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ORIGINAL ARTICLE

Correctional nursing in Liguria, Italy: examining the ethical challenges

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Keywords

Correctional nursing • Moral distress • Nursing ethics • Italy

Summary

Introduction. *Correctional nursing can involve significant ethical difficulties. This study examined ethical challenges encountered by correctional nurses in the Italian region of Liguria. Empirical data were analyzed in relation to relevant ethical standards. The former involved a study of 75 nurses and managers in the Ligurian correctional system, while the latter involved an analysis of the Italian Code of Ethics for Nurses and related standards for correctional practice.*
Methods. *Quantitative and qualitative methods were used for the empirical study. Questionnaires were administered to collect data on participants' characteristics and care settings. The Measure of Job Satisfaction (MJS) was also administered. Five focus groups were conducted.*
Results. *Quantitative Data: Respondents identified factors that mostly impacted on recruitment and retention. Unfavourable factors included: structural, organizational, and relational factors. Favourable factors included: nursing consultation, continuing education activities, and peer support. MJS results were equal to 'unsatisfied'. Qualitative Data: five themes were identified through thematic analysis of focus group data: Health needs of incarcerated persons; Negotiation of the boundaries between care and custody; Job satisfaction related to nursing in a correctional setting; Barriers to providing good care; and Security needs. Ten categories of norms were identified in the Code as areas of ethical standards relevant for the empirical data.*
Conclusions. *Our empirical findings demonstrate that these nursing standards can be systematically compromised in correctional settings. Nurses feel compelled to provide ethically-problematic nursing services, with situations of moral distress. This research informs the development of needed policy, educational, and practice changes for nurses in correctional settings.*

Introduction

The aim of this study was to examine the ethical challenges encountered by nurses practicing in correctional settings in the Italian region of Liguria. Despite the regional focus of this research, we believe that this investigation will also help advance our understanding of correctional nursing in other settings internationally. The term 'correctional nursing' is sometimes used in this article because it is widely used in the international literature, although we recognize the problematic tone of the term. For this reason, we frequently use the expression 'nursing practice in correctional settings' as an alternative.

International literature has demonstrated that nursing practice in correctional settings can involve significant ethical challenges [1-4]. These ethical challenges have been under-examined; frequently relating to dilemmas for which existing ethical standards are unclear or even contradictory. In particular, as nurses in correctional settings strive to attend to the health needs of patients and clients who are incarcerated, they are often called upon to use their clinical expertise for purposes of control or punishment.

Nurses practicing in correctional settings confront complex problems [1, 5-10]. They have a high degree of responsibility as they are required to manage emergencies and mental health problems, among other chronic conditions. Patient health information must be kept confidential and not generally shared with correctional officers unless there is a justifiable reason. Nurses practice in settings where safety is a constant workplace concern. Nurses often report to a warden, rather than a health administrator, facing difficult negotiations of care practices [1].

The number of incarcerated persons in the United States has been increasing significantly. Incarcerated men and women have increased rates of serious and chronic physical and mental illnesses [2]. Maeve and Vaughn [2] highlighted numerous ethical problems faced by nurses in correctional settings: maintaining patient confidentiality; using chemical restraint for security rather than medical purposes; working with underqualified personnel; providing care outside their scope of practice; caring for addicted prisoners; caring for the mentally ill; caring for incarcerated mothers and their newborns; managing the visitation rights of children whose parents are incarcerated; dealing with violence; coping with prolonged isolation and segregation of inmates; providing adequate planning for released detainees; and involvement of nurses and physicians in carrying out the death penalty [2].

In a critical examination of forensic psychiatric nursing in corrections, Holmes has reported that nurses are 'objects of governmental technologies' [11]. They become the body onto which processes of conforming to the correctional setting is dictated and inscribed. Nurse–patient relationships involve under-recognized power structures. Nurses frequently participate in behaviour modification programmes that involve unethical nursing approaches to mentally ill offenders [12].

An ethnographic study of twelve prisons in England highlighted the significant responsibilities borne by nurses [8]. The National Health System has recognized the importance of synergy in the role of nurses with other health professionals in prisons (e.g., psychiatrists, social workers, etc.). In new models of care, nursing roles are authorized to provide prescriptions for minor illnesses (e.g., constipation, toothache, colds), perform intake assessments (e.g., nurse-led triage), and evaluate and manage complex chronic illnesses (e.g., nurse-led clinics). Physician assessments follow from assessments performed by nurses. Nurses are central agents in rehabilitation programs for substance, psychotropic drug, or nutritional abuse; prescribing non-pharmacological treatments such as physical activity or behavioral programs that promote sleep. The health service has developed a culture that recognizes the importance of health and quality of care, limiting the abuse of control measures.

National evidence in Italy has highlighted that illness levels and health care needs are significantly more elevated among detainees than in the general population [13-15]. The most common illnesses include: tuberculosis, HIV, hepatitis, syphilis, and other sexually transmitted infections. Mental illness is significantly elevated, as well as substance abuse [14]. Nursing ethical concerns relating to correctional settings have been scarcely examined in Italy. One study was conducted with detainees and nurses to investigate the roles of nurses in these settings [16]. Most participants regarded nurses as mere treatment providers.

A number of international statements and research reports have highlighted standards that should be upheld for nursing in correctional settings. For example, the European Code for Health in Prisons recognizes the rights of detainees to have access to health care without discrimination and highlights the 'pathogenic' impact of confinement on mental health [17].

In Britain, recent increases in nursing staffing, training, and development of holistic practices and promotion of a code of ethics have demonstrated improvements in the health and social integration outcomes of detainees [14]. The National Commission on Correctional Health Care identified six ethical principles for nurses in correctional settings: a) respect for persons (autonomy and self-determination); b) beneficence (doing good); c) nonmaleficence (avoiding harm); d) justice (fairness, equitability, truthfulness); e) veracity (telling the truth); and f) fidelity (remaining faithful to one's commitment) [18].

The journal *Nursing Standard* published a theme issue in 2010 that focused on correctional nursing. Within this volume, Perry published a competency mapping and a grid for evaluating the performance of nurses in correctional settings [6]. These competencies included: prevention of communicable diseases; the management of mental disorders and chronic illnesses in an inadequate context; integration with other professionals for evaluation activities; and regional networking to ensure continuity of care.

The International Association of Forensic Nurses has highlighted guiding principles for ethical decision-making in forensic nursing, that is: a) fidelity to patients and clients; b) responsibility to the public; c) obligation to science; and d) dedication to colleagues [19].

The American Nurses Association has highlighted that correctional nurses have to balance an attitude of care while maintaining safe boundaries. Nurses should advocate for access to care. For patients that die while incarcerated, nurses should help patients die with dignity and comfort. The American Nurses Association has also argued that correctional nurses should not participate in executions [20].

There is an absence of explicit ethical standards for nursing practice in correctional settings in Italy. There have been, however, some significant structural shifts in correctional health services that imply potential improvements in nursing practice conditions [21]. Heath professionals practicing within correctional settings, including nurses, are now administratively accountable to the Public Health Branch of the National Health System; rather than the correctional services administration, as they were before. This initiative sought to bridge practice standards as well as collaborations among health professionals practicing within prisons with the broader community of practitioners in the general population. Moreover, this restructuring establishes a clearer boundary between security measures and responses to the health needs of detainees.

The principal objective of this study was to examine the ethical challenges encountered by nurses practicing in correctional settings in the Italian region of Liguria. Drawing on a framework for ethical analysis referred to as the 'is-ought problem' [22], an empirical examination of clinical practice was analyzed in relation to relevant ethical standards to highlight tensions that may exist between the a) 'is' of current practices (i.e., what nurses *are doing*); and b) 'ought' applicable to these practices (i.e., what nurses *should be doing*). The former were documented through a quantitative and qualitative investigation and the latter were examined through an analysis of the Italian Code of Ethics for Nurses [23] and related standards for correctional practice in Italy and Europe. This research was conducted to help inform the development of policy, practice change, and educational initiatives to address the ethical challenges encountered by nurses in correctional settings.

Methods

The empirical component of this study is based on a reanalysis of data collected from an earlier study conduct-

ed by three of the authors (i.e., Bagnasco A, Delogu B, Sasso L.) [24]. The study was conducted as part of one author's (Delogu B.) graduate studies. The aim of the initial study was to document occupational challenges and job satisfaction among nurses working in correctional settings in Liguria, Italy. Upon completion of the research, the authors noted significant ethical concerns that were underlying the data. They therefore recruited the remaining author (FAC), a nursing ethicist, to assist with an ethical analysis of the empirical data along with an analysis of relevant norms.

Description of participants

Participants in the study included nurses and their managers in the Ligurian correctional health system (i.e., Medicina Penitenziaria delle cinque AASSLL della Liguria) as well as nurses that worked within this system in the past. A total of 74 nurses participated in the study.
A mixed methods design was used for the study, drawing on quantitative and qualitative methods. Measurement instruments from the international literature (described below) were translated, adapted, and validated for an Italian context by the University of Genoa doctoral nursing program.

Quantitative methods

Participants were administered a questionnaire, adapted from the work of Almost et al. [25], to document the: a) demographic characteristics of the sample; b) care provision settings represented in the study context; and c) factors associated with job retention and nurses' intention to leave their jobs. To measure the latter, a validated measure of job satisfaction was attached to the questionnaire (i.e. M*easure* of J*ob Satisfaction,* MJS) [26]. Work satisfaction is an important predictor of retention and intent to leave [27]. The MJS consists of 38 items grouped into five factors: a) personal; b) workload; c) professional support; d) training; and e) economic remuneration and opportunities for career development. For each MJS item, participants responded to the following question: 'How satisfied are you with this aspect of your job?': 1) very dissatisfied; 2) dissatisfied; 3) neither satisfied nor dissatisfied; 4) satisfied; 5) very satisfied.

Qualitative methods

Focus groups were used to collect qualitative data. Five focus group meetings were conducted with nurses and nursing managers in: La Spezia, Savona, Genova Marassi, Pontedecimo, and Sanremo. Chiavari and Imperia were excluded as study settings because the number of nurses in these settings was too limited for the study.
Five principal questions were used to orient the focus groups: a) How do you identify the health needs of detainees and which prisoners do you think have the greatest health needs?; b) How would you describe the differences between working in a hospital and working in your context?; c) What are your needs today to perform this work?; d) What are the sources of satisfaction in your work activities?; e) What are the obstacles to providing good health services in your work setting? Qualitative data were analyzed with NVIVO 10 software.

Results

Empirical Analysis

Quantitative Data

Respondents identified favorable and unfavorable factors that had the most significant impact on the recruitment and retention of nurses in their setting. Unfavorable factors included: structural, organizational, and relational factors (Tab. I). Favorable factors included: nursing consultation: 35.1%; continuing education activities: 31.1%; and peer support: 16.2%.

Measure of job satisfaction

Fifty-nine participants completed the MJS to measure their level of satisfaction regarding five specific factors. None of the measures for the five factors reached a mean as high as 4.0, the level corresponding with 'satisfied'. Personal Satisfaction and Satisfaction with Professional Support were the most highly rated (i.e., 3.878 and 3.814, respectively) and Economic Remuneration and Opportunities for Career Development had the lowest rating (i.e., 3.034).
It is noteworthy that none of the means for the five factors were less than 3.0; that is, none were oriented toward a clear measure of dissatisfaction. All means were below 4.0 (satisfaction) and above 3.0 (neither satisfied or dissatisfied), which implies that despite the significant difficulties encountered by these nurses they also derived some favorable returns from their work to counter these difficulties.

Qualitative data

Five major themes were identified through a thematic analysis of data recorded during the focus groups:
(1) Health needs of incarcerated persons (detainees); (2) Negotiation of the boundaries between care and custody; (3) Job satisfaction related to nursing in a correctional setting; (4) Barriers to providing good care; and (5) Security needs.

Tab. I. Summary of quantitative results.
Themes identified within each factor are listed.

Theme I: Structural	
Distance & isolation	32.4%
Logistical	27.0%
Absence of a care setting	21.6%
Theme II: Organizational	
Insufficient staff	24.3%
Heavy workload	21.7%
Limited professional autonomy	17.6%
Excessive professional autonomy	16.2%
Resource restrictions	13.5%
Theme III: Relational	
Absence of continuing education	29.7%
Conflict with care recipients	35.2%
Conflict with correctional officers	20.3%
Conflict with the medical team	10.9%

NB: The proportion of respondents who reported each theme is indicated in parentheses.

1. Health needs of incarcerated persons (detainees)
When compared to practicing in conventional hospital settings, correctional settings entail: (a) a much greater number of patients for each nurse; (b) greater professional autonomy and therefore increased individual responsibility; (c) a particularly high proportion of health concerns related to mental health and substance abuse problems; and (d) a number of barriers for the nurse-client relationship, which require an alteration in how nurses approach patients.

2. Negotiation of the boundaries between care and custody
Correctional settings have a culture of order and disciplinary control, which overshadow concerns about the health of detainees. Participants reported that a greater proportion of their time is devoted to maintaining security rather than promoting health or managing illness.

3. Job satisfaction related to nursing in a correctional setting
Nursing practice in these settings can provide some opportunities for personal and professional enrichment, which was related to inter-professional work, detainee multiculturalism, and trust relationships that can be established with patients. On the other hand, job satisfaction can be compromised when: a) correctional officers expect nurses to collaborate with them to exert control measures on detainees; b) detainees try to manipulate nurses to obtain favors; c) there is insufficient time for nurses to develop a non-judgemental attitude with detainees; d) nursing practice requires advanced expertise in assessing health needs of detainees who are not presenting their symptoms honestly; e) working with substance abuse and mental health problems; f) personal freedom is restricted in the workplace; g) there are insufficient nursing staff, which increases workload and reduces opportunities for rest breaks; and h) there is little recognition of the specialized competence required to practice in correctional settings.

4. Barriers to providing good care
Security requirements seem to limit the professional autonomy of nurses. That is, nurses are not recognized as professionals but as mere providers of treatments without any autonomous thought. Prison administrators refer exclusively to physicians as the health care professionals. Care is also sometimes compromised by conflictual relationships with correctional officers who tend not to recognize the health needs of detainees. Some prisons draw on 'cooperatives' for nursing staffing, which results in very high nursing turnover rates. This limits nurses' ability to consolidate their competencies and compromises trust relationships between nurses and detainees as well as nurses and correctional officers.

5. Security needs
The principal priority in correctional settings is security. Consequently, nursing actions are predominantly focused on managing medications and sharps – rather than providing care.

Normative Analysis

Empirical findings helped orient an analysis of relevant ethical norms that define ethical practice for nurses in correctional settings in Italy. The principal normative source that was examined was the Code of Ethics for Nurses in Italy (referred to below as 'Code') [23].
Ten categories of norms were identified in the Code as areas of ethical concern highlighted by the empirical data. These included: General Responsibilities; General Ethical Considerations; Nursing Competence; Respect for the General Rights of Patients; Respect the Autonomy of Patients; Respect Patients' Privacy and Confidentiality; Respect for the Wellbeing of Patients; Promote Inter-Professionalism; Promote Patient Safety; Prevent Conflict of Interest. Table II lists the specific sections of the Code related to each normative category. These normative standards highlight explicit nursing standards that can be systematically compromised in a correctional setting – given the empirical findings reported above – placing nurses in situations where they feel compelled to practice against the standards of the profession.
Additional sources were examined for articulations of practice standards specifically relevant for health professionals in correctional settings; in Italy and Europe. Although these were not specifically focused on nursing practice, they provided specificity that complemented the more general norms drawn from the Code.
The Italian National Bioethics Committee prepared a Report on ethical considerations that should be applied to the health of detainees, citing relevant Italian & European norms [15]. The Report outlines health risks identified among incarcerated populations and the health-related rights of detainees that should be respected. The Report commends the shift of administrative responsibility for health services from correctional authorities to state health services administration. This will help preserve the professional autonomy of health professionals and prevent the confusion of health services with security services (i.e. dual roles) within these settings, among other merits of such a restructuring. For example, health professionals responsible for providing health care to detainees should not also be responsible for providing expert assessments of the detainees' health for the justice or security procedures of the courts or correctional systems such as prisons (e.g. assessment of detainee's capacity to endure disciplinary measures such as solitary confinement). A limitation of this Report, for the purposes of this study, is that it is predominantly focused on the practice of physicians, with occasional references to health professionals more broadly. Although the Report appears directly applicable to other health professionals, such as nurses, this is not explicitly articulated.
The Report corroborates related international standards regarding detainees. Specifically, the European Code for Health in Prisons recognized that a) detainees should have a right to health services without discrimination; and b) the restriction of personal freedom can have a harmful impact on the mental health of detainees [17]. Disciplinary measures should therefore be restricted to minimize these harms. The World Health Organization

Tab. II. Analysis of Italian Code of Ethics for Nurses (From Federazione Nazionale Collegi IPASVI, 2009 [23], mod.).
General responsibilities
Article 1: A nurse is a healthcare professional in charge of nursing care. Article 3: Nurses have the responsibility to assist, look after and take care of people in the respect for the individual's life, health, freedom and dignity.
General ethical considerations
Article 8: In situations of conflict, caused by divergent ethical opinions, nurses do their best to find a solution through dialogue. In the event of a persistent request for an action that goes against the ethical principles of the profession or personal values, nurses may avail themselves of the clause of conscience, to ensure the patient's safety and life. Article 16: Nurses should be proactive in analyzing the ethical dilemmas they experience in their everyday practice and seek ethical advice, and thus help deepen bioethical reflection. Article 43: Nurses report to their respective Nursing Council any abuse or unethical professional conduct of their colleagues. Article 50: To protect the public, nurses must report situations of unlawful practice of the nursing profession to their Nursing Council. Article 51: Nurses must report to their Nursing Council situations involving circumstances or the persistence of conditions that limit the quality of treatment and care or the dignity of professional practice.
Nursing competence
Article 2 : Nursing is service to the person, families and the community, provided through specific, autonomous and complementary interventions of intellectual, technical-scientific, managerial, relational and educational nature. Article 11: Nurses perform evidence-based practice and refresh their knowledge and competences by means of life-long education, critical reflection on experience and research, they design, carry out and take part in educational activities and promote, start and take part in research activities and disseminate the findings. Article 13: Nurses take on responsibility proportionally to their level of competence and if necessary, seek the intervention or advice of nurse practitioners or specialists. They give advice by putting their knowledge and skills at the disposal of the professional community. Article 15: Nurses should ask for training and/or supervision for practices that are new or for which they have no experience.
Respect for the general rights of patients (i.e., Detainees)
Article 4: Nurses provide care according to the principles of equity and fairness, taking into account the ethical, religious and cultural values, as well as the gender and the social conditions of the person. Article 5: The respect for the fundamental human rights and the ethical principles of the profession is an essential condition to practice nursing. Article 20: Nurses listen to, inform, and involve patients and together they assess their healthcare needs, in order to provide the proper level of care and help patients make their own choices. Article 21: Nurses, by respecting the patients' will, favour their relationships with the community and with their next of kin, by involving them in their healthcare plan. Nurses consider both the intercultural dimension and the healthcare needs linked to it. Article 30: Nurses do their best so that they resort to constraint only in exceptional cases, supported by medical prescription or by documented healthcare exams. Article 32: Nurses help protect patients who find themselves in conditions that limit their development o expressions, when their family and context are not adequate for their needs. Article 47: Nurses, according to their level of responsibility, contribute to guide the policies and the development of the healthcare system, to ensure that the patient's rights are respected, resources are sensibly and appropriately allocated and that the professional role is valued.
Respect the autonomy of patients (i.e., Detainees)
Article 5: The respect for the fundamental human rights and the ethical principles of the profession is an essential condition to practice nursing. Article 20: Nurses listen to, inform, and involve patients and together they assess their healthcare needs, in order to provide the proper level of care and help patients make their own choices. Article 30: Nurses do their best so that they resort to constraint only in exceptional cases, supported by medical prescription or by documented healthcare exams. Article 32: Nurses help protect patients who find themselves in conditions that limit their development o expressions, when their family and context are not adequate for their needs. Article 37: When patients are unable to express their will, nurses take into account what they had previously clearly declared or documented.
Respect patients' privacy and confidentiality
Article 26: Nurses do not disclose any confidential information on the patients. When gathering, handling and reporting data on patients, nurses limit themselves only to what is relevant to the nursing process. Article 28: Nurses respect professional secrecy not just because it is a legal obligation, but because they are deeply convinced that this is a concrete expression of their relation with patients built on trust.
Respect for the wellbeing of patients (i.e., Incarcerated)
Article 6: Nurses consider health as a fundamental gift for the person, as well as the best interest of the entire community and engage in protecting it through prevention, care, rehabilitation and palliation. Article 7: Nurses act in the best interest of the patient, by promoting his/her resources in order to help him/her achieve the highest possible level of autonomy, especially when the patient is disabled, disadvantaged or fragile. Article 22: Nurses know the diagnostic-therapeutic project due to its influence on the nursing process and on the relations with the patient. Article 23: Nurses understand the value of integrated multi-professional information and do their best so that patients have all the necessary information for their daily life.

continues

Tab. II. *(follows)*
Article 24: Nurses help and support patients in their choices, providing healthcare information regarding their diagnostic-therapeutic projects and adapting their communication so that they can easily understand. Article 31: With regard to healthcare, diagnostic-therapeutic and experimental decisions, nurses do their best so that the opinion of a minor is taken into consideration according to his/her age and level of maturity.
Promote inter-professionalism
Article 14: Nurses recognize that both interaction among professionals and inter-professional integration are essential conditions that allow to meet all the patient's needs.
Promote patient safety
Article 29: Nurses contribute to the promotion of better safety conditions for patients and their families and to the development of the culture of learning from errors. They take part in clinical risk management initiatives. Article 33: When nurses notice any abuse or deprivation at the expense of the patient, they use all means to protect him/her and, if required, report the case to the competent authority.
Prevent conflict of interest
Article 17: Nurses, in their professional practice refuse any conditioning, pressure or interest deriving from the patient, the family, other health workers, companies, associations or organizations. Article 49: Nurses, in the best interest of their patients, make up for the deficiencies and the disorganization that exceptionally occur in the centre they work for. They must abstain themselves from doing this, by producing documentary evidence, when the above deficiencies and disorganization are habitual or recurrent, or in any case systematically compromise their professional mandate.

Note: Some sections are cited more than once, as they correspond with multiple themes.

has outlined steps that correctional systems should take to reduce the public health risks that can result from compulsory detention, drawing on internationally recommended standards for prison health [28]. The WHO Guide for prison health states: 'People who are in prison have the same right to health care as everyone else; Prison administrations have a responsibility to ensure that prisoners receive proper health care and that prison conditions promote the well-being of both prisoners and prison staff; Health care staff must deal with prisoners primarily as patients and not prisoners; Health care staff must have the same professional independence as their professional colleagues who work in the community; Health policy in prisons should be integrated into national health policy, and the administration of public health should be closely linked to the health services administered in prisons; This applies to all health matters but is particularly important for communicable diseases; and The European Prison Rules of the Council of Europe provide important standards for prison health care.

Integration of empirical and normative analyses

Although some gaps persist in the development of ethical norms for correctional nursing in Italy, existing norms highlight major health-related rights and entitlements of incarcerated persons that correspond to the ways that non-incarcerated persons should be treated. However, the empirical evidence reported here demonstrates that nurses confront significant barriers in their attempts to respect these standards. A serious gap exists between the 'is' and the 'ought' of correctional nursing in this setting. These nurses feel systematically compelled to provide ethically-problematic nursing service.

This scenario of feeling impeded from practicing according to one's understanding of what is ethically required corresponds with situations described in the literature that lead to *moral distress*. Originally defined by Jameton [29], moral distress refers to the malaise that results when one knows how one ought to act in a situation but feels prevented from doing so by barriers presented by the situation. This phenomenon was initially described in the nursing literature and has remained a significant nursing concern. This may be attributable to a common disconnect between the professional responsibilities held by nurses in various practice contexts and the limited authority that they are granted to fulfill these responsibilities. Moral distress frequently results in strong feelings of guilt, regret, and remorse toward one's actions or inaction – while having a sense of inability to act differently. The data reported by the nurses participating in this study highlight a significant risk for moral distress among nurses practicing in Italian correctional settings.

Discussion

The prison environment has a culture characterized by order, discipline, and control [2, 4, 11, 12, 25, 30]. This culture can impede nurses' responses to the health needs of detainees. The results from our research reveal the experiences of nurses who care for detainees, which is sometimes challenging and frustrating and can lead to moral distress.

The recent 2008 shift of responsibility for prison health to the regional health system in Italy [21], has had an impact on the professional role of nurses practicing in prisons. Adjustments have had to be made for health services provided in correctional settings, to ensure that they are comparable to services provided to the non-incarcerated. The goal of this shift is to ensure that health care providers are not responsible for performing security and control measures. This will also help correctional settings with a nursing shortage to supplement staffing with nurses from the regional health care sector.

In many cases, health care professionals employed by the Ministry of Justice have asked to be transferred to settings

other than prisons. The initial lack of knowledge on the part of the regional health system about prison health regarding the specific particularities of a) this context, b) clients, and c) relational dynamics, resulted in errors of judgment in the assignment of nursing staff [14]. These nursing staff assignments were unsuitable for ensuring the performance of activities required in this setting. This has caused difficulties in nursing staff retention and increased turnover, resulting in the fragmentation of continuity of care. Consequently, most of the nurses currently working in the correctional settings of Liguria have practiced in this context for only a short time. This leads to difficulties in the assessment of detainees' health needs; as they are often not sincere about their state of health in their interactions with nurses as well as correctional officers. This highlights a need for specialized training for correctional nursing, which entails a broad scope of expertise requiring university-level education [1-6].

This is corroborated by Powell who highlighted that policies and organizational changes have an impact on professional roles and that conflict can develop between detention and health care delivery systems [8]. We support that the 'ethos of health care for prisoners', identified by Willmott [4], must be further developed and should be the object of future research.

Focus groups data in this study revealed how participants thought that the real challenge was to meet the everyday health needs of prisoners while negotiating compliance with safety requirements. This continuous bargaining caused conflict between parties that have different mandates; caregivers in prison are viewed ambivalently by those responsible for safety. Nurses were considered by correctional staff as a hindrance to the conduct of non-health-care prison activities. Correctional officers, usually with limited work experience, are led to believe that detainees do not have any illnesses or health needs. Listening to patients, by nurses, is considered a waste of time. This discounting of professional nursing practice can further contribute to moral distress among nurses.

The findings in this Italian study corroborate the findings reported in the international nursing literature. Correctional nurses have reported tremendous pressure to speed up their provision of care [9, 25, 27]. Nurses have described interference with their professional autonomy, as their practice can be severely restricted by prison rules [31]. Some studies have revealed bullying practices by correctional officers toward nurses [9]. Future research should examine the dangerous alliances that can sometimes develop between nurses and correctional officers at the expense of the patient.

Nurses in these settings are aware of being regarded by correctional officers as more directly accessible than physicians. This results in frequent and unnecessary calls that distract the nurse from other activities [32]. These calls are scarcely related to health problems; as officers solicit nurses to administer 'treatments' aimed at controlling detainees. Nurses' refusal to agree to such requests may lead to further conflict [30].

Correctional nurses seek recognition of the importance of their role. Some correctional nurses have reported feelings of marginalization [8, 9, 14, 25, 33]. Colleagues and acquaintances demonstrate pity as well as suspicion toward them. This nursing practice is often denigrated and inadequately compensated, when compared to workers in other high-risk sectors [33].

Our results have implications for nursing practice as well as nursing education. Some nurses highlighted the need for specific training in the management of conflicts, including ethical conflicts. Training initiatives should focus on the specific features of nursing practiced in correctional settings. These settings are significantly different from other practice settings.

We conclude that an important practical outcome of this research should be the development of educational programs to help nurses manage the complex ethical challenges they confront in their practice. These challenges include maintaining the integrity of nursing practice as well as the safety of both nurses and patients [10].

Conclusions

Correctional nursing operates in a particular context that is not primarily health-oriented; where the principal objectives are safety, control, and serving of prison sentences. Security requirements are commonly posed as a priority over the health needs of detainees. Recent policy and organizational changes strive to advance the professional role of nurses; recognizing the conflict between control and health care provision. Significant turnover compromises continuity of care and the therapeutic relationship between patients and nurses. Nurses need special training and adequate skills and experience to provide required care for detainees, who are often difficult and manipulative patients.

Future Developments

Future research should focus on the development of ethics-related knowledge and professional practice standards for correctional nursing. This should examine how to help nurses cope with moral distress associated with working with this difficult population and practice setting.

We also recommend further research on the development of effective strategies for improving relationships among detainees, correctional officers, and health care providers. Nurses are often considered as central agents in managing conflict and feel great a responsibility to support the needs of the different actors involved.

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Conflict of interest statement

None declared.

Authors' contributions

AB and LS supervized the study and reviewed the manuscript. FC conducted the data analysis and drafted the manuscript. BD collected the data and conducted her thesis on the topic of this manuscript.

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