health status of Canadian inmates found that overall, inmates are in poorer health than the general population and that "providing health services to inmates is an extremely challenging undertaking" (Correctional Services Canada: CSC, 2004, paragraph 12).

In Canada, correctional nursing and healthcare is an area that has not been widely studied either by the nursing profession or by corrections. Studying correctional nursing is necessary to identify the specific limitations, complexities, opportunities and challenges that Canadian correctional nurses encounter while caring for a vastly diverse client population. Such research is also necessary to support the development of best practice guidelines and is important to the growth and advancement of nursing knowledge and scholarship within the context of correctional nursing in Canada.

1.2 Purpose of the Study

The purpose of this study was to describe the experiences of correctional nursing in a Canadian context. The specific context selected for this study was the detention centre setting in Ontario. Detention centres were selected in part because of their geographical location and in part because of the limited literature available on the experiences of nurses working in detention centres.

The focus of this study was to describe the experiences of correctional nurses working in two Ontario detention centres. The use of a descriptive phenomenological approach provided an opportunity for correctional nurses to describe their experiences of correctional nursing.

1.3 The Research Question

The overarching research question for this study was: "What are the lived experiences of nurses working in two Ontario detention centres?" This open-ended question is consistent with the tradition of descriptive phenomenology. Its design provided study participants the opportunity to describe multiple experiences in as much detail as they were comfortable with sharing.

1.4 Significance of the Study

It was posited that the use of narrative descriptions and qualitative analysis would elucidate the essential structures of the study participants' experiences, thus providing a better understanding of correctional nursing in a Canadian context. This study contributed to illuminating the essence of correctional nursing. The findings have potential significance for policy, administration, as well as nursing practice, education and research.

It is anticipated that dissemination of study findings will generate discourse, scholarly debates, and communication amongst nurses and correctional administrators. It is hoped that this will ultimately lead to the enhancement of correctional nursing care. Study findings may also stimulate the development and implementation of further nursing research in the area of correctional nursing. Such research will increase the understanding of the needs of correctional nurses and inmate clients. It is hoped that the study findings will motivate correctional administrators to review current and other correctional healthcare service delivery models, with the aim of better facilitating the goals of custody and care. It is hoped that the findings of this

study will also provide insight and inspiration for the development of practice standards for correctional nursing.

1.5 Outline of the Thesis

This first chapter provided background information regarding correctional nursing and the need for the study. It has also outlined the study and its parameters. Definitions of key terms and concepts are provided in the glossary, located on page 129. The second chapter includes a review of the literature concerning various aspects of correctional nursing; chapter 3.0 presents the study's methodology and procedures; chapter 4.0 presents study findings; and chapter 5.0 is the discussion of the study findings, implications and conclusions.

CHAPTER 2.0 – AN OVERVIEW OF THE CORRECTIONAL SETTING AND LITERATURE REVIEW

INTRODUCTION

The purpose of this chapter is two-fold: first to provide an overview of corrections (section 2.1) and secondly to present a literature review (section 2.2). The overview of the correctional setting provides the reader with some background information about the correctional setting (section 2.1.1) including a description of the daily operations of detention centres. The policy context – government and correctional healthcare (section 2.1.2) provides an overview of the policy context in which correction centres exist.

The literature review (section 2.2) is divided into the following subcategories: inmate health (section 2.2.1); the culture of corrections (section 2.2.2); transcultural nursing (section 2.2.3); caring for the inmate client (section 2.2.4); the nurse-inmate client relationship (section 2.2.5); and work-related stress, coping and nursing (section 2.2.6); and correctional nursing in Canada (section 2.2.7). Prior to conducting this study a literature review was carried out in order to determine what was already known of the "lived experiences" of Canadian correctional nurses.

2.1 An Overview of Corrections

This section provides background information with a brief description of the correctional setting as well as the policy context within corrections.

2.1.1 The correctional setting

The Ministry of Community Safety and Correctional Services (MCSCS), a provincial ministry, employs nurses who work in detention centres. Detention centres house incarcerated individuals accused of committing an offence and are: a) awaiting a bail hearing; b) awaiting, or

on trial; or c) convicted and waiting to be transferred to a provincial correctional centre for short term sentences or to a federal penitentiary for sentences of two or more years.

One of the overarching goals of healthcare in corrections is to provide care to inmates at the same level as offered in the community. Nurses are the primary healthcare providers, providing 24-hour care at each of the detention centres with the goal of providing continuity of care to inmate clients while they are in custody. Nurses also coordinate the care of inmates with other healthcare staff including consultations with correctional medical doctors, psychiatrists and dentists as well as healthcare consultations with community partners.

While in custody, an inmate's movements and freedoms are greatly restricted. Inmates are completely dependent on correctional officers for even the very basics of everyday living. For example, inmates rely on correctional officers for basic items such as toothbrushes, combs, underwear, toilet paper, pencils, paper, soap, showers, meals, etc. Correctional officers also control the flow of everyone and everything-including information that moves in-and-out of the unit. Therefore, if an inmate has an urgent health concern he depends on the officer to relay that message to the nurse; likewise if a nurse needs to speak to an inmate he/she depends on the correctional officer to provide access to and supervision of the inmate for the duration of the encounter.

Nurses visit the living units of inmates at least twice daily for medication administration. However, a nurse can only administer the medications when a correctional officer is available to accompany the nurse. In the detention setting it is expected that correctional officers are always present during nurse-client interactions. This measure was designed to maintain institutional order and the protection of nurses.

Maintaining safety is also an issue when inmates require an outside consultation or emergency treatment. After being informed by the nurse that an inmate requires outside treatment, an operational manager (OM) is responsible for arranging the security detail for escorting inmates. Operational managers are a rank above correctional officers and look after the institutional daily operations. Once the security detail has been arranged the inmate is then transferred out for assessment.

2.1.2 The Policy Context - Government and Correctional Healthcare

The standard of health care services offered within correctional facilities mirrors the values, beliefs and attitudes of both government and society regarding the treatment of individuals who are in conflict with the law. Correctional health care services have received more attention in countries such as the USA, Europe and Australia, where national reviews of their correctional health care systems have been initiated. For example, in the USA the mission of the National Commission on Correctional Health Care (NCCH) is "to improve the quality of health care in jails, prisons and juvenile confinement facilities" (NCCH; www.ncchc.org). Similarly, in the UK, the ministries of Her Majesty's Prison Services (HMPS) and National Health Service (NHS) have jointly formed what was previously known as the Prison Health Research Network (PHRN). The aim of PHRN is "to develop the infrastructure needed to establish and sustain a strong program of research and development into prison health care" (PHRN, 2007, http://www.phrn.nhs.uk/about). The network is now known as The Offender Health Research Network (OHRN) whose website is www.orhn.nhs.uk.

The idea of a national strategy to address prison health has been endorsed by the World Health Organization (WHO). Based in Europe and stemming from the attention placed on prisons and prisoners related to the disbanding of the Soviet Union, the WHO published a guide

entitled, *Health in prisons: A WHO guide to the essentials in prison health* (2007). This was derived from expert advice (including two contributors with Canadian experiences in law and prison services) and the experiences from more than 28 European countries. The document written by WHO states that government action is essential to establishing healthy prisons and identifies three important first steps to accomplish this goal: 1) political leadership; 2)"establish[ing] national policy through advice from senior staff members in the prison services and senior health policy advisors"; and 3) "check that prison staff members have easy access to key documents, such as this [WHO's] guide, in their own language or another language they understand" (WHO, 2007, p. 2).

In Canada, research on correctional health care has received less attention than in other parts of the world. Correctional Services Canada, a federal ministry, is responsible for operating the federal penitentiaries. Penitentiaries house individuals serving a sentence of two or more years. Though a national program of study concerning correctional nursing has not been established, Canada does produce a national publication, *Forum on Corrections Research*. This publication addresses issues in corrections, which may include, but is not limited to correctional health care. Additionally, there is an annual national correctional nursing conference where research and advancements in the area of correctional nursing and health care are presented and discussed. However, the research presented at this conference is not documented nor provided in a written format that would aid in the further dissemination of the research presented to those who did not attend the conference. Overall, in Canada, correctional nursing remains an area of health care that is understudied.

At the provincial level, there is also a gap in the literature regarding correctional nursing. In Ontario, there seems to be little political or professional interest in developing a program of

research that examines and addresses the issues related to correctional nursing. In previous years, the governing provincial political party adopted a "get-tough" or a "no-frills" approach to crime, placing a premium on community safety. A former corrections minister was quoted as saying that "Jails should be punishment", that losing one's liberty is not enough and that "convicts must be subjected to a harsher environment" (Griffiths, 2004, p.58). Such attitudes and philosophies of correctional facilities perpetuate the devaluing and marginalization of the incarcerated populations and by extension the correctional nurses who care for them.

Ontario's approach to crime and punishment has left a punitive overtone in Ontario's correctional institutions. However, more recently, with new leadership, there have been efforts made by MCSCS to correct this negative perception. Policies and procedures have been put in place to ensure that inmates receive health care that was on par with that offered in the general community. Additional efforts have been made to improve the overall working environment of correctional facilities [Joanne Shaw, MCSCS, personal communication, 2005].

Also important to note is the organizational structure within which study participants work. At the institutional level, the organizational structure is hierarchical and based on a paramilitary system consisting of different ranks of officers and officials. The superintendent of the institution is the top official, with correctional officers, nurses and other "line-staff" at the bottom of the hierarchy. In between these two levels, there are two additional levels of management. A diagram of this hierarchical structure can be found in Appendix A. Correctional nurses report directly to the Health Care Manager (HCM), who then reports to the Deputy Superintendent of Programs, who then reports to the Superintendent.

The organizational structure is even more complex when considering that each institution is a small part of the larger MCSCS structure. Specific to healthcare, the additional ministry

hierarchy component consists of senior healthcare consultants including two nursing positions – a Senior Nursing Consultant and the Manager of Corporate Health Care. These individuals develop, manage and are responsible for healthcare initiatives and programs province-wide within corrections. They are also responsible for managing existing funding and for seeking additional funding from the government to support the healthcare programs and initiatives. A visual representation of this structure is presented in Appendix B.

2.2 Literature Review

An initial review of the literature was conducted prior to carrying out this study in order to determine what was already known about the lived experiences of correctional nurses within Canada and beyond. The following databases were searched: ProQuest, CINAHL, Medline, Cochrane Library, PsychInfo, PubMed, EBSCO HOST, Academic Search Premier, Web of Science, E-journals @ Scholars Portal, Scholarsportal.info, and OVID Journals. Many key word searches were used, including but not limited to, correctional nursing, corrections, nursing, inmate, health, culture, prison, jail, detention centre, prison culture, and other key words specific to the subcategories of literature reviewed. Much of the literature retrieved specific to the nurses' experiences of correctional nursing were testimonials and anecdotal accounts of issues concerning various aspects of the corrections practice milieu. Many empirical studies addressed specific medical and psychological pathologies of inmates. There was minimal research concerning the description and analysis of correctional nursing as experienced by nurses. There were no Canadian research studies that were specific to the Canadian experience of correctional nursing, thus highlighting a gap in the literature.

2.2.1 Inmate Health.

The health problems of inmates are similar to those of the general community but are impacted negatively by individual demographic factors (e.g. low socio-economic status, lower education, unstable or poor housing and nutrition), imprisonment, and a minimal political will to allocate resources to adequately address inmate health problems. The prevalence of illnesses and diseases associated with marginalized populations are often more prevalent in the inmate population than the general public. For example, the needs of those with drug dependencies are often marginalized. In addition, those individuals who use and share needles to inject drugs are at greater risk for contracting HIV and Hepatitis C virus (HCV) infections. There are many studies and reviews regarding the identification, treatment, care, and public health concerns of inmates with HIV and HCV (Boutwell, Allen, & Rich, 2005; Calzavara et al., 2007; Elliot, 2007; Laurent, 2007; Poulin et al., 2007; Staton-Tindall, 2007). In Canada, two studies provided evidence that the prevalence of HIV and Hepatitis C virus (HCV) in the inmate population in Quebec (Poulin et al.) and in Ontario (Calzavara et al.) is significantly greater than in the general Canadian population. This led to recommendations that the government be obliged to provide healthcare services including harm reduction strategies that are aimed at reducing the transmission and prevalence of HIV and HCV.

WHO (2007) has identified common health issues in the correctional setting as "substance dependence, infections, dental disease, chronic disorders, low mood or self-confidence, anxiety, depression, severe mental disorders, poor hygiene, nutrition, or mobility, personality disorders, and physical and mental trauma and stress" (p. 26). Addressing these issues is often complicated by co-occurring problems such as vulnerability (individuals with

learning disability or a brain injury) or nature of sentence (offences against women or children) and bullying or being bullied (WHO).

The healthcare issues and concerns of specific groups of inmates have been studied and discussed in the literature. For example some of the issues for women inmates include coping with family relationships (Poehlmann, 2005); experiencing irregular menses, breast lumps, miscarriages (Hatton, Kieffel, & Fisher, 2006); and use of contraceptives (Clarke et al., 2006). Health issues for men and women with mental health illnesses included: understanding the prevalence of and various types of mental illnesses such as major depression, psychosis and personality disorders (Fazel & Danesh, 2002); suicide prevention programs and health issues related to close confinement (Metzner, 2007) and access to treatment and care (Morgan, Steffan, Shaw & Wilson, 2007). Aboriginal inmates' health concerns have been discussed in light of programs aimed at offering aboriginal inmates traditional healing methods (Darsie, 2006) and prisons as a point for accessing health care (Kariminia, Butler, & Levy, 2007).

The health issues and healthcare needs of the inmate population are diverse and dynamic. Prison environments themselves negatively impact on inmates' health and the poor health conditions of prisons increases inmates' risk of acquiring infections and diseases such as sexually transmitted infections, influenza, hepatitis, and tuberculosis (Bick, 2007). Presently, and in the future, the aging demographic of inmates complicates and will continue to complicate inmate health issues. Related issues of palliative care and end-of-life issues require correctional institutions to provide quality palliative care services including supporting companionship and family support for inmates, pain management and do-not-resuscitate orders (Bolger, 2005; Linder & Meyers, 2007; Wood, 2007).

2.2.2 Culture of corrections.

The review of the literature concerning the culture of corrections is presented first, to provide the context within which correctional nurses practice. Correctional institutions as organizations are hierarchical and are part of a much larger bureaucracy. While there are advantages to such organizational structure, it is noted in the literature that there are significant limitations inherent in hierarchies and formal chains of command. Philip Selznic, an organizational behaviour theorist, noted that when formal chains of command exist they are accompanied by informal ones (Kernaghan & Siegel, 1999). Often, such dualities exist when the mission, vision and goals of those individuals higher up in the hierarchy are not communicated, shared, or valued by those lower in the chain of command.

In the literature, it is recognized that in corrections, three realities exist. One is the official rules and policies that govern conduct; the second is the interpretation and application of the official rules by correctional staff (who have been referred to as 'street level bureaucrats'); and the third is referred to as inmate culture or prison subculture (Hufft & Kite, 2003; Kifer, Hemmens, & Stohr, 2003). Inmate culture has an unwritten code of conduct that incorporates inmate values, concerns, roles and language (Hufft & Kite). Prison subculture is dynamic and dependent on the diversity of the inmate population including age, gender, sexual orientation, ethnicity, group affiliations (gangs), and crimes committed.

Prison culture has been defined by Hufft & Kite as valuing "order and obedience, power over the weak or disenfranchised, and strict adherence to polices and procedures" (p. 20). They also note that offenders are kept powerless and dependent on correctional officers for delivery of services as a means of control. Control, fear, sexism, racism, oppression, and bullying, are also characteristics of prison culture (Hufft & Kite; Lambert et al., 2005; Nurse, Woodcock, &

Ormsby, 2003). One of the sources of the perpetuation of the negative correctional culture experienced by both correctional staff and inmates can be attributed to differing outcome orientation of the goals of incarceration.

Crewe (2006), through an ethnography study, found that the administrative goals for inmates differed from the goals of inmates themselves and that this proved to be a source of tension within the culture. Often, administrative goals were perceived by inmates as an imposition and unhelpful. Nevertheless inmates continued to satisfy administrative goals as their doing so served as a stepping stone to satisfying their personal goals.

2.2.3 Caring for the inmate clients.

Caring is a concept that is central to nursing. Many nursing theorists have stated that caring is the art of nursing and many efforts have been made to inculcate caring in the nursing curriculum and to cultivate caring qualities in nurses. According to Leininger, the goal of nursing actions is to support, enable and empower individuals or groups with obvious or anticipated needs to attain a better state of health or to cope with changes, loss or death (Leininger, 1991; 2002). Although one cannot directly empower another individual; one can provide the support and access to resources that enable that person to experience a stronger sense of autonomy, choice and personal involvement in his/her living situation (Fry, Slivinske, & Flitch, 1989). However, practicing the art of caring within a correctional setting is often difficult and contentious.

A review of the literature indicates that caring for inmate clients is difficult and limited by custody and security issues; and requires nurses to adapt their nursing processes while maintaining their professional standards (Maroney, 2005; Willmott, 1997). Weiskopf (2005) investigated nurses' experience of caring for inmate clients employing descriptive

phenomenology. Her findings indicated that nurses were struggling to create a caring environment; continually negotiating the boundaries between custody and caring, and often experienced risky situations. She has highlighted some of the issues correctional nurses face that nurses working in traditional settings do not usually encounter.

Also noted in the literature, is a suggestion that a transcultural approach to nursing care of inmates may be beneficial. Transcultural nursing is defined as "a formal area of study and practice focused on comparative human-care (caring) differences and similarities of the beliefs, values, and patterned lifeways of cultures to provide culturally congruent, meaningful and beneficial health care to people" (Leininger & McFarland, 2002, pp. 5-6). Transcultural nursing offers nurses a framework to provide culturally universal and culturally diverse nursing care (Giger & Davidhizar, 1999, Leininger, 1991; 2001). When applying the tenets of transculural nursing, nurses use a culturally universal as well as a culturally diverse lens when assessing the client's needs (Leininger, 1991; 2001). Culturally sensitive care and culturally competent care are terms used by others to refer to this process (Leininger, 2001). Hufft (2006) stated that "the goal of culturally competent care for clients in the correctional settings is to encourage appropriate exchanges of collaborations among offenders, healthcare providers, and correctional staff" (p. 642).

Hufft & Kite's (2003) study specifically addressed culturally sensitive nursing in the correctional setting. This American study extended the idea of cultural competency to the correctional nurses. Hufft and Kite proposed that prison culture is similar to other cultures through "expressions of values and norms, beliefs and attitudes, relationships, communication and language, sense of self and space, appearance and dress, work habits and practices and food and eating habits" (p. 20). Their proposition was tested by implementing an intervention of staff

training and education in cultural competency as well as the specific health care needs of the selected population. As a result of this intervention, policies and procedures of the selected institution were revised to be culturally sensitive; relationships between correctional staff and nurses were renegotiated to be collaborative; and offender success was defined in terms of health outcomes and not security goals. Therefore, by providing culturally competent care, correctional nurses may lay the foundation for more trusting, therapeutic relationships within which changes in health status and health promotion strategies are sustained (Hufft & Kite).

Evident in the literature are the challenges of caring for inmate clients. The correctional environment coupled with the fact that healthcare and nursing are not the primary focus of correctional facilities makes caring for inmates particularly challenging (Droes, 1994; Griffiths 2004; Hufft, 2006; Maroney; WHO 2007).

2.2.4 Nurse-inmate client relationship.

Traditionally, nurse-client relationships are therapeutic, holistic and based on trust. How this relationship is adapted or changed within the correctional setting has not been studied in any depth or breadth within the nursing literature. Much of the conceptualization of this phenomenon is fostered though one's synthesis of data regarding prison culture and subculture, environment, health-specific needs and role of correctional nurses. Shield and De Moya (1997) examined nurses' attitudes toward inmate clients and found that correctional nurses were likely to have a negative construction of and attitude towards inmate clients, classifying inmates as manipulative and difficult. One of the challenges noted in the literature that may affect the professional-client relationship is the professional's ability to empathize with clients (Bayne, 2006; Dhawan, Steinbach, & Halpern 2007). Bayne suggest that "unless a nurse genuinely has experienced poverty, it may be difficult for him or her to truly understand the struggles that

impoverished patients face" (p. 837). Much of the literature regarding specific health issues or prison populations speak of the nurse-client relationship but do not specifically describe this relationship nor provide evidence of how this relationship can be therapeutically fostered and maintained to positively affect inmate health and quality nursing care.

2.2.5 Work related stress, coping and nursing.

Coping is defined as "the efforts we take to manage situations we have appraised as being potentially harmful or stressful" (Kleinke, 2007, pp. 290-291). Panzarine (1985) identified that coping strategies are multidimensional, and vary according to the nature and amount of stress involved in the situation, the environment, and personal characteristics such as the age and particular lifecycle stage of the individual. Coping strategies have been divided into two groups, problem-focused coping and emotion-focused coping. The former is often used when an individual perceives he/ she can influence the situation and the latter is used when an individual perceives that he/ she cannot change or influence the situation (Lazarus & Folkman, 1984). Kleinke emphasised that coping was a process that occurs over time; requires effort and planning; and does not always assume a positive outcome.

A review of the literature indicates that the type, amount and intensity of work related stress that nurses experience varies according to the individual nurses; the nature of work; and work-family conflict (Parikh, Taukari, & Bhattacharya, 2004). Some stressors common for nurses that have been identified include: job strain; role ambiguity; interpersonal relationships; shift work; organizational reorganization and work environment. Another potential stressor suggested in the literature are nurses' perceived lack of support from their employer and from their union. There seems to be a somewhat moderate positive correlation between nurses' perceptions of hospital and union support and their sense of well-being (Greenglass & Burke,

2001). This literature also identifies common coping strategies among nurses including: control, avoidance, problem-solving**,** and talking about the stressors (Hannigan, Edwards, & Burnard, 2004; Parikh, Taukari, & Bhattacharya, 2004; Tyson, Pongruengphant, & Aggarwal, 2002).

The literature regarding forensic and correctional nursing acknowledges that work-related stress particular to these settings includes: isolation; lack of resources; stigmatization; a confined work environment; and the struggle to balance custody and care (Goldkuhle, 1999; Morrison, Burnard & Phillips, 1997; Watson, Stimposon, & Hostick, 2004; Weiskopf, 2005). Coping strategies particular to forensic and correctional nursing have not been clearly identified in the literature. As well, how phenomena such as restructuring, privatization and union dynamics influence work-related stress and coping strategies of correctional nurses is not discussed in the literature.

2.2. 6 Correctional nursing in Canada.

In reviewing the literature, there was a dearth of research studies and findings concerning correctional nursing in Canada. Most often, issues and experiences related to correctional nursing in Canada are presented anecdotally in the literature. There have been many international studies that have examined various experiences of correctional nursing (Dale & Woods, 2002; Dores, 1994; Goldkuhle, 1999; Hammer, Moynihan, & Pagliaro, 2006; Hardesty, 2000; Hufft, 2006; Hufft & Kite 2003; Kifer, Hemmens, & Stohr, 2003; Maeve, 1997; Maeve & Vaughn, 2001; Maroney, 2005; Norman & Parrish, 1999; Shields & De Moya, 1997; and Willmott, 1997). While it may be reasonable to use the literature originating abroad to speak generally on the nature of correctional nursing, further research concerning the specific structures and experiences of Canadian correctional nurses is necessary. Uncritically adopting and assuming that the experiences of correctional nurses abroad are the same as Canada would

also mean accepting the underlying assumptions, beliefs and values embedded in those experiences. To make such assumptions, in the absences of supporting research, would be problematic and marginalizing to Canadian correctional nurses and nursing. The judicial system, culture and correctional system of Canada are different from other countries such as the USA, the UK and Europe and therefore the experiences of correctional nurses can not by assumed to be the same as Canadian correctional nurses. This therefore, supports the need to investigate the experiences of correctional nurses within the Canadian context.

SUMMARY

In summary, the literature review conducted established that correctional nurses have the difficult task of balancing the goals of nursing and health care with the goals of custody and security (Goldkuhle, 1999; Morrison, Burnard, & Phillips, 1997; Watson, Stimposon, & Hostick, 2004; Weiskopf, 2005). Correctional nurses care for a population that is socially marginalized, in poorer health than the general population, and for whom the provision of health care is very challenging (Watson, Stimposon, & Hostick, 2004; Weiskopf, 2005). There is a gap in the literature about the nature of correctional nursing. It is important to establish the requisite knowledge correctional nurses need to have in order to meet the needs of inmate populations (Hufft & Kite, 2003; Watson, Stimpson, & Hostick, 2004). The World Health Organization (WHO, 2007) recognizes that prison environments negatively impact the mental health of both inmates and staff. WHO has established guidelines to create health promoting prisons and is promoting the adoption of these guidelines as international standards for prison health care.

In Canada, correctional health care has received less scholarly attention than in the USA and the UK. At both the federal and provincial levels, programs of research and research initiatives regarding correctional nursing are sparse. As noted earlier, there is a need to

specifically describe and understand the experiences of Canadian correctional nurses. Hence, there is a need for a descriptive phenomenological study such as this one. Describing and understanding the Canadian experience of correctional nursing will help to establish priority areas of research. Improving our understanding of correctional nursing care in Ontario, may contribute to improving both inmate health and the correctional healthcare system.

CHAPTER 3.0 – METHODOLOGY AND PROCEDURES

INTRODUCTION

This chapter is divided into seven sections and will discuss the method and procedures that were used to study the lived experiences of correctional nurses working in two Ontario detention centres. The first section, 3.1 descriptive phenomenological design, addresses the research design of the study, describes the philosophical underpinnings and phenomenological approach to determining the essences and structures of the phenomena being studied. In the second section 3.2 – the theoretical underpinning of this study is presented. In the third section (3.3) the selection of participants is discussed including sections to address: sampling strategy (3.3.1); participant recruitment process (3.3.2) including inclusion criteria and the challenges of recruitment; and a description of the study sample of participants (3.3.3); and the process of obtaining informed consent (3.3.4). The fourth section, 3.4 - ethical considerations addresses: the ethical principles of autonomy (3.4.1); confidentiality (3.4.2); and risks and benefits (3.4.3) and were included to demonstrate the integrity of this study. The fifth section, 3.5 - data collection, describes the process that was used in the interviewing of the participants (3.5.1). The sixth section, 3.6 - data analysis, describes how the data was analyzed using the phenomenological psychological method. This chapter concludes with section 3.7 - maintaining study rigor, and addresses how this research process demonstrates rigor (3.7.1), credibility (3.7.2), dependability (3.7.3), transferability (3.7.4) and confirmability (3.7.5).

3.1 Descriptive Phenomenological Design

"Phenomenology is a science whose purpose is to describe particular phenomena, or the appearance of things, as lived experience" (Speziale & Carpenter, 2007, p.76). It is a tradition of qualitative inquiry that aims to examine individuals' perceptions of their lived experiences of

everyday life (Knaack, 1984). Phenomenological inquiry is a research methodology that is in keeping with the development of nursing knowledge since it enables the nurse researcher to examine participants' experiences of health and illness (Lopez & Wills, 2004). Phenomenology is both a philosophy and a research method (Cohen, Kahn, & Steeves, 2000; Lopez & Wills, 2004; Speziale & Carpenter, 2007). Phenomenological studies can be descriptive or interpretive. Interpretive phenomenology, also referred to as hermeneutic phenomenology, aims to interpret the meaning of a phenomenon as described by participants (Polit, Beck and Hungler, 2001). Descriptive phenomenology aims to describe the essential structures of a phenomenon in scientific language, as expressed in the concrete language of participants (Giorgi, 1997). Since I was interested in uncovering the essential structures of the lived experiences of correctional nurses working in Ontario detention centres I selected to engage in descriptive phenomenology.

Descriptive phenomenology is rooted in the philosophy of Edmund Husserl and is often used when a phenomenon, such as the lived experiences of Canadian correctional nurses, is poorly conceptualized in previous research and this research aims to uncover the essence of the phenomenon. Giorgi (1997) stated that at the very least conducting this type of analysis requires an understanding of the following concepts:

1. Consciousness refers to the awareness of the system, "embodied-self-world-others," all of which (and aspects and parts of which) are intuitable, that is, presentable; and precisely as they are presented, without addition or deletion, that is the strict meaning of phenomenon.
2. Phenomenon within phenomenology always means that whatever is given, or present itself, is understood precisely as it presents itself to the consciousness of the person entertaining the awareness.
3. Intentionality means that an act of consciousness is always directed to an object that: transcends it (paragraph 9).

Descriptive phenomenology is "the direct investigation and description of phenomena as consciously experienced, without theories about their causal explanation and as free as possible

from unexamined preconceptions and presuppositions" (Spiegelberg, 1975, p. 3). The central concepts of descriptive phenomenology are: 1) phenomenological reduction; 2) description and intuiting; and 3) a search for essences (Giorgi, 1997). These concepts will be discussed as they applied to this study.

Phenomenological reduction means “recovery of original awareness” (Speziale & Carpenter, 2007, p. 459). Phenomenological reduction as formulated by Husserl was intended to help make research findings more precise (Girogi, 1997). Engaging in this process required that I fulfilled two conditions: 1) I bracketed or held in abeyance any preconceptions or previous knowledge that I had relating to lived experiences of correctional nursing in order to encounter the data provided in a fresh manner; and 2) I considered the descriptions and data as it is presented and precisely as it was given (Giorgi, 1997). Prior to collecting data, I reflected on my experiences of correctional nursing and recorded my knowledge and preconceptions of correctional nursing in a journal. Being a correctional nurse myself, and engaging in research involving colleagues, I felt that engaging in bracketing of my preconceptions and holding them in abeyance facilitated my ability to encounter the data collected in the manner they were presented. Bracketing did not negate my preconceptions nor did it serve to sever them from my being. As a qualitative researcher, I am an investigational instrument so my thoughts and interpretations are recognized as both unavoidable and valued.

Bracketing brought to consciousness, as much as possible, those preconceptions, which might have otherwise influenced this study on a subconscious level. I engaged in this process, by keeping a written record of all that I found necessary to bracket. This included bracketing my personal thoughts and feelings, before the study began, before every interview, and throughout all phases of the study. While engaging in data collection and analysis I continued to document

my personal reflections. A chart was created to aid with the documentation of my thoughts when encountering data that was new, different, or familiar. The chart included the original transcript, identification of meaning units and personal reflections. For example, one participant described that the presence of racism within corrections discriminated against and disadvantaged non-white inmates. This description of correctional nursing was different from my own and I documented my personal thoughts about this description. This process of phenomenological reduction was shared with my thesis supervisors.

Within the tradition of descriptive phenomenology, the concept of description can be defined as "the use of language to articulate the intentional objects of consciousness within the constraints of intuitive evidence" (Giorgi, 1997, paragraph 16). As the researcher I use linguistic expressions to communicate or describe the objects of consciousness, which in this case are the lived experiences of correctional nurses. I described these experiences as precisely as they were presented to me– this is also referred to as eidetic intuiting. Eidetic intuiting is a particular way of thinking about things with the goal of gaining insight, or grasping the form or true meaning of these things. A process of thinking through the data in order to uncover the structure of, or an accurate interpretation of what is meant in a particular description (Giorgi 1997; Speziale & Carpenter, 2007; Sokolowski, 2000).

Description speaks to the idea that the phenomenon is described as opposed to explained or constructed (Giorgi, 1997). Keeping in mind the alternative ways of representing phenomena, I strived to describe the phenomenon as it was presented. For example, in relation to describing what it is like working in a correctional environment Participant 3 states "it's frustrating sometimes, but I think in general – I think the big thing for me is don't get defeated by the system and don't just shrug my shoulders". Delving into the physiological aspects of frustration

may be one attempt to explain this statement. Similarly, a constructive representation of this statement could include suppositions of the characteristics of the system or reasons why "it's frustrating". Contrastingly, a descriptive approach limits the description of the participant's experience to what is given and within the rich data given, an intrinsic account would be provided (Giorgi).

The concept of searching for essence is important to phenomenological studies because essences constitute study findings. An essence is the basic unit of a common understanding or the most invariant meaning of a context without which the phenomenon cannot adequately be described (Giorgi 1997; Speziale & Carpenter, 2007). Some of the difficulties with the term essence may be the Platonic connotation, which refers to essences as a 'universal', or a standard against which all instances are measured or compared. In descriptive phenomenology, a researcher is interested in discovering meanings of phenomena from lived experiences rather than from universal principles. Therefore, essence is taken to mean the most essential meaning for a particular context (Giorgi 1997; 2003 as cited in Kleiman, 2004, pp. 9-10). The search for essences involves what Husserl referred to as engaging in free imaginative variation. That is, as the researcher I engaged in a process whereby I varied, changed or multiplied different aspects of the lived experiences of correctional nurses or parts thereof in order to ascertain the structures or essences of phenomenon as given to me.

3.2 Theoretical Underpinnings of the Study

This study was framed within a critical social context. Critical social theorists purport that knowledge as truths is derived both empirically and interpretively. That is, truths or facts are not only elucidated by testing the validity of propositions; but are also derived through our

observations and sensory impressions (Calhoun, 1995). As such, there is value and importance to investigating and describing the lived experiences of correctional nurses.

Critical social theory (CST) is a collection of critical theories which assumes that mainstream ideologies and normative behaviours are potentially oppressive and coercive (Duchscher, 2000). It provides a framework for asking different and new questions regarding the status quo and the bedded social norms, traditions, values, habits and rules within a social setting (Calhoun, 1995; Whitfield, 2008). Additionally, CST seeks to expose oppressive relationships and to give voice to groups that may be smaller in number, underprivileged, marginalized or oppressed (Kuokkanen & Leino-Kilpi, 2000; Speziale & Carpenter, 2007).

The purpose of this study was to describe the essential structures of the lived experiences of correctional nurses. As mentioned previously in section 3.1, the guiding principles and assumptions of descriptive phenomenology as attributed to Husserl and as described by Giorgi provided the theoretical underpinnings for the formation of the study question and the method in which the data collected were analyzed and study findings elucidated. A critical social framework allowed me to think critically about the role of nurses in corrections and facilitated my critique of routine processes and common place attitudes in corrections that serve to perpetuate the difficulties participants described when caring for inmate clients. In addition, it allowed me to critically reflect on, and elucidate the historical paramilitary and medical model values that remain embedded within the correctional system, but are at odds with the reality of study participants. In their discussion of oppressed groups and empowerment, Kuokkanen and Leino-Kilpi, identified both nurses and clients as belonging to oppressed groups. As there has been minimal research conducted in Canada regarding correctional nursing, conducting this

descriptive phenomenological study with the findings framed within critical social theory provided an opportunity for a small number of correctional nurses to have their voices heard.

3.3 Selection of Participants

3.3.1 Sampling strategy.

Purposeful sampling was used in this research study, as it was necessary to obtain information-rich data to describe the nature of correctional nursing in a Canadian detention centre, which only such correctional nurses could provide (Creswell 1998; Denzin, & Lincoln 2000; Speziale & Carpenter, 2007). Correctional nurses were sampled from two Ontario Detention Centres. Prior to recruiting any research participants, ethics approval to conduct this research was obtained from Ryerson University Research Ethics Board (Appendix C). Approval was then sought and granted from the Ministry of Community Safety and Correctional Services Research Ethics Board. A detailed discussion of the process that was used to obtain informed consent and other ethical considerations observed during this study follows later in this chapter.

3.3.2 Participant recruitment process.

After receiving ethical approval to conduct this study, potential study participants were recruited from two Ontario detention centres. All documents, including introduction and information letters, advertisements, and consent forms were submitted to the research ethics boards and received approval prior to recruiting participants. To begin recruiting study participants, a descriptive letter outlining the purpose of the study, the sampling criteria, and my contact information (Appendix D) was sent to the superintendents of each of the detention centres in order to obtain permission to contact potential study participants. Secondly, the Health Care Coordinators (HCC) were then contacted in order to arrange a meeting with the staff nurses during one of their monthly staff meetings. At the meeting, I presented the details of the

proposed study and spoke about informed consent and that participation was voluntary. I left behind a few flyers with a description of the study and with my contact information for those nurses who may have been interested in participating in this study (Appendix E). After that, potential participants contacted me, usually by telephone, at which time I explained the purpose of the study, inclusion criteria and informed consent. An initial meeting was then set up to provide the participant with a letter of explanation outlining the purpose of the study and answer any questions they may have had. At the end of the first meeting, a second meeting was arranged for the purposes of: 1) obtaining written informed consents from the willing participant for both participating in the study and for audio-recording of the scheduled interview (Appendix F and Appendix G); and 2) setting up a future appointment with the participant to conduct the estimated 1-2 hour long interview. Finally, the interview was scheduled at a time and place that was convenient and private for the participants.

3.3.2.1 Inclusion criteria.

As mentioned, the participants had to meet three inclusion criteria. First, participants had to speak English. Secondly, they had to be a staff nurse currently employed with the Ministry of Community Safety and Correctional Services and working in one of the two detention centres. The detention centre setting was the context of the lived experiences this research aimed to describe. Third, the participants had to be employed as a correctional nurse for a minimum of two years, this was to increase the likelihood of collecting information-rich data.

3.3.2.2 Challenges in recruiting research participants.

The process of recruiting participants was slow and difficult. Most nurses preferred to be interviewed at their place of work, which was not ethically permissible. Other difficulties in recruiting participants stemmed from the fact that correctional nurses were often working long

hours, many consecutive shifts and overtime shifts, and on their days off had other commitments that they had to fulfill before returning to work again. In addition, recruitment for this study commenced in the summer months – a time when many correctional nurses were away on vacation and the remaining nurses were working extra shifts. This was also a stressful time for the nurses given the environment within one site.

3.3.3 Sample description.

In total, eleven nurses expressed interest in participating in this study. Seven nurses were able to participate in the study. All satisfied the inclusion criteria. Recruitment and interviewing of participants ceased, when the new data provided were consistent and did not vary from data that were provided in the previous interviews. Of the seven participants, five were female nurses and two were male nurses. Five nurses were born outside of Canada; six nurses had lived abroad; and all of the nurses had lived in Canada for more than 20 years. Participants ranged in age from 40's to early 60's. Two nurses were married, one nurse was single and four nurses were divorced or separated.

3.3.4 Obtaining informed consent.

Central to preserving the participants' autonomy within the field of healthcare research, is the obtaining of informed consent (Beauchamp & Childress, 2001). I obtained informed consent from each of the participants for this study by:

1) explaining the purpose of this research study to the participants both verbally and with a written letter indicating the purpose of this study.
2) ensuring all questions participants have regarding the study were answered to the best of my ability.

3) assuring the participants that they may withdraw from the study at anytime without having to defend or explain their decision, even after signing the consent form.
4) ensuring that each participant signing the consent form was alert and orientated.
5) obtaining informed consent from each participant both verbally and in writing.

Additionally, given the evolving nature of the questions and answers in a qualitative study it was important for me to be aware of and deal with unforeseen ethical issues that might have arisen. Though this did not occur, if it had became necessary, I was also prepared to obtain process consent - renegotiating consent with the participants should any unanticipated events or consequences have arisen (Munhall, 2007). Consent for audio recording of the interviews was explained as providing a separate consent from consenting to participate in the interview and participants had the option to participate in the interview without having the interview audio recorded. In such a case, a detailed set of notes would be taken during the interview and used as the data set to be analyzed.

3.4 Ethical Considerations

Obtaining informed consent was one aspect of maintaining high ethical standards during this study. This section will highlight and discuss two other ethical considerations as they pertain to this study: confidentiality, and risks and benefits. Maintaining these principles was critical to conducting research that was ethically sound.

3.4.1 Confidentiality.

Protecting and maintaining confidentiality of personal information gathered throughout the research process including the reporting of research results is most important (Speziale & Carpenter, 2007). The confidentiality of participants' identity and information were assured in the following steps: 1) participants were interviewed in settings that offered privacy and

confidentiality – participants determined the location of their interview to ensure they felt safe and comfortable; 2) they maintained the right to refuse to answer any questions throughout the interview process; 3) all data was coded and the names of the detention centres have not been mentioned; 4) all data including audio tape recordings and fieldnotes, were transported: a) in a locked container, to prevent accidental spillage of container contents; and b) directly – non-stop from place of interview to place of data storage to safeguard against vehicular theft; and were then stored in a secure place at destination; and finally 5) quotations and data used when reporting research findings do not contain any personal identifying data.

3.4.2 Risks and benefits.

As the researcher, I endeavoured to ask the questions with sensitivity and respect for the participants both as a professional and a person. I allowed the participants to direct the depth of the narrative offered according to his/her comfort level. The participants were reassured that they may choose to not answer the questions asked at any point in the interview(s) and that doing so, either by remaining silent or terminating the interview, was their decision and would be respected. Should any of the participants have become visibility upset, he/ she would have been directed to the appropriate employee assistance program services. I reaffirmed to the participants that all sessions would be kept confidential and I remained respectful of all information shared with the participants.

As identified in the literature review there is a need in nursing and in corrections to gain a greater understanding of the experiences of nurses working in the field of corrections. This knowledge and understanding is valuable to advancing the nursing profession of nursing in correctional institutions as well as advancing the provision of healthcare to and promoting

wellness in incarcerated populations. The experiences of correctional nurses can be used to guide the development of healthy and effective organizational policies, procedures and practices.

3.5 Data Collection

In keeping with the philosophy, values and principles of phenomenological qualitative research (Speziale & Carpenter, 2007), data collection and data analysis were iterative processes. As such, even though the two sections have been separated for reporting purposes, the process was by no means linear but cyclical in nature. Data collection and analysis were conducted for each interview individually and as part of the larger data group.

3.5.1 Interviews.

The overarching question that guided this study that was posed to each participant at the beginning of the interview was: "Tell me about your experience of correctional nursing in the context of a detention centre?" This question met the criteria of being very broad, open ended, non- directional and evolving, necessary to guide phenomenological inquiry (Creswell, 1998). Sub-questions and probes were developed and used to allow participants to thoroughly and comprehensively describe their lived experiences. The interview guide that was used is located in Appendix H. Research participants were asked to talk about their experiences of correctional nursing in the context of a detention centre. Subsequent questions and probes were posited once the participants indicated they would like further direction for describing their experiences. A total of seven open, semi-structured interviews were conducted. Data collection consisted of four face to face interviews and three telephone interviews. The interviews ranged in length from 45 minutes to two hours. Secondary interviews, for the purpose of clarification, were not necessary. Interviews were conducted over a span of four months.

At the beginning of each interview, I provided each participant with a copy of the introduction letter and an additional copy of his/ her signed consent. In the cases of telephone interviews I read these documents to the participant. I again reminded the participant of his/ her right to stop and end the interview at any time for any reason or without any stated reason. Again the participant was reminded that consent for the audio recording was a separate issue and that the participant could choose not to have the interview audio-recorded and still participate in the interview. At the conclusion of every meeting, I provided the participant with details of a possible subsequent meeting, which again was voluntary. With the consent of all participants, all interviews were audio-recorded and transcribed verbatim. In order to gain a sense of the data as a whole I was involved in transcribing, verbatim all the interviews.

3.6 Data Analysis

Analysis of the data was completed using the phenomenological psychological method as described by Giorgi (1985; 1997) and Speziale and Carpenter (2007) and congruent with Husserlian Phenomenology. As per Giorgi (1997), this type of analysis has been delineated and includes the following components in sequential order: 1) read the entire description of the phenomenon in order to get a general sense of the whole statement; 2) reread the description to identify meaning units; 3a) clarify and elaborate the meaning by relating units to each other and the whole; 3b) reflect on the meaning units in the language of the participant; 4a) transform all meaning units into the concepts and language of science; and 4b) synthesize all transformed meaning units into a statement reflective of the participant's experience – often regarded as expressing the structure of the phenomenon (Giorgi, 1985; Speziale & Carpenter, 2007). Meaning units are defined as "spontaneously perceived discriminations within the subject's description arrived at when the researcher assumes a psychological attitude towards the concrete

description, and along with it, the set that the text is an example of the phenomenon" (Giorgi, 1985, p. 11). In other words, those ideas and notions that spontaneously appear to be of importance to the researcher while engaging in data analysis are characterized as meaning units. These meaning units help to concretely describe the phenomenon and the text related to the meaning unit provides an example of the phenomenon. Commonly, the theme of a unit can be identified or differentiated in a single sentence (Wertz, 1985).

As mentioned in section 3.1 of this chapter (page 24) before beginning data analysis I engaged in the process of phenomenological reduction - holding in abeyance my previously bracketed preconceptions regarding the lived experiences of correctional nurses. Then, with an open mind and a consciousness of receiving the phenomenon as it was given to me, I first read the entire description of the phenomenon contained in the verbatim transcript of interview one, and each subsequent interview, in order to immerse myself in the data and to develop a general sense of the whole statement. I repeated this step until I developed a general sense of the data. Secondly, I reread the text with the intent of discriminating meaning units and focusing on the phenomenon under investigation in the words of the participant. Next, I analyzed each meaning unit individually and in relation to the whole, then using the language and concepts of science, expressed the insights contained within each meaning unit describing the phenomenon being investigated. The following is an example of a meaning unit from an interview:

> …by then I had sort of learned an awful lot. I was given the best mentor of all – I did have Nurse A as my mentor – I think nurse A is very gifted in mentoring. And because she's had so much experience I've learned so much from her and I have such a respect and I just thank God for her because the mentoring was excruciatingly important… (Participant 3).

This meaning unit was first transformed to reflect the following: Participant 3 - described learning a lot about correctional nursing over time; described the mentor as "gifted"; expressed

gratitude for experiencing mentoring; and described mentoring as excruciatingly important. Another transformation reflected the following: Mentorship for nurses new to corrections is an important way of orientating and educating nurses to correctional nursing; the skill of the mentor to impart information to the mentee is important to the mentee's learning; and the participant experiences feelings of gratitude and respect when successfully mentored to the role of correctional nursing. A later transformation included: mentoring is a necessary part of the positive and successful orientation of a new nurse to the role of correctional nursing.

During the final stage of analysis and in the search for essences, I synthesized the transformed meaning units into a consistent statement reflecting many descriptions. This synthesis is expressed as the structure of the phenomenon. After analysing the combined transformed meaning units from all the interviews, I selected those components that were essential in the descriptions of the life-world experiences provided by each participant. For example, one of the essential structures of the lived experiences of correctional nurses, in relation to the example above, is expressed in the following structural statement:

Essential Structure 3
This study found that nurses identified three factors that facilitated their decision to remain in correctional nursing. These included: having a good mentor; supportive nursing colleagues; and with the passage of time, resolving to do the best they can within a correctional context.

The above statement is an essence of the lived experiences of correctional nurses. It is of the most basic of structures and is expressed linguistically in the language of nursing science precisely as it was presented. This structure is necessary to describing the lived experiences of correctional nurses and without it the description would be incomplete.

In addition, as data collection and data analysis were iterative processes, as the researcher, I had the flexibility to explore new aspects of the phenomena that came to light in subsequent interviews. This was accomplished by using open-ended question probes aimed at describing this new data in following interviews. These questions have been included in the interview guide. Data collection and analysis ceased with the seventh interview. It was evident that the meaning units and the transformed meaning units had revealed several structures of the phenomena with enough data to support the various presences of the structures within the phenomena being studied.

3.7 Maintaining Study Rigor

3.7.1 Rigor.

Throughout this research process "checks and balances" were incorporated to achieve and maintain rigor. The trustworthiness of this study was maintained through the establishment of an audit trail (Creswell, 1998). An audit trail is the documentation of how decisions and conclusions were arrived at, most often during data analysis. This measure allows an outside person to read the documentation to see how connections and decisions were made in interpreting the data (Speziale & Carpenter, 2007).

Maintaining rigor or demonstrating trustworthiness throughout this qualitative inquiry is paramount to the overall merits and findings of the study. While there are many ways to address rigor in qualitative studies, here attention to rigor, is addressed under the following categories: 1) credibility; 2) dependability; 3) transferability; and 4) conformability (Lincon & Guba, 1985).

3.7.2 Credibility.

Credibility refers to the authenticity and accuracy of the descriptions of the phenomenon being investigated. As a measure of integrity and rigor, I took several measures to reduce the

likelihood of obtaining only socially acceptable responses. One such measure was to obtain data from multiple informants. Another measure was to engage in a collaborative research process verifying the data collection procedures; data transcription; analysis process; and coding and development of meaning units and themes by my supervisor for accuracy and consistency (Miles & Huberman, 1994; Rolfe, 2006; Speziale & Carpenter, 2007).

Further, the credibility of the data was safeguarded by reviewing the transcriptions of audio recordings of interviews for accuracy, and by returning to participants to ask subsequent questions about data that had been previously collected to ensure detail, clarity and accuracy of the data. I engaged in bracketing throughout data collection and analysis to identify researcher bias.

3.7.3 Dependability.

Dependability in qualitative inquiries is usually a criterion met once credibility has been established. The dependability of the data collected and analyzed was established by maintaining an "audit trail". The audit trail consists of the transcripts of the audio tape recordings, fieldnotes, identification of meaning units and themes (Miles & Huberman, 1994; Speziale & Carpenter, 2007). My thesis supervisors reviewed this for accuracy and appropriateness.

3.7.4 Transferability.

Transferability refers to the ability of the research findings to be applied to or transferred to other settings, situations and/ or groups. Transferring study findings rests with the judgement of the research consumer and his/ her perceived usefulness or relevance. The results of this research are "context-bound" in that it is limited to these correctional nurses interviewed herein. Transferability of these findings are limited to a similar context (Lincoln & Guba, 1985).

Making judgements of the appropriateness and level of transferability of findings may be assisted by reviewing the detailing of the data collection and analysis throughout the study (Miles & Huberman, 1994) and situating the findings within current bodies of literature.

3.7.5 Confirmability.

Confirmability refers to how the findings of the research are supported or refuted in the literature (Creswell, 1998). A review of the literature found that many of the experiences of Canadian correctional nurses, such as correctional nurses being the primary healthcare providers; difficulty in negotiating the correctional environment and the physical environment negatively affecting the mental health of correctional staff, were similar to other findings of correctional nursing. Chapter 5 – Discussion, offers an overview of how this study's findings relate to the literature.

CHAPTER 4.0 – FINDINGS

INTRODUCTION

The purpose of the study was to describe the phenomenon of the lived experiences of correctional nurses working in two Ontario detention centres. This chapter presents the findings of this study. In keeping with the data analysis process as described by Giorgi (1985; 1997) the data was analysed for meaning units. The meaning units were then clarified and elaborated on by relating the units to each other and the data as a whole. The meaning of each unit was then reflected upon in the language of the participants and then transformed into the concepts and language of science. These statements were then synthesized into statements reflective of the participants' experiences. Fourteen of these reflective statements, known as the *essential structures* of the phenomenon, emerged during the data analysis process. These essential structures describe various aspects of the lived experiences of correctional nurses. Together, these structures are necessary for describing the lived experiences of the participants.

In order to present the findings clearly, each essential structure has been placed within a text box and assigned a reference number. Placing the essential structure within a text box was done in order to distinguish the text of the essential structure from other explanatory texts. In order to identify one essential structure from another, each essential structure was assigned a number from 1 to 14. The numbers do not reflect any rank order of the essential structures and do not indicate any importance of one essential structure over another. The numbering of the essential structures is reflective only of the order in which they appear in the chapter. Additionally, to present a logical description of the essences of the lived experiences of the correctional nurses in this study, the essential structures have been placed into four sections.

This chapter consists of four sections. Section 4.1 describes nurses' initial experiences of discovering correctional nursing and presents essential structures 1-3. Section 4.2 describes nurses' experiences of their physical workspaces and presents essential structure 4. Section 4.3 presents essential structures 5-9 and describes essences of the working relationships correctional nurses have with both, correctional officers (subsection 4.3.1) and with management (subsection 4.3.2). Section 4.4 describes essences related to caring for inmate clients and presents the remaining essential structures 10-14. A complete list of essential structures is provided in Appendix I. The study findings will be discussed in the following chapter 5.0.

4.1 Discovering Correctional Nursing

This study found that all participants, to varying degrees, described a process of discovering correctional nursing while working as a nurse. This process involved moving from being unaware of the existence of correctional nursing to being introduced to it; to being oriented and mentored into the role of correctional nursing in a detention centre; and then overcoming initial apprehensions and resolving to remain in correctional nursing. The essential structures that emerged in relation to this process are discussed in this section. Essential structure 1 is presented in the text box below and supporting evidence and explanations follow thereafter.

Essential Structure 1
This study found that nurses were unaware of correctional nursing, and passively gained awareness by being introduced to it via a peer or at his/her place of employment.

This study found that nursing in a correctional facility, caring for inmate clients and becoming a correctional nurse were not part of the original aspirations and goals of any of the study participants. For example, one nurse stated, "I guess when I think about it—I guess what I marvel at is how in all…the dreams of nursing as a student or whatever I certainly never

dreamed of working in corrections" (Participant 3). Participants were not introduced to correctional nursing while attending nursing school. All participants had prior nursing experiences and discovered correctional nursing either through previous work experiences or were recruited by their peers who were correctional nurses themselves. In four cases, participants learned about correctional nursing while being employed at another facility and three were personally recruited by correctional nurses themselves. One participant recalls, "…my very good friend kept saying 'come and work with us'… And to this day I, I do not regret it, I, I will always be grateful to my friend" (Participant 2). Many participants made similar statements that reflected similar experiences of not being aware of the possibility of correctional nursing and through a particular event gained awareness of the opportunity of nursing in corrections.

A second study finding, related to the discovery of correctional nursing is explained below.

Essential Structure 2
This study found that participants' initial experiences of negotiating the security aspects of correctional nursing fostered feelings of frustration and disappointment, and of not wanting to remain in corrections.

After nurses accepted the job-offer to work in a detention centre, they experienced a period of adjustment. All participants described correctional nursing as being a very different nursing experience than what they had previously experienced. Three participants indicated that they initially did not want to continue working in the correctional setting. As participants discovered their work environment, including the limitations imposed by security on nursing and the resulting difficulties of caring for their clients, they considered the possibility of not

continuing with correctional nursing. They experienced feelings of frustration and disappointment as they discovered or experienced that nursing and healthcare are "just" secondary goals with corrections. In the following excerpt, Participant 1 expressed feeling frustrated and disappointed with the correctional system when security is perceived as the primary goal:

> Correctional nursing is really different in the sense that …you are in a correctional facility and the first priority is security not health - health is *just* secondary in the facility. So, you always have to think security first. You always have to check with security whether you can do what you need to do and even things that you know that are necessary to happen to a client or take place you must check with security if security allows that first. So, it's … annoying in a sense because then the correctional person - like people working with you too they really don't understand the role of a nurse and what the capacity or the responsibility - they don't quite understand it. They just feel they are your boss because you are just under their umbrella there, and it's a tug of war all the time – to save a life and to balance it with safety. It's always not that easy but with experience more experience you get to know what to do, your limits, and …what you have to do. But at the beginning it's a real struggle that is very, that is very disappointing at times. But you get to know what to do with time (Participant 1).

Another participant stated, "there [in the institution] security comes first"; though this participant "appreciates" that correctional officers "safeguard [them] from the inmates", the participant still found it "stressful" and "difficult to provide the care that you want to" (Participant 6) within such a context. The experience of nursing and healthcare as being secondary goals within the institution lead to feelings of frustration and disappointment and was essential to describing the initial experiences of correctional nurses.

A third essential structure elucidated from data analysis and identified below also relates to the theme of discovering correctional nursing.

Essential Structure 3
This study found that nurses identified three factors that facilitated their decision to remain in correctional nursing. These included having a good mentor; supportive nursing colleagues; and with the passage of time, resolving to do the best they can within a correctional context.

The initial experience of participants practicing within the correctional context was described as a "very different" experience. Participants identified three factors that were key to overcoming their initial apprehension of remaining in correctional nursing. These factors included having a good mentor, supportive nursing colleagues, and the passage of time. Three participants found that mentorship in orientation was a very important part of being socialized to the role of correctional nursing and to the work environment. They also expressed that it was important that there was a good fit between the mentor and new nurse. For example, one participant stated, "I was given the best mentor of all… because she's had so much experience I've learned so much from her… the mentoring was excruciatingly important..." (Participant 3). Another participant, in the quote below, describes the benefits of being paired with a nurse who is skilled at orientating or mentoring nurses to their new role:

> I wanted that individual to train me to the desk because she certainly had things under control at all times. And she imparted information very quickly and um without saying it 14 times. That was good being oriented by that particular nurse I picked up more from her than the other nurse so I mean, there's not enough thought put into who's training who because some of them are not good educators (Participant 6).

Regarding the second factor of collegial support, four participants described support from their colleagues and teamwork as an important factor in their decision to

remain in corrections. One participant described colleague support and working as a team as necessary to working within a very restricted environment.

Lastly, five participants' descriptions indicated that with "time" they become more "familiar" and more "comfortable" practicing nursing within the correctional system. The following quote provides an example of this: "at first I didn't think I would like to stay there, but gradually as the time go by I, I really got to like it" (Participant 2). Four participants descriptions' of their various experiences indicated a recognition that although nursing practice required changes, they were resolved to "do the best they can" within the context they worked. The quotation below provides an example of such resolve, whereby one participant is determined to "let go" because there is not "a whole lot" the participant can do to change things:

> You know- if something happens and I have a concern – it's my responsibility to try and deal with it as best to whatever has happened and try to put it as objectively as I can in my charting etcetera. And then let go because I can't do a whole lot to change things (Participant 3).

For two participants resolving to do the best they can within the detention setting was related to their aspirations of a new administration that would facilitate change. For example, in the following quote, one participant described aspirations of change made possible by new administration:

> I like where I work, I like the people I work with, and I see potential for growth and good things to happen, maybe it will with this new [administration] because that's where it has to happen. It has to come from the top, it can't come from down below. We won't get the changes made, we need someone at the top agree to have the changes made (Participant 6).

Earlier in the interview, this participant had described strong feelings of distress and illness during the initial period of working at the detention centre. However, over time

this participant came to like working at the detention centre and wass hopeful that change would occur.

In summary, the findings presented reflect the participants' first experiences of correctional nursing. The three essential structures presented described participants' experiences of journeying from being unaware of the possibility of correctional nursing to being employed as a correctional nurse. The essential structures described how participants' experienced a process of discovering what it was like working in a detention centre which included working in a context where the perceived primary goal is security and nursing and health care goals are "just secondary". While adjusting to this new and "very different" type of nursing, the participants stated that they were able to overcome their initial apprehensions with the support of a good mentor, supportive colleagues and resolving in time to do the best they could given the context of their work. For a couple of participants, doing the best they could was coupled with their aspirations for change. The hope for change was placed on the new administration of the institutions. These participants described that in the correctional setting, change for nurses and nursing was only possible with the support and leadership of the institutional administration. Thus, the participants hoped that the new administration would support their aspirations for change.

In the following section 4.2, the findings related to working in the physical environment of a correctional facility will be presented.

4.2 Correctional Nurses' Workspaces

In this study, participants described many experiences related to their physical workspaces. These workspaces are referred to herein as the healthcare unit. One essential structure was elucidated from the data and is presented below.

Essential Structure 4
This study found that the physical work environment affected participants' emotions. A poorly organized and unkempt environment evoked feelings of confinement, depression, and diminished professional value.

The findings indicate that the confining spaces nurses found themselves working in evoked strong emotional descriptions from participants. Participants expressed emotions of confinement, depression, and diminished professional value. Three participants described feelings of confinement related to their work environment. For example, participant 5 stated, "Number one it's [the healthcare unit] too clustered—closed up, you don't get air", thus indicating a sense of confinement that is related to the cluttered and closed nature of the workspace within which, even air flow is restricted.

Participants also described their working environment as "depressing". In the following quote, one participant describes the physical workspace with strong emotions:

> The physical aspects of it [the healthcare unit] are really the most depressing single place to walk into. The first time I walked into it I thought I would die. I thought 'oh God it's so depressing. It's not even kept up nicely' (Participant 3).

This participant also describe how the confining space of the unit affects work productivity stating "it's taking everyone's resources right now to make it [the healthcare unit] function at a very basic level".

The unkempt nature of the physical working environment fostered feelings of diminished professional worth. That is, the disarray and lack of attention paid to the physical upkeep of the healthcare units by institutional administration was perceived by participants as diminishing their professional worth by the institutional administrators. For example, participants drew parallels between the valuing of managers and the maintenance of managers' offices with that of nurses and nurses' workspace. Participants perceived that nursing managers, as well as institutional administrators, were more valued than nurses were and as such were provided with well-kept working environments; unlike nurses who were less valued and as such worked in a physically disordered environment. The following quote provides an example of the sense of diminished professional worth that the participants described:

> We are like an after-thought…the nursing station is what we've got, and it looks like its been furnished from Goodwill and that's atrocious…that we don't rate, having walls that are painted. We don't rate having nice tables, desks whatever, chairs that match, pictures on the wall. You go down to any management room, and they're all nice and cozy, rugs on the floor, etcetera, etcetera. But healthcare has been put together- piecemeal … where we work could be changed to make it more pleasant and that makes it more pleasant to work, and that helps your mood and how you start the day off (Participant 6).

Additionally, as mentioned in the above quote, participants commented that a better-designed and outfitted workspace would likely improve the mood of nurses. In the following quote, one participant also describes that up keeping the physical environment was a way of addressing the negative emotions nurses expressed in relation to their work environment:

> The institutions should be cleaner. That's one. It should be very safe to do dressings, you know we have a lot of those MRSA, we have a lot of cellulitis cases…It takes many years, a lot of whining, a lot of probably aggravation for that to change, where we were, we had a small desk, it's so hard to work…there's a lot of files, there's a lot of movements[traffic in and out of the unit]…[there is a] little bit of changes…at least to comfort us a little (Participant 7).

This participant described the unit not only as difficult to work in but that it was also not sanitized appropriately, thus decreasing client safety and increasing the risk of spreading infections among clients and staff. Additionally, this participant described the "whining" or "continuous complaining" on the part of nurses, was one of the behaviours that nurses engaged in over many years resulting in only minimal changes. This participant stated that some changes to the physical aspect of the unit had occurred and that it had eased some of the difficulties of working within the unit.

There were accounts from many participants who described the difficulties of working within the physical confines of the healthcare units. The strong emotional responses about the physical workspaces as portrayed above are essential to describing the lived experiences of nurses working in detention centres.

4.3 Working Relationships

This study found that two working relationships greatly influenced the lived experiences of correctional nurses. This section is divided into two subsections. Subsection 4.3.1, will describe essential structures 5 and 6 related to the correctional nurse-correctional officer (CN-CO) relationship. The second subsection, section 4.3.2 presents the essential structures 7 and 8 which relate to the working relationship between correctional nurses and management (both their direct manager and other middle and upper management).

4.3.1 The correctional nurse (CN) –correctional officer (CO) working relationship.

This study found that a lot of time and energy was utilized by correctional nurses to negotiate and collaborate with correctional officers. Two key findings arose: first, that when there was good communication between the participants and the correctional officers the CN-CO relationship was experienced positively; and the second finding indicated that poor

communication and other systemic issues fostered aspects of a counter-productive CN-CO working relationship, and was experienced negatively by study participants. These findings are expressed below in essential structures 5 and 6 respectively.

Essential Structure 5
This study found that nurses experienced a positive working relationship with correctional officers when a shared understanding or common purpose existed.

Three participants indicated that they had experienced positive working relationships with individual correctional officers on a personal level. A key factor in these experiences was a sharing of a common understanding. One participant described experiencing a positive CN-CO relationship with correctional officers describing them as "polite" and "understanding". These descriptions were used in the context that the correctional officers understood the needs of both the nurse and the inmates and responded positively. In another description, a positive CN-CO relationship was fostered when the participant understood the needs of the correctional officer and was willing to collaborate to make alternative arrangements for delivering care. For example, one participant described a situation where awareness of a "security matter happening" on the unit, aided in the participant's willingness to collaborate with the correctional officer to continue nursing care at a different time, thus accommodating the need for correctional officers to deal with the security issue at hand.

The CN-CO working relationship was not always experienced so positively. Participants also described negative experiences of the CN-CO relationship. These findings are presented below.

Essential Structure 6
This study found that nurses often experienced role and goal ambiguity in their working relationship with correctional officers. This fostered poor communication between the correctional nurses and the correctional officers and resulted in nurses feeling frustrated, impatient and less valued within the correctional nurse-correctional officer working relationship.

Participants often characterized working with correctional officers as challenging. Role ambiguity for both correctional nurses and correctional officers, and minimal recognition of a common goal, were both factors that affected the working relationship of nurses and officers. These factors fostered poor communication between nurses and officers, as well as feelings of frustration, impatience, and of being less valued as described by the nurses.

Beginning with role ambiguity, five participants described that correctional officers did not clearly understand the role of the nurse. Two participants expressed confidence in knowing the role of the correctional officers while two participants indicated that the role of the correctional officers was ambiguous. For example, in the following quote, one participant describes role ambiguity as one of the challenges of the CN-CO working relationship:

> The people we work with…like correctional officers…need to realize that we need more time to speak with the clients in order to understand what their needs are. And… we just need to understand each other. I think we also, on the other hand as nurses, don't fully understand what safety entails on the whole (Participant 1).

Additionally, three participants expressed frustration with correctional officers who were not fulfilling the role of security as perceived by the nurses. For example, in the next quote, one participant felt frustrated and less valued because the correctional officer was not supporting the nurse to complete a nursing assessment and, in fact, was hindering the process:

> Sometimes the officers, not all of them…[think inmates] shouldn't be cared [for]. And in way you are a lousy stupid person to help them [the inmates] because they shouldn't be helped…you are trying to break the ice a little [with the inmate] and the officer is telling you don't worry about it, we [the nurses] should do this and that and they [officers] are not allowing you or making it difficult. As if you were trying to do something illegal or not good, it makes you feel angry, it makes you feel really frustrated, because you know you have to do it, and yet you cannot (Participant 7).

Three nurses attempted to clarify the role of the nurse with correctional officers. For example, in the following quote, one nurse described discussing the nurse's role with correctional officers:

> The perception of the officers, of the nurses, of what we're there to do is –'push the pills and go back to the nursing station'. I personally find that offensive, and I'm trying to educate people over time to what we do and why we do it. And there's no one side that we're on, we are all part of a team that monitors, granted that they maintain the security, but we maintain health (Participant 6).

The findings demonstrate that poor communication and the lack of open communication between correctional nurses and correctional officers were characteristic of the CN-CO working relationship. Four participants described situations where lack of communication fostered feelings of impatience and of being devalued. For example, these feelings are represented in the following quote:

> ...sometimes we get upset at them [correctional officers] because we feel ignored. When we go to the range [inmate living units] to deliver service and they just don't attend to us to help us. We just feel ignored and feel less important yet there might be something that they have to act the way they're acting for safety reasons. But we don't get the explanation why they act the way they act and we

> just harbour anger towards each other because we feel like we're just being ignored (Participant 1).

Analysis of the data indicated that for the most part there was minimal recognition of a common goal between nurses and officers. In fact, three participants described correctional nurses and correctional officers as having opposing goals. One participant characterized the CN-CO relationship as a "tug of war" and another participant offered the following description, indicating that sometimes the CN-CO working relationship is facilitated because nurses find it easier to satisfy the goals of correctional officers before healthcare goals are addressed or satisfied:

> Correctional officers - working with them many times is a challenge. But, you try to make it smooth and try to go sometimes even though you are against it, but sometimes you have to go with their way, because you cannot go against them most of the time (Participant 5).

The above description was a common description among the participants. This supported a common feeling amongst participants that correctional officers perceived nursing goals as less valuable than those of correctional officers and by extension, valued nursing less.

Data analysis also indicated that although participants were aware of the need to address and improve the working relationship between themselves and correctional officers, this awareness has not yet been acted upon in any sort of systematic way. One participant attempted to address the issue of role clarity with the nursing manager in order to have the issue addressed on an institutional level. This participant, as described in the following quote, described suggesting that meetings be held between the nurses and correctional officers in order to facilitate role clarity:

> I have even suggested to my manager…we could have some meeting with correctional officers so that they can just understand…they forget that health is changing all the time… and they don't understand that and they don't want to accommodate anything that pops-up out of the blue (Participant 1).

Two participants indicated that although the goals of correctional nursing and the goals of correctional officers were different, they believed that all goals were achievable. One nurse described struggling to find a framework that allowed the worldviews of both correctional nurses and correctional officers to be considered together. This participant offers the following account of the need for a combined worldview:

> …I'd like to have gone in for officer's training and somehow been an officer and a nurse combined. So at times one could get in and have access to seeing things up-close without having to run into interference every minute… [for example] if someone has a cut or something that they're concerned about—that it could be looked at both as a nurse and an officer and decisions could be made much faster than it can happen in the present set-up (Participant 3).

The awareness amongst participants that the CN-CO working relationship is difficult and needs improving has not seemed to materialize into action, thus far. Participants have not offered any descriptions or evaluations of experiences involving systemic efforts being made to improve the CN-CO working relationship.

In summary, these study findings revealed that when there is understanding between the nurses and the officers, it is possible to experience a positive CN-CO working relationship. Thus, the CN-CO relationship was characterised as challenging and it was common for nurses to struggle to negotiate a therapeutic working relationship with correctional officers. Participants continue to experience feelings of - frustration, impatience and being less valued within the CN-CO relationship. While some nurses recognized and strived to overcome some of the difficulties with the CN-CO relationship, they also acknowledged that lasting solutions required managerial support and leadership. The following section will examine study findings as they address the working relationship between correctional nurses and management.

4.3.2 Correctional nurse - management working relationship.

In this section, the term management is used broadly to refer to anyone in a position of authority above the rank of nursing within the organizational structure. This includes the direct manager of participants – health care coordinators, as well as operational managers, department heads, and administrators such as deputy superintendents as well as the superintendent of the institution.

During the analysis of meaning units and the search for the essence of the lived experiences of correctional nurses among the essential structures that emerged, three essential structures described the working relationship between correctional nurses and management. These structures identified herein as essential structures 7-9 are presented and explored below. It was found that participants' relationships with managers were experienced on two levels: on a personal level and on a professional level. The first structure to be presented, essential structure 7, describes an essence of the positive aspects of the correctional nurse-management relationship.

Essential Structure 7
This study found that nurses experienced the correctional nurse-management relationship positively when management demonstrated active listening and offered positive feedback.

Participants experienced relationships with management on two levels. The first level was the personal relationship participants had with the individuals in management positions. At this level, participants described managers as "nice individuals", and recognized that to the best of their potential "do the best they can". Some participants described a few experiences whereby operational managers, on a personal level, offered positive feedback to individual nurses and listened to, and attempted to address nurses' individual concerns that fostered feelings of

"comfort" and "accommodation" among the nurses. Additionally, one participant described one experience of a direct manager (a health care coordinator) "trying" to maintain a good relationship with nurses by, "accommodating [nurses'] requests [for]…time off and vacation".

On a professional level, only one participant described experiencing positive feedback from managers regarding the nursing profession within corrections stating: "I've heard many times that the… managers…mention that 'without you nurses we… wouldn't be able to run this institution.' … I believe they are genuine [and]… they perceive us as necessary and essential" (Participant 2). The description of this experience brings to light that some managers recognized the professional value of nursing within the correctional setting.

Although, the above accounts highlight the very positive aspects of the CN-management working relationship, these accounts seemed to be exceptional. Findings of this study indicated that most participants often received feedback from management, which was more negative than positive. The following two essential structures address other aspects of the nature of the nurse-management relationship.

Essential Structure 8

This study found that nurses often experienced minimal support, from management for: 1) their professional growth and development; and 2) for overcoming the organizational challenges they encountered in their role as correctional nurses. This resulted in nurses feeling discouraged and less valued within the organizational structure of the detention centre.

Study findings indicated that all participants acknowledged that career advancement in corrections was limited. One participant, as stated in the following quote, described that, unlike

correctional officers who have many options for advancement, correctional nurses have very few opportunities:

> Unless you want to go into health care coordination, how much opportunity is there within the ministry?… I would think if you went on to do your officer training you could have a huge opportunity… Become an OM16 [operational manager] and become involved in heading up for the deputy superintendent to be in charge of nursing. I think that would be wonderful for someone (Participant 3).

Another participant gave a similar account by drawing on parallels from other nursing setting. In the following quote, this participant described that in corrections, the room for advancement was so limited that nurses who begin their correctional career as a staff nurse, would most likely end their career in corrections as a staff nurse:

> I don't find much advancement in that any of the nurses…works 20-30 years as a nurse and they are still correctional nurses…they don't go up anywhere. As opposed to an acute care setting…going higher in education you always have a chance of going into higher job positions… higher paid. But, in correctional nursing you are a correctional nurse and you will die as a correctional nurse (Participant 5).

Analysis of the data found that, given that there was minimal advancement within the institution, as depicted in Appendix A, participants did not seek support for career advancement in the organization. Rather, they sought managerial support for dealing with the systemic issues of their day-to-day nursing, as well as support for professional development opportunities related to their current role in corrections. Four participants described attempting to improve aspects of their professional role as a correctional nurse by bringing forth their ideas and suggestions, seeking support from management. However, each participant became discouraged when managerial support was not offered at all, or not offered in a timely manner so that the momentum for change was quelled and participants became discouraged. One such example was offered in the following quote: "if you bring up issues, or other problems with the authorities…it is not responded to properly and your concerns are most of the time not addressed by the

management" (Participant 4). This participant sought support from management in order to resolve previous issues and concerns but felt the support sought was not given or not of the appropriate type. The fact that participants experienced, on multiple occasions, unsatisfactory or no support from management, contributed to feelings of disappointment, with Participant 4 stating, "they [management] don't care about us". Another participant stated "it is useless to tell them [management] anything – they wouldn't do anything", reflecting that the participant no longer seeks support from management as the anticipated response would not be supportive to nursing.

Additionally, participants experienced that their professional value within the institution was diminished when managers would instruct a nurse to perform a task without being provided sufficient reasons, or without an opportunity to discuss the matter further. In the following quote, one participant provides a description of being asked to do a task without being provided the supporting rationale:

> They are used to giving instructions and not wanting to be questioned. And when the nurses want clarification so they know why they have to do what they have to do – they [managers] feel like their authority is being challenged. Yet with nursing you just can't perform an action without proper reasoning for it (Participant 1).

As well, six participants experienced that management tended to narrowly focus on the "tasks" of nurses, with two participants indicating that nurses were regarded as "pill pushers". Another participant stated that within the present framework of healthcare, nurses practice in a minimal capacity role, and that professional growth is neither encouraged nor expected. Six participants expressed experiences of not even being supported in obtaining ongoing continuing education in order to maintain their basic nursing skills.

Participants also expressed discouraging emotions when describing experiences related to the orientation and acculturation of new staff nurses. Participants described experiencing less managerial support associated with the orientation of new staff. For example, one participant, in the quote below, described that management provide new staff with only partial orientation and this affects the workload of the other nurses as well as fostered feelings of frustration:

> Nowadays, when people come to our place I think they get two weeks [orientation] and they still don't get a full picture of [correctional] nursing. Mostly they are prepared for cart nursing [medication administration], which is not a full one, which is not fair; it's not good to us. We need nurses who know how to give medication, methadone, but also to do follow up with the community, with the paperwork… [the] desk nurse [nurse in charge] and the 4th nurse [the nurse who works with the doctor]. They are the position that come early in the morning, and they are basically running all this place you know, uh from paper to paper talking to lawyers and following up with the clearances [and] transferring patients and not much of the nurse to patient, but rather the documentation. It is really important, and nobody wants to do that either. It's a very frustrating job, because you are doing 5, 7 jobs, you answer the phone, you go over there, someone calls you in between you even forgot what your supposed to do now. So…they are not oriented to that. Why not? - Because it gives us really running like crazy and [the new staff] giving medication, signing medications and going home. That's frustrating, and that's management. Either they find those people really not smart enough to do it, or they don't bother them, or they don't have enough time and money to pay for their 2, 3 [weeks of], orientation I don't even know, but its something to be changed (Participant 7).

What was also apparent from the descriptions of participants was that managerial support was experienced as a key part of the progress many participants sought within their practice. Often participants experienced feelings of frustration and disappointment when they did not receive the managerial support they sought. What was also apparent in many of the above quotes was the breakdown in communication between nurses and management. The following essential structure describes communication between nurses and managers.

Essential Structure 9

This study found that communication between correctional nurses and management was delayed, infrequent; and consisted of more negative than positive feedback. This again fostered feelings of: disregard, being unappreciated and diminished professional value among correctional nurses.

It was evident that communication between correctional nurses and management was problematic. Descriptions from four participants indicated that management communicated infrequently with nurses and, they were slow to respond to the concerns voiced by nurses. Additionally, at times, management was non-responsive to participants' concerns. In the following quote a participant, reflected on an experience that described how the length of time it took management to address nursing concerns, fostered feelings of disregard and diminished professional value. This description is offered below:

> I and other nurses feel at times we are not getting any support – or the kind of support we'd like, which is true, because of all the protocols and all the steps that have to be taken from one level to the next. You have to start at the bottom and work up to the superintendent and …umm… this – the issue takes a long time before something could happen. So, in the mean time, in the interim, while these things are being processed, we think we are not getting any support. Eventually things do happen we do get some sort of support and issues are umm, umm not worked out 100% but there is some umm you know - something is done about our issues (Participant 2).

Another issue concerning communication between correctional nurses and management was that of the giving and receiving of feedback. There were occasions, again on a personal level, when nurses were offered positive feedback from management. These included comments such as "good job, nurse". However, regarding nurses and nursing on a professional level, often the feedback participants received contained negative content and consisted of messages of fault or blame as was experienced by five participants. Another participant offered a similar

description in the following quote. This quote describes an example of the communication difficulties between correctional nurses and management, and the resulting feelings of being unappreciated and diminished professional value:

> Management, I don't know if they appreciate that much what the correctional nurses, or nurses do it, because once everything is set up and everything in place it will go smoothly, mainly because the nurses are the ones who are running the show and management doesn't have to worry anything about it unless there is any issue comes up. Because, we don't find that much appreciation from the management at all, especially I mean they just say: 'Hi', they never come and ask you 'how is the work? …you face any difficulties or you have any problems with the inmates, or anyone is giving you any hard time?' It's very seldom on the management's part (Participant 5).

These feelings of lack of support for the work that correctional nurses do, is also described by another participant whose description of the lack of material support for nursing also speaks to the fact that poor communication from all levels of management to staff nurses impacts on nurses:

> Other institutions have it (a computerized system). Our institution doesn't have it, and of course explanations are from the stupid to the smart ones- bottom line, we don't have it. And its something that would perhaps make it faster, clearer, exchange of information, avoid medication errors, no. it's not happening. Management up there, not even in our institution, but up there, it is just so narrow-minded. I don't know (Participant7).

The descriptive language of the participant reflected feelings of frustration and of being devalued because of ineffective communication. During data analysis, lack of and ineffective communication were determined to be characteristic of the nurse-management relationship.

Four other nurses experienced that feedback from management was more often negative in content than positive. Participants' descriptions indicated that often the good job nurses did went unnoticed while their mistakes were amplified. One participant described in the following quote that often management did not communicate with the nurses until something went wrong, at which time communication occurred, but it was usually negative (accusatory) in nature. In

addition, the manner with which the communication happened detracted from the professional value of the nurse:

> for the most part nobody says anything about the nurses, until an oversight or a mistake happens and then we're all idiots and the blame game starts… the way the managers had learned to do their job was counter-productive… [and] it's counter-productive to staff morale (Participant 6)

Amidst the difficulties participants experienced in their relationship with management this study found that there were elements of hope evident in their descriptions. Study participants felt hopeful that the new administration of their institutions would bring about the changes they sought. Three participants described that change had to "come from the top down". Theses participants described that management, especially the superintendent position, were filled on a temporary basis, so proposals were delayed and, had to be resubmitted whenever new management was hired. However, participants had a renewed sense of hope that new management would bring new leadership, and nursing would be better supported within the institution. As stated by one participant "hopefully that [the apathy and indecision of management] is going to change, with the new management team" (Participant 6).

4.4 Caring for "Inmate" Clients

Analysis of the data found that nurses described caring for inmates as a "very different" experience than caring for non-inmate clients. This study found five essential structures (essential structures 10-14). Essential structure 10, speaks to correctional nurses' experiences of providing non-judgemental care. Essential structure 11, addresses the experiences of building a trusting nurse-client rapport. Essential structure 12, describes the importance of nursing assessments and nursing intuition when caring for inmate clients. Essential structure 13, describes correctional nurses' experiences of providing holistic care. Essential structure 14,

addresses the rewards of caring for inmate clients. Together, these essential structures are part of the lived experiences of correctional nurses that relates to caring for "inmate" clients.

The first structure speaks to correctional nurses' experiences of providing non-judgemental care.

Essential Structure 10
This study found that nurses necessarily practiced within a consciously non-judgemental attitude when caring for inmate clients in order to provide appropriate nursing care.

This study found that each participant described caring for inmate clients meant having to remain consciously non-judgmental of their clients, in relation to the client's criminal charges, in order to provide appropriate nursing care. For some participants, practicing within this context was a different experience. One participant, for example, indicated that having to practice with a consciously non-judgemental orientation was different from past experiences, and changed the participant's regard for clients and nursing:

> I'll say I am more understanding of this type of nursing which I had no idea about before coming here. And although in other areas you have to be non-judgemental and do all the other things and in this area sometimes it's difficult but I find that it has changed the way I see everything (Participant 2).

Another participant conveyed that it was not appropriate for clients to be perceived with the stigmas associated with labels such as "killer", nor should clients be perceived as personally offensive. Rather, as indicated in the quote below, this participant viewed clients as individuals who required care and attention at that moment:

> You are a profession[al], you are an educated person, whatever their crime it doesn't matter, because it might be somebody here the person might have killed somebody in the family, but when you look after them if they have an injury or something, you look after them as a patient who needs help at that time. That is the way you look at it, you don't look at it as they did this to your family, or they

> did it to your friend's family. You look at it as an individual who needs attention—who needs caring at that time. And you do your professional duty at that time (Participant 5).

Another participant brings to the fore that in spite of the criminal aspects of the client, correctional nurses are obligated to maintain a humanitarian disposition and provide non-judgemental nursing care to the clients:

> Yeah he's a psychopath, but he's depressed. They get depressed, just like we do. Yeah he's a sociopath, but he's got a rash and he deserves to have medical treatment. We are not in the game of punishment; we're in the game of nursing. We're not judge and jury and that's a huge issue for the officers and some of the nursing staff, and I've had a few get angry at me because I would say 'where is your compassion, what happened to your humanity?' (Participant 6).

However, remaining non-judgemental for many participants was an ongoing struggle. An example of one participant's struggle with this process is described in the following quote:

> With the hospital when a client comes in you don't know anything about this person. You don't know if they have a record or not. But [here] you… know in the back of your head that this person coming to you is a killer - not that you are afraid – but you feel you just judging him. And it shouldn't be like that. But hearing, you know the officers and them saying, 'oh he's a wife beater' or you know 'why should he get this' or 'why should he get that' and it kind of say 'well - you know - they know more about this field and so - why this one was arrested you know' (Participant 4).

The above quote also highlights that often the values and normative attitudes within corrections is often juxtaposed to the professional ethics and values of nursing. Providing appropriate nursing care required that nurses recognize this and continue to practice within their professional values. One participant, who had several years of experience in caring for inmate clients, described that the process of remaining non-judgemental became easier with more experience.

This study also found that participants described using a variety of strategies to maintain a non-judgemental attitude towards inmate clients. Three participants said they frequently

reminded themselves that it was important to remain non-judgmental, trying to put the clients' charges out of their minds in order to care for their clients appropriately. One participant stated, "I try not to think about what they did, I put it out of my mind. And umm I just…treat them like another person in the community". Another participant described trying to mentally block out the client's charges, but adds "I am only human" indicating that remaining non-judgemental is difficult at times. Thus, nurses need to be continually focused on this process as part of their day-to-day work.

Three participants drew upon their faith or religious beliefs to remain non-judgemental. In light of their belief system, participants imagined that they could themselves be in similar circumstances as their clients and that judgement was reserved for a higher power. One participant described, in the following quote, how faith in God helped to maintain a non-judgemental approach to caring for inmate clients:

> Maybe its just me, but I think when someone comes in and its just something totally out of the blue – like perhaps they didn't know there was a warrant for them because they hadn't paid parking tickets or something I think - *but for the Grace of God there go I* - or I see someone come in and in a moment of anger has done something totally terrible like… 2nd degree murder or something. Again I would think that. …it makes me very aware of how we never know how things are going to unfold and we hope and we pray for the best. That we can respond and be the best we can be but we never know. I often think of that phrase "before the Grace of God – there go I" and I realize how easily I can be looking at someone I know on the other side of the grill (Participant 3).

Similarly, in the quote below, another participant described being non-judgemental as part of the participant's personal belief system:

> These are the hardest guys to care about. They've murdered people, they're run-'em over drunk drivers, they've raped little girls, all kinds of nasty stuff up here, if you can't learn, or it's not part of your values that… 'I am not without sin - I'm not throwing the first stone', I'm here as a nurse to do ABC….We're not here to judge and we're not here to be jury, we're not (Participant 6).

Additionally, three participants reminded themselves that in a detention setting clients were only accused of committing crimes. These clients were not yet convicted of the crimes for which they were accused. Thus, participants were cognizant of the Canadian legal principle that people are innocent until proven guilty. Belief in this principle is described by a participant in the following quote: "they [inmate clients] are not convicted so not actually bad guys. If someone works in the federal institution, they may say 'ok, he was already proven to be guilty' or bad or whatever, in our institution we don't know" (Participant7). This example once again, underscores the rationalization of correctional nurses in their effort to remain consciously aware of being non-judgemental of their clients, when they are confronted daily with issues surrounding criminality, such as the stigma and marginalization of this population.

The second essential structure of nurses' experiences of caring for inmate clients addressed aspects of building a trusting nurse-client rapport.

Essential Structure 11
This study found that nurses' experiences of being manipulated by inmate clients for the purposes of breeching the safety and security protocols of corrections, often lead to feelings of suspicion and mistrust between nurses and their clients. This affected the development of a trusting nurse-client relationship. It was found that a trusting nurse-client relationship evolved over multiple interactions with the client, and when nurses engaged in active listening.

Describing the experience of trust was also a key part of describing the experience of caring for inmate clients. All participants described various experiences whereby they questioned the trustworthiness of the information they received from the clients they cared for. In this study, some participants described experiences whereby inmate clients who were attempting to breech safety and security measures manipulated the participant. For example,

participants described experiences where inmate clients manipulated nurses by pretending to suffer from chest or abdominal pain in order to be taken to the hospital. Clients' reasons for doing so were varied and ranged from wanting to be removed from their current living unit, or wanting to eat different foods; to attempting to escape. One participant indicated that suspicion of inmate clients was necessary because an inmate attempting to escape put the lives of officers at risk. This participant described this suspicion as a "negative part of correctional nursing … [The] constant fear of being a part of the wicked intentions of patients" (Participant 7). This participant later added "And that [the responsibility of sorting out manipulative behaviour from genuine concern] comes with the lawsuits that we are facing" Together, managing manipulative behaviour with the threat of having to face lawsuits, made it difficult for the participant to know the degree of care which the inmate required.

The experiences of being manipulated and its related dangers present a challenge to building trusting nurse-client relationships in the correctional setting. One participant, in the following quote, described experiences with clients getting to know the "system" and then manipulating it to their benefit: "They get to know the system and understand it and learn how to manipulate it too. So they, they get to know their rights – health wise- and they will use that inappropriately to just…manipulate safety" (Participant 1). However, the study findings also indicated that clients are not trusting of correctional nurses. Building of a trusting nurse-client relationship was possible and often evolved over multiple interactions and over multiple incarcerations. The quote below provides a description of such an experience:

> It is also not always easy to get the truth from the questions we are getting and I don't really know exactly what's causing that but you - we usually find conflicting stories. You get a certain story at the beginning and then as you continue asking you find a different answer altogether that contradicts what you had at the beginning. So I don't know if it's because they are offenders or it's because they don't know you that well at the beginning; and they didn't trust you

> with their information; and then as they probably feel that they can trust you that they change the story (Participant 1).

Another participant described that one way of building nurse-client relationships involved recognizing that as a nurse, you will be manipulated by inmate clients, and as long as the nurse is aware of this it is "ok". This awareness allows the nurse to negotiate care with the client, thus developing a trusting relationship also based on the principle of "give a little…get a little".

The act of listening was also a factor in building trusting relationships with clients. For example, one participant described an experience of developing a trusting nurse-client relationship within the correctional setting with active listening and overtime. An excerpt from the interview with this participant is provided below:

> I could give you an example one inmate asked me – he did asked me when he came …to put him in the dorm – just to get through the [admission] interview I told him "yes". Now I thought he had a mental health issue. I hadn't seen that inmate in two weeks and umm when I went to the grill to give him his medication – yes, he took his medication and he throw the water on me. That didn't bother me because he had reminded me that I had made him a promise - to put him in the [medical] dorm and the officer said to me well "what you want to do with him?" I say "well he's already in confinement, that's fine with me". When I went back in the evening 'cause I was working a long shift he did apologize to me and he kept on apologizing (Participant 4).

This participant was able to listen to the client, acknowledg the client's feelings of frustration, and the participant was able to respond appropriately. This provided the basis upon which a trusting nurse-client relationship could develop. Another participant experienced truth-telling among inmate clients was fostered when the nurse demonstrated active listening and open communication. This participant stated:

> You [nurses] have to give [inmates] some kind of sign that you trust, and that you are willing to listen" in order for the inmate to indicate what is the truth of the matter. In that case, an inmate will feel comfortable to say 'no actually it's not chest [pain], but I'm not comfortable on the unit. And I tried to get off the unit to send me somewhere else because the guys are muscling me for my pills, or something (Participant7).

Developing a trusting relationship was also necessary to provide appropriate nursing care, to avoid delays in care, or to avoid inappropriate use of resources such as taking an inmate to the hospital to investigate non-existent chest pains.

Along with resolving aforementioned matters of trust between nurses and their clients, another essential structure regarding the importance of nursing assessments when caring for inmate clients was determined during analysis. This essential structure (essential structure 12) is presented below.

Essential Structure 12
This study found that nurses relied on their assessment skills and their intuitive knowledge in order for them to be able to provide sound nursing care to inmate clients.

Nursing assessment skills and nursing intuition were two aspects of nursing care that were found to be essential when caring for inmate clients. The importance of these skills and abilities, in this study, were determined to be a key part of providing sound nursing care in this environment, i.e. a secure environment with limited recourses. Participants described resources being limited to only very basic wound care supplies and limited diagnostic tools. Within the context of these limitations, nurses relied greatly on their assessment skills and intuitive knowledge when providing care to inmate clients. Additionally, and as indicated by a participant in the following quote, the institutional physicians, when on-call, rely on nursing assessments and knowledge when considering their own plan of care for inmates: “the doctors depend heavily on the nursing assessments to make their decisions well” (Participant 1).

Three participants identified that good assessment skills were necessary to determine the degree of illness the inmate was complaining of and, the client’s motivation for bringing this

concern forward to the nursing staff. Regarding the former; determining the degree of illness, one participant described below, one experience where, in lieu of having diagnostic tools that would better aid in determining the degree to which a client was ill, the participant had to rely on one's own assessment skills:

> We are limited in our tools, we don't have an ECG [electrocardiogram machine], we don't know if this guy is really in cardiac arrest, or really in serious trouble, we have to send him out…[or decide] is it really required and necessary? But at the same time, so you know you have to give this guy a chance, that he's not faking but it gives you some sort of um, maybe I'm too soft, maybe I'm not really making assessments correctly, that's part of nursing and corrections that you're dealing with less resources. In a hospital if there is a code, you can call a special team, and they can help you, you have a doctor over there, many doctors, even specialty. In corrections you are almost an emergency nurse, a psychiatric nurse, everything in one. Which I guess puts a lot of responsibilities [on correctional nurses] (Participant 7).

Regarding the later, participants described that in addition to the health assessments they do, they also have to assess the client's motivation for bringing forward their presenting health concerns. For example, one participant, in the following excerpt, described an experience of caring for a client with chest pains. This participant describes having to explore the possibilities of motivating factors that may have precipitated this complaint of chest pains:

> So it is really a difficult one to do it where [you are] in between your license as well as in between your assessment skills and in between other issues. So whether this inmate doesn't want to stay in that unit is that why he is making up this chest pain, or is he making up for some other reason, or is he going to court why he's making up this chest pain issue. So, it is really challenging one compared to acute care setting, where the patients come and tell you what they feel and you can believe that. So, it is really a challenging one (Participant 5).

In as much as nursing assessments are essential to caring for clients often, nurses are denied access to inmates for security reasons and therefore, nurses are unable to fully assess clients. Again, this limited the ability of nurses to provide sound nursing care. This study found that three participants described experiences of having to make nursing judgments without being

able to satisfactorily assess the client. For example, one participant described an experience whereby the nurse wanted to assess the client on the unit, but because the officers wanted to secure the inmates in their cells, the nurse was not allowed sufficient time to complete the assessment:

> And if you try to assess somebody over the grill you know they want to hustle you out because you know they want to lock down [secure the inmates in their cells]. So you don't get a lot of time you know – to ask questions (Participant 4).

As well, all participants described being limited in acquiring education that would increase their nursing capacity, enhancing their assessment skills and improving client care. Many nurses described experiences of wanting to enhance their assessment skills. For example, in the following example one participant describes some of the areas that would benefit nurses in their work:

> [Nurses need to] Learn more about diabetes because we have people there who are diabetic. As the years gradually come along you see more diabetics, you see people with HIV. Learn more about asthma because there is a lot [of inmates] who come in there with asthma. Learn more about sickle cell. You know. We should have the books - modern books you know - Not old books. We should even have a little library where we have updated books that you could just [open] a book and see what you could look at – you know. [Learn more about] drug withdrawal, certain types of street drugs – you know things like that (Participant 4).

Intuitive knowledge was also found to be an essential part of caring for inmate clients. Four nurses have described using intuitive knowledge while caring for inmate clients. For example, in the following quote, one participant described an intuitive experience when caring for a client:

> the experiences you have with them even the new ones you meet for the first time you just get something within you that tells you to watch for certain things. You still know you are not sure because you don't live in the person's body. But… even when you are in doubt you'll still choose to believe what they are telling you but you keep watching…(Participant 1).

This example demonstrates that the nurse was intuitively aware that there was something at odds with the presentation of the client and, therefore, continued to monitor the health status of the client. Similarly, another participant described being "a little more sensitive to listen to my gut instinct about things sometimes" (Participant 3) and that sometimes that was necessary when making nursing decisions.

The fourth structure of the experience of caring for inmate clients is related to correctional nurses' experiences of providing holistic care.

Essential Structure 13
This study found that nurses working in detention centres encountered challenges when attempting to provide nursing care outside the narrowly defined nursing role.

The findings of this study identified that the nurse's role was defined by the organization, and was limited to a few specific nursing tasks. Participants described that despite spending more time with inmate clients than any other healthcare professionals, the current service delivery model did not support an expanded, more current view of the role of correctional nurses. The services participants experienced as necessary but difficult to provide included addressing issues of literacy education, life counselling, and spirituality of clients, health teaching, health promotion, recognizing the client as a whole being. Three participants described experiencing inadequacies, at a systemic level, in the way that healthcare is provided to inmate clients. For example, one participant described the illness based-approach to health care for clients in a setting where the nurses are the primary health providers as "difficult". The following excerpt describes this participant's experience:

> …the way the nursing situation is set up, it's all set around the doctors' parade [doctor clinic], and processing orders and getting tickets and all of that done

> towards the goal of meds or treatments for the individual inmates. So everything is a big rush to get it done and then when you get all of the orders done, then…nurses… complain about the amount of medications people are on. I find it difficult in that, I'm a nurse, I'm in nursing… [and] it's not just specifically goal-directed, you know 'push the pills and go back to your nursing station'… I think together we can do a lot more than what we are doing now (Participant 6).

Three participants described being well acquainted with their clients' health status, through ongoing and daily assessments of clients, and interaction with them. However, this knowledge was not regarded as valuable information within the present model of healthcare. The following quote describes one participant's assessment of a medical treatment, ordered for an inmate client as not appropriate, yet because of the narrowly defined role of correctional nurses, the participant's input is not as valued as that of the doctor. This precipitates the participant's feelings of being obligated to carry out the physician's order:

> As a nurse it's really a challenge, because you are in between where you know exactly this drug-seeking inmates and how they—when they come to see a doctor the way they pretend and they explain and say things that is not right—there are inmate incidents when you go upstairs they say: 'Oh I made up a story to the doctor, so I can get this drugs.' Meanwhile, you as a nurse you have an order from the doctor, and we are forced to give that drug. Even if you sometimes bring it to the attention of the doctor they won't—they may also try to protect their license. As well as they also look at them as their patients. So, you are in between type thing, where you know this is a drug-seeking individual, which you cannot stop it and you don't have much say (Participant 5).

Some participants described experiences of knowing that the inmate clients would benefit from nursing care beyond their narrowly defined role within corrections. One participant stated that inmate clients sometimes need to be cared for within a more holistic approach to healthcare; one that includes prayers and education: "they [inmate clients] should have an hour or two … [so they could] learn something that will give them structure when they leave" (Participant 4). Another participant stated that: "the lack of knowledge with inmates is huge. And as a nurse…I can fill that gap" (Participant 6). One participant asserted that inmate clients' mental health

status would also benefit from alternative therapies and strategies which would provide them with more mental and physical stimulation - stating that if clients "received formal education or productive activities…they would have less time to think they are not that healthy and they need medications" (Participant 1). Nurses, as the primary healthcare providers for inmates within a detention centre are capable of, and attempt to assume an expanded nursing role when caring for inmate clients. However, in so doing, they are continually challenged by the limited expectations of nurses in the detention centre setting.

There is some evidence amongst the study finding that suggests the role definition of nurses may vary according to inmate population and correctional setting. Two participants had previously cared for incarcerated populations other than the adult male population. These participants described practicing correctional nursing with a broadly defined nursing role. Both participants described their experience of caring for other populations as "richer" and "more therapeutic". Both participants described experiences of being able to care for female inmate clients in a more holistic manner. One participant described working at another Ontario correctional facility whereby the institution and its staff supported nurses in a more widely defined nursing role. These participants noted experiencing a very limiting nursing role once they started nursing at the detention centre with an all-adult male population. An account of this difference is described in the following quote:

> It is difficult to practice nursing in a detention centre, basically with my background, we interact with inmates on a more interpersonal level. Therapeutic level per say. That's not particularly condoned in a detention centre. So that leaves me basically doing specific task-oriented nursing. …I would like to have more contact with the inmates but it's not possible in a detention centre setting. …working in corrections, in a detention centre is totally different to what I was used to when I first went into corrections…my position is to nurse them, and that's very hard for…[staff at the detention centre] to even understand what that means.

The findings of this study indicated that participants were capable of and wanting to provide a wider range of nursing care to inmate clients. They felt that on an institutional level, the role of nursing was narrowly defined to the few tasks that nurses do in relation to carrying out physician orders. Additionally, there was some evidence to suggest that the range of practice of nurses may be determined based on the type of correctional facility as well as the characteristics of inmate population (i.e. female, male).

The fifth structure and the last finding associated with caring for inmate clients addresses the rewards of caring for inmate clients.

Essential Structure 14
This study found that correctional nurses described caring for inmate clients as being intrinsically rewarding.

All participants identified having intrinsic feelings of reward (including feeling good, feeling rewarded and appreciated) when: clients expressed their appreciation for nurses' actions either verbally or non-verbally; when participants were able to follow through with care of clients; when participants successfully advocated for clients; when participants were able to engage in client education; or when they were able to help restore clients to a healthy state.

For example, one participant described in the following quote, experiencing a great sense of satisfaction and reward when clients respond positively: "I feel a great sense of satisfaction, I find it's rewarding working there [at the detention centre] when I do something for these clients - the care I give them and they respond in a positive way" (Participant 2). In another example, another participant described caring for clients with genuine health problems as always rewarding: "When we have a genuine case you will know, as well as caring for them is always rewarding and [those] patients always appreciate what you do". A third participant stated feeling

good when advocating for a client and communicating with his family in order to achieve continuity of care. This participant also felt rewarded when counselling inmates; and when offering them strategies for coping with their incarceration. One participant identified having the feeling of being rewarded with a "simple 'thank you'" or "a polite smile". However, a few participants described the feelings of reward as "short lived" and attributed that to the fact that many of the inmate clients were homeless, and so when they were released and rearrested they were no longer in the healthy state that was achieved during their previous incarceration.

Three participants described achieving job satisfaction when they were able to engage in client education, though those opportunities only occur occasionally. An excerpt from one interview below highlights an occasion where a participant felt rewarded after engaging in health teaching and patient education:

> "I experience a lot of good things from inmates, when you bring some kind of humour, or joke, or nice open smile you know - look at them honestly, they think that is someone at least, I don't know what they think after but at least in face they say 'thank you nurse', that's really nice and that's really important to me. And a few times the health teaching if we have time to do, very often it just hits the spot." (Participant 7)

It is the experience of being intrinsically rewarded for the care participants provide to inmates that was found to be a key reason participants remained in correctional nursing. The essential structures 10-14 described the essences of the lived nurses' experiences of correctional nurses that together describe the experiences of caring for inmate clients.

CONCLUSION

This study presented fourteen essential structures of the lived experiences of correctional nurses working in two Ontario detention centres. The quotations provided herein provided a vivid description of the experiences of the correctional nurses who participated in this study.

The participants provided insight to a field of nursing that few nurses have the opportunity to experience and an area with limited research and examination related to the role of nurses. Study findings will be discussed further in the following chapter.

CHAPTER 5.0 - DISCUSSION

INTRODUCTION

This chapter discusses the findings of this study, and is divided into three sections. The first section 5.1 provides the main discussion of study findings. The second section 5.2 discusses the nursing implications from the study. The third section of the chapter 5.3 highlights the limitations of this study after which concluding remarks are presented.

5.1 The Challenges and the Opportunities of Correctional Nursing

This section of the discussion is intended to situate the findings of this study within the current body of literature and to discuss some of the challenges and opportunities of correctional nursing related to the study findings. In order to facilitate a more coherent discussion, this section has been further divided into four sub-subsections. These sub-subsections offer discussions on the challenges and opportunities of: supporting the professional role of new and current nursing in corrections (5.1.1); caring for inmate clients (5.1.2); the physical workspace (5.1.3); and correctional nurses' working relationships. A quick reference list of the essential structures is located in Appendix I.

5.1.1 Supporting the professional role of new and current nurses in corrections.

The first of the essential structures reported in the last chapter addressed the participants' initial experiences of correctional nursing (essential structures 1-3). Nurses, in the literature have been characterized as a marginalized group because it is considered predominantly a female profession and historically females have been discriminated against (Kuokkanen & Leino-Kilpi, 2000). Correctional nurses are further sidelined because within the nursing profession, they are small in number and work in an environment that is not well known to nursing or the general public. Therefore, given the untraditional setting that correctional nurses work in, it was not

surprising that participants reported not learning about correctional nursing while in nursing school. However, what was surprising was that many of the participants came to know of correctional nursing through passive means and agreed to give it a chance. Participants happened to discover the possibility of correctional nursing either by chance at their place of work, or they were recruited by their peers who were correctional nurses. This is significant for two reasons: first, it highlights a potentially effective way of recruiting correctional nurses if current staff were encouraged to recruit new staff; and secondly, the recruiting nurses may also assume the role of a mentor for the newly recruited correctional nurse. This would also facilitate the retention of new correctional nurses. As described in essential structure 3, mentorship was a key experience for participants, and facilitated their decision to remain in correctional nursing. The fact that these nurses still remain in corrections today is perhaps an indication that peer recruitment and mentoring may be a worthwhile venture.

The culture of corrections is also another part of the correctional experience that participants were not well equipped for, or supported in coping with. Comprehensive orientation and mentoring were key factors to helping study participants cope with both the nuances of working in a secure environment and helping them to overcome initial feelings of frustration and disappointment and of not wanting to remain in corrections (essential structure 2 and 3). The feeling that the participants in this study experienced of being overwhelmed by the need for security, is also documented in the literature. Dale and Woods (2002) reported that correctional nurses found that physical aspects of the secure environment were "awesome" and "intimidating" at times. The importance of mentoring and comprehensive orientation for correctional nurses is also strongly supported in the literature (Cashin & Potter, 2006; Maroney 2005; Norman & Parrish, 1999). Norman and Parrish reported: "if nurses are to be retained in

the prison service, induction and support for new staff is essential" (p.654). Similarly, in a review article by Cashin and Potter (2006) on mentoring in clinical and forensic nursing, they concluded that mentoring is often regarded in the literature as a "successful and worthwhile endeavour within nursing" (p. 190). Maroney found that new correctional nurses did not receive training related to coping with difficult inmate behaviours. However, like the findings of this study, correctional nurses in Maroney's study of correctional nursing practice, also indicated that "with experience and appropriate mentoring, new [correctional] nurses can develop an authoritative (versus authoritarian) presence that is more effective in handling manipulative behaviours" (p. 165).

Cashin and Potter also noted that mentoring was beneficial to both the mentor and the mentee. Therefore, the benefits of supporting such programming in the correctional setting would be two-fold: first, nurses new to corrections would be better supported to practice correctional nursing; and secondly, mentorship may provide the professional growth and development that participants in this study sought, as described in essential structure 8. Also, since a key finding of this study was that correctional nurses relied heavily on both their assessment skills and intuition, mentorship would provide an opportunity for the mentor to share with the mentee nursing knowledge gained through the art of correctional nursing. Along with mentorship and orientation, the participants also recommended additional education focused on the specific needs of correctional nurses.

Participants in this study also felt they would have been better prepared and would continue to benefit from ongoing continuing education that addressed the most current information and best practices related to caring for inmate populations. For example, participants described relying heavily on their assessments skills. Therefore, ongoing education

that provides up-to-date information regarding mental illnesses, drug abuse, diabetes, emergency care, and dealing with manipulative behaviours would be particularly beneficial to their role as correctional nurses. Evans (1999) also reports similar findings of correctional nurses often starting to work in corrections without having special training or education with regard to the specific healthcare needs of inmates. Evans described that correctional nurses had educational needs that were unmet and necessary for practicing in the correctional environment. She described how the development of a diploma level module designed specifically to meet the educational needs of correctional nurses was beneficial to correctional nurses, and she suggested that nurses should have post-registration training prior to practicing correctional nursing.

In the USA, the National Commission on Correctional Health Care (NCCHC) recognizes the unique challenges that the correctional environment poses for health care professionals working in corrections and has developed a certificate program. The aim of the certificate program is to ensure that healthcare professionals have a sound knowledge of the national standards and knowledge expected of leaders working within correctional healthcare (http://www.ncchc.org/cchp/index.html, retrieved July 27, 2009).

5.1.2 Caring for inmate clients.

As part of the phenomenon of the lived experience of correctional nurses – this study explored the experience of caring for inmate clients within a detention centre setting. Participants described this experience as a "different" experience than caring for non-inmate clients. The difference they described related to the fact that, unlike other settings, in correctional nursing they were continuously striving to provide non-judgemental care to their clients. The fact that being non-judgmental was found to be an integral part of the lived experience of correctional nursing emphasizes that nurses are continually struggling to reconcile

competing values, attitudes and behaviours. Similarly, other studies found that correctional nurses described caring for inmates to be a different experience and they found it difficult to cope with the knowledge of inmates' crimes (Hardesty, 2000; Maeve 1997; Weiskopf, 2004). Weiskopf also found that correctional nurses emphasized the need to remain non-judgmental when caring for inmate clients. The fact that study participants were conscious of being non-judgmental towards inmates may suggest that nurses are at least aware of the presence of competing values, and are striving to ensure that clients receive appropriate care; which further suggests that nurses have a positive attitude towards inmates; viewing them as clients who have value and rights. This is a positive finding as the literature indicates that correctional nurses' attitudes and philosophical orientation towards inmates affects the amount and type of care inmate clients receive (Dores, 1994; Hardesty, 2000' Shields & De Moya, 1997).

Additionally, the literature supports the experience of being non-judgemental as essential to the lived experience of correctional nursing as Maeve and Vaughn (2001) state that correctional nurses engage in ethical caring. They identified this to be different from other types of nursing, whereby nurses practice from within a natural caring attitude. Gadow (2003) stated that unlike other types of nursing "correctional nursing is a prism that refracts ethics into sharply different colours" which separates "competing philosophies of punishment and their implications of practice" (p.167). Therefore, depending on which philosophy is dominant, it can determine whether nursing care is more punitive and punishment-oriented, or therapeutic and restorative oriented (Gadow). Shields and De Moya (1997) found that correctional nurses scored lower on a scale designed to measure attitudes toward inmates. This suggested that correctional nurses had a more negative attitude toward inmate clients. While participants' attitudes toward inmate clients cannot be determined from the findings of this study, participants' efforts to provide non-

judgmental care to their clients reflects a philosophy resembling restorative care and demonstrates a valuing of clients.

This study also found that nurses struggled with issues of trust and the establishment of therapeutic nurse-client relationships. Participants' experiences of feelings of frustration related to coping with inmate manipulative behaviour is echoed in the literature (Hardesty 2000; Maeve & Vaughn, 2001; Maeve 1997; Maroney, 2005). Maeve and Vaughn identified manipulation as a survival tactic for inmates and that it was endemic to the correctional setting. They also acknowledged that correctional nurses found it frustrating to deal with this type of behaviour and as such the development of the nurse-client relationship was compromised. They also noted that correctional nurses required support and education related to coping with such behaviours.

However, the participants did indicate that they were able to establish therapeutic nurse-client relationships. What is interesting to note, is that study participants described two factors in particular that aided in establishing therapeutic nurse-client relationships: 1) the use of active listening; and 2) multiple interactions with inmates – even over multiple incarcerations. The identification of these two factors constitutes the second key insight to caring for inmate clients. There is limited research concerning the dynamics of the nurse-client relationship and only one study (Weiskopf, 2004), highlighted listening as a factor in establishing a therapeutic nurse-client relationship. However, more than listening to the clients as a means to "get to know" the client better (Weiskopf), participants here described that listening to the concerns of inmates helped to establish therapeutic nurse-client relationships. The fact that nurses still, despite contravening the social norms and the challenges posed by security, were able to find the time to engage in active listening with clients suggests that there is a foundation, or at least the making of one upon which correctional nurses can build in order to improve client care.

Despite all the challenges of correctional healthcare, participants experienced caring for inmate clients to be intrinsically rewarding. Participants felt most rewarded when engaging in holistic care with inmates. Though this aspect of nursing was not supported in the correctional setting, participants would go beyond what was expected of them to provide holistic care to inmates. Participants recognized that in addition to any medical issues that clients have; they may also be affected by poverty, homelessness and/or other social determinants of health. Participants recognized that inmates required literacy programs and family counselling and that these services required additional time and service providers to be actualized. Participants described experiencing many challenges when attempting to provide holistic care, which included: health teaching, counselling or follow-up care. This is quite insightful into the character and calibre of the nurses working in the correctional setting: that nurses are dedicated to their professional standards and aim to the best they can. Dale and Woods (2002) described finding that correctional nurses often experienced that their role was often more about breadth than depth. Similarly, the participants of this study were frustrated by the prevailing attitude that nurses were "pill pushers" or were frustrated by being limited to the task that they performed. They preferred to offer holistic care and in so doing they felt intrinsically rewarded.

5.1.3 The physical workspace.

It is argued that the physical nature and structure of correctional facilities adversely affects the health of not only inmates but of staff as well. WHO (2007) states that the poor working atmospheres of correctional facilities are a source of job stress for correctional staff. The physical workspace of study participants was another area that was found to greatly affect the work of correctional nurses. It is a finding of this study that over time the physical workspace of participants has not received due attention to ensure it meets the growing

demands placed on institutional healthcare. The study's participants shared very emotional experiences about their physical workspace; describing the environment as "depressing" and "confining" and not conducive to the work they do. Vischer's (2007) systematic review of the relationship between the physical work environment and employee responses to their work environment aimed to develop a theory of workspace stress - building on the well established fields of stress research and environment psychology. Vischer described that daily hassles and energy-consuming impediments of one's workspace creates a situation whereby one must start to employ coping mechanisms, thus, slowing down the user even more. This was evident in this study when participants described experiencing issues of control over workspaces. Thus, suggesting that the uncontrollability of one's workspace could lead to feelings of disempowerment, devaluing and "learned-helplessness". This was observed as the experience of participants in relation to their physical work environment.

The Habitability pyramid (as cited in Vischer, 2005, see Appendix J) depicts a model of environment comfort where each level comfort is based on satisfying the level before it. It was also found that nurses described their workspace as unkempt and not cleaned regularly which, in the 'Habitability' pyramid is part of the very basic level of physical comfort within one's workspace. The three hierarchical levels of comfort are physical comfort, functional comfort and psychological comfort. Physical comfort is the least of comforts that must be satisfied in order to have a work environment that is habitable. The study finding of participants' descriptions of an unkempt work environment would suggest that participants' workspace is indeed teetering on the threshold of the unacceptable and lends validity to the associated feelings of diminished professional value. Greater and more immediate attention should be paid to the

work environment of correctional nurses in detention centres in order to improve staff morale, to better support them and to improve proficiency among correctional nurses.

5.1.4 Correctional nurses' working relationships.

Study participants frequently described their experiences with correctional officers, managers and institutional administration when describing their lived experiences. These two working relationships were determined to have the greatest influence on correctional nurses' work and were the most challenging relationships to negotiate. Study participants described that correctional officers were integral to accessing inmates and to facilitating the delivery of healthcare services. Participants also described spending a lot of time and effort negotiating the working relationship with correctional officers. It has been well documented in the literature that correctional officers greatly influence, not only the provision of health care services to inmates, but also affected nursing practice (Droes, 1994; Dvoskin & Spiers, 2004; Godin, Gagnon, Alary, Noel, & Morissette, 2001; Holmes, 2005; Kifer, Hemmens, & Stohr, 2003; Weiskopf, 2004). Participants described experiencing role and goal ambiguity and poor communication with officers. Participants were often challenged to maintain open communication with their co-workers. Similarly, participants in this study expressed experiences of trying to improve communication between correctional officers and themselves; however, these efforts were not supported by administration. The lack of strong organizational leadership and management, and poor communication of organizational goals within correctional facilities has been identified in the literature as fostering role and goal ambiguity amongst line staff (WHO, 2007).

The literature offers an expanded view of correctional officers as helpers and as part of the healthcare team. The expanded view of correctional officers has been considered when working with those inmates with mental illnesses (Appelbaum, Hickey, & Packer 2001; WHO,

2007). The findings of this study suggest that serious consideration needs to be given to the relationship between correctional nurses and officers. Evident in the findings are many examples of opportunities to nurture and build upon the positive experiences of the correctional nurse – correctional officer working relationship. The participants discussed many examples of experiences where they demonstrated knowledge and understanding that a good relationship with correctional officers is essential to providing optimal nursing care (essential structure 6). However, without managerial and organizational support, it is not possible to move forward with long-term solutions. As indicated in the literature, the challenges that correctional nurses encounter with correctional officers is often related more to systemic issues than individual conflict (WHO, 2007).

Two systemic and interrelated challenges noted in the findings were that of: 1) inadequate leadership and; 2) poor communication. WHO (2007) stated that archaic management structures within correctional facilities, which do not resemble modern personnel management, are a major source of stress for correctional employees. This approach to management perpetuates many of the challenges employees face, including the lack of strong leadership, poor communication, and ambiguity of role and goals among line staff (WHO, 2007). Participants in this study stated that they often experienced delayed and infrequent communication, and more negative messaging and feedback from managers. They also described role and goal ambiguity. Communication within the detention setting is definitely an issue that needs to be addressed by the administration of these institutions.

Kernaghan & Siegel (1999) described that within hierarchical structures, the absences of strong leadership leading to the existence of dualities of institutional mission, vision and goals, is inevitable. When the mission, vision and goals of individuals higher up in the hierarchy are not

shared by, or communicated well to those lower in the hierarchical structure, then unofficial missions, values, and goals, and an informal chain of command are established. Kifer, Hemmens and Stohr (2003) described, correctional staff, and in particular correctional officers, as being: "street-level bureaucrats" who hold the power to either carry out or destroy the institutional mission" (p.67). This again speaks to the need to include correctional officers along with nurses in order to ensure the sustainability of solutions aimed at addressing the root causes of the problems and challenges correctional nurses face in their day-to-day work.

WHO (2007) identifies the need for strong leadership at all levels, political leadership, prison administration leadership, nursing administration leadership and leadership from individual nurses and correctional employees. WHO recognizes that strong leadership, and especially at the higher levels, is necessary to move correctional healthcare and nursing forward. In relation to this study, strong nursing leadership would provide institutional administration with the evidence and nursing knowledge necessary to inform institutional policies and procedures. Strong nursing leadership is necessary in order to better equip healthcare units and to implement programs that will improve orientation for new staff working within the correctional environment

Leadership is necessary to facilitate and incorporate systemic changes that would facilitate solutions to the challenges correctional nurses face, and that would better support the rewarding aspects of their job. One of the opportunities of correctional nursing is to build on the present capacity of correctional nurses and link with community partners such as public health. Participants demonstrated leadership in their efforts to provide holistic care. WHO (2007) promotes a model of correctional health care that encourages holistic care of not only inmates, but of employees as well. This model is part of a public health agenda and as such, correctional

health care is included under the umbrella of public health, explicitly linking the health of individuals in prison to the overall health of society. This type of partnership provides the infrastructure correctional nurses need to adequately care for inmate clients, and to work towards a healthy correctional environment. The present partnerships that correctional institutions have with local public health departments provide an opportunity and a rudimentary foundation to support the exploration and development of a health promotion approach to healthcare in corrections.

5.2 Implications for Study Findings

The findings of this study offer many implications for correctional nursing and healthcare. Section 5.2.1 describes the implications of study findings related to Critical Social Theory. Thereafter, the following sub-subsections offer implications related to policy and administration (5.2.1), nursing practice (5.2.2), nursing education (5.2.3), and future research (5.2.4).

5.2.1 Implications of study findings related to Critical Social Theory (CST).

The structures of correctional nursing identified in this study were framed within a critical social framework. Critical social theories (CST) assume that within any social context there are imbalances in power distribution. Within a critical social framework, the value of knowledge lies in its application and should not be generated solely for the sake of knowledge. Rather, the knowledge gained from any investigation should be used to facilitate change (Duchscher, 2000). Therefore, in addition to describing the structures of correctional nursing, it is necessary to also use this knowledge to facilitate change in an attempt to rectify the imbalances known through the social context.

A critical social reflection on the findings of this study helped to identify both correctional nurses and inmates as being marginalized groups. In this study, correctional nurses described nursing goals as "just secondary" to the goals of security, and that often, participants felt devalued within the correctional setting when caring for inmate clients. Situating such findings within a critical social framework brought to light the historical context of nursing and of corrections. Briefly, traditionally nursing has been considered a predominantly female profession, and historically females have been discriminated against. As such, nurses generally have been considered a marginalized group (Kuokkanen & Leino-Kilpi, 2000). Historically, the guarding of prisoners and offenders was a male dominated profession. Therefore, correctional nurses work in an environment that has traditionally valued the associated male norms, goals and ideals of corrections. Correctional nurses are further marginalized because within the broader nursing profession they are small in number and work in an environment that is not well known to nursing or to the general public. Within this small group of correctional nurses, CST helped to identify that members of this group may face additional challenges and other forms of oppression related to being associated with, or belonging to an ethnic or racialized group.

CST facilitated personal critical reflections of the status quo in corrections as well as the organizational structure and culture; and the historical context of corrections. It also facilitated the critical reflection of current communication structures within corrections. Together, these critical reflections highlight several power imbalances and tensions of past and present values. Historically, imprisonment and medicine have had a tendency to perpetuate male dominant values, such as physical strength, obedience and the 'doctor knows best'. These continue to be embedded within the correctional setting. However, this sharply contrasts with many present-day values of corrections, healthcare and nursing as described by the study participants. These

values include valuing of: a rehabilitative approach to incarceration; knowledge as power; health promotion; and holistic care. More than identifying the inequities that the correctional nurses face, it is important that action be taken to address these concerns and to begin to rectify these imbalances. CST has guided the implications for nursing policy, administration, practice, education and research which are presented in the following sections.

5.2.2 Implications for policy/ administration.

There are several key implications for policy and administration related to correctional healthcare and nursing. Study findings suggest policy implications for recruitment and retention of correctional nurses. This study highlighted that correctional nurses were recruiting nurses from among their peers to work in corrections. This strategy, if supported, perhaps by offering an incentive program for current nurses, may be a viable and cost-effective way of recruiting new nurses.

Study findings support implications for developing programs that support retention of correctional nurses. Comprehensive orientation and mentorship of new correctional nurses were found to be an important part of their decision to remain in correctional nursing. Supportive programs should address the overall role of correctional nurses; ethical concerns of caring for inmate clients; and orientation to the security aspects of the job. It is further suggested that supporting mentorship programs may not only be beneficial to new staff, but may also benefit current staff. It was found in this study that participants experienced minimal support for their professional growth and development. Assuming a mentor role could also provide current nurses with an opportunity for professional growth and development. In addition, more mentorship opportunities could be offered to correctional nurses by building relationships with academic

institutions. Providing learning opportunities to nursing students may serve to promote correctional nursing; while providing a professional opportunity to current correctional nurses.

This study also found that participants described correctional nursing as intrinsically rewarding. These feelings were often tied to the participants' experiences of providing holistic client care. Such care included health teaching and promotion, assisting with discharge planning, and addressing family concerns. Therefore, it is suggested that supporting initiatives within the ministry that facilitate the rewarding aspects of correctional nursing may also increase nursing retention rates.

Further study to review the role and scope of nursing in order to better facilitate the delivery of healthcare within corrections is recommended. This study indicated that participants often struggled with ethical issues when caring for inmate clients. An advanced practice nurse employed at the Ministry level could facilitate forums, be it an online intranet chat room or a monthly teleconference. This would allow correctional nurses from all parts of the Ministry to talk about ethical issues they faced, and together correctional nurses could discuss better practice solutions for similar situations in the future. Such a forum could be opened to all correctional healthcare providers (physicians, social workers, psychiatrist, etc.) at times, to share ideas for providing better and more effective care. For issues that require working together with security staff, correctional officers could also join in on the discussion as a means of keeping the lines of communication open, and ensuring the sustainability of solutions.

It is evident from the findings that poor communication was an essential part of the description of correctional nursing. Improving communication is imperative for all levels of administration within corrections. The process of better communicating information between the Ministry, the institutions, and the frontline nurses should facilitate the flow of accurate and

timely information. Sustainable strategies for improving and facilitating communication between correctional nurses and correctional officers need to be developed and implemented.

Improvements to the work spaces where correctional nurses work also need to be addressed. Study participants were adversely affected by the unkempt nature of their work environment. This affected their sense of professional value within the organization. There is documentation in the literature that supports the need to address workspace issues described by participants. It is important for the administration of correctional institutions to regularly assess the workspaces of correctional nurses and to address any resulting concerns. Thus, possibly reducing the adverse effects of a poorly organized workspace on nurses; and potentially enhancing the efficiency and productivity of healthcare in the intuitions.

Finally, study findings also have implications for the larger correctional healthcare delivery system. Study findings indicated that there was a need for the current correctional healthcare system to be reviewed. The mission, vision, and goals of healthcare need to be re-examined, and should reflect the current inmate population health needs, and the capacity of healthcare service providers. Participants in this study indicated that the current medical model of healthcare offered in the detention centres did not adequately address the healthcare needs of inmates. The review of the correctional healthcare system should examine current and other correctional healthcare delivery models, as well as the overall health of institutions and correctional employees. Alternative models of correctional healthcare such as WHO (2007) should be studied and evaluated for the benefits and limitations of adopting an alternative way of delivering healthcare services within Ontario correctional centres. This evaluation could be a joint effort between the Ministry of Correctional Services, and other related ministries such as the Ministry of Health and Long Term Care, and the Ministry of Health Promotion. Partnerships

between these ministries and other related ministries such as the Ministry of Education and the Ministry of Training, Colleges and Universities could help to establish the infrastructure necessary to address continuing education needs of correctional nurses, correctional officers as well as address issues of literacy amongst inmates. As reflected in this study and corroborated in the literature (Maeve & Vaughn, 2001), correctional nurses require support and education related to coping with many complex behaviours exhibited by inmate clients. Collaborative partnerships between and among these various Ministries and institutions may be one way of addressing such education needs.

5.2.3 Implications for nursing practice.

The findings identify that participants encountered many challenges when caring for inmate clients. It is recommended that current nursing practices and support structures be reviewed with the purpose of developing best practices standards within correctional healthcare, and supporting nursing care of clients in secure environments. As described in this study, participants were continually challenged with situations where it was necessary for them to choose between the seemingly competing goals of client care and the safety and security of correctional officers and the public. Participants were also challenged to develop trusting relationships with inmate clients. As suggested in the literature, it may be particularly helpful to correctional nurses to consider alternative approaches to caring for inmate clients by adopting a transcultural or culturally competent approach to client care. This may support nurses in their quest to develop therapeutic relationships, and to advocate successfully for the needs of their clients. It was found that client advocacy was a part of correctional nursing and participants were able to practice this to varying degrees.

It is recommended that correctional nurses build upon the structures of positive working relationships within corrections as described in this study; and utilize their advocacy skills to advocate for better nursing care, and a better correctional healthcare system. This study found that correctional nursing was often experienced as less important and that the professional worth of nurses was diminished within the correctional setting. It also found that many participants expressed ideas for improving the system but were hampered by poor communication. It is recommended that correctional nurses seek leadership roles, and seek creative ways of having their concerns heard and addressed. This may include addressing all concerns and issues (feelings of being devalued, poor communication, difficulty negotiating custody and care, etc.) placed on staff meeting agendas. These concerns should then be discussed and action steps delineated and assigned to individuals during the meeting. Deadlines for completion should be set and evaluations should take place.

Since correctional nurses care for a socially marginalized population, it is necessary that nurses become politically active and bring the work they do to the public arena for exposure, discussion and gaining support for overcoming the challenges of, and to build on, the opportunities of correctional healthcare and correctional nursing. While it is acknowledged that correctional nurses work in environments that are often understaffed, it is important that all nurses support the effort of those who assume leadership roles in order to advance correctional healthcare. This support may be as simple as taking a few moments to forward a preformatted email, or to provide feedback when solicited by those seeking to improve correctional healthcare. Correctional nurses can also become active members of their professional associations, and take advantage of the resources such associations may provide to support the promotion of correctional nursing in the public and political spheres.

5.2.4 Implications for nursing education.

Leadership in nursing education is necessary to ensure that correctional nurses are adequately prepared to work in the correctional setting. This study has confirmed what is documented in the literature; that nurses in the correctional setting necessarily care from an ethical standpoint and require additional knowledge in areas such as mental health, addiction, chronic illness (e.g. diabetes), infection control, and sexually transmitted infection. The philosophical orientation and the practice of ethical caring, and their implications for client care and the nursing profession, necessitate that nursing education support the links between research, theory and practice within the correctional setting. Nursing education should include correctional nursing as a viable option for nursing students, and as a nursing career. Those in nursing education need to build partnerships with correctional facilities in order to understand the opportunities and challenges of correctional nursing. Because correctional nurses practice ethical caring, examples of the ethical dilemmas correctional nurses face should be presented and discussed in ethics courses in order to challenge and build on the critical thinking and problem-solving skills of nursing students.

As noted in the discussion, strong nursing leadership is needed within corrections. Beyond the basic degree program for nurses, nursing educational institutions need to collaborate not only with corrections, but also with other community partners in public health; mental health and addictions; and local hospitals in order to provide education that will prepare advanced practice nurses for this clinical setting. Advanced practice correctional nurses would be able to establish the strong nursing leadership needed in corrections. Advance practice nurses should have the skill and ability to support correctional nurses in their role and in their professional growth and development. These nurses should be able to evaluate, inform and support

institutional policies and procedures; offer guidance and direction for future health related policies; conduct research and build a network of community partners to better support correctional nursing and correctional healthcare.

5.2.5 Implications for nursing research.

This research has provided insight to the complex nature of correctional nursing within detention centres in Ontario. To date there has been minimal research conducted in the realm of correctional nursing with the Canadian context. Leadership in nursing research related to Canadian correctional nursing is necessary to establish a dedicated program of research within this area. An organized and systematic approach to research is necessary to determine priorities, and establish an agenda of correctional nursing at both provincial and federal levels. As demonstrated in other parts of the world such as the USA, the UK and Europe, establishing such a program was facilitated with political leadership and governmental commitment – leading to the establishment of a national entity responsible for addressing correctional nursing and health care issues. Such research would provide evidence necessary for the establishment of evidence based practice and of nursing standards within corrections.

As suggested by the findings of this study, further research is necessary to address issues unique to caring for the accused adult male population. Of the participants, there were two nurses who worked with other populations and described having fewer available resources when working with this adult male population. As previously mentioned, a critical social lens necessitates that questions regarding systemic marginalization of the accused adult male population be raised. For example, the following questions may be raised: what are the assumed social normative perceptions of adult male behaviours; how do these affect the custody and care

of this population; and what gender values and assumptions are embedded in the justice system that serves to disadvantage this population and what does this mean for correctional nursing?

The findings also suggested that further research is necessary to investigate the presence of racism in corrections, and its effects on correctional nursing and correctional healthcare. The experience of racism did not emerge in this study as an essential structure of the lived experiences of correctional nursing. Perhaps, that was because the question asked was not sufficiently detailed to assess whether or not participants recognized what racism is, and whether or not their experiences were, in fact, related to racism. Two nurses did express encountering racism on occasion, against themselves, either from other staff or from inmates. Two nurses also felt that there was systemic racism against inmates. Racism, like other prejudices, can adversely affect the health of individuals, and as a result further research in this area is necessary.

Lastly, there was some evidence in the data from this study to suggest that future research should focus on the prevalence of post traumatic stress disorder (PTSD) among correctional nurses. "Post traumatic stress disorder is an anxiety disorder following an event a person perceived to be physically-threatening or life-threatening" (Stewart-Amidei, 2005, p. 179) and often precipitates and is co-morbid with other health problems. PTSD in nurses has been documented in the literature (Carson et al., 2000; Mealer, Shelton, Berg, Rothbaum, & Moss, 2007; Rassin, Kanti, & Silner, 2005; Robinson, Clements, & Land, 2003). It is suggested in the literature that PTSD in nurses is not recognized, or is often misdiagnosed as burn-out or another secondary health problem (Schwarz, 2005; Stewart-Amidei, 2005).

Correctional nurses care for a population who have diverse health problems of varying acuity levels, and who have been accused, or convicted of a wide-range of crimes including violent and heinous crimes. They do so in an environment where it is generally assumed that

their clients are a threat to their personal safety and security. Study participants often commented on understanding the need for the presence of correctional officers when providing care, indicating an underlying tone of danger or an atmosphere of managed fear. One participant in this study described that coping with violence amongst inmates was difficult. One participant reported that inmates are "territorial" and if another inmate encroaches on another's space then "it's a bashing he's [the offending inmate] gonna get" (Participant 2). While nurses working in stressful environments such as the emergency department, intensive care unit, and psychiatry, may be at an increased risk for experiencing PTSD, common events such as medication errors, may also be a very traumatic event for some nurses. Rassin, Kanti and Silner (2005) found that making a medication error, depending on the outcome, was very emotionally distressing for some nurses and, over time, they exhibited symptoms associated with PTSD. There is consensus in the literature that being more aware of PTSD in the workforce and providing necessary supports, may help nurses and other professionals to resolve this disorder and improve their functionality (Carson, 2000; Mealer et al., 2007; Rassin, Kanti & Silner, 2005; Schwarz, 2005). There are many examples of experiences described herein by participants which examined as a whole and support the need to investigate the prevalence of PTSD among correctional nurses.

5.3 Study Limitations

The findings of this study are reflective of the descriptions provided by study participants. This study aimed to describe the lived experiences of correctional nurses working in two Ontario detention centres. The broad nature of the research question provided a wide-range of descriptions. Therefore, the transferability of study findings herein may be limited when considering other types of correctional facilities; or detention centres located in different jurisdictions.

CONCLUSIONS

The purpose of this study was to examine the lived experience of correctional nurses working in detention centres in Ontario. As there has been minimal research conducted in Canada regarding correctional nursing, conducting a descriptive phenomenological inquiry within a critical social theory framework served the dual purposes of providing a description of what it is like to work inside a provincial correctional facility, while providing an opportunity for correctional nurses to have their voices heard.

Through data analysis, the elements that were essential to the description of this experience were elucidated. These essential structures were varied and described many aspects of the lived experiences of correctional nursing. What is apparent from this study is that correctional nursing is a different type of nursing that requires nurses to be continually conscious of the secure environment in which they work, and to move beyond the natural attitude of caring for clients to an assumed ethical attitude of caring for inmate clients. Participants described the need to always practice from a consciously non-judgemental attitude. Participants also acknowledged that it was often more difficult to remain non-judgemental if the client was associated with a heinous crime.

Situating study findings within the general body of literature concerning correctional nursing, demonstrated that there were many similarities with the findings of this study. Many of the challenges study participants experienced, such as the lack of support of new and current correctional nurses, communication problems, lack of managerial/ organizational support, and working within an archaic healthcare model, were also highlighted in the literature. From a critical social viewpoint, more dialogue and discourse are necessary to identify, challenge, and

change many of the assumed truths about the purpose of incarceration, the value of inmates, and the value of correctional healthcare and nurses.

There are many opportunities within correctional nursing. As indicated in both this study and previous literature, correctional nurses are the primary healthcare service providers within correctional facilities who collectively, have a wealth of knowledge and experience to address the many issues concerning correctional healthcare, but they lack organizational support within which to do so.

Leadership in corrections is needed at all levels in order to improve and move correctional healthcare and nursing forward. A review of the current correctional healthcare model along with other models, and approaches to correctional healthcare and nursing (e.g. a public health approach to correctional healthcare), should be explored and evaluated; and changes should be implemented to strengthen the current system. There is a need to build upon the current infrastructure of correctional health care in order to support, adequately, the needs of correctional healthcare and nursing. The establishment of a program of research focusing on correctional nursing would help to better understand the challenges, opportunities and best practices of healthcare within the correctional setting.

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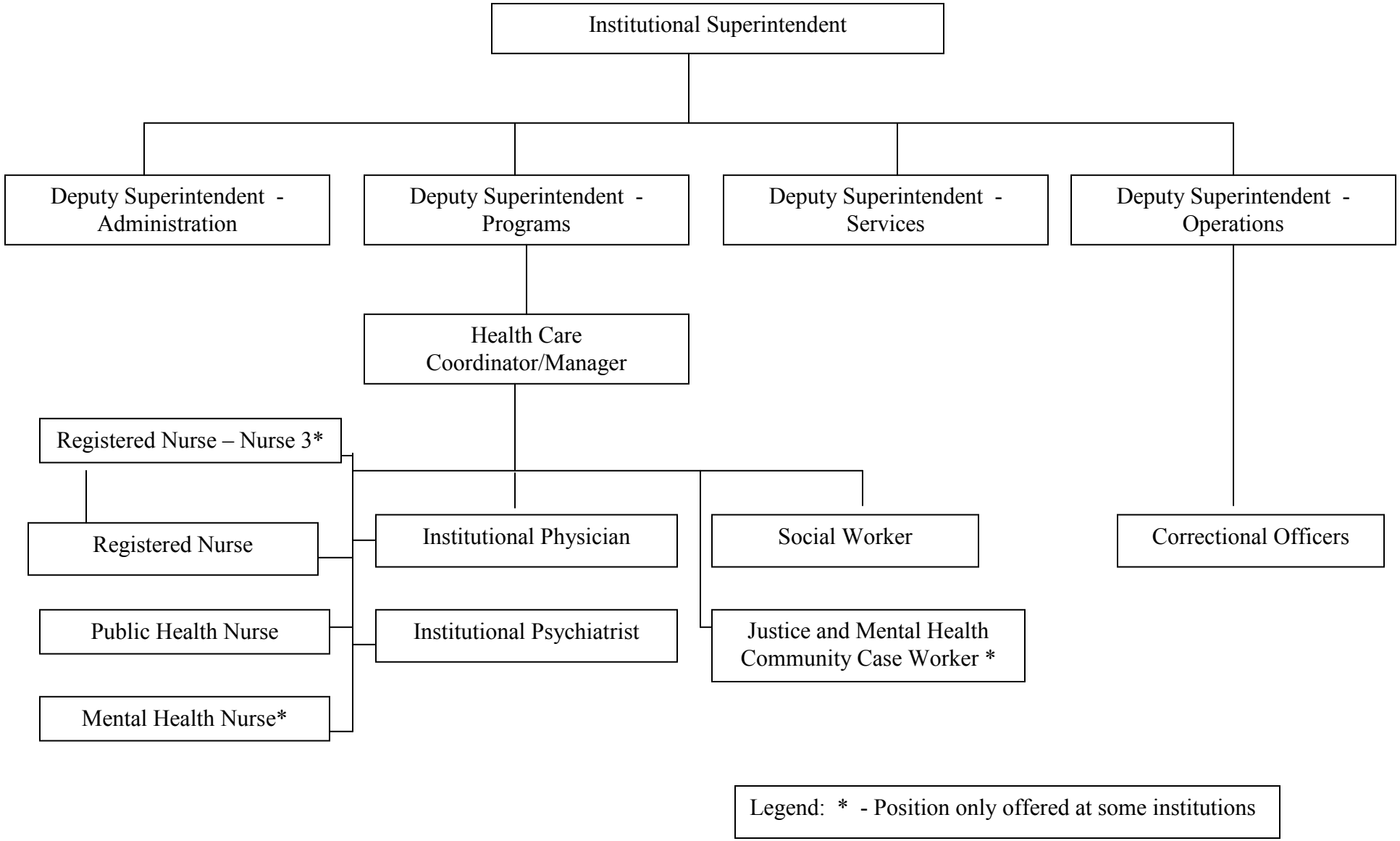
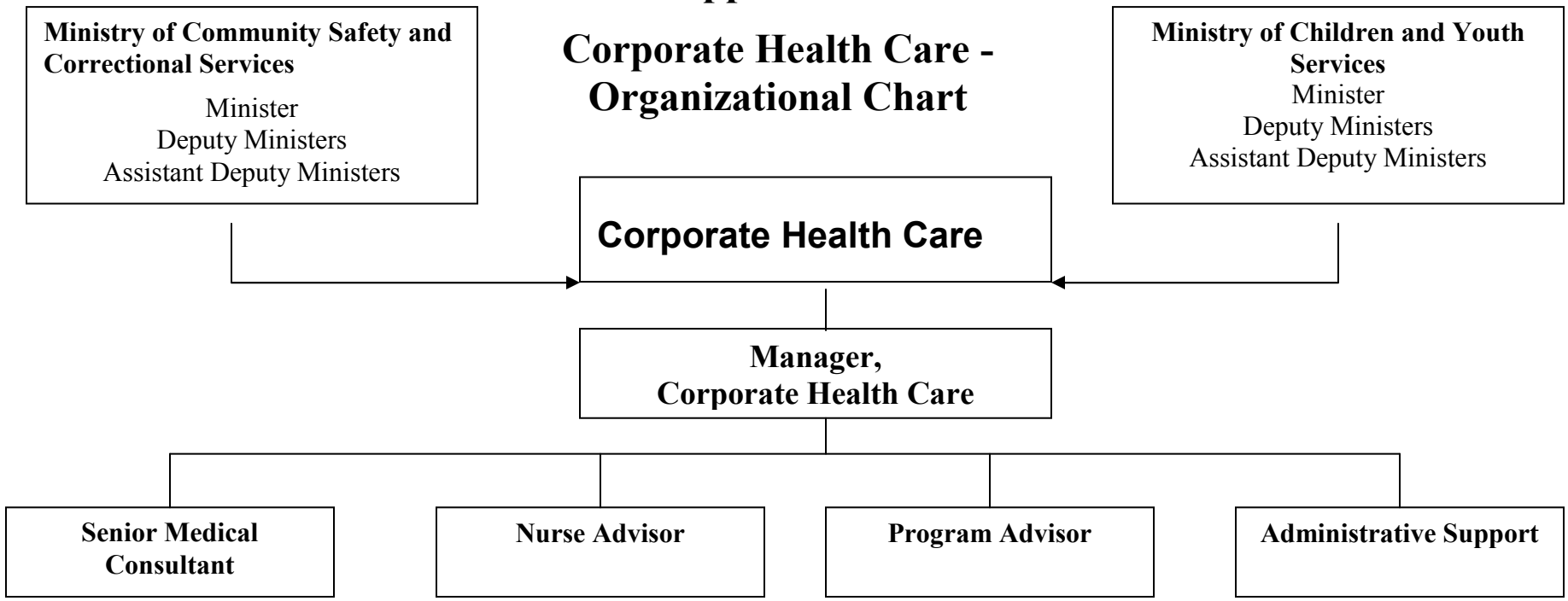
Appendices A-J

Appendix A– Institutional Organizational Chart – Health Care



Appendix B

Corporate Health Care - Organizational Chart



CORPORATE HEALTH CARE

Corporate Health Care supports health care professionals working in the MCSCS institutions and MCYS custody/detention facilities to provide health care services that:

- are multi-disciplinary, comprehensive and holistic
- provide patients with opportunities for choice
- meet the normal requirements of health care service provision which minimally includes safe, effective and ethical care
- are appropriate to the patient's age and gender
- respect religious and cultural values
- assist patients to be responsible for self-care, where possible
- assist patients to make informed decisions regarding their health care
- assist patients to make positive personal and social adjustments
- emphasize health promotion, health education and prevention of health problems

Appendix C - Ryerson University Research Ethics Board - Approval

RYERSON UNIVERSITY
RESEARCH ETHICS BOARD

To: Sheleza Latif
Re: REB 2008-009: The Lived Experience of Correctional Nurses Working in Two Ontario Detention Centres: A Descriptive Phenomenological Study
Date: February 4, 2008

Dear Sheleza Latif,

The review of your protocol REB File REB 2008-009 is now complete. The project has been approved for a one year period. Please note that before proceeding with your project, compliance with other required University approvals/certifications, institutional requirements, or governmental authorizations may be required.

This approval may be extended after one year upon request. Please be advised that if the project is not renewed, approval will expire and no more research involving humans may take place. If this is a funded project, access to research funds may also be affected.

Please note that REB approval policies require that you adhere strictly to the protocol as last reviewed by the REB and that any modifications must be approved by the Board before they can be implemented. Adverse or unexpected events must be reported to the REB as soon as possible with an indication from the Principal Investigator as to how, in the view of the Principal Investigator, these events affect the continuation of the protocol.

Finally, if research subjects are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with the REB prior to the initiation of any research.

Please quote your REB file number (REB 2008-009) on future correspondence.

Congratulations and best of luck in conducting your research.

Nancy Walton, Ph.D.
Chair, Research Ethics Board

Appendix D – Sample Recruitment Letter Sent to the Detention Centres

RYERSON UNIVERSITY **Master of Nursing**

Research Project Title: The Lived Experience of Correctional Nurses Working in Two Ontario Detention Centres: A Descriptive Phenomenological Study

Investigators:

Sheleza Latif RN, BScN, MN student
Masters student within School of Nursing
Ryerson University

Dr. Diane Pirner RN PhD
Assistant Professor, Ryerson University
School of Nursing

Sponsor: None

name of contact within institution

Thank you for your interest in this study entitled " *The Lived Experience of Correctional Nurses in Ontario: A Descriptive Phenomenological Study*" This research study is being done by Sheleza Latif (RN, BScN), a MN graduate student at the School of Nursing at Ryerson University.

The purpose of this study is to describe the essences of correctional nursing as experienced by nurses working within Ontario's correctional setting. I will be meeting with the participants on 1-2 occasions for about 1-2 hours to hear their accounts of their experiences of correctional nursing. These interviews will be tape-recorded. All information collected will be kept confidential. It is hoped that this study will yield findings to document the structure and nature of correctional nursing in Ontario, Canada and will add to the foundational knowledge of correctional nursing in Canada.

Included with this letter are a number of advertisements aimed at recruiting study participants. It would be most appreciated if you could provide each nurse with a flyer and post some flyers in suitable places.

Thank you,

Sheleza Latif, RN, MN student

Appendix E- Sample of Recruitment Flyer

RYERSON UNIVERSITY | **Master of Nursing**

The Lived Experience of Correctional Nurses Working in Two Ontario Detention Centres: A Descriptive Phenomenological Study

Hello Everyone! My name is Sheleza Latif and I am a registered nurse and a correctional nurse. I am completing a Master of Nursing Thesis at Ryerson University. I am very interested in studying the experiences of nurses working in Canadian correctional facilities. I have chosen to focus this study on the experiences of correctional nurses working at either Metro West Detention Centre or Toronto East Detention Centre. This study aims to describe the uniqueness of correctional nursing. I am kindly seeking your participation in this study.

ATTENTION CORRECTIONAL NURSES:

SEEKING YOUR PARTICIPATION IN A RESEARCH STUDY ABOUT THE EXPERIENCES OF CORRECTIONAL NURSES!

Would you be interested in sharing your experiences of correctional nursing?

Would you like to contribute to the further understanding of correctional nursing in Canada?

Would you like to know more about this research study?

If you answered "YES" to any of the above questions or if you would like more information

Please Contact: Sheleza Latif, RN, MN student at:
Phone number: XXXX or Email: XXX
Or
My Faculty Thesis CO-Supervisor, Dr. Diane Pirner, RN, PhD at:
Phone number: YYYY or Email: YYY

Appendix F – Sample Informed Consent Agreement

RYERSON UNIVERSITY | **Master of Nursing**

Informed Consent Agreement

The Lived Experience of Correctional Nurses Working in Two Ontario Detention Centres: A Descriptive Phenomenological Study

You are being asked to participate in a research study. Before you give your consent to be a volunteer, it is important that you read the following information and ask as many questions as necessary, to be sure you understand what you will be asked to do.

Investigator:
Sheleza Latif, RN, BScN. Graduate Studies, School of Nursing, Ryerson University, Toronto, Canada. Faculty Thesis Supervisor: Dr. D. Pirner, RN, PhD Professor, School of Nursing, Ryerson University, Toronto, Canada.

Purpose of the Study: The purpose of this study is to describe the essences of correctional nursing as experienced by nurses working within Ontario's correctional setting. A range of 6-10 participants is required for this study. You are eligible for this study if you are presently employed with the Ministry of Correctional Services as a nurse; if you work in a correctional facility; if you speak English; and if you are willing to be interviewed by research investigators.

Description of the Study: You will be asked to participate in an audio-recorded interview. The purpose of the interview is to collect data about your lived experiences of nursing in corrections. Generally, interviews will be conducted at Ryerson University. However, interview locations and times are negotiable and are based on mutual convenience, comfort and security. The length of the interview is not predetermined and concludes when you have completed telling your story of nursing in corrections. Traditionally, the average duration of the initial interview ranges from one to two hours. Subsequently one additional follow up interview may be necessary to further explore specific aspects of initial interview or to address points of clarification. The second interview will take approximately one half hour and is, again, entirely voluntary, i.e. consenting to the initial interview does not imply that you are obligated to take part in a second interview.

What is Experimental in this Study: None of the procedures or questionnaires used in this study is experimental in nature. The only experimental aspect of this study is the gathering of information for the purpose of analysis.

Risks or Discomforts: As with all studies, there are associated risks and discomforts. Specific to this qualitative inquiry it is possible that you may experience some discomfort or become uncomfortable as you recall and reflect on negative or unpleasant aspects of correctional nursing. It is important for you to know that if at anytime you begin to feel uncomfortable, you may choose to discontinue your participation, either temporarily or permanently.

Benefits of the Study: The expectation of this study is that its finding will be beneficial to the nursing profession and to the government and society in general. It is expected that the findings of this research will identify the essence of correctional nursing in a Canadian context. Additionally, it is hoped that by drawing on the experiences of nurses from various institutions the study result may be used to foster and promote communication and networking of correctional nurses across institutions. It is also expected that study findings will assist the government with the recruitment and retention of correctional nurses. This study may provide the basis for long-term efforts to ensure a proficient and progressive correctional health care system.

Confidentiality: Protecting and maintaining confidentiality of your personal information gathered throughout the research process including the reporting of research results is most important. As a study participant confidentiality of your identity and information will be assured in the following steps: 1) you will be interviewed in an environment that offers privacy and confidentiality – you have the right to determine the location of the interview so that you feel safe and comfortable and your privacy maintained throughout the interview process; 2) you have the right to refuse to answer any questions throughout the interview process; 3) all data will be coded to ensure confidentiality; 4) the researcher will be respectful of all stories told by you; 5) transportation of all data including audio tape recordings and field notes, will be transported a) in locked containers, to prevent against accidental spillage of container contents; and b) directly – non-stop from place of interview to place of data storage to safeguard against vehicular theft; 6) all data retained after the completion of the study will be secured and coded for your protection; 7) the names of the institutions in which you work will not be released, institutional names will also be coded with all other incoming data; 8) quotes and data used when reporting research findings will not contain any personal identifying data; and 9) all findings will be made available to you, the Ryerson University Faculty of Nursing, and may be published in a scientific journal.

An audio recording of the interviews will be made for the purposes of ensuring that your entire story is captured and considered for data analysis. The audio recordings will be transcribed to assist with data analysis. As a study participant you will not be able to review nor edit audio recordings or transcripts of your interview(s). This information will be kept for two years. Items will be kept in a secured container and only the primary researcher will have access to these items. After two years the audio recordings will be physically destroyed and the transcripts will be shredded and disposed of.

Incentives to Participate: You should know that you will not be offered any tangible incentives to participate in this study. That is, you will not be paid for participating in this study. Rather incentive to participate in this study is intrinsic to the study and it provides an opportunity for your voice, as a correctional nurse, to be heard and provides data necessary to aid research and professional development within a correctional nursing context.

Costs and/or Compensation for Participation: There are incidental costs that you may incur as a result of participating in this research, which includes the cost of transportation to and from the interview. If you choose to participate in this research study you will not be compensated for your travelling expenses.

Compensation for Injury: It is unlikely that participation in this project will result in harm to participants. If any complications arise, we will assist you in obtaining appropriate attention. If you need treatment or hospitalization as a result of being in this study, you are responsible for payment of the cost for that care. If you have insurance, you may bill your insurance company. You will have to pay any costs not covered by your insurance. Ryerson University will not pay for any care, lost wages, or provide other financial compensation.

Voluntary Nature of Participation: Participation in this study is voluntary. Your choice of whether or not to participate will not influence your future relations with Ryerson University, your institution of employment, or the Ministry of Community Safety and Correctional Services. If you decide to participate, you are free to withdraw your consent and to stop your participation at any time without penalty or loss of benefits to which you are allowed.

At any particular point in the study, you may refuse to answer any particular question or stop participation altogether.

Questions about the Study: If you have any questions about the research now, please ask. If you have questions later about the research, you may contact.

Faculty Thesis Supervisor: Dr. Diane Pirner
Telephone Number:
Email:

If you have questions regarding your rights as a human subject and participant in this study, you may contact Alexander Karabanow of Ryerson University Research Ethics Board for information.

Alexander Karabanow
Research Ethics Coordinator
Telephone:
Fax:

Email:

Contact address:

Research Ethics
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street, Suite
Toronto, Ontario

Agreement:

Your signature below indicates that you have read the information in this agreement and have had a chance to ask any questions you have about the study. Your signature also indicates that you agree to be in the study and have been told that you can change your mind and withdraw your consent to participate at any time. You have been given a copy of this agreement.

You have been told that by signing this consent agreement you are not giving up any of your legal rights.

_____
Name of Participant (please print)

_____ _____
Signature of Participant Date

_____ _____
Signature of Investigator Date

Appendix G – Consent to Audio Record Interview

RYERSON UNIVERSITY | **Master of Nursing**

Consent to Audio- Record and Disclose Personal Information

I, _____,
(participant's name)

authorize Sheleza Latif, RN, BScN, MN student, the researcher, to audio - record personal information disclosed by me in interviews with the researcher.

I further authorize the researcher to disclose information given by me in those interviews, excluding information which would identify me by name, to the researcher's students or colleagues assisting in the analysis of the information, to any professional peer reviewers of the research, and to the readers of any draft or final written reports on the information disclosed, including any published reports.

I understand the purpose for disclosing this personal information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:_____

Address:_____

Telephone:_____

Signature:_____ Date:_____

Witness Name:_____

Address:_____

Telephone:_____

Signature:_____ Date:_____

(Adapted from Ontario *Personal Health Information Protection Act* (2004) Consent form)

Appendix H - The Interview Guide

Interview Guide

Before beginning the interview I provided each participant with an explanation of the purpose of the research and interview session - helping participants to gain a better understanding of the correctional nursing experience and its opportunities and challenges.

"This research project/interviews will provide me with an opportunity as a researcher to gain a better understanding of what the correctional nursing experience is, and what are its opportunities and challenges."

I began the interview with an open ended question,

1. Tell me about your experience of correctional nursing in the context of a detention centre.
    a. What is it like caring for clients who are inmates on a daily basis?
    b. How many years have you been employed as a correctional nurse?

Subsequent questions and probes may include:

2. Tell me about what it is like to care for clients who are inmates
    a. Would you like to care for clients who are inmates in a different manner?
    b. How would you like to care for clients who are inmates?
    c. What is most rewarding about caring for inmate clients?
    d. What is most challenging about caring for clients who are inmates?
    e. How do you think the clients you care for perceive correctional healthcare and correctional nurses?
    f. Have you cared for other incarcerated populations (different from adult male population)? How was this similar? Different?

3. Describe for me what it means to you to be a correctional nurse.
    a. How has this evolved over your years of experience?
    b. Tell me about the value of correctional nursing
    c. Describe the ideal correctional nurse – characteristics

4. Tell me what it is like working within a correctional environment
    a. Tell me about how correctional nursing is perceived by others (staff, management, upper management – be more specific i.e. correctional officers, social worker, MD's, HCC, Lieutenant, Superintendent, Deputy Superintend, etc.)
    b. Tell me about your working relationships as a correctional nurse
        i. Who do you interact with on a daily basis?

5. Tell me how your education prepared you for working as a correctional nurse
    a. How has your nursing education prepared you for correctional nursing?

        i. Educational background

    b. How has your life experience prepared you for correctional nursing?
    c. How do your values and personal beliefs influence your practice as a correctional nurse?
    d. How did your employer prepare you for this position?
        i. Orientation/education opportunities and what are they

6. Tell me about the challenges of correctional nursing.
    a. How is it different than past nursing experiences?
    b. What do you think contributes to these challenges?
    c. Tell me about some of the stressful situations you face as a correctional nurse

7. Tell me about the opportunities of correctional nursing.
    a. How is it different than past nursing experiences?
    b. What are some of your thoughts about ways of moving correctional nursing practice forward? I.e. recruitment and retention – standards in place, greater visibility
    c. What are some positive changes occurring within correctional health care?

8. Is there anything else you would like to comment on in correctional nursing that we have not covered as yet.

Demographic/Background questions to be asked at end of interview sessions if not covered during interview

Age
Marital status
Level of nursing education
Number and age of children
Country of birth
Number of years lived in Canada
Places lived before Ontario
Previous Nursing/Work Experience
Number of Years Employed in Corrections

Appendix I – List of Essential Structures

4.0 FINDINGS

4.1 Discovering Correctional Nursing

Essential Structure 1: This study found that nurses were unaware of correctional nursing, and passively gained awareness by being introduced to it via a peer or at his/ her place of employment.

Essential Structure 2: This study found that the participants' initial experiences of negotiating the security aspects of correctional nursing fostered feelings of frustration and disappointment, and of not wanting to remain in corrections.

Essential Structure 3: This study found that nurses identified three factors that facilitated their decision to remain in correctional nursing. These included having a good mentor; supportive nursing colleagues; and with the passage of time, resolving to do the best they can within a correctional context.

4.2 Correctional Nurses' Workspaces

Essential Structure 4: This study found that the physical work environment affected participants' emotions. A poorly organized and unkempt environment evoked feelings of confinement, depression, and diminished professional value.

4.3 Working Relationships

4.3.1 The Correctional Nurse –Correctional Officer Working Relationship

Essential Structure 5: This study found that nurses experienced a positive working relationship with correctional officers when a shared understanding or common purpose existed.

Essential Structure 6: This study found that nurses often experienced role and goal ambiguity in their working relationship with correctional officers. This fostered poor communication between the correctional nurses and the correctional officers and resulted in nurses feeling frustrated, impatient and less valued within the correctional nurse-correctional officer working relationship.

4.3.2 Correctional Nurse - Management Working Relationship

Essential Structure 7: This study found that nurses experienced the correctional nurse-management relationship positively when management demonstrated active listening and offered positive feedback.

Essential Structure 8: This study found that nurses often experienced minimal support, from management for: 1) their professional growth and development; and 2) for overcoming the organizational challenges they encountered in their role as correctional nurses. This resulted in nurses feeling discouraged and less valued within the organizational structure of the detention centre.

Essential Structure 9: This study found that communication between correctional nurses and management was delayed, infrequent; and consisted of more negative than positive feedback. This again fostered feelings of disregard, of being unappreciated and of diminished professional value among correctional nurses.

4.4 Caring for "Inmate" Clients

Essential Structure 10: This study found that nurses necessarily practiced within a consciously non-judgemental attitude when caring for inmate clients in order to provide appropriate nursing care.

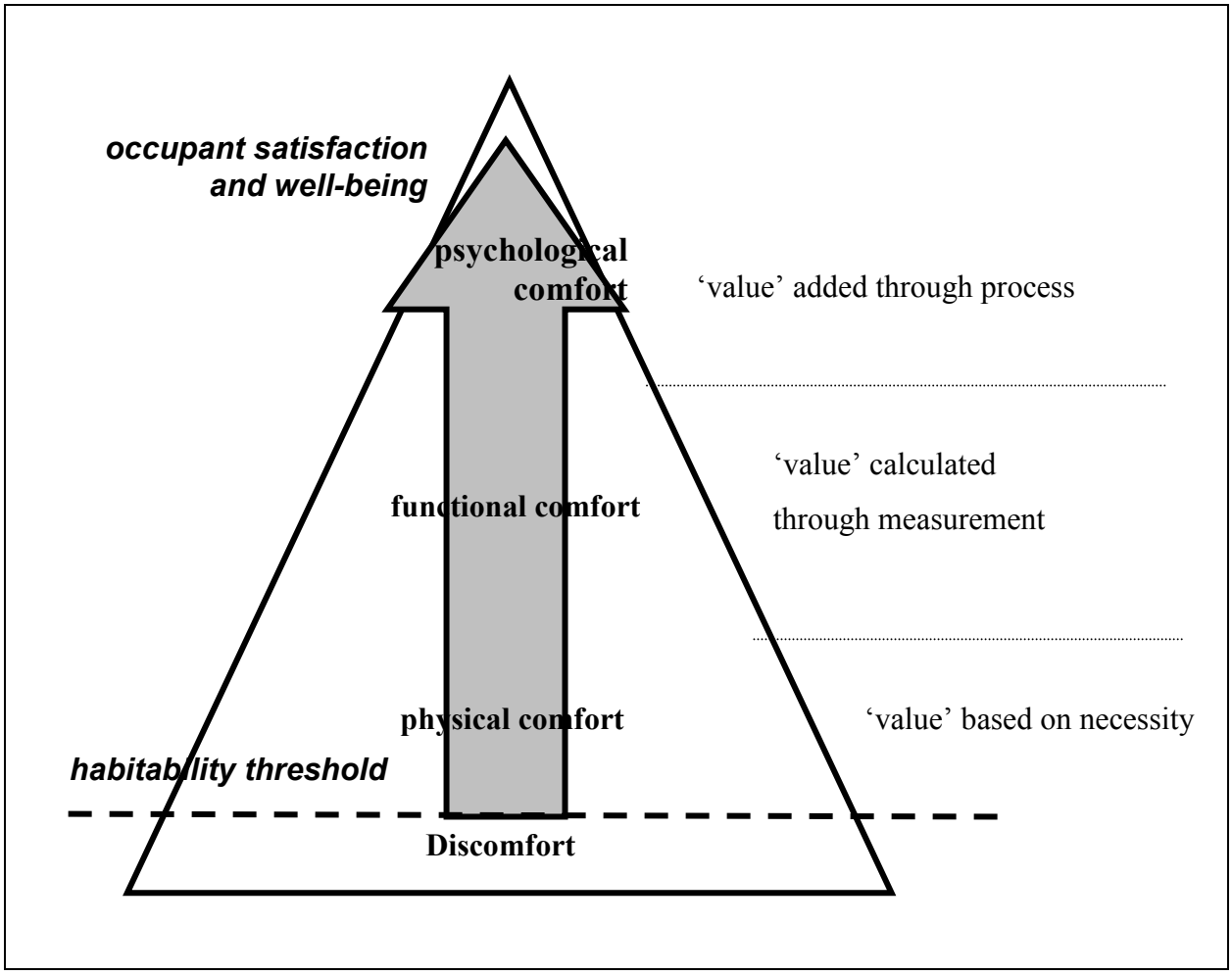
Essential Structure 11: This study found that nurses' experiences of being manipulated by inmate clients for the purposes of breeching the safety and security protocols of corrections, often lead to feelings of suspicion and mistrust between nurses and their clients. This challenged the development of a trusting nurse-client relationship. It was found that a trusting nurse-client relationship evolved over multiple interactions with the client, and when nurses engaged in active listening.

Essential Structure 12: This study found that nurses relied on their assessment skills and their intuitive knowledge in order to provide sound nursing care to inmate clients.

Essential Structure 13: This study found that nurses working in detention centres experienced the nursing role within the detention centres as narrowly defined and encountered challenges when attempting to provide nursing care outside the narrowly defined nursing role.

Essential Structure 14: This study found that correctional nurses described caring for inmate clients as intrinsically rewarding.

Appendix J - The Habitability Pyramid



Source: The Habitability Pyramid (Vischer, 2005) as cited in Vischer 2007, p.180

Glossary

Correctional Facility

An institution that houses incarcerated individuals and includes correctional centres, detention centres, jails, penitentiaries, prisons. The security levels of these facilities can range from minimum security to maximum security.

Correctional Nurse

A professional nurse employed by the government, provincial or federal, to provide health care services to inmates. Correctional nurses are the primary health care providers within the correctional health care system (Watson, Stimpson, & Hostick, 2004; Weiskopf, 2005). They provide a wide range of health care services ranging from primary health care, management of chronic health and mental health conditions to palliative care. Correctional nurses are expected to provide excellent nursing care in a very restrictive environment within which custody and security issues are paramount (Droes, 1994; Kifer, Hemmens, & Stohr, 2003).

Correctional Nursing

Correctional nursing is a general term used to identify those nurses who practice nursing and care for inmate clients within a correctional setting. Correctional nurses are often characterized as the backbone of correctional health within the institutions. They have the task of balancing the goals of nursing and health care with the goals of custody and security (Goldkuhle, 1999; Morrison, Burnard, & Phillips, 1997; Watson, Stimposon, & Hostick, 2004; Weiskopf, 2005). Correctional nurses care for a population who is socially marginalized, in poorer health than the general population, and for whom the provision of health care is very challenging.

Correctional Officer

A peace officer (as defined under the Criminal Code of Canada) charged with the care, custody and control of offenders. This care includes supervision of inmate activities; control of inmate movement throughout the institution; and facilitating counselling of inmates with regard to personal and behavioural problems. Additionally, correctional officers are trained in search procedures, self-defence, dealing with emergencies, using tactical weapons, and dealing with people. (http://www.mcscs.jus.gov.on.ca/english/corrserv/careers.html, retrieved June 19, 2007).

Culturally Sensitive Nursing Care

Culturally sensitive nursing care is the application of the principles of transcultural nursing to care. Nurses who apply the tenets of transcultural nursing use a culturally sensitive lens to recognize and assess how those transcultural universals as well as the specifics of diverse cultures influence clients' needs and client care (Leininger, 1991; 2001). Culturally sensitive care and culturally competent care are terms used by others to refer to this process (Leininger, 2001).

Culture

As defined in research, culture is the shared belief patterns, values and way of life of a particular group (Edleman & Mandle, 2002). Leininger and McFarland (2002) also suggest that these shared beliefs, values and ways of life are passed on intergenerationally, and strongly influence one's patterns of behaviour, thought processes, and decision making. Culture shapes the way individuals come to know and relate to their life-world.

Inmate and Offender

Correctional employees often use the terms inmate and offender interchangeably. However, within the Criminal Code of Canada, an offender refers to a person who is guilty of an offence, as determined by a court of law. Therefore, by definition, the term offender does not accurately apply to those incarcerated individuals awaiting trial. For this reason, the term inmate was be used in this study and refers to all incarcerated individuals who are housed within correctional facilities.

Intentionality

A term meaning that consciousness is always consciousness of something. Thus, one does not hear without hearing something or believe without believing something (Cohen, 1987, p. 32).

Jails and Detention Centres

Jails are older, generally smaller institutions, originally established by counties or other municipalities. Detention centres (DC) are larger, more modern facilities that were built to serve the needs of several regions. Jails and detention centres serve as points of entry into the institutional system. They house persons on remand (awaiting trial, sentencing or other proceedings); inmates sentenced to short terms (approximately 60 days or less); and inmates awaiting transfer to a federal or provincial correctional facility. Both types of facilities are maximum security facilities**.**

Marginalize

"To relegate to an unimportant or powerless position within a society or group" (Marriam-Webster Online Dictionary).

Penitentiary

A penitentiary is owned and operated by the federal government, and generally houses offenders who have been sentenced to two or more years. There are approximately 13,000 offenders in federal custody. Canadian penitentiaries vary in size and security levels - maximum, medium and minimal security. Penitentiaries are located in eight out of ten provinces (http://www.csc-scc.gc.ca/text/employment_e.shtml, retrieved on February 1, 2007).

Perception

"Perception is not a science of the world, or even an act, a deliberate taking up of a position. It is the basis from which every act issues and it is presupposed by them (Speziale & Carpenter, 2007, p. 77).

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder is an anxiety disorder. Its definition has been revised many times since it was first defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders in 1980. There has been much debate regarding the requisite stressor that precipitates the development of PTSD. In the forth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) the requisite stressor is characterized as an extreme traumatic stressor, involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close

associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (Criterion A2; American Psychiatric Association, 2000, p. 463).

The symptoms of PTSD are continuous and directly related to the traumatic event; present for more than one month; and cause significant distress or impair functionality. Symptoms include: re-experiencing the trauma; avoiding related stimuli; and increased arousal – insomnia, anxiety, gastrointestinal irregularities, etc. (American Psychiatric Association, 2000; Schwarz, 2005).

Prison

The term prison includes penitentiaries, common jails, public or reformatory prisons, lock-ups, guard-rooms or other places in which persons who are charged with or convicted of offences, are usually kept in custody.

Range

A range is the term used in the correctional setting to describe and refer to the living quarters of inmates within the institutions.