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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

# 'If we truly cared': understanding barriers to person-centred nursing in correctional facilities

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**Abstract**

*Background:* Incarcerated people in the US are an often forgotten patient population with legal rights to healthcare. Correctional nurses are required to enact ethical and quality care regardless of any bias about patients' backgrounds. However, correctional structures and institutional power relations restrict nurses' free expressions of care.

*Aim*: This qualitative study explored US nurses' experiences and perceptions of caring in carceral environments to analyse the possibilities of and barriers to enacting person-centred care for incarcerated people.

*Methods*: Data were collected in REDCap, an online survey tool, through six demographic questions and six open-ended questions. A convenience sample of 78 correctional nurses was identified through US nursing associations. Responses were analysed by thematic analysis. Full ethical approval was obtained.

*Results*: Nurses identified the carceral environment and considerations of security as barriers to care. Other barriers included biases that nurses and correctional officers bring to their work. Yet many correctional nurses seek to provide compassionate care and advocacy despite these challenges. Within the findings, three main themes emerged: types of care; barriers to care; and strategies for change.

*Conclusions*: There has been little examination of theoretical frameworks regarding the implementation of nursing values that may enable care for the person, rather than a 'prisoner-patient.' Correctional nursing is thwarted by existing historical and structural barriers that can dehumanise incarcerated patients. Nursing care in correctional facilities should be considered within the context of implicit biases, the care environment and the person receiving care.

*Implications for practice*:

- The Person-centred Practice Framework provides a potential way forward for addressing nursing biases and structural awareness
- An expanded understanding of the care environment as a prerequisite encourages correctional nurses to engage with the historical, economic and political forces that act against person-centred nursing in correctional facilities

**Keywords**: Correctional nursing, criminal justice, prison health, person-centred care, quality care, human rights

**Introduction**

Inmates are both patients and people with valid health needs and a constitutional right to healthcare under the US Supreme Court's 1976 ruling in *Estelle v. Gamble* (Wright, 2008; Sufrin, 2017). Patients in correctional institutions, however, are an isolated population with inequitable access to healthcare. As the primary care providers in prisons, correctional nurses should ensure quality care for their patients, who are, first and foremost, humans (Christensen, 2014). Studies point to the beneficial influence of caring values on a patient's health status. The American Nurses Association's code of ethics mandates the application of these values to all patients regardless of their background (Schoenly and Knox, 2012). Thus, exploring correctional nurses' attitudes regarding caring in carceral environments – defined as correctional institutions such as prisons or jails – is vital to ensuring quality healthcare for one of the most vulnerable and isolated patient populations. In this article, we explore some of the attitudes expressed by correctional nurses about their struggle to provide adequate care and consider the ways that structural factors contribute to poor care for incarcerated people. We conducted a thematic analysis of responses, which revealed three key themes related to nurses' work in corrections: types of care, barriers to care and strategies for change. These findings were then compared with various aspects of the Person-centred Practice Framework (McCormack and McCance, 2017) in order to consider the limitations and possibilities of person-centred nursing in correctional facilities.

**Background and significance**

The ongoing expansion of the criminal justice system in the US has been described as leading to mass incarceration, with more than 2.3 million people currently serving custodial sentences (La Cerra et al., 2017; Sufrin, 2017). This includes the escalating numbers of people detained by the federal agency Immigration and Customs Enforcement (Southern Poverty Law Center, 2019). Current health concerns include substance misuse, mental health, pharmacy needs and managing acute and chronic illness (La Cerra et al., 2017). In particular, reports indicate that although mental health accounts for a large proportion of health needs in this setting, these services are seriously inadequate and underfunded, which has contributed to a suicide crisis (Wilper et al., 2009; Powell et al., 2010; Southern Poverty Law Center and Alabama Disabilities Advocacy Program, 2014).

According to the US Department of Health and Human Services, a National Sample Survey of Registered Nurses – the most recent data on the correctional nurse workforce – estimates that there are 14,214 registered nurses working in correctional facilities, around 0.5% of the registered nurse population (2010). Thus, the estimated ratio of nurses to incarcerated people is 1:162. This value does not account for the large number of licensed practical nurses, who are distinct from registered nurses in the US in that they do not hold a bachelor's degree and have a smaller scope of practice. Advanced-level nursing professionals are also represented among correctional nurses (US Department of Health and Human Services, 2010), but exact numbers are unclear. Correctional nurses represent a unique and vital nursing role, as they are often the first and primary healthcare provider incarcerated people will encounter (Sufrin, 2017).

The experiences of correctional nurses in providing healthcare for incarcerated people are navigated in the context of caring for a unique patient population, the theories surrounding how best to care for this population, and barriers to care stemming from the inherent constraints and security of correctional systems. This study assesses the impact of this complex set of interactions on the ways in which correctional nurses conceptualise and provide care.

***Caring in correctional institutions***

For the purpose of this study, carceral/correctional institutions include prisons and jails, and the population of incarcerated people comprises inmates/prisoners in correctional institutions who require or receive healthcare in any form. Correctional nursing is the delivery of patient care within the criminal justice system, epitomised by 'caring for and respecting the human dignity of the incarcerated' (Schoenly and Knox, 2012, p 4). This includes the provision of necessary healthcare and advocacy for incarcerated people (Droes, 1994; Weiskopf, 2005). In practice, correctional nurses triage new inmates

with a thorough health assessment and continue healthcare in their setting by providing medications, routine health visits, preventive care, management of chronic illness, emergency or acute treatment, patient education, and care coordination with other members of the correctional healthcare system, both inside and outside the facility (Schoenly and Knox, 2012).

As set forth by the American Nurses Association, correctional nurses' work is expected to respect certain 'nursing values', such as: restoring patients' health with compassion; preserving confidentially; encouraging health promotion; and collaborating with healthcare colleagues to meet patients' holistic needs, including physical, psychosocial, and spiritual care (Schoenly and Knox, 2012). These values reflect actions and approaches that nurses should bring to their care, but they do not define caring itself. Debates and theories about the nature of nursing care in the US have a long and complicated history. The late nursing theorist Madeline Leininger argued that caring in nursing is a 'universal trait vital to human survival, required for healing, and the essence of nursing,' which is transmitted through 'actions, attitudes, and practices to help others toward healing and wellbeing' (Christensen, 2014, pp 224-225). This definition emphasises the humanistic nature and necessity of healthcare. However, applying caring in the carceral environment and its patient population sets correctional nursing apart as a unique role that is often isolated from the rest of the nursing profession (Maroney, 2005; Weiskopf, 2005; Powell et al., 2010). It is important to explore correctional nurses' perspectives regarding their ability to care in a constricted environment. Without an understanding of attitudes and challenges experienced by nurses themselves, we cannot fully grasp the relationship between nursing care and patient health outcomes, especially in this unique setting (Droes, 1994).

***Barriers to care***

Correctional nurses often find themselves in a conflict between custody and advocacy that reduces quality of care; this conflict is influenced by the healthcare demands of incarcerated people and the prison system (Flanagan and Flanagan, 2001; Weiskopf, 2005; Holmes, 2008; White and Larsson, 2012). The custody environment can deter a caring nurse-patient relationship or the use of touch with patients (Weiskopf, 2005); the non-caring attitudes displayed by security can reinforce this (Flanagan and Flanagan, 2001). Nurses report the need to objectively reconcile patients' criminal background with their humanity but recognise that knowing incarcerated people's criminal status may hinder the ability to enact caring in their practice (White and Larsson, 2012). Caring for incarcerated people often creates an environment in which bias and stigma go unchecked, because correctional systems create negative narratives surrounding incarcerated people as a whole. Furthermore, a large majority of those people do not receive comprehensive treatment while in correctional facilities due to a lack of resources, short-staffing and disjointed systems of correctional healthcare (Flanagan and Flanagan, 2001; La Cerra et al., 2017).

Other barriers to care exist in part due to the premise and punitive goals of the correctional system. Gaps in the US welfare and public support net have led to an increase of incarceration of those with mental illness, drug misusers and those ostracised by social narratives, including poor women and mothers (Sufrin, 2017). These interrelated causes are economically and racially driven, and are conflated by the way that incarceration serves to remove the 'politically resented', the urban poor (Sufrin, 2017, p 46). The complicated history and politics of incarceration creates tensions between custody and advocacy in correctional healthcare, which positions correctional nurses into carceral frameworks that can hinder their caring roles (Perron et al., 2005).

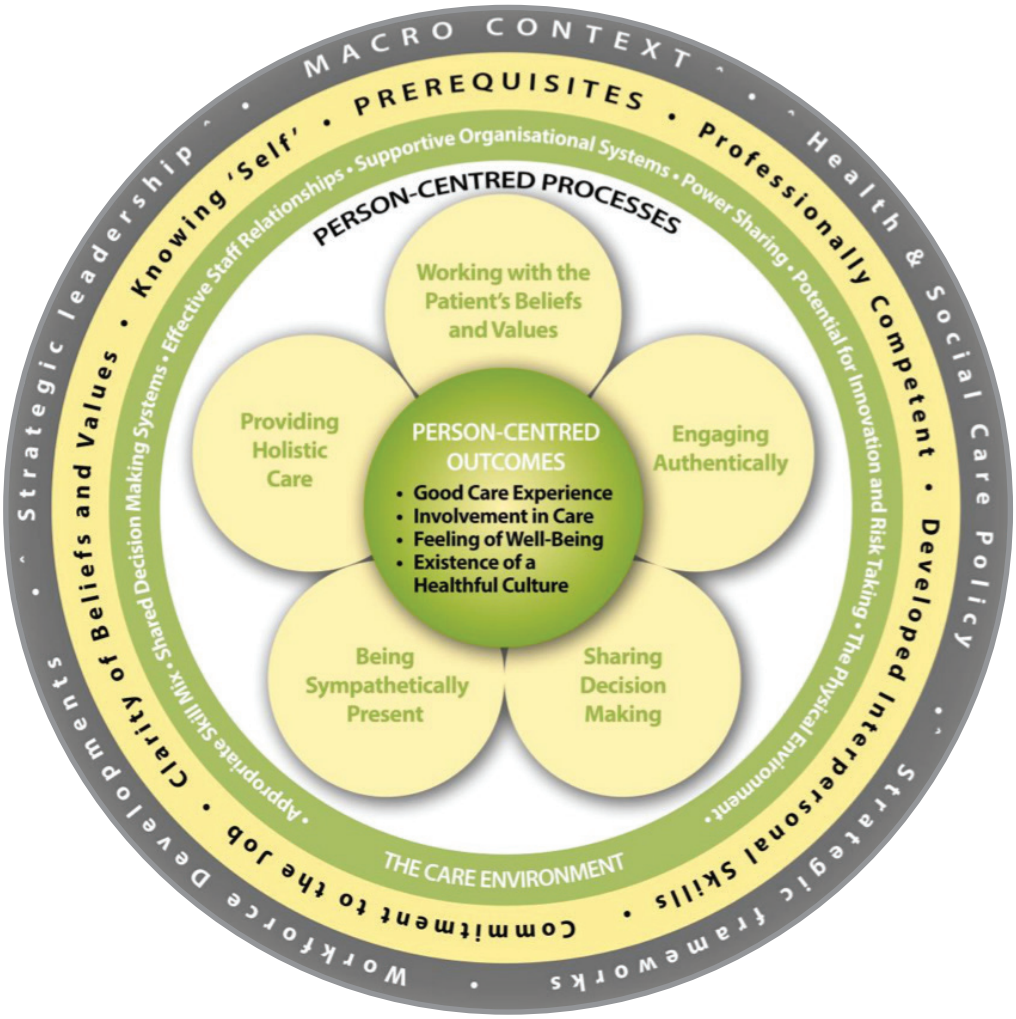
***Caring for the person***

While studies have focused on correctional nurses' role as an autonomous primary caregiver, and problems arising in their specific field and experiences of caring for inmates (Flanagan and Flanagan, 2001; Weiskopf, 2005; Powell et al., 2010; La Cerra et al., 2017), there has been little if any examination of nurses' perspectives regarding the implementation of nursing values that may enable care for the person, rather than a 'prisoner-patient'. In the US, healthcare systems predominantly refer to general

populations seeking healthcare as 'patients' or 'clients' and have not progressed to conceptualisation of patients as people and humans first. Person-centred care goes beyond patient-centred care – while it also acknowledges the basic patient-centred concepts of the holistic background and accumulated experiences of a patient seeking care, person-centred nursing accounts for also recognising and addressing environmental structures, nursing prerequisites and attitudes, and staff relationships.

Person-centred care research and literature primarily stems from the UK (McCormack and McCance, 2006; McCance et al., 2011), with the World Health Organization (2015) recognising that this type of care needs to be a global priority in nursing. The Person-centred Practice Framework consists of layers of relationships between the nurse's prerequisites for care, the care environment and care processes for person-centred outcomes (McCormack and McCance, 2017; Figure 1).

**Figure 1: Person-centred Practice Framework (McCormack and McCance, 2017)**

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The framework's prerequisites for person-centred nursing stress the importance of nurses' own values and the care environment (McCormack and McCance, 2017). It is potentially useful for correctional nurses, who have the challenge of providing person-centred and values-based care within an environment that emphasises correctional security and labels patients as prisoners, offenders, or inmates – labels that have the effect of depersonalising and dehumanising them. This study sought to answer the research question: 'What are possibilities for and barriers to providing person-centred care in a carceral environment?' The experiences of nurses working to deliver authentic nursing practice

within the confines of correctional cultures were analysed with a view to a possible application of the Person-centred Practice Framework to correctional nursing.

## Methods

Correctional nurses' experiences of caring are best understood through qualitative research, which enables an understanding of the meaning people assign to their experiences.

Nurses who have worked in or currently work in US correctional healthcare were surveyed online (n=78). A convenience sample of anonymous nurses was recruited by email, sent to 10 correctional nursing associations' electronic mailing lists and to 15 professional contacts. The respondents did not identify their affiliation with any mailing list and the contacts remain anonymous to maintain confidentiality. Inclusion criteria were that correctional nurses self-identify as working or have worked in a prison, jail, or other correctional facility in the US and were able complete the survey in English.

### *Ethical considerations*

Approval for the study was obtained through Emory University's internal review board. Recruitment consisted of an email describing the project, its role in identifying the experiences of correctional nurses, and a consent overview. Participants indicated that they had read and understood the informed consent document on the survey by clicking a 'yes' selection.

### *Data collection*

Study data were collected from September to December 2018 and managed using REDCap (Research Electronic Data Capture). REDCap is a secure, web-based application designed to support data capture for research studies, through data entry, tracking, and export procedures (Harris et al., 2009). REDCap also complies with the security protocols and policies of Emory's Health Insurance Portability and Accountability Act.

The online, untimed survey consisted of a demographic section of six short questions followed by six semi-structured questions on the experiences of correctional nurses. Demographic information sought included: age; gender; state; years worked in a correctional field; highest educational qualification or other certifications; and setting/branch of work (jail, prison, county, state, federal, private, or other).

The survey questions were of original design, as no tool currently exists to measure correctional nurses' experiences of caring for incarcerated people. The six questions were developed after a literature review of correctional nursing. They were:

- What sort of 'care' do you provide for incarcerated people?
- What nursing skills/strategies/approaches do you use to provide the best care possible?
- What are some barriers you experience in providing that care?
- How is correctional nursing different than providing care to the non-incarcerated population?'
- What do you think 'the best possible' care for incarcerated patients/inmates should or could look like?
- How do you perceive the role and significance of the nurse in correctional healthcare?

The question design aimed to gather responses regarding how correctional nurses care and the barriers they perceive in providing that care.

### *Data management and analysis*

Data were stored in REDCap and imported into Microsoft ExCel for manual coding of themes within and across questions. A thematic analysis process was used, through a constant comparison method to identify themes and phenomena of interest across questions. Glaser and Strauss (1999) describe the constant comparison method as an iterative process, where each piece of data in the responses is compared with prior responses. The spreadsheet of responses was read independently by the authors

(PS, KS) without prescribed themes in mind. Repeated concepts from participants were highlighted and grouped together. The researchers compared findings and agreed on significant emerging themes; associated subthemes were also identified and finalised. The researchers conducted analysis at regular intervals while coding for themes until saturation was achieved.

Researchers also have a responsibility to interpret the voices of the people whom they study, understand actions of individuals and the collective, and produce a social statement on the phenomena of study (Strauss and Corbin, 1994). Thematic analysis further allowed for a cultivation of patterns, systems, outliers, and norms across the data and for an interpretation of the context in which correctional nurses make sense of their own caring practices.

**Results**

The responses of 78 correctional nurses were collected across a multitude of settings. A total of 38 respondents reported that they worked in a jail and 46 worked in a prison, while 12 indicated they worked in another correctional setting. Twenty-eight respondents worked for the county branch of correctional systems, 29 for the state and 12 at federal level. Other correctional healthcare settings were indicated as private (n=4) and agency/contract work (n=4). Most correctional nurses (47.4%) had an associate degree as their highest educational qualification, generally defined as a registered nursing degree from a two-year college programme. In addition, 14.1% had a diploma, 23.1% a bachelors degree, 10.3% a masters, and 5.1% a doctorate.

Three broad themes emerged from data analysis across responses:

- Types of care
- Barriers to care
- Strategies for change

Within each theme, data are grouped into smaller subthemes that are explored in further detail below.

***Types of care***

This theme reveals the different ways that nurses conceptualise the way they provide care in prison settings. Two subthemes emerged: health assessment, and firm, fair and consistent care.

*Health assessment*

The survey asked participants to characterise the nature of their work in the correctional setting. Information about nursing roles and responsibilities emerged across a number of questions. The responses indicate that correctional nurses provide routine or emergent care for incarcerated people, with an emphasis on substance misuse and mental health. These activities fall under the broad theme of ‘health assessment’.

Nurses in correctional facilities emphasised assessment techniques honed to identify and prioritise health needs. Correctional nurses indicated that their ‘frontline’ role is to provide primary and as-needed medical care. Responses mentioned intake screenings and routine assessments (n=15), medication pass (n=39), and sick call (n=31) as their main primary care provision roles. As-needed medical treatment included acute and chronic management of incarcerated people’s illnesses (n=19), wound care (n=23), substance withdrawal and detoxification care (n=9), and emergency treatment (n=37). A total of 22 respondents mentioned mental health as a crucial part of their nursing care and role. Eight respondents indicated an administrative role, which included running the medical unit, training new nursing staff and serving as a resource for policy and procedures. Further roles included patient education and communication. Correctional nurses also provide care specific to the type of patient population. Some respondents mentioned maternal, geriatric or juvenile patients as having specific health assessment needs. In general, correctional nurses in jails mentioned more acute care provision roles, while those in prisons mentioned more chronic care. Some correctional nurses also

stressed the number of incarcerated people they were responsible for, ranging from 800 to 1,000, but did not mention what responsibility was assumed by other healthcare professionals within these numbers.

*Firm, fair, and consistent care*

Along with the need for complex health assessment skills, correctional nurses described their care and relationships with patients as needing to be fair and consistent to all, while also being compassionate and non-judgmental.

Correctional nurses frequently used the phrase 'firm, fair, and consistent' (n=21) to emphasise the importance of developing an objective approach to care. One nurse stated that:

> *'Because [incarcerated people] have a tendency to be manipulative, we teach our nurses to be firm, fair and consistent with patients.'*

Respondents reiterated that firm, fair, and consistent care allows for collection of accurate assessment data in order to create a trusting and clear nurse-patient relationship, enact effective treatment and maintain a professional role in the correctional system. Correctional nurses have to enact complex assessments to ensure the clinical picture/objective matches the subjective: *'Listening to what is being said and not said is important.'* As one nurse explained:

> *'I attempt to get as much information as possible about the situation to determine the best steps to take. Inmates speak more freely when I look them in the eye, smile, and treat them with respect.'*

Respondents emphasised that the nurse-patient relationship takes a unique form within carceral settings, requiring the nurse to be fair but firm in their individual relationships with patients, and consistent across the entire population.

Correctional facilities create a unique and challenging environment in which to provide care, yet correctional nurses still expressed caring values. Some respondents (n=4) mentioned that this unique patient population warranted holistic care, individual respect and compassion. They mentioned that correctional nurses need to understand the complicated background incarcerated people often come from and maintain caring values and compassion regardless of the backgrounds and crimes of those they care for. Correctional nurses noted that they provide non-judgmental care through listening, observing and a respectful nurse-patient relationship. Others used a humanistic, person-centred conceptualisation to *'treat the inmates as humans and provide the best care possible within the confines of a prison setting'.* One nurse stated:

> *'I try to be non-judgmental but firm, and I do try to treat the inmates the way I would want a nurse to treat my family member if they were in prison.'*

Another further stressed the importance of being non-judgmental:

> *'The corrections nurse must be willing and able to ignore the reason the client is incarcerated and be able to provide what care is needed without hesitation, all the while maintaining a safe environment for all involved.'*

For one nurse, this creation of a safe environment required practising trauma-informed care:

> *'I used a lot of active listening and validation. Most of my patients had been traumatised by someone during their lives, including the law enforcement officers who brought them to us. I tried the best I could in that space to be a safe person for them.'*

***Barriers to care***

Throughout the survey, every nurse noted multiple barriers that affected nursing care, represented by the following subthemes: the incarcerated person's background and care needs; correctional staff's language and attitudes; and a conflict between custody and care.

*The incarcerated person's background*

In general, incarcerated people are already an underserved healthcare population. Correctional nurses noted that:

> *'Many of these patients… have not received medical care for many years, if ever. They don't necessarily even know basic health practices like we all take for granted.'*

The nurses acknowledged that when their patients are released, they do not have a way to follow them up to ensure medication or treatment regimens are kept up with, and that formerly incarcerated people face access and cost barriers:

> *'When released, a very large percentage of these patients will not continue with any of the treatment regimens they have received while in custody.'*

Therefore, a lack of continuity of care is a barrier in correctional healthcare. One nurse noted that:

> *'Each person… should be treated individually and have a set plan for follow-up that is carried out immediately after being released.'*

*Correctional staff's attitude and language*

Generally, correctional protocols require that officers are present when nurses are trying to provide care. Correctional nurses expressed that the officers' attitudes could act as a barrier to care:

> *'Correctional officers do not care about what we need to do. They do not have any concept of what it means to be a licensed health professional and they do not realise the trouble we can be in if we do not take care of the inmates properly. They want us to ignore their health issues.'*

> *'Security always trying to second-guess us is very frustrating.'*

Nurses noted frustration with correctional and security norms, because they could not show compassion or a caring presence. One conceptualised the impact of attitudes on nurses:

> *'If we are too compassionate or caring, we are labelled "thug huggers" or teased/ridiculed by correctional officers.'*

Another response stood out about labeling and attitudes:

> *'There is no therapeutic touch in incarceration. I can put an offender's condom catheter on three times in one day where he has an erection each time. But no pat on the shoulder as you pass by in the hall, or hug as an offender is going out by EMS with chest pain... It is like we go back 30 years in nursing.'*

Respondents explicitly highlighted the labeling of this patient population as influencing the nurse-patient relationship. One nurse mentioned that:

> *'Unfortunately, some of the bigger barriers were presented by other staff, many of whom did not believe that "inmates" deserved the same level of nursing care provided to people in the free world.'*

The accumulation of correctional attitudes influences correctional nurses' ability to care for and build therapeutic relationships with incarcerated people:

> *'We can't build nurse-patient relationships like in a [doctor's] office. It is inappropriate. No calming touches... no big sympathy... it will all be misconstrued by the inmate.'*

Despite rules about patient contact, however, some correctional nurses value touch as a caring value and *'part of human nature and healing'* and incorporate it in practice:

> *'I take every patient's vital signs and listen to every patient's heart and lungs whether it pertains to the visit or not, to not only make them feel like a patient, but to allow for human touch.'*

*Conflict between custody and care*

Nurses noted frustration with the correctional environment itself, because they could not show compassion or a caring presence, which indicates a fundamental conflict between the culture of custody and the need to care. The rules of correctional institutions create an environment focused on security, where at times the nurses' safety is put above that of the patients. Some nurses (n=4) stated that they felt safer in the correctional system than in the hospital setting. However, the framework that correctional nursing takes place in a setting where the primary mission is not healthcare but safety and security interferes with the goals of correctional healthcare and nursing itself. In comparison with 'outside' care, one respondent noted that:

> *'The main difference… is that [correctional nurses] work in non-healthcare facilities. Care is not the shared goal. Departments of "correction" say that they endeavour to rehabilitate people, which is closely aligned to a caring orientation, but my experience and the existing research suggest that US prisons and jails exist to punish.'*

This affects healthcare in the correctional setting, because inmates needing care are seen as not deserving, or accused of somehow manipulating the system. Attempts at caring are thwarted by carceral attitudes.

The emphasis on security is noted and felt by correctional nurses. Security rules and the punitive culture of correctional systems create a duality of custody versus advocacy.

> *'Reinforcing my role as a provider and not a "cop". Though, my first mission is security. It is sometimes a tough line to walk.'*

These responses identify barriers from nursing and from correctional attitudes that influence care for incarcerated people. Barriers to care within the microcosm of correctional systems are situated at the intersection of the special considerations of care for vulnerable patients, biases held by correctional staff, and the wider context and purpose of correctional institutions.

***Strategies for change***

At the same time as articulating the difficulties faced in providing care for incarcerated persons, nurses also spoke about various ways in which they sought to counter these barriers, at both the individual and collective level. These are explored in the two subthemes of quality care everywhere, and the nurse as an advocate.

*Quality care everywhere*

Across the data, correctional nurses repeatedly emphasised that correctional healthcare should be the same as that available elsewhere. If correctional healthcare was to meet quality community care standards, it would require greater investment in healthcare resources in all settings and an emphasis on the provision of humane care.

One nurse summarised how they thought best care would look, noting that:

> *'Although there is a whole different language inside [correctional facilities], one fact remains the same: taking care of the patient is priority.'*

While five respondents indicated they thought incarcerated people already received the best care possible, others mentioned timeliness of care (n=15), staff numbers and resources (n=10), and patient education (n=10) as points to improve on. Timeliness of care was affected by low staffing numbers, of both correctional officers and nurses, and by the rules regarding security. Some nurses commented that improved staff resources should include better job training and prior nursing education about caring for incarcerated people. This could in turn improve patients' long-term outcomes. Correctional nurses acknowledged that education could help people leave in a better condition than when they arrived, noting this as representing quality care. One respondent noted that:

> *'When a nurse can educate the patients on healthy lifestyle choices, everyone wins, except the canteen vendor.'*

Nurses compared 'inside versus outside' care frequently (n=25), mentioning that correctional healthcare should 'meet or exceed the community standard of care'. However, one respondent clearly articulated the social conditions that create patients inside the correctional system:

> *'The best possible care would look like care that would meet community standards in my neighbourhood, not the standards our country accepts in many of the communities that are disproportionately burdened by incarceration.'*

A total of 13 responses noted the need for holistic, compassionate care, but further mentioned that care itself needs to be conceptualised more comprehensively, to go beyond a nurse-patient relationship or biomedical outcomes:

> *'Best care would actually look like less incarcerated patients. If we truly cared, more people would be receiving high-quality psychiatric and substance use treatment, and safe housing in the community as opposed to being warehoused in prisons and jails.'*

Quality care would include incarcerated people being *'treated humanely and respectfully'*. Correctional nurses identified best care as not only the highest standards of clinical practice, but also the necessity of addressing upstream factors in healthcare to promote the advancement of health equity and cultivate community action. Furthermore, quality care would comprise a wider consideration of the purpose, structure and barriers in carceral environments, in conjunction with improving healthcare systems outside them.

*The nurse as an advocate*

Respondents identified the capacity of correctional nurses to act as advocates for a large, vulnerable, patient population, saying they could be advocates for their patients, profession and for correctional reform to ensure quality care.

Respondents said they felt they had greater autonomy in correctional healthcare than in hospital or primary care settings, since they were the main providers in their facility. Correctional nurses saw their role as key informants and advocates in correctional healthcare due to this autonomy, and as a link between incarcerated people and other healthcare professionals (n=38). One nurse conceptualised this using a wheel metaphor:

> *'I have always envisioned the nurse as the hub, next to the patient, in a wheel of which the spikes are all the other members of the interdisciplinary team.'*

In order to coordinate care, correctional nurses have to work in an interdisciplinary capacity alongside security staff and communicate effectively with correctional officers, other providers who work in the facility, outside healthcare staff for external medical needs, and the patients themselves. Correctional nurses are stakeholders as both *'the backbone of correctional health and the sharp end of the spear'* due to their unique role in the healthcare team. This was described as:

> *'A pivotal role in correctional healthcare… as the caregivers 24/7 and [those with] the most contact with the patients. The system would not function without nursing.'*

One nurse mentioned their significance as a primary provider for a vulnerable population, stating:

> *'We are often the only healthcare [incarcerated people] will ever get. We must show them the correct way medicine/nursing should be practised.'*

The nurses were keen to enact their advocacy role but identified that correctional security could impede their capacity to do so:

> *'The patients are used to being treated (intentionally) by seemingly callous and uncaring officers who are often viewed as the enemy. The correctional nurse must adhere to strict relationship boundaries... but somehow form a trusting relationship.'*

Other nurses mentioned that correctional officers being able to decide if and when incarcerated people receive healthcare hinders their role as a patient advocate.

Nurses drive correctional healthcare in practice, but responses mentioned that they also need to be healthcare leaders. As well as being advocates for their patients, they also want to advocate for their own nursing role. Despite their interdisciplinary role, one stated that:

> *'The nurse is not invited to "sit at the table" in most correctional settings, despite having more education and experience than most of the individuals who have a seat.'*

Another nurse noted that to combat this, *'nurses need to feel confident in shaping this system through approaches to promoting the profession'*. This was echoed in another response, encapsulating the conclusions of the study:

> *'Nurses, especially those with correctional experience, must engage in conversations around criminal justice reform. As the most trusted profession, our voices matter and can add needed status to advocacy groups working to humanise our criminal justice system.'*

***Other themes***

Respondents had an additional section to provide more information, and some nurses (n=9) used this to state that they love their job and autonomous role, despite its challenges. Others noted that although their roles are unique and crucial, they felt isolated in their practice through stigma against the role of being a nurse caring for inmates. Overall, correctional nurses' desire to provide better care for their patients is continually met by barriers in the form of regulations, the history and culture of the correctional system, and the institutional environment.

**Discussion**

This qualitative study aimed to explore correctional nurses' perceptions of caring in carceral environments to conceptualise possibilities for and barriers related to enacting person-centred care. Responses also highlighted the importance of addressing structures and systems that create and reproduce barriers to care. A critical review of carceral environments through a nursing lens

demonstrates how person-centred care for individuals and populations should be considered in the context of the structures that influence care.

The 'metaparadigm' of person-centred nursing involves the nurse, person, environment, and health (McCormack and McCance, 2017). Correctional nurses identified barriers and possibilities to person-centred care within each of the dimensions. The Person-centred Practice Framework (McCormack and McCance, 2017) is based on nurses' integral role in healthcare, and this is exemplified by correctional nurses. Previous studies have addressed the autonomous role of correctional nurses (Weiskopf, 2005; La Cerra et al., 2017), and the responses in this study reiterate that nurses are primary healthcare providers in correctional facilities. Thus, correctional healthcare is a nurse-driven system, but the nursing role operates within the context of correctional healthcare policies and institutional barriers to best care.

Correctional nurses attempt to incorporate 'prerequisites' (McCormack and McCance, 2017), such as professional competence or honed nursing assessment skills. However, the institutional demands of control, coercion, and security inhibit 'person-centred nursing processes'. Correctional nurses did not mention an ability to make decisions with patients, a critical component of nursing (McCormack and McCance, 2017). Authentic engagement with incarcerated people to provide holistic care is also hindered by barriers in correctional systems. Correctional nurses encounter ideologies in their environments that raise significant ethical and professional questions that resonate beyond the carceral setting. That is, they recognise the need to respect incarcerated people as humans but encounter frustrations and hindrances in environments designed to remove the person and label the body as inmate, offender or prisoner. Some nurses fear manipulation in this setting but this idea puts the blame on the labeled individual as opposed to acknowledging a person shaped by systems and structures that create a need for care. Respondents themselves displayed some of these attitudes in their responses without actually naming them as barriers – for example, identifying the importance of non-judgmental caring but using labels perpetrated by the correctional system such as 'offender' and 'thug'. Bias against incarcerated people's background hinders humanistic care and generates a culture of stigma and marginalisation. Language can be unintentionally revealing, as demonstrated by the influence of caring for patients who are labeled 'inmates'. The role of the nurse in carceral environments is significant, but so is the system in which they care. The Person-centred Practice Framework (McCormack and McCance, 2017) is an important model for understanding correctional nursing, as the carceral environment itself acts as a barrier to quality care and reinforces value judgements about the patients themselves.

In this care environment, themes of custody versus advocacy inhibit the ability to collaborate with security officers and other correctional staff to ensure effective staff relationships, including power sharing. Nurses who express a desire to enact ethical and compassionate care are thwarted by structural barriers, including attitudes and language, that dehumanise incarcerated people. Correctional nurses are situated in two systems: a punitive framework to punish and a correctional framework to rehabilitate (Droes, 1994; Weiskopf, 2005; Dhaliwal and Hirst, 2016). The juxtaposed influences make it difficult to create a caring environment in a system that does not value caring. This dichotomy clashes with nursing's inherent and expected professional value of caring (Schoenly and Knox, 2012) and creates difficulties in enacting person-centred nursing processes.

'A good care experience' – the ideal outcome of person-centred nursing – thus cannot occur without factoring in the correlation between the care environment and the wider social system. Correctional nurses address the institutional demands of control, coercion and security while still providing care for the individual (Holmes, 2005). Patient care is often conceptualised with a focus on clinical outcomes for individual patients influenced by nursing care actions or practice. However, nursing care in carceral environments warrants a broader understanding of the relationship between the immediate care environment and the social system that creates it. The criminal justice system has perpetrated blame on the individual rather than on systems to influence social narratives, further racial injustices and

perpetuate public involvement in governmental discipline (Alexander 2010; Hinton, 2016; Forman 2017). Carceral expansion leads to contemporary consequences of mass incarceration, including health inequities (Sufrin, 2017). Correctional nurses themselves articulated a need for carceral reform when they emphasised their desire to act as advocates both for patients and for wider correctional change.

An understanding of the social forces that have led to increased incarceration, especially for minor crimes and drug offences, or of people with mental illness, is necessary for nurses to reflect on their own socially constructed biases. At the same time, an understanding of these structures allows for nurses to act as advocates for incarcerated people within a human rights framework, and to develop arguments for prison reform based on nursing's social justice agenda. This is entirely possible within the bounds of the Person-centred Practice Framework, because:

> *'The discourse of practice and the dialogue created between nurses and patients illustrate the potentials of person-centred nursing. The framework makes explicit the need for nurses to move beyond a focus on technical competence and requires nurses to engage in authentic humanistic caring practices that embrace all forms of knowing and acting to promote choice and partnership in care decision-making'* (McCormack and McCance, 2006, p 478).

To be true advocates however, correctional nurses would also need to understand their role as part of the very system they seek to reform. Nursing philosophers have argued that federal and state powers, as well as social narratives about incarcerated people, situate correctional healthcare workers as controlling incarcerated populations through the regulation of inmate bodies (Holmes, 2005). Holmes draws on Michel Foucault's theories of biopower and governmentality. The concept of governmentality provides a critical lens through which to view the ways that healthcare is influenced by structures and systems beyond factors generally attributed to disease processes (Foucault, 1973, 1995). It analyses the conduct of people through relationships with organised and ideological powers and situates healthcare providers, such as nurses, as potential biopolitical agents of those powers, rather than agents of care (Foucault, 1995; Perron et al., 2005). Nursing care influences individuals to prescribe to specific, predetermined health behaviours, theoretically serving to ensure a homogeneous, normalised and ordered society (Perron et al., 2005). In this way, correctional nursing through a 'Foucauldian' reading is a distinctive example of governmentality in practice, due to the influences of the unique carceral environment, the correctional healthcare system and the specific population (Holmes and Gastaldo, 2002). The nurse is an object of carceral environments' punitive and security purpose, yet also a subject by carrying reproduced attitudes and biases about incarcerated people (Holmes, 2002; 2005). Thus, correctional nurses are themselves 'governed' by the punitive purpose of correctional facilities, but they also perpetrate this in their care as agents of custody (Holmes, 2005). Tensions between custody and advocacy create the potential for ethical violations, institutional violence and barriers to quality care. Scholars argue that correctional healthcare systems thus have barriers regarding health-related 'deservingness', through a conflict between the premise of the carceral system's punitive framework and its responsibility to ensure incarcerated people's wellbeing (Holmes, 2008).

**Conclusion**

This qualitative study analysed correctional nurses' perceptions about the challenges of enacting caring values in carceral environments. Enacting nursing values in correctional healthcare is justified both legally and ethically, because these patients are people with valid health needs and constitutional rights. As established by US law, not providing healthcare for incarcerated people is a form of cruel and unusual punishment and a violation of the Eighth Amendment (Sufrin, 2017). Correctional nurses' perception of caregiving may further illuminate the connection between the application of nursing values and the implications for patient care. Experiences from correctional healthcare can shed light on the impact of labeling people in such a way as to signify they are worthy of 'less' care, and to what extent a shift to the concept of person-centred care can mitigate these issues. Furthermore, understanding the influences of sociopolitical structures and systems on correctional facilities is crucial

to understanding the carceral environments within which nurses are required to provide care. The institutional framing of correctional facilities as places of punishment shapes the values, language and practice of healthcare within their confines; nurses who care for incarcerated people are supposed to enact nursing values, as nurses do in general patient care, but they are impeded by normative systems of control, order, security, and a frank lack of care. Correctional systems and correctional nurses should reckon with these historical and structural underpinnings of a system that dehumanises people and not only impedes a nurse-patient relationship but furthers structures of power and control in healthcare.

**Implications**

Thinking about this study in relation to the Person-centred Practice Framework (McCormack and McCance, 2017) raises two main implications for both the framework and for nurses themselves. These implications relate to the primacy of the care environment, and require an expansion of how that is conceptualised, and to how nurses themselves understand their role in that environment. The prerequisites for person-centred care require personal characteristics such as non-judgement, professional competence and commitment to nursing values. Yet structures of correctional environment create an inherent tension between prerequisites and person-centred outcomes. Although nurses identified a need for correctional reform and a reframing of social narratives about incarcerated people, social justice change is haltingly incremental in the US. What nurses can do, however, is expand nursing values to acknowledge person-centred care, nursing biases and structural knowledge, including an understanding of the historical and social factors that drive mass incarceration, which may help challenge some of the tensions created by carceral systems. At the same time, the concept of the care environment within the Person-centred Practice Framework need not apply only to the immediate physical institution within which care occurs, but could be expanded to require an understanding of the historical, social and political contexts and discourses that shape material and ideological approaches to care.

This study reveals that correctional nurses encounter significant barriers to care that are intrinsically tied to the historical purpose of prisons and jails, as well as social narratives of incarcerated people as ‘the other’. Incarcerated people are dehumanised and othered in the carceral system, and nurses should use professional and ethical advocacy to promote human rights not only in correctional institutions, but in the structures and systems that encompass them.

Nurses struggle to provide care in a space historically designed to punish those who are considered outside ‘the norm’ (Holmes and Gastaldo, 2002; Metzl and Hansen, 2014). Nurses reflecting on their own socially constructed biases should understand that carceral frameworks shape their role to conduct others, but that they are also being conducted themselves. An understanding of these structures allows for nurses to act as patient advocates and to ensure professional and ethical obligations to quality care by furthering nursing’s social justice agenda. The Person-centred Practice Framework, which creates space for the articulation of structural prerequisites, allows correctional nurses to understand their place in carceral frameworks and their role in perpetrating governmentality, which furthers inequities in care. Advocating for addressing the inherent power and vindictive structure of the US carceral system promotes an awareness of the web of interpersonal, sociopolitical and power relations that surround clinical encounters, which often occur before the person ever becomes an inmate. Incorporating person-centred theories in conversations about understanding health inequities is a beneficial way to further the wellbeing of individuals and populations, by addressing the systems and structures that shape the clinical encounter.

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