Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Seirbhís Phríosúin na hÉireann

Nursing in the Irish Prison Service

Working Together to Meet the Healthcare Needs of Prisoners

Nursing and Midwifery Planning and Development
&
Irish Prison Service

ISBN 978-1-906218-28-7

June 2009

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Foreword

It is increasingly being recognised that good prison health is good public health. It is for this reason I am pleased to present the findings of the first research study on prison nursing in Ireland. Nurses were recruited to the Irish Prison Service (IPS) in a full time capacity in 1999 and to date there are 117 nurses employed nationally in the Irish Prison Service. This report identified prisoner health needs and examined these against the current provision of healthcare by nurses employed in the prison system. As nurses deliver the majority of the professional healthcare provided to the prisoner population nationally, it is timely to produce an evidenced based framework to inform the Irish Prison Service of what actions are required to further develop and enhance the role of the nurse that reflects the health needs of the prisoner population.

Following a recommendation from the Report of the Group to Review the Structure and Organisation of Prison Healthcare services (Olden Report) the Nursing & Midwifery Planning & Development unit undertook this research in partnership with the IPS. This report was co-funded by the Health Service Executive and the National Council for the Professional Development of Nurses & Midwives. The purpose of this work was to inform how nurses working within the Irish Prison Service can maximise their contribution to prisoner healthcare through role development.

The healthcare of prisoners is an integral aspect of incarceration. The provision of healthcare within a custody environment is challenging for all staff who work in the Irish Prison System and particularly for nurses who have to adapt to the environmental constraints of prison life. Role development for nurses working within prisons is about enhancing the nursing contribution to a more prisoner focussed service, consequently improving their health and well being, developing clinical effectiveness and delivering better outcomes for prisoners. This also ultimately impacts positively on the prison environment.

The principles and recommendations identified in this report should be understood and valued for many reasons: this is a national study following extensive consultation with all relevant stakeholders; it is ground breaking and will inform a baseline from which advancing professional nursing and healthcare practices in the Irish Prison Service can be measured.

The report is not only firmly grounded in the expressed health care needs of prisoners and the perceptions of clinical professionals, it is also based on the Irish Prison Service Governors, Senior Managers and Prison Officer's Association's vision for integrating healthcare in the prison system. This report will assist the IPS to review their client's needs and develop systems to map out new, more efficient and effective ways of working and delivering healthcare services.

I wish to thank the advisory group who provided expert guidance and support for the project. I am indebted to the Governors, Prison Managers, Nursing Staff, Medical Staff, Security Staff, Prisoners and other key stakeholders who participated in the project and provided a wealth of information to inform this report. Particular thanks are extended to Ms. Frances Nangle-Connor who demonstrated the leadership and vision to support this work and to Ms. Loretto Grogan, project manager for her hard work, enthusiasm and professionalism.

Eithne Cusack
Chairperson

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ABBREVIATIONS

ACO	Assistant Chief Officer
AMA	American Nurses Association
CEO	Chief Executive Officer
CPR	Cardio Pulmonary Resuscitation
GP	General Practitioner
HSE	Health Service Executive
ICN	International Council of Nurses
IPS	Irish Prison Service
NCNM	National Council for the Professional Development of Nursing and Midwifery
NMPDU	Nursing & Midwifery Planning and Development Unit
PMRS	Prisoner Medical Record System
POA	Prison Officers Association
RCN	Royal College of Nursing
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WHO	World Health Organisation

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TERMS OF REFERENCE

The 'Nursing in the Irish Prison Service – working together to meet the healthcare needs of prisoners' project was established with the following terms of reference:

- To establish the scope of current roles of nurses and medical orderlies
- To identify the skills and competencies required by nurses to meet the healthcare needs of the prison population
- To establish the professional development and educational supports required by nurses to meet these
- To identify and explore the challenges to the development of a quality nursing service
- To establish areas for further development in response to service needs
- To make recommendations based on the findings

Executive Summary

Nursing in prisons in Ireland is a relatively recent service innovation and the findings and recommendations of this report should be viewed in this context. Nurses and medical orderlies provide health care to 9711 people entering prison each year (11934 committals), of whom 16% are under 21 years of age, 12% are female and 70% have a prison sentence that is more than two years.

Healthcare (and nursing) in prisons in Ireland is supported by a clearly-defined legal basis for prison healthcare (the 'Prison Rules') and the IPS therefore has statutory responsibility for prison healthcare. While the potential role of the HSE in prison healthcare has been recognised and initiatives to progress this have been pursued, the HSE still remains peripheral to prison healthcare delivery.

This project set out to examine ways of maximising the effectiveness of nursing interventions and care in the management of prisoner health, to identify what supports are required and to inform a strategy that facilitates the effective utilisation of nurses skills and competencies in the management and efficient delivery of quality healthcare in this system.

The findings in this report are not attributable to individual prisons but represent data collected from all prisons in Ireland. The findings offer a comprehensive analysis of the health needs of prisoners in Ireland and when compared to our analysis of current nursing practice in prisons, highlight a significant number of gaps in healthcare delivery and its management.

Nurses working in the IPS have a wide range of professional experience and qualifications. Their clinical role is diverse and encompasses a wide range of responsibilities and functions. Similarly, the health needs of prisoners are diverse and include: addiction, mental health, infectious diseases, chronic illness, acute illness and health promotion. This suggests nursing care might optimally be delivered within a prison healthcare system that incorporates a comprehensive primary care system integrated with appropriate secondary care services.

The findings of this study indicate that the role of the nurse could be more effectively utilised within the IPS with greater scope to enhance existing clinical capacity to meet the healthcare needs of prisoners. Nurses described the prison environment as having an impact on their clinical practice. The role of medical orderlies was also wide-ranging and includes a large number of clinical tasks involving direct patient contact.

A number of measures that would support the future development of nursing in the IPS were identified, including: clarification and definition of the nursing role, the establishment of a quality / governance framework, effective management and clear leadership at operational and directorate level, workforce planning, professional development structures, improved documentation systems, infrastructure development, an awareness of professional and workplace culture, a formal partnership with the HSE and an overall strategy for prison healthcare.

Prison health is an important issue for population health and our understanding of its importance is evolving with an increasing evidence base. Prisoners have increased health needs compared to the general population and addressing these needs can be more difficult as prisoners experience greater degrees of social exclusion. Nurses and other healthcare professionals have an enormously important role in addressing these health needs.

There are many positive aspects to take from this project. It highlights strong awareness of the importance of prison healthcare, recognition of the role nurses play in this and strong support for innovation in healthcare delivery among all key stakeholders. The report makes extensive recommendations on the future development of prison nursing and healthcare in Ireland and these recommendations are likely to be cost effective in terms of improved health and social outcomes. It should be noted however that many of the recommendations require little or no additional funding or resources to implement. Restructuring and integration of existing services and resources would support the implementation of many of our recommendations. In that regard, we highlight a pressing need for effective collaboration at all levels – policy and practice.

Recommendations

Goal	Recommendation
Enhance the strategic development of prison healthcare	1.1 The role of the Department of Health and Children is clarified in relation to ● Advising on the strategic development of the prison health system including policy and legislation ● Evaluating the performance of health and social services to this population and ● Working with other sectors to enhance prisoners health and wellbeing 1.2 A formal partnership between the IPS and the HSE is established. 1.3 A strategic plan is developed for prison healthcare in consultation with key stakeholders nationally.
Identify and meet prisoner health needs	2.1 Healthcare is considered an integral aspect of incarceration by those responsible for the planning and provision of services. 2.2 There is an evaluation of current healthcare provision in the IPS to ensure the health needs of prisoners are being met. 2.3 A prison health surveillance system is developed to document and monitor the health needs of the prison population. 2.4 The health needs of prisoners inform the development of nursing and other health services to this population. 2.5 A structured, coordinated interdisciplinary discharge planning system where prisoners health and other needs are met in the community following discharge is developed. 2.6 Discharge planning is incorporated into the role of health professionals in the service.
Develop and implement policies, procedures, protocols and guidelines	3.1 Existing local and national policies, procedures, protocols and guidelines are employed in the IPS to support practice. 3.2 In areas where there is an absence of relevant policies, procedures, protocols and guidelines to support practice these should be developed collaboratively with practicing nurses and other health professionals.
Develop nursing role – role definition	4.1 The role of prison nurses in healthcare provision should be explicitly defined and reviewed on an on-going basis to ensure it is appropriate to the health needs of the prison population. 4.2 The role of prison nurses is communicated to and understood by all prison staff at corporate and operational level. 4.3 The role of prison nurses should integrate with any new service delivery frameworks through initiatives such as multidisciplinary / interdisciplinary care, structured / shared care protocols, clinical audit and education / training. 4.4 The concerns identified in relation to the lack of a nursing management structure are addressed by the recently introduced nursing managers.
Develop nursing role – advance capacity for specialist and advanced nursing practice	5.1 The IPS conducts a needs analysis to determine areas of care where specialist or advanced nursing practice is required to deliver high quality care. 5.2 The National Council for the Professional Development of Nursing and Midwifery provide guidance and support to prison management and their staff regarding the development of nursing roles.

Goal	Recommendation
Develop nursing role - advance skills and competencies	6.1 Further work is needed to identify the core skills and competencies for prison nursing. These should be determined by both the health needs of prisoners and by wider developments in healthcare which support multidisciplinary / interdisciplinary care teams. 6.2 A competency framework specific to prison nursing is developed and the competencies used to inform the design of nursing roles, induction for those roles and continuous professional development.
Develop professional development infrastructure	7.1 An education framework for prison nursing is developed with consideration given to developing a national postgraduate training programme in prison nursing. 7.2 A mechanism is established to enable professional development plans to be developed with staff. 7.3 A dedicated post in clinical practice development to support prison management in the planning and delivery of the continuing professional development needs of nurses is established. 7.4 The IPS establishes formal links with education providers. Flexible approaches to learning such as distance / online learning strategies are explored given the geographical spread of the prisons. 7.5 Formal mechanisms to support professional networking should be pursued at local and national level. 7.6 A formalised process of support such as clinical supervision is available to all nurses. 7.7 Management at local and strategic level support the professional development of all nurses. 7.8 Education facilities such as internet access, training / study areas are provided across the IPS.
Support practice within the Scope of Nursing and Midwifery Practice Framework	8.1 Prison management at corporate and local level are aware of, and ensure that nurses are aware of and work within the professional and legal obligations of the scope of nursing and midwifery practice. 8.2 Nurses are supported to: • Evaluate practice to ensure they are educated, competent and have the authority to carry out their range of roles, functions, responsibilities and activities. • Review, describe and expand their scope of practice to meet the health needs of the prison population.
Enhance quality and governance	9.1 Integrated quality assurance mechanisms, capable of providing regular evaluation and monitoring of prison healthcare, should be introduced in the IPS. 9.2 A mechanism is advanced to facilitate the involvement of prisoners in the design, delivery and evaluation of healthcare services. 9.3 The IPS should be included in any national developments regarding clinical governance.
Develop workforce planning	10.1 Workforce planning is undertaken in the IPS to ensure there are an appropriate number of nurses in the right place, at the right time, with the right skills to provide care to the prison population.

Goal	Recommendation
Develop workforce planning	10.2 The prison service effectively utilise the skills and knowledge of nurses within the service and organise nursing teams that meet the health needs of the particular prison population.
Strengthen nursing practice – access	10.3 Skills, knowledge and experience in the principal identified health needs of the prison population are considered at recruitment.
Strengthen nursing practice - access	11.1 Formalised structures to improve prisoners interface with and access to nurses are developed in conjunction with prison management.
Strengthen nursing practice – committal assessment and care planning	12.1 The current 'committal assessment' process is revised to facilitate: • The development of a more comprehensive nursing assessment tool • The development of formal training in conducting assessments with a particular focus on the area of mental health for nurses with no training in this area • The provision of adequate facilities and time to conduct the assessment • The provision of information to prisoners on prison health services and an opportunity to address any immediate health concerns that present • The provision of guidance to security staff in relation to accommodation and level of observation appropriate to presenting health concerns 12.2 Formal nursing care plans are introduced. 12.3 Care plans are devised in collaboration with the prisoner.
Balance the therapeutic and custody roles	13.1 The interface between the work of prison officers and nurses be explicitly addressed, examining both complementary and differing modes of practice. 13.2 Consideration should be given to formal training in issues related to prison healthcare forming part of prison officers' and prison managers' training and development. 13.3 The role of medical orderlies in prison healthcare delivery is reviewed as a priority, with consideration given to establishing an accredited training programme if this grade is to be continued.
Develop prison healthcare infrastructure	14.1 Increased access to administrative / clerical assistance to support the provision of healthcare in the service is provided. 14.2 Current healthcare facilities are reviewed in terms of adequate space, physical condition, provision of equipment and hygiene. 14.3 Healthcare staff inform the design and planning of healthcare facilities. The healthcare needs of the population in the particular prison should also be incorporated. 14.4 Communication strategies are improved in the IPS to facilitate communication channels that are clearly defined and open.
Implement recommendations	15.1 Across the IPS, and within each prison, healthcare management should work collaboratively and in partnership with prison management at corporate and local level to address the findings of this report and to drive the implementation of its recommendations.

Chapter 1: Background to 'Nursing in the Irish Prison Service' Project

1.1. National health policy

Equity, people-centeredness, quality and accountability are central elements of national health policy in Ireland which aims to: 'develop a system in which best health and social well-being are valued and supported ... and … include every person and institution with an influence or role to play in the health of individuals, groups, communities and society at large' [1].

Ireland's national health strategy incorporates health services provided outside the remit of the Department of Health & Children and makes specific reference to the health of the prison population and cites implementation of recommendations made by 'Report of the Expert Group on the Structures and Organisation of Prison Healthcare Services in Ireland' as a priority, attributing overall responsibility for implementation of these recommendations to the Irish Prison Service [2].

1.2. Prison healthcare policy

The 'Report of the Expert Group on the Structures and Organisation of Prison Healthcare Services in Ireland' was published by the Department of Justice, Equality & Law Reform in Ireland in 2001 and outlined recommendations on the future of prison healthcare in Ireland [2].

The report was bought about by the increasingly recognised challenges involved in delivering healthcare in prisons [3] and the findings of previous reports on prison healthcare in Ireland, which included:

- In 1994, it was recognised that the organisation and provision of medical services in Irish prisons had failed to keep up with developments in both medical and ethical standards [4].
- In 1998, the 'European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment' reported concern at the absence of qualified nursing staff and the number of hours for which prison doctors were present (nurses were subsequently introduced to the Irish Prison Service (IPS) in 1999) [5].

- In 2000, a 'General Healthcare Study of the Irish Prisoner Population' reported mortality and morbidity levels among prisoners that were higher than among the general adult population and highlighted the areas of mental health, addiction, infectious diseases and primary care as priority health needs [6].

The terms of reference of the 'Expert Group on the Structures and Organisation of Prison Healthcare Services'included: 'to consider and make recommendations regarding the structure and organisation of primary medical and nursing services within the prison environment in light of the development of healthcare services generally and the needs of the prison population' [2].

The report acknowledged a long-term under-resourcing of prison healthcare services in Ireland and made 43 recommendations, many with direct implications for prison nursing in Ireland and these included:

- comprehensive and structured education and continuing professional development infrastructure and a nursing management infrastructure be implemented;
- opportunities for the role development of nurses to meet the healthcare needs of the prison population be explored;
- multidisciplinary approach to care delivery;
- clear and defined set of healthcare standards be identified;
- arrangements be put in place for the monitoring of staff performance;
- nurses discontinue carrying out duties of a custodial nature;
- prison healthcare facilities be developed to mirror equivalent facilities in community primary care facilities;
- time spent by nurses on medication management be minimised;
- additional administrative support be provided to improve the throughcare and aftercare of prisoners;
- care provision to special prisoner groups be reviewed, specifically health promotion initiatives to women and juveniles in the prison system;

- formal partnership between the Department of Justice, Equality & Law reform, the Irish Prison Service and the Department of Health & Children and / or statutory health boards be established.

Nurses have been working in the Irish Prison Service (IPS) since 1999 and are now key members of healthcare teams working in prisons. Prior to the introduction of nurses to the Irish Prison Service, medical roles such as first aid, dispensing and administration of medication, and associated care were provided by medical orderlies*.

1.3. Function of the NMPDU

In Ireland, the 'Nursing & Midwifery, Planning and Development Units (NMPDUs)' were established on a regional basis, in response to the recommendations of the Commission on Nursing's 'A Blueprint for the Future' [7]. They have the role of strategic planning & development and quality assurance. Their functions also include workforce planning, continuing professional development, research and information communication, service development, practice development and quality and clinical governance.

1.4. Origins of this report and overarching objectives

A working group was established to progress the implementation of the report of the 'Expert Group on the Structures and Organisation of Prison Healthcare Services in Ireland' and this group comprised representatives from the Department of Health and Children, the former Health Boards, Department of Justice, Equality & Law Reform and the Irish Prison Service.

The working group, through its chairman (Mr P McLoughlin), requested a formal association be established between the NMPDU (in the Eastern Region) and the IPS.

The Director of Nursing in the IPS subsequently approached the NMPDU to collaboratively explore opportunities for the development of nursing services in the IPS.

* Medical orderlies are prison officers who have undergone short training courses in first aid and aspects of prison healthcare. They are not registered with An Bord Altranis therefore do not work under the same professional regulations as nurses. IPS recruitment policy indicates that in the event of retirement, resignation etc, medical orderlies will be replaced by nurses. Since 1999, no new medical orderlies have been appointed.

The two agencies therefore developed a collaborative proposal for a project, with overarching objectives to‘

- establish the scope of current roles of nurses and medical orderlies
- identify the skills and competencies required by nurses to meet the healthcare needs of the prison population
- establish the professional development and educational supports required by nurses to meet these
- identify and explore the challenges to the development of a quality nursing service
- establish areas for further development in response to service needs
- make recommendations based on the findings

1.5. Outline of the project

The project was led by the NMPDU and IPS. At the outset of the project, an ‘expert advisory committee’ was established to oversee and advise on strategic priorities for the project. Individuals and agencies with a special interest in prison healthcare / nursing were invited to join this committee.

The project was conducted between November 2005 and December 2007* and consisted of three related work packages, which are presented as follows:

- A literature review on the role of nurses in prison healthcare (Chapter 2);
- Descriptive reviews of the Irish Prison Service, its existing health structures (Chapter 3) and of recent developments in nurses’ professional role in Ireland (Chapter 4);
- A mixed-methods study of the role of nurses in prison healthcare in Ireland (Chapters 5-7).

* During this time, the project findings were reported at regular intervals to the IPS, the NMPDU and the expert advisory committee.

Chapters 8 and 9 offer a critical analysis of the programme of work described in this report, considers its implications, and offers key recommendations for the role of nurses in prison healthcare delivery in future years.

Chapter 2: The role of nurses in prison healthcare: a literature review

2.1. Introduction and methods

Health in prisons is an important priority for global population health. The World Health Organisation (WHO) advocates its members states 'improve public health by addressing health and healthcare in prisons and by facilitating the links between prison health and public health systems both at national and international levels' [8].

Providing optimum healthcare in prisons is a complex issue and our understanding of this issue is evolving. A recent review of healthcare provision in prisons has outlined some of the essential components of prison healthcare systems and these include: a requirement that 'everyone working in prisons understands how imprisonment affects health and the health needs of prisoners and that evidence-based prison health services can be provided for everyone needing treatment, care and prevention in prison' ... [and] … 'being aware of and accepting internationally recommended standards for prison health, providing professional care with the same adherence to professional ethics as in other health services and, while seeing individual needs as the central feature of the care provided, promoting a whole-prison approach to the care and promoting the health and well-being of those in custody' [9].

This chapter aims to present an overview of key literature in relation to the role of nursing in prison healthcare. The contents of the electronic database 'PubMed' for the period January 1989 to October 2007 were searched using the search terms "prison" and "healthcare" in combination with the following search terms: "nurse's role" and "nursing". All relevant articles were identified and retrieved, and the references of each hand searched for further articles of relevance. In addition, the online listing of publications of World Health Organisation (http://www.who.int/en/) and the Irish Government were searched for relevant articles and reports.

2.2. Healthcare needs of prisoners

Prisoners have diverse and complex health needs. Compared to general adult populations, prison populations have poorer physical, mental and social health than the general population and experience considerable social exclusion [10].

In a literature review to identify models of prison healthcare to inform care delivery in the UK prison service, Watson et al identified three principal health issues (mental health, communicable diseases and substance abuse), two discrete population groups (women and older prisoners) and two thematic domains (health promotion and the health of the community) in prison healthcare [11].

The issue of mental health has been widely studied among prison populations. Mental health problems are more prevalent among prison populations than among the adult population and this finding has been reported in studies from Europe [12], New Zealand [13] and the United States [14]. In addition, a systematic review of studies reporting mental health problems among prisoners highlights that this group of health problems has a prevalence that is increasing internationally [15]. Suicide rates are higher among male prisoners than among general adult populations [10].

Substance abuse has been identified as a likely factor associated with both mental health problems among prisoners and communicable diseases [16] [17] and 90% of all prisoners have a diagnosable mental health problem, substance misuse problem or both [10]. In a systematic review of substance abuse among prisoners, Fazel et al identified 13 studies reporting on 7563 patients and found a prevalence of alcohol abuse / dependence of 18-30% among male prisoners and of 10-24% among female prisoners and of substance abuse / dependence of 10-48% among male prisoners and of 30-60% among female prisoners [18].

Communicable diseases are also an important issue in prison healthcare. In particular, HIV infection has been shown to have a high prevalence among prisoners compared to the adult population [19] [20]. HIV infection is spread by both sexual transmission and by percutaneous blood exposure and in this regard, prison populations are at high risk of other sexually transmitted infections [21] [22] and other bloodborne viruses (hepatitis B, hepatitis C and HIV) [23] [24].

The issue of bloodborne virus infections among prisoners in Ireland is especially problematic. Among a national sample of prisoners, Allwright et al reported HIV, hepatitis B and hepatitis C prevalence rates of 2%, 9% and 37% respectively [25], while Thornton et al have highlighted that many prisoners do not accurately report their bloodborne virus status [25] [26].

The issue of women's health and the challenges involved in providing care in this regard have been described [27]. Particular problems affecting women prisoners include: gynaecological problems, substance abuse and chronic disease [28].

Young people too, have been identified as a group with potentially unique healthcare needs. A retrospective review of nursing clinical records of young males admitted to a New South Wales prison identified physical injury, sexually transmitted infections, respiratory disease and mental health as especially common – with 26% and 9% reporting they had respectively considered and attempted suicide [29]. Coffey et al demonstrated that young male offenders were nine times more likely and female offenders were 40 times more likely to die than young people in the general population. Drug related causes, suicide, and non-intentional injury were the leading causes of death [30].

The importance of health promotion in prison healthcare has also been recognised [31] and prisoners as a group can lack knowledge or have misperceptions about health promotion and disease prevention (Flanagan, 2001). In a survey of male prisoners in Cardiff, 25% drank 90 or more units of alcohol weekly before prison, 84% smoked, 68% never took vigorous exercise and 62% ate less than three portions of fruit and / or vegetables daily [32]. Advice on prevention of communicable diseases and modifying high-risk lifestyles / behaviours and implementing measures to promote mental health are just some of the opportunities for health promotion in prisons that have been identified [33].

Imprisonment can have an impact on prisoner health, especially mental health. Nurse et al reported that long periods of isolation with little mental stimulus contributed to poor mental health, with prisoners indicating they misused drugs to relieve the tedium [34].

Autonomy in and taking responsibility for one's health are restricted by the constraints of a prison regime. This has been identified as a factor limiting well-being in prison [35] [36]. Sim identified the factors that affect physical and mental health during imprisonment as: limited access to information about prison routines, overcrowding and the inadequacy of basic commodities such as 'fresh air' when exercise can be cancelled or allowed sporadically [36].

Prisoners identified the following factors as affecting their health: threatening behaviour by other prisoners, cell conditions, physical violence and racism. In relation to outside factors many prisoners were worried about home and family. The main concerns highlighted were regarding money and maintaining the home, family illness or death, their relationship with a partner and not seeing their family.

2.3. Healthcare delivery in prisons

Coyle has outlined the key principles of effective healthcare in prison and these include: 'healthcare decisions must be made on clinical grounds and with the patient's interests and consent underlying every clinical judgement and action' … 'professional independence and patient autonomy, even within prisons are crucial, as is the need for equivalence of care' … 'these requirements are most likely to be met if the arrangements for delivering healthcare in prison are closely linked to the provision of healthcare in the rest of society' [37].

However, healthcare faces additional challenges in view of the universal recognition of prison populations as socially excluded. Among prison populations, 56% are unemployed before sentencing, 50% have poor reading skills, 80% have poor writing skills, 67% have poor numeracy skills, 38% will be homeless on release, 47% are in debt at time of sentencing, and the population have little or no contact with regular health services in their local communities [10].

To successfully deliver a quality healthcare service in prisons, Norman and Parrish emphasise firstly the importance of the recruitment and retention of good staff who have a range of skills, experience and abilities [38]. The approach to care should be of a multidisciplinary nature. In many settings this will include prison officers, with or without a nursing qualification, who traditionally will have delivered much of the nursing care.

Secondly it is essential that a working environment is produced which allows staff to use their skills and not be restricted by bureaucracy.

Watson et al in endeavouring to identify models of prison healthcare to inform care delivery in the UK prison service did not uncover any single model which could be applied. There were components identified that should possibly be considered to include: health promotion as a unifying concept for healthcare in prisons incorporating health needs assessment, health screening on arrival in the prison system incorporating standardised protocols and validated instrument with an emphasis on mental health, partnership between prison services and health services, telemedicine as a mode of delivering healthcare in prisons, education of prison staff, including healthcare staff about the health needs of prisoners, developing a model of prison healthcare which looks beyond the prison environment to the communities which the prison serves [39].

2.4. Nursing care in prisons

Although, the potential benefits of prison nursing to health outcomes are increasingly recognised [40], a recent review has highlighted the need for further research to determine how nursing can best address prisoners' health needs [41], especially in promoting access to healthcare [42].

Nursing in prisons has implications for nurses' professional practice. A review of nursing in prison healthcare highlighted ways in which nursing in this environment is different from in other environments, with prison regimes, security and culture all impacting on the role [43]. A qualitative study of psychiatric nurses' experience of working in prisons, highlighted how prison nurses must adapt to working in less than ideal practice conditions, with challenges that are unique to nursing in prisons including: personal safety, dealing with challenging patients, the technology of confinement, conflicting values of correction staff, and stigma by association with prison administration [44].

Similar issues regarding the professional challenges posed by nursing care in prisons have been identified by Peternelj-Taylor and Simpson, who described a tension between caring and security and also identified an evolving professional roles for nurses and nurse-patient relationships in prisons [45].

Maeve has also suggested prisons pose challenges to those involved in care delivery, in particular the challenges where having a caring relationship with women prisoners is concerned [27]. Nurses working in prisons have limited control over the types of patient they are nursing compared to nurses working in other clinical settings [46].

Nursing in prisons also has implications for nurses' clinical practice. In prisons, nurses encounter a range of clinical presentations ranging from mental health to acute or chronic medical conditions. Nursing in prisons has been described as a specialised role [47]. Norman and Parish describe the role as multifaceted, embracing 'the assessment of the physical, psychological, emotional, spiritual and special needs of individual clients in custodial care, the actual transaction of care delivery and care management, counselling, health education, collaboration with other agencies, clinical decision making, advocacy and rehabilitation'[48].

Peternelj-Taylor and Johnson identified mental health and substance abuse as two important clinical areas in prison nursing [45]. Health promotion has also been highlighted as an area in which nursing care can play a particularly important role in improving population health and Whitehead has advocated that if provided with appropriate resources and structures, nursing can 'embrace the radical health promotion reforms that are emerging from the current literature' [49].

A survey of prison nursing practice, reported the following activities performed daily: patient education, physical exams, medication distribution, first aid, counselling, health screening, staff education and to a lesser extent postoperative care, drawing blood and detoxification [50].

When asked to identify priority training needs, nurses identified the following: triage and treatment of emergencies, assessment skills, techniques to interact with difficult patients (two separate dimensions of interactions were highlighted, training to deal with disruptive, manipulative patients and training to enable nurses to maintain their professional demeanour and judgement when dealing with difficult patients), additional training on security issues, education about health problems to include further education in relation to health promotion and disease prevention [50].

A review of prison nursing by the Royal College of Nursing identified the key elements of a prison nurse's role to include: inpatient care, primary and outpatient care, prison community nursing, health promotion, reception and screening, emergency nursing and crisis care [51].

Other professional issues that emerged from the study included:

- the majority of nurses did not identify discharge and community support as part of their nursing role
- strong emphasis on competency-based professional development
- the problem of providing care in a secure environment where the primary purpose is not healthcare
- the nursing role is more about breadth than depth
- the potential for specialisation exists, particularly in larger nursing teams [51]

The recommendations from this report included: the development of comprehensive care plans based on individual needs assessments, the introduction of a more comprehensive health check after the initial reception screening, formal mechanisms to support nurse triage and regular literature searches as part of nurses' continuing professional development [51].

2.5. Professional development of nurses

Professional development has been recognised as important for nurses and the organisations in which they work in order to maintain and enhance professional standards and to provide the highest quality of healthcare [52].

Nursing in prisons requires staff with specific expertise who have considerable professional development needs [53]. The context in which prison nursing occurs means that nurses are regularly presented with complex clinical and professional issues [54]. Consequently, the majority of nurses commence working in this environment without all the core competences required to be clinically effective and confident in their role.

Internationally, variations in the professional background of prison nurses have been reported. Semi-structured inspections conducted in UK prisons to investigate facilities for prisoners with mental health problems highlighted deficits in the qualifications and training of medical and nursing staff [55].

In a review to establish how nursing is undertaken in secure settings, a strategic approach to the development of the workforce in order to meet client and organizational need was found to be lacking [53]. In addition, the method in which individuals were supported in their continuing professional development was found to be inconsistent. A subsequent recommendation was the use of competencies to inform the design of nursing and midwifery roles, induction for those roles and continuous professional development. The review also acknowledged that the maintenance and monitoring of professional standards to include the professional development of nurses in prisons relies on a joint approach by practitioners, prison managers, prison health services and policy makers in the prison services and statutory agencies.

2.6. Healthcare in prisons in Ireland

In recent years, increasing literature on health issues in Irish prisons has been published and this section presents a synopsis of the most relevant:

2.6.1. General Healthcare Study of the Irish Prisoner Population

A review of prisoners' health in Ireland demonstrated that compared with the general population, Irish prisoners have greater healthcare needs. Particular associated healthcare needs are in the areas of: mental health, addiction, infectious diseases and primary care. The study also highlighted that mental health indicators were much worse for prisoners than the general population (and especially so for female prisoners) and reported high rates of lifetime substance misuse including polydrug use, high levels of alcohol use and cigarette smoking.

The review recommended the introduction of a comprehensive prison health service, which would include adequate staffing by doctors and nurses, a uniform prison service drug policy, multidisciplinary life skills and environmental change health promotion

programmes and an appropriate training and education programme for staff. In addition, it recommended a health promoting prison approach addressing adverse aspects of the prison environment, a clear custody and through care planning strategy and a multidisciplinary approach to the education, training and social rehabilitation of prisoners [6].

2.6.2. Bloodborne viruses among Irish prisoners

Allwright et al conducted a national cross-sectional study of bloodborne virus infections among Irish prisoners and reported 9% of Irish prisoners were infected with hepatitis B, 37% with hepatitis C, and 2% with HIV, with 81% of injecting drug user prisoners hepatitis C antibody positive [25].

The study confirmed the high rates of injecting drug use and sharing of injecting equipment within Irish prisons, with one-fifth of injecting drug users reporting starting injecting in prison. The authors recommended improved access to harm reduction strategies for prisoners and although higher than in many countries, suggested increased uptake of hepatitis B immunisation

2.6.3. The structure and organisation of prison healthcare services

In 1999, the 'Expert Group to Review the Structure and Organisation of Prison Healthcare Services' was established [2]. The aims of the group were:

- To consider and make recommendations regarding the structure and organisation of primary medical and nursing services within the prison environment in light of the development of healthcare services generally and the needs of the prison population.
- To consider and make recommendations regarding the provision of psychiatric services to prisoners (taking into account changes in service provision generally and the potential ramification of possible new mental health legislation).
- To consider the appropriate need and level of in-house provision of specialist medical services and make recommendations accordingly.

- To consider structures for the legal and professionally appropriate control of pharmaceutical products within the prison system.
- To consider the present organisation of prison dental services and make any appropriate recommendations.
- To consult with all relevant professional and representative bodies in this connection.

The key recommendations in relation to nursing were:

- There should be equivalence of care between the prison population and the general population
- The overall objective should be the creation of a healthy environment in each prison and place of detention
- A multidisciplinary approach should be adopted for the delivery of prison healthcare services
- The establishment of a formal partnership between the Department of Justice, Equality and Law reform, Irish Prison Service and the Department of Health and Children and / or the statuary health boards. A working party should be established to examine the specifics of such a partnership.
- In the interests of overall consistency, a clear and defined set of healthcare standards be introduced.
- Prisons and places of detention should actively support and participate in achieving the various aims and objectives outlined in the National Health Promotion Strategy and related national policy documents.
- In any National Health Strategy proposed by the department of Health and Children, prisoners should be designated as a special needs group in terms of meeting their health requirements.
- Arrangements be put in place for the monitoring of the performance of all prison healthcare staff.
- Provision should be made to enable prison healthcare practitioners to participate in continuing professional development activities
- Prison nurses should not have any duties of a custodial or non-nursing nature
- A new nursing grade, Nursing Manager, should be established at institutional level

- A special induction course in prison practice should be developed for newly recruited nurses and that the training of nurses should be completely separated from the training of discipline staff
- The establishment of a Postgraduate Diploma in Prison Nursing
- Adequate pharmacy supervision should be put in place at institutional level. This could be either full time or part time pharmacy input dependent on the size of the institution
- Measures should be put in place for the external monitoring of compliance with pharmaceutical regulations
- Consideration should be given to the feasibility of community psychiatric teams having direct involvement in the psychiatric care of prisoners
- Mental health legislation should be introduced in a way that would facilitate diversion of mentally disordered individuals from the criminal justice system to alternative treatment, supervision and care service
- The medical unit in Mountjoy Prison be entirely dedicated for treatment of addiction and related purposes
- In general, the development of prison psychiatric units and prison hospitals be avoided
- A new designated post of Healthcare Manager be created at institutional level
- Prison healthcare facilities should mirror equivalent facilities in well run community primary care facilities as much as possible. In the planning of new prisons and the renovation of existing prisons, the needs of healthcare staff ought to be considered from the first planning stage
- To allow for the more productive use of scarce healthcare staff time, all appropriate steps be taken to minimise the proportion of time spent by such staff on the preparation and administration of medicines
- In relation to aftercare for prisoners, appropriate arrangements are put in place where possible with community healthcare resources
- To improve the general through / after care for prisoners, civilian medical secretaries must be assigned to all institutions as soon as possible
- Special prisoner groups should receive special attention from healthcare staff. Women and juveniles detained in the prison system should be a high priority for any health promotion initiatives

- The use of padded or strip cells for reasons of self protection should be kept to an absolute minimum
- The Prison Service, Department of Health and Children and local health boards should ensure that proper structures and protocols are in place to ensure a consistent and equivalent approach to the issue of infectious diseases.

2.6.4. Healthcare needs assessment in Irish prisons

In 2003, the Irish Prison Service carried out a needs assessment in conjunction with the Health Board of healthcare in the Irish Prison Service. This comprehensive study involved a detailed review of the status of healthcare services and needs and obtained feedback from all key stakeholders in the prison service including the prisoner population [56].

The needs assessment identified many areas within the current prison healthcare system which do not meet the needs of the prisoners. Organisational concerns included: an absence of local clinical management structures, insufficient monitoring and evaluation, and inadequate record keeping. Gaps were identified in mental health, pharmacy, GP and specialist services. Overcrowding, insufficient healthcare facilities and inadequate sanitary conditions were also identified in many prisons. Furthermore, health promotion policies and programmes, improved health screening, access to regular health clinics, rehabilitation programmes including drug treatment, improved aftercare and through care, as well as the implementation of the Irish Prisons infectious disease policy were identified needs as well.

The needs assessment suggested that achieving a healthcare system in Irish prisons equivalent to healthcare in the community poses a significant but important challenge for the future and recommended:

- The introduction of healthcare managers at local prison level with overall responsibility for the efficient and effective management of healthcare services
- Development of links with relevant outside agencies
- Engagement of health boards to deliver services to prisoners in their area
- A review of current practices for prisoners attending hospital departments
- Introduction of healthcare standards

- Compliance with all national health policies
- Introduction of a system of clinical governance
- Evaluation and monitoring of healthcare services
- Full implementation of Prison Medical Record System (PMRS)
- Collection of data pertaining to disease prevalence etc.
- Ensuring female prisoners have access to female staff
- Appropriate staffing compliments
- A Health Promotion manager to be appointed to healthcare directorate
- Provision of a pharmacy service in each prison
- Mental Health nurses should be appointed in all closed prisons to provide mental health services
- Substance misuse specialist nurses should be appointed in all prisons where there is a demonstrated need
- Provision of clinics to be needs based
- Specific clinics to be developed for chronic disease management
- Triage system to be developed in each prison to maximise usage of resources
- Standard screening protocols for toxicology, infectious diseases, cervical screening etc
- Drug treatment services to be made more accessible in all prisons
- Appropriate arrangements should be made for the supply of necessary medication to prisoners on release
- All prescribing and administration of medication to be fully documented and regular review and monitoring of medication usage
- Introduction of a health promotion specialist and subsequent development and introduction of written health promotion policies on Drugs and Alcohol, nutrition, physical activity, tobacco control, sexual health, mental health and work place health promotion
- Development of guidelines to ensure confidentiality in regarding health issues
- Provisions to ensure that all healthcare staff avail of continuing professional development

- The development of appropriate prison health related education programmes
- Encouragement of nurses to develop specialist roles in line with prisoner healthcare needs
- Healthcare directorate to have overall budgetary responsibility for healthcare provision in all prisons
- Special needs of minority prisoners including women, juveniles and ethnic minorities to always be addressed
- Appropriate complaints procedure to be developed to deal with prisoners' dissatisfaction with healthcare provision

2.6.5. Mental Illness in Irish Prisoners

A survey of mental illness in Irish prisons found drugs and alcohol dependence to be by far the most common mental health problems, present in between 61% and 79% of prisoners. Prisoners were using multiple intoxicants, including alcohol, benzodiazepines, opiates, cannabis and stimulants [57].

The study also demonstrated that for all mental illnesses combined, rates ranged from 16% of male committals to 27% of sentenced men, while in women committed to prison the rate was 41%, with 60% of sentenced women having a mental illness.

They concluded that there is an excess of those with severe mental health illnesses in all parts of the Irish prison population. They propose that there is an urgent need for measures to correct this, including increased capacity for transfer of the mentally ill from prison to hospital, legal structures and procedures for diversion of the mentally ill form the criminal justice system and a radical overhaul of prison regimes to changer the pro-drug culture that prevails among inmates.

They recommended: mental health services should be reorganised with the adoption of a multidisciplinary approach for its delivery. This should include:

- Prison mental health nurses (with training in psychiatry) dedicated to mental healthcare of the prison population;
- Better screening procedures undertaken by persons trained in the assessment of mental illness and suicide risk;
- Better access to allied health services including occupational therapy, psychology and counselling.

2.7. Synopsis

Prison health is an important issue for population health nationally and internationally and our understanding of its importance is evolving with increasing evidence base. Prison populations have increased health needs by comparison with the general populations and addressing these needs is additionally challenged by the extent to which this population experience greater degrees of social exclusion. Nursing care has an important role in addressing these needs however the role of nursing in prisons faces many challenges.

With regards to the provision of nursing care in prisons there is literature available to examine the role of the nurse in the provision of healthcare to prison populations however there is a dearth of literature regarding precisely how nurses deliver care to this population. Allied to this is the dearth of literature regarding the factors that have contributed to or hindered the development of nursing roles in prisons.

Chapter 3: Project context (I): A descriptive review of the Irish Prison Service

3.1. Introduction

This chapter aims to describe the prison system in Ireland and the organisation and delivery of healthcare in the Irish Prison Service.

3.2. Overview of the Irish Prison Service

The mission statement of the Irish Prison Service (IPS) is "to provide safe, secure and humane custody for people who are sent to prison. The service is committed to managing custodial sentences in a way which encourages and supports prisoners in their endeavouring to live law abiding and purposeful lives as valued members of society."

The Irish Prison Service administers 14 prisons namely:

- Arbour Hill
- Castlerea
- Cork
- Cloverhill
- Dochas Centre
- Limerick
- Loughan House
- Midlands
- Mountjoy
- Portlaoise
- Shelton Abbey
- St Patricks
- Training Unit
- Wheatfield

'Open prisons' have minimal internal and perimeter security, 'semi-open prisons' have minimal internal, but perimeter security while 'closed prisons' have robust internal and perimeter security. Closed prisons are more likely to have prisoners whose escape would be considered a danger to the general public and prisoners spend a longer proportion of their time locked in their cells with quite rigid 'lock down' times. 'Open' and 'semi-open' prisons have prisoners who are non-drug using and have committed a non-violent offence, or prisoners who are coming to the end of their sentence.

There is one prison for young offenders and two prisons for women. The Dochas Centre is the main women's prison and Limerick prison also has a small number of women (approximately 5% of all prisoners at any time).

3.3. Prisoner demography

During 2007, 11934 prison committals (9711 people) were reported. One thousand, two hundred and forty nine (10.5%) people entering prison were immigration detainees. Of people entering prison 8556 (88%) were male and 1155 (12%) were female. The average daily population in the IPS in 2007 was estimated to be 3321 prisoners. People sentenced to two years or more accounted for 15% of all new committals and 70% in custody at any given time were serving sentences of two years or more. A total of 23 persons were committed for life [58]. The number of persons under 21 years of age committed under sentence in 2007 was 1053 (16% of total).

Table 3.1. presents data on the age and gender of prisoners in Ireland in 2007.

Table 3.1 Age profile of prisoners in custody under sentence (on 5th Dec 2007)

Age group	Female	Male	Total	%
16	0	10	10	0.4
17	0	21	21	0.8
18 – <21	7	290	297	11
21 – <25	7	543	550	20.4
25 – <30	24	588	612	22.7
30 – <40	16	677	693	25.7
40 – <50	8	306	314	11.6
50+	4	195	199	7.4
TOTAL	**906**	**7,780**	**8,686**	**100%**

3.4. Organisation of healthcare in the IPS

The aim of healthcare in the IPS is 'to provide prisoners with access to the same quality and range of health services to which they would be eligible within the general community …priority is given to the promotion of health through the positive intervention of staff' [59].

The legal obligations of prisons are specified in the 'Prison Rules' [60]. These identify prison governors as responsible for the provision of safe and secure custody services including healthcare delivery and identify the Director of Prison Healthcare as being specifically responsible for the control, management and administration of prison healthcare.

At the time of this report being prepared, prison healthcare was co-ordinated by a central management structure, which is outlined in Figure 3.1 and a formal healthcare management structure was being established, with consideration being given to the appointment of a complex health manager at each of the Mountjoy, Cloverhill / Wheatfield, and Portlaoise prison complexes and a nursing manager in each of the closed prisons.

Figure 3.1 Central Healthcare Management Structure

3.5. Legal basis for prison healthcare

The 'Prison Rules' (Part 10) refer specifically to healthcare and the roles of healthcare professionals in the IPS [60]. The rules define a 'healthcare professional' as a registered medical practitioner, a registered dentist, a registered nurse or as 'such other persons belonging to a class of persons approved by the Director of Prison Healthcare Services for the purpose of these Rules engaged in the provision of services of a healthcare or medical nature'.

Rule 100(1) with regards to healthcare professionals states:

A healthcare professional shall, in the performance of his or her functions –

(a) comply with these Rules and any local order for the time being in force,

(b) in so far as is practicable, make arrangements for the continued provision of medical or healthcare of the type provided by the healthcare professional concerned to a prisoner upon his or her release from prison, where appropriate,

(c) treat prisoners with the same dignity and respect as would be afforded to any patient who is not a prisoner,

(d) subject to these Rules, deal with any information of a medical or healthcare nature relating to a prisoner in the same manner as that information would be dealt with if the information related to a person who is not a prisoner,

(e) as far as possible involve the prisoner in making decisions in relation to his or her own healthcare, and encourage him or her to take a responsible attitude towards his or her health while in prison and upon his or her release from prison,

(f) provide prisoners with such information as will enable them to make free and informed decisions regarding their own healthcare,

(g) only administer treatment to a prisoner or conduct any tests on a prisoner with the consent of that prisoner except in the case of treatment or a test required by or under these Rules, any statute, or by order of a court.

(h) where he or she becomes aware of an aspect of the prison environment or regime that he or she considers to be particularly detrimental to the physical or mental health of any prisoner or other person, draw it to the attention of the Governor as soon as may be after his or her becoming so aware,

(i) consult with the Governor, as he or she considers appropriate, on matters relating to -

(i) the general health of prisoners, and

(ii) the more efficient operation of the prison insofar as matters of a medical, health or safety nature are concerned,

(j) participate in the implementation of any plans to which paragraph (6) of Rule 75 (Duties of Governor) applies and cooperate with the Governor, prison officers, and any persons that the Governor may specify for the purposes of that Rule in relation to the implementation of any such plan, and

(k) provide such reports as requested.

(l) provide to the Governor such periodic reports as are necessary to satisfy the Governor as to the efficient and appropriate carrying out of the duties for which they are responsible, and

(m) participate in and contribute to multi-disciplinary working in the prison for the effective delivery of services.

Rule 100 (2) with regards to emergency care states: 'Nothing in this rule shall prevent a healthcare professional from providing a prisoner with treatment or medication, he or she believes is necessary to prevent loss of life or injury.'

3.6. Delivery of healthcare

Prison has several purposes, including: separation from society and confinement for the safety of society, punishment for crime, correction and rehabilitation to the community. Safe custody is paramount in prisons. The prison service in Ireland has established its own healthcare facilities for prisoners with the Department of Justice, Equality and Law Reform having overall responsibility for prison healthcare.

At the time of this report, primary care was provided by nurses (95 whole time equivalents), medical orderlies (36) and GPs (three full-time and 15 part-time). No pharmacists were employed in any of the prisons. Other primary care services include:

- Oral and dental health: Dublin Dental Hospital provides dental services in the majority of Dublin prisons and visiting dentists provide these services regionally.

- Optical care: opticians visit each prison on an 'as required' basis.
- Chiropody: chiropodists visit each prison on an 'as required' basis.

Secondary care includes treatment and care provided by the following specialist services:

- Psychiatry services are provided by the Central Mental Hospital mental health team in all of the Dublin prisons and in the Portlaoise / Midlands complex. Limerick prison has a community forensic mental health team providing services under the auspices of the HSE. Otherwise psychiatrists are privately contracted to provide services locally.
- Addiction services are provided by visiting consultant psychiatrists contracted under service level agreements in partnership with the HSE. The consultants and their teams attend prisons with established addiction treatment programmes. Addiction counselling services have been contracted by the IPS and are now present in most prisons.
- Infectious diseases services are provided by visiting consultant physicians contracted under service level agreements in partnership with the HSE. These services are currently available in Wheatfield and Cloverhill prisons.
- Psychology: The majority of prisons have regular input from psychologists, although the level of service varies between prisons.

It should be noted that the level of secondary care in relation to input from the psychiatry, addiction and infectious diseases services varies greatly from prison to prison. All other secondary care is provided by acute hospitals in the Irish health service.

3.7. Access to healthcare

3.7.1. Legal basis

The 'Prison Rules' offer directives regarding access to healthcare. Rule 102 states:

(1) 'The Governor shall -
(a) upon being informed that a prisoner requests or is in need of medical attention, or
(b) upon forming the view that a prisoner -
(i) requires medical attention, or
(ii) requires, on medical grounds, special care, or to be kept under observation, inform the prison doctor, nurse officer or other member of the prison healthcare staff thereof, and shall keep a record of the prisoner's name, the nature of the information received, the name of the person who has been informed and the time when this was done.

(2) The prison doctor, nurse officer or other member of the prison healthcare staff shall, as soon as practicable, assess a prisoner in respect of whom information has been received under paragraph (1).

(3) In the case of a medical emergency involving a prisoner, or where a prisoner is otherwise in need of urgent medical attention, a prison doctor, nurse officer or other member of the prison healthcare staff shall, immediately upon receiving information under paragraph (1), attend the prisoner and administer or arrange for the administration of medical care to him or her.'

3.7.2. Registration and initial assessment

All committals to the IPS have a committal interview carried out by a nurse or medical orderly. This initial assessment is completed within the first 24 hours of committal. This screening procedure captures socio-demographic details, current and past medical / psychiatric history, substance misuse history and medications that are currently prescribed. The assessment is designed to highlight any healthcare needs that require immediate intervention and to identify chronic illnesses that will require management. All new committals generally are assessed by a GP within 24 hours.

If a prisoner is not scheduled to see a member of the healthcare team s/he can request to be seen by his / her GP or visiting specialist by notifying a prison officer, nurse or medical orderly. In some prisons, the nursing staff operates a triage system in relation to accessing the doctor.

3.7.3. Emergencies / on-call services

Currently nurses or medical orderlies provide 24-hour healthcare cover in all closed prisons and 12-hour (08.00-20.00) health cover in open and semi-open prison. Generally, there are no GPs on duty in the IPS after 5pm. The majority of GPs provide one session daily either in the morning or afternoon. The Midlands and Cloverhill are the only prisons that have fulltime doctors. GPs are 'on call' for telephone advice otherwise and attend the prison where necessary. The Mountjoy prison complex has established a rota system for out-of-hours cover.

All prison officers receive training in healthcare, which includes Basic First Aid Training during their IPS induction, although there is little provision for updating of skills.

3.7.4. Prison regime

The secure custody of the prisoner is paramount and it follows that very fixed routines and procedures must be in place and these can impact on access to healthcare. These include:

- Lock down, cell opening, 'Governor's parade', Doctor's clinic, meals, visits and recreation all happen at set times
- Many prisoners have to attend court in the mornings and must be available for transit to the courts
- The segregation of some prisoner groups from other prisoner groups is common and this must be considered in determining daily schedules
- Managing new committals
- Education attendances
- Work detail
- Hospital appointments.

All closed prisons have very rigid 'lock down' times that generally correspond with various prison activities. A typical daily schedule in a 'closed prison' might be:

8.15am – 8.40am	Collect breakfast and return to cell
9.15am – 12.30	Various activities, workshops, school, yard etc.
12.30pm – 2.15pm	Lock down and meal break
2.15pm – 4.30pm	Various activities as above
4.30pm – 5.30pm	Lock down and meal break
5.30pm – 7.30pm	Recreation
7.30pm	Lock down for the night

Occasionally, prisoners may be on a '23 hour lock down' for security or mental health reasons (the prisoner spends 23 hours in their respective cell).

3.8. Healthcare standards

Following an identified need for a broad set of healthcare standards to guide the provision of health services to prisoners [2], the healthcare directorate developed a set of standards for the IPS which was published in 2004 and updated in 2006 [59].

These standards are to provide governors, other managers and healthcare staff with clear guidance regarding the health services to be provided and the facilities required to provide them. In addition the standards are intended to assist in the formulation of the healthcare aspects of local business plans.

3.9. Organisational change

Working arrangements in the IPS were restructured in line with the recommendations of 'Proposal for Organisational Change in the Irish Prison Service' [61]. This restructuring included revised working arrangements and changes in the condition of service of grades. The new system is based on an 'additional hours' system, whereby staff contribute to a pool of additional hours to satisfy the operational needs of the prison.

There are four 'additional hours' bands 360, 240, 112 and 0 hours a year with corresponding pay scales. The majority of nurses are on the 360 hours band. At the time of the report, a review of these restructured working arrangements was due.

3.10. Interaction with Health Services

A Prisoner Healthcare Working Group comprising members of the healthcare directorate in the IPS, representatives from the Department of Justice Equality and Law Reform, Department of Health and Children and Chief Executive Officers (CEOs) from the health services was established to examine the implementation of the 'Report of the Group to Review the Structure and Organisation of Prison Healthcare Services'.

This group met for a two year period and was chaired by Mr P McLoughlin. HSE restructuring led to the work of this group being suspended. In 2006, the group was subsequently re-convened in an effort to develop links between the IPS and the HSE, but has since disbanded. Currently there is no defined or structured interface between these two agencies.

3.10. Synopsis

There are currently 14 prisons in Ireland. Most recent data indicates an annual committal rate of 11934 committals per annum, of whom 16% are under 21 years of age and 12% are female. The majority of prisoners in Ireland have been in prison for two years or more. The 'Prison Rules' govern all aspects of prison life, including healthcare. The IPS has lead responsibility for healthcare delivery in prisons and employs nurses, doctors and medical orderlies for that purpose. All new prisoners undergo an assessment on entering prison (committal assessment) and access to healthcare is on an as required basis thereafter. Although most prisons have 24 hour nursing cover, medical cover is mostly provided during normal working hours, with a variable 'on-call' service. While the potential role of the HSE in prison healthcare has been recognised and while initiatives to progress this issue have been pursued, the HSE still remains peripheral to prison healthcare delivery.

Chapter 4: Project context (II): A descriptive review of the professional framework for nursing in Ireland

4.1. Introduction

This chapter aims to describe the professional context of this project and recent developments in nursing in Ireland.

4.2. Definitions of nursing

Nurses practice in a variety of settings worldwide and the nature of clinical practice is determined by the clinical specialty and by geographical location. A number of contemporary definitions of nursing practice have been advanced:

The International Council of Nurses defines nursing as encompassing: 'autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles' [62].

The Royal College of Nursing defines nursing as: 'The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death' [63].

The American Nurses Association defines nursing as: 'Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in healthcare for individuals, families, communities, and populations' [64].

4.3. Nursing in Ireland

4.3.1. Regulation of practice

All registered nurses working in Ireland including those who work in the Irish Prison Service are registered with An Bord Altranais. The role of An Bord Altranais is: 'the promotion of high standards of professional education, training and practice and professional conduct among nurses and midwives thus ensuring the protection of the public. The concern of An Bord Altranais in the protection of the public acknowledges the issue of quality in education, actual practice of nurses and midwives and the need for practice to be grounded in appropriate current evidence' [65].

4.3.2. Scope of practice

The term 'nursing scope of practice' refers to the 'range of roles, functions, responsibilities and activities, which a registered nurse is educated, competent, and has authority to perform'. All nurses practicing in Ireland are professionally and legally obliged to practice within An Bord Altranais' 'Scope of Nursing and Midwifery Practice Framework' [65].

This Framework outlines principles which are used to review, describe and expand the parameters of practice for nurses and midwives. The Framework supports and promotes best practice for nurses and midwives and ensures the protection of the public and the timely delivery of quality healthcare in Ireland. In addition, the Framework recognises the constant change in nursing care that occurs in response to ongoing changes in healthcare delivery and therefore is enabling and aims to support nurses and midwives in determining their scope of practice and, in so doing, to practice with flexibility and innovation [65].

The Framework considers the following values should underpin nursing practice and provide the basis for the formulation of a philosophy of nursing [65]:

- In making decisions about an individual nurse's scope of practice, the best interests of the patient and the importance of promoting and maintaining the highest standards of quality in the health services, should be foremost.

- Nursing care should be delivered in a way that respects the uniqueness and dignity of each patient regardless of culture or religion.
- Fundamental to nursing practice is the therapeutic relationship between the nurse and the patient that is based on trust, understanding, compassion, support and serves to empower the patient/client to make life choices.
- Nursing practice involves advocacy for the individual patient/client and for his/her family. It also involves advocacy on behalf of nursing within the organisational and management structures within which it is delivered.
- Nursing practice is based on the best available evidence.
- Nursing practice should always be based on the principles of professional conduct as outlined in the latest version of the Code of Professional Conduct for each Nurse and Midwife produced by An Bord Altranais*.

The scope of practice for nurses and midwives in Ireland is determined by legislation, EU directives, international developments, social policy, national and local guidelines, education and individual levels of competence.

The Framework outlines six areas to be considered when determining scope of nursing practice:

Competence: In determining his/her scope of practice, the nurse must make a judgement as to whether they are competent to carry out a particular role or function. The Framework defines competence 'as the ability of the registered nurse or registered midwife to practice safely and effectively fulfilling his/her professional responsibility within his/her scope of practice'. Nurses are responsible for developing and maintaining the competence necessary for their professional practice. Competence is not static, a nurse may have acquired a particular skill, however the knowledge underpinning that skill may change over time, which can affect the ability to practice the skill.

* Code of Professional Conduct: The purpose of this code is to provide a framework to assist the nurse to make professional decisions, to carry out his/her responsibilities and to promote high standards of professional conduct.

Accountability and autonomy: Accountability is imperative in professional nursing practice and means being answerable for the decisions made in the course of one's professional practice. Nurses are accountable both legally and professionally for their practice. They are accountable to the patient, the public, their regulatory body, their employer and any relevant supervising authority.

Continuing professional development: Continuing professional development is required in order to maintain and enhance professional standards and to provide the highest quality of healthcare. It encompasses experiences, activities and processes that contribute towards the development of a nurse as a healthcare professional. It is a lifelong process of learning, both structured and unstructured. The individual nurse has a responsibility to develop themselves as a professional and healthcare organisations have a responsibility to access the professional development needs of their staff and to provide appropriate support for staff to enable them to practice to high standards. Examples of activities that may contribute to a nurse's professional development include formal education programmes, reflective practice, journal clubs, case conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops, distance learning, accessing and sourcing information.

Support for professional nursing and midwifery practice: Certain supports need to be in place for nurses to practice competently and to realise their potential in the interests of quality patient care. These include local and national guidelines, policies and protocols that have been developed collaboratively with practicing nurses and midwives and with reference to legislation and research-based literature, where this is available. Nursing and Midwifery managers need to ensure that there are systems in place that will provide support for nurses and midwives in determining and expanding their scope of practice.

Delegation: Delegation is the transfer of authority by a nurse or midwife to another person to perform a particular role. The nurse or midwife who is delegating is accountable for the decision to delegate. When delegating a particular role, the nurse or midwife must take account of the following principles:

- The primary motivation for delegation is to serve the interests of the patient
- The delegation is appropriate with reference to the definitions and philosophies of nursing and midwifery as appropriate

- The level of experience, competence, role and scope of practice of the person to whom the role/function is being delegated is taken into account
- With regards to junior colleagues tasks and responsibilities beyond their skill and experience should not be delegated to them
- Appropriate assessment, planning, implementation and evaluation of the delegated role/function must be ensured
- The role/function must be communicated in a manner understandable to the person to whom it is being delegated
- The level of supervision and feedback necessary must be decided upon

A nurses or midwife to whom a particular role has been delegated should take account of the following principles:

- Consider if it is within their scope of practice
- Acknowledge any limitations of competence
- Provide appropriate feedback to the delegator

Emergency situations: In the case of an emergency nothing in the "Scope of Nursing and Midwifery Practice Framework" is to be construed as preventing a nurse or midwife from taking appropriate action. The best interests of the patient must be served by appropriate nursing or midwifery intervention in emergency situations.

4.4. Nursing in the Irish Prison Service

Prior to the first nurses being appointed to work in Irish prisons in 1999, first aid, dispensing of medication and all associated medical care was provided by 'medical orderlies'. Although medical orderlies have undergone training in first aid and aspects of healthcare, this would be considerably less than other healthcare professionals, especially nurses.

In 1999, the IPS implemented a policy whereby registered nurses would provide healthcare in the Irish Prison Service. Following consultation with and agreement by the Prison Officers Association, nurses were contracted on a 'prisons service grade (nurse officer)', which means their terms and conditions of employment are comparable to

those of prison officers. Nurses were introduced to the prison system without a corresponding clinical management structure.

Since 1999, it has been IPS policy that all medical orderlies who retire / resign, will be replaced by nurses and no medical orderlies have been appointed since 1999.

As a result, nursing care in Irish prisons is provided by a combination of nurses and medical orderlies. In the more recently opened prisons (Castlerea, Cloverhill, Midlands) healthcare is provided exclusively by nurses. A combination of nurses and medical orderlies provide healthcare in Arbour Hill, the Dochas Centre, Limerick, Mountjoy, Portlaoise, St Patrick's, the Training Unit, Wheatfield and Shelton Abbey. In Cork and Loughan House, healthcare is provided exclusively by medical orderlies.

4.5. Synopsis

Nursing in Ireland is regulated by An Bord Altranais which has outlined a 'Scope of Nursing and Midwifery Practice Framework' to guide nurses to practice in accordance with their training, skills and competencies. Nurses were first appointed to the IPS in 1999 and are employed on a similar basis and scale as prison officers. More extensive nursing management structures have been advocated. While the number of nurses working in the IPS continues to rise, medical orderlies deliver a substantial contribution to prison healthcare.

Chapter 5: A mixed-methods study of the role of nurses in prison healthcare in Ireland (I): Methodology

5.1. Overview of methodology

The project adopted a 'mixed-methods' approach, which combines two complementary research methodologies, quantitative and qualitative, and this approach is used widely in health services research [66].

In this project, four discrete research activities were used:

- Participant observation
- A questionnaire-based survey
- Semi-structured interviews
- Focus groups.

These activities were sequential. The principal researcher conducted a number of observations and this informed the content of a questionnaire. The findings from these activities subsequently informed the design of the qualitative phase, which included both semi-structured interviews and focus groups. The qualitative phase allowed themes identified in the questionnaire to be further explored and issues raised in some of the open ended questions to be further quantified.

5.2. Research activity #1: Participant observation

The project manager attended 13 of the 14 (with the exception of Loughan House) prisons in Ireland for a period of time in an observational capacity. The purpose of the visits was to observe healthcare delivery and nursing practice in the Irish Prison Service, specifically as many healthcare processes and interventions as was possible while in each prison. In addition, it was anticipated that the visits would provide invaluable insight into the cultural aspects of working in a custodial setting which is different to a conventional clinical setting.

Each attendance involved the project manager spending a minimum of one full shift with the team responsible for prison healthcare.

5.3. Research activity #2: A questionnaire-based survey

All nurses and medical orderlies working in the Irish Prison Service were invited to participate in a questionnaire-based survey on existing practice structures in place for nurses working in the Irish Prison Service and priority areas for development.

The questionnaire's content was determined by the literature review, initial participant observation and by the expert advisory committee and consisted of the following key areas:

- Personal information (including socio-demographic information, professional qualifications and experience);
- Professional development (including types and frequency of professional development undertaken since commencing employment in the Irish Prison Service and the tools available to address professional development requirements);
- Clinical role including:
  - types and frequency of clinical tasks and activities undertaken
  - clinical skills perceived by nurses and medical orderlies as important for their practice and subsequent rating of importance using a five-point likhert scale (where 1 = not at all important and 5 = an essential skill)

The questionnaire also contained open-ended questions to elicit information on:

- Priority areas for professional development;
- Perceived barriers to further development of a comprehensive nursing service;
- Professional and clinical roles that nurses and medical orderlies would like to undertake and additional supports that would be necessary in order to undertake these roles;
- The potential for specialist and / or advanced nursing practice in the prison service and identification of possible areas for development of such practice*.

* Note: the definition of specialist and advanced nursing practice as defined by the National Council for the Professional Development of Nursing and Midwifery was provided on the questionnaire.

Prior to its dissemination, a draft of the questionnaire was piloted among a group of nurses working in the prison service and among a group of nurses with previous research and service development experience. Each participant was asked to complete the questionnaire and to make comments regarding the structure of the questionnaire and aspects they found to be unclear or difficult to follow. In addition, the questionnaire was reviewed by members of the advisory group to the project to ensure it appropriately reflected the purpose of the project. Small suggested amendments were made to the questionnaire before dissemination. Appendix 1 contains the final draft of the questionnaire.

At the time of the survey, a total of 138 nurses and medical orderlies were employed by the Irish Prison Service (88 nurses and 50 medical orderlies). An e-mail outlining an overview of the project and notice that the questionnaire would be circulated was forwarded to all staff approximately one month prior to dissemination of the questionnaires.

Questionnaires were distributed in a sealed envelope and were posted to the nurses or medical orderlies' primary place of work. Each envelope included an information sheet and instructions for completing and returning the questionnaire. An additional explanation sheet regarding participation in a focus group was included and an agreement form should the individual decide to participate in a focus group. Two stamped addressed envelopes with the return address were also provided, one to return the questionnaire and one to return the agreement form to participate in a focus group.

The nurses and medical orderlies were asked to return the questionnaire within four weeks.

5.4. Research activity #3: Semi-structured interview survey

A series of semi-structured interviews with key informants was undertaken to explore in greater detail:

- Healthcare needs of the prison population
- Current structures surrounding healthcare provision
- Future structures that would enhance healthcare provision
- Current practice of professionals focusing on nurses and medical orderlies but also including all professional groups
- Future practice of healthcare professionals focusing on nurses and medical orderlies but also including all professional groups that would enhance healthcare provision
- Challenges in developing a more comprehensive healthcare service.

The key informants included:

- Prison management, including prison governors
- Prison health services, including representatives of the prison healthcare directorate, individuals that provide healthcare in the prison service (employees of the service and professionals from external organisations that are involved in care delivery), or
- Representatives of agencies that influence prison health strategy and policy
- A representative from the Prison Officers Association (POA).

The interviews were arranged by telephone and the interview purpose and procedure was explained to each individual. Prior to each interview an information sheet was read to the participant and they were given an opportunity to ask questions and to withdraw from the study if they wished. Following the permission of the participants the interviews were commenced and recorded on audio cassette.

Each interview was transcribed verbatim. Following transcription, the tape was replayed by the project manager and compared against the text for accuracy. The transcript was then sent to the interviewee and interviewees were invited to check the transcript for accuracy and to clarify any points in the transcript they felt required clarification.

5.5. Research activity #4: Focus groups

Six focus groups were conducted with three groups of nurses and three groups of prisoners:

Nurses who had indicated their interest in participating in a focus group during the questionnaire survey, were contacted and invited to participate in a focus group. There were two groups of three participants and one group of four participants. After the third focus group, data saturation, or a point at which all possible theories had been identified, had been reached. Prior to each focus group, an information sheet was read to participants, the process of the focus group was explained, an opportunity was given to ask questions and ground rules for participation were agreed by all involved. Each participant was then asked to sign a consent form (see Appendix 2) which was witnessed by the project manager.

Three focus groups were held with prisoners (two male groups and one female group). Male prisoners were sampled from those in the Training Unit at Mountjoy Complex. This setting was selected as prisoners in this unit usually have had extensive contact with prison health services and as this is a pre-release prison, generally represents a more stable population. Female focus group participants were recruited from those at the Dochas Centre, the main women's prison in the country (Limerick prison is the only other prison that accommodates females and has approximately 10 – 20 females in custody at a given time).

For security reasons, the prisoners were recruited by prison healthcare staff.
The recruitment process involved the following steps:

- The project manager liaised with the governor of each prison to confirm that firstly it was acceptable that the focus group could take place and secondly that the dates and times concurred with the particular regime in each prison;
- Posters outlining the purpose of the project, what participating would entail and instructing the particular prisoner to put their name forward to a dedicated member of the healthcare team if they were interested in partaking were then forwarded to the healthcare staff of that prison;
- The posters were placed in visually strategic locations in the prisons;

- An information sheet was also included for the healthcare staff and contact details for the project manager were provided;
- Several information sheets were also included for the prisoners;
- Prisoners' expressed interest in participating to healthcare staff in the prisons;
- The project manager visited each prison and spoke to prisoners who were interested in participating about the project and what participation would involve.
- The information sheet was read to prisoners (as literacy issues, especially language and communication difficulties have been identified as common among prisoners [67]);
- Prisoners were invited to ask questions or to express any concerns they may have regarding participating in the study;
- An interval of one week between the information session and focus groups was allowed.

Before the focus group, the information sheet was read through with the participants, the structure of the focus group was explained, an opportunity was given to ask questions and ground rules for participation were agreed by all involved. Each participant was then asked to sign a consent form which was witnessed by the project manager.

The focus groups were facilitated by the project manager who gathered data using the questioning route, observed group interactions, noted key areas of agreement or disagreement and provided a summary of the discussion to participants at the end of the session to check that their meanings and experiences had been accurately understood.

Following permission of the participants, each focus group's discussion was recorded on audio cassette. The discussions were transcribed verbatim. Following transcription, the cassettes were replayed by the project manager and compared against the text for accuracy. In the case of the nurse focus groups, a copy of the transcript was sent to each participant, who were invited to review the content and raise any issues or queries they may have had in relation to the focus group proceedings.

The participants that took part in the prisoner's focus groups indicated they did not wish to review the transcriptions.

5.6. Data analysis

Analytical techniques used were separate and appropriate for each data set.

5.6.1. Quantitative data analysis

The data from the questionnaire survey was entered onto 'Statistical Package for the Social Sciences' (SPSS) version 14. A primary analysis was conducted whereby descriptive statistics were prepared.

5.6.2. Qualitative data analysis

The data from the semi-structured interviews and focus groups (in 'Microsoft Word' format following transcription) was imported into 'NVivo7' (a qualitative research software programme) and followed the principles of framework analysis which involved five key stages:

- Familiarisation (preliminary examination of all data);
- Developing thematic framework (producing analytical categories: respondents' responses to researchers' enquiries; other factors identified by respondents themselves);
- Indexing the material (identifying data relating to analytical categories);
- Charting (grouping instances under headings relating to research questions or issues raised by participants);
- Mapping and interpretation to inform the key objectives of the research (synthesising the range of views under headings, producing an overall picture relating to study objectives, issues raised by participants and other relevant research and theoretical perspectives).

Both approaches for the quantitative and qualitative data were blended at the level of interpretation and findings were merged from each technique to derive a cohesive outcome.

5.7. Project governance and ethical considerations

5.7.1. Project governance

The project was a collaborative endeavour between the Nursing and Midwifery Planning and Development Unit and the Irish Prison Service.

An expert advisory committee was established at the outset of the project to provide guidance in relation to various aspects of the project. The committee consisted of representatives from Public Health, Addiction Services, Mental Health Services, Forensic Mental Health Services, Prison Management, Human Resources (Irish Prison Service), the Health Service Executive, Primary Care (Irish Prison Service), Dublin City University (faculty of Health Sciences) and the Irish Prison Officers Association.

The overarching objectives, specific aims and methodology were discussed and agreed by the two lead agencies and the expert advisory committee, who also had access to the findings of each research activity once available.

5.7.2. Ethical considerations

Ethics approval for all parts of the research that involved prisoners (i.e. focus groups) was granted by the Ethics Committee of the Irish Prison Service.

Participation in the research was voluntary, non-participation did not influence potential participants' circumstances and volunteers were offered no inducements to participate. The following procedures were used to deal with the ethical issues of confidentiality and informed consent:

In the questionnaire survey, the importance of confidentiality was emphasised in the information sent out with the questionnaire. It was recognised that participants could be identified by their socio-demographic information and therefore after consultation with the advisory group it was decided that a question that identified where the participant worked would be optional. In addition, the project manager was the only person with access to the questionnaire data.

There is no identifying information on the database in which the questionnaire data was entered and this data is stored in a password-protected electronic file on a password-protected computer at the Nursing and Midwifery Planning and Development Unit of the HSE.

With regards to the semi-structured interviews and focus groups, again the importance of confidentiality was emphasised. The project manager was the only person with access to the audio data. The transcriptions are stored on a secure password protected computer network that has restricted access. No identifying details for any participant are documented on any of the transcriptions and for the purpose of illustrative quotes, pseudonyms are used for the prisoners' quotes. In the event that a quote will be used from other participants that may be easily identifiable it was agreed they will be contacted to seek permission before use.

With regard to informed consent, each participant had adequate information regarding the project, was capable of comprehending the information and had the power of free choice enabling them to consent voluntarily to participate or decline participation [68].

5.8. Strengths and weaknesses of this study

By adopting a 'mixed-methods' approach, this study combined quantitative and qualitative research methods to facilitate the collection of data that is both richer in content [69], and more complete, thereby offering a more accurate picture of a phenomenon [70]. 'Triangulation' is the term describing how the findings of multiple complementary research activities are combined in a single investigation [71], thereby enhancing credibility as the limitations of one single strategy are minimised [72].

The credibility of our findings is supported by the high degree of concordance between the quantitative questionnaire-based survey and the qualitative research activities. The six major themes that make up the theoretical framework and the issues / minor themes contained within each are all supported by the findings of the questionnaire-based survey.

In interpreting this study's generalisability, a number of sources of potential bias must be recognised:

Although the study did not adopt a formal 'action research' approach [73], whereby research is conducted with the explicit aim of improving services through a cyclical process of preliminary enquiry, feedback, change and repeated enquiry, it was conducted within a framework that allowed key stakeholders access to the findings through membership of an expert advisory committee. Therefore, the possibility that preliminary findings arising from this study may have impacted on service delivery can not be discounted and this in turn may have impacted on data collected during the latter stages of the project.

Volunteer bias must also be recognised as another factor that influenced our findings. Only nurses, medical orderlies, prisoners and key informants who volunteered to participate were included in the study. It is therefore possible that members of these groups with strong views (either positive or negative) are over-represented in this study. In addition, prisoners were recruited for the study by prison staff and therefore participants may not have been representative of prisoners generally.

In the quantitative survey, the response rate was 32%. Demographic data on respondents would indicate the sample was broadly reflective of nurses and medical orderlies working in the IPS at the time of the study. While all prisons were represented among respondents, it should be noted that despite assurances regarding confidentiality and anonymity, 14/44 respondents did not indicate the prison in which they worked.

These potential sources of bias should be recognised but should also be balanced against the uniform concordance between the findings from both the quantitative and qualitative research activities, when determining the ultimate credibility of the study's findings.

5.9. Synopsis

A mixed-methods approach was adopted which involved four research activities:

- participant observation, in which the project manager observed nursing practice in 13/14 prisons;
- a questionnaire survey of all nurses and medical orderlies working in the IPS regarding existing nursing practice structures and priority areas for development;
- semi-structured interview survey of key informants;
- focus groups of nurses and prisoners.

Although we recognise methodological weaknesses and their potential impact on the generalisability of our findings, combining quantitative and qualitative research methodologies and the high degree of consistency in the findings using these two methodologies strengthens the credibility of our findings.

Chapter 6: A mixed-methods study of the role of nurses in prison healthcare in Ireland (II): Quantitative results

6.1. Response rate and sample characteristics

A total of 138 nurses and medical orderlies working in the Irish Prison Service (IPS) were invited to participate in the survey and 44 questionnaires were returned (32% response rate). The response rate among nurses was 31/88 (45%) and this was significantly higher ($chi^2 = 4.13$, $p<0.05$) than the response rate among medical orderlies 13/50 (26%).

Of those who responded, 25 (57%) were male and 19 (43%) were female, 41 (93%) worked full-time and 3 (7%) worked part-time. The majority were aged 31-50 years (see figure 6.1) and while each prison was represented in the sample, 14 respondents (32%) did not indicate the prison in which they worked (see figure 6.2).

Among medical orderly respondents, three reported they had been working in the IPS for 15-20 years, five for 20-25 years and three for 25-30 years. Twelve reported they were due to retire within ten years of whom eight reported they were due to retire within three years. Among nurse respondents, six reported they had been working in the IPS for least than three years, seven for three to five years and 18 for five to seven years.

Figure 6.1 Age Distribution of Study Sample

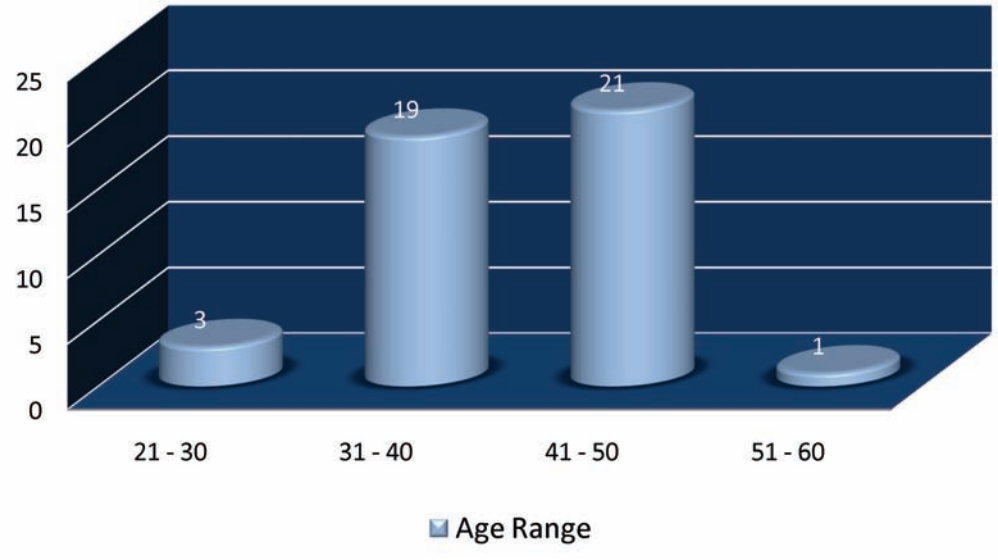
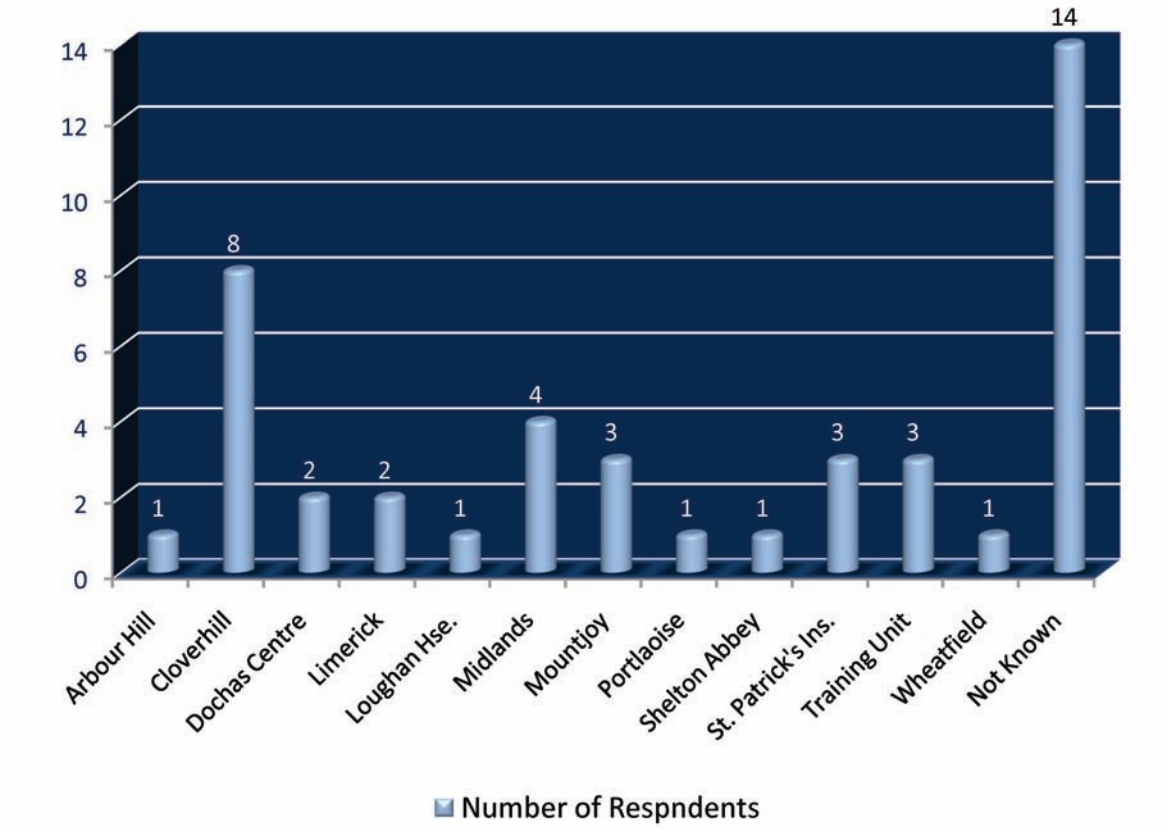


Figure 6.2 Prison in Which Respondents Worked



6.2. Professional qualifications of nurses

All nurses were registered with An Bord Altranais, with 20 (66%) on the Registered General Nurses' division of the register, two (6%) on the Registered Psychiatric Nurses' division and nine (29%) on more than one division of the register. All nurses reported they had academic qualifications: 11 (35%) had a hospital or college certificate, seven (23%) had a diploma and 13 (42%) had a primary degree (of whom one person reported s/he had a masters degree).

A wide range of qualifications and experience were reported by nurses. While nurses reported previous experience in a large number of specialty areas, 'acute nursing' was the specialty in which the largest number reported previous experience (see Table 6.1).

Table 6.1. Nursing specialty area and number of nurses with experience in that area.

Specialty area	Number with previous experience
Acute Nursing	24
Critical Care	10
Rehabilitation	9
Gerontology	7
Mental Health	7
Paediatrics	4
Midwifery	3
Intellectual Disability	2
Addiction	1
Clinical Pharmacology	1
Practice Nursing	1

6.3. Professional development issues

Twenty-three respondents (52%) had completed some form of in-service training in the previous two years, with 13 (30%) having attended a conference, 20 (45%) having attended a 'study day', three (7%) having attended a distance education module, six (14%) having completed some form of training at work and 18 (41%) having read professional journals relevant to prison healthcare. Four (9%) had attended networking meetings with other nurses in the prison service.

None of the respondents reported they had an agreed professional development plan. None reported they had internet or library access in the workplace, although four (9%) reported access to professional journals and 16 (36%) had access to practice related text books in their workplace.

6.4. Clinical role of nurses and medical orderlies

Participants were presented with 42 clinical tasks and asked to indicate the frequency with which they performed each. The following sections present an overview of the clinical tasks that were performed with high, intermediate and low degrees of frequency respectively. Clinical tasks are presented as those tasks which involve direct patient contact and those which do not.

6.4.1. Most frequently performed clinical tasks

Table 6.2. presents the most frequently carried out activities, which for the purpose of this analysis, were considered as those tasks carried out on a daily basis by 50% or more of respondents.

- Tasks involving direct patient contact:
- Medication administration
- Committal assessments
- Assessing prisoners presenting with healthcare complaints
- Providing first aid / emergency procedures
- Triaging for the doctors clinic
- Wound care and management
- Substance misuse related care *

* In relation to substance misuse related care, respondents reported the following specific tasks:
- Methadone maintenance and detoxification
- Librium detoxification
- Drug free support
- Guidance and advice
- Taking urine samples
- Obtaining history
- Throughput management
- Liaising with outside agencies
- Education regarding safe drug use
- Withholding medication if the prisoner is considered intoxicated

Tasks not involving direct patient contact:

- Administrative / clerical duties
- Accompanying / escorting doctors
- Referral management
- Liaising with other healthcare professionals and organisations
- Communicating test results to GPs
- Ordering and maintenance of non-controlled drugs
- Stocks / stores management.

There was no discernible difference in the frequency with which medical orderlies and nurses reported performing each task.

Table 6.2. Clinical tasks performed most frequently by respondents (ranked in order of frequency).

Activity	Daily	Weekly	Monthly	Occasionally	Not at all	Not Known
Medication administration	Total	43	0	0	1	0 0
	Nurses	30	0	0	1	0 0
	MO	13	0	0	0	0 0
Administrative / clerical duties	Total	41	1	0	0	2 0
	Nurses	30	1	0	0	0 0
	MO	11	0	0	0	2 0
Assessment (committal)	Total	41	2	0	1	0 0
	Nurses	30	1	0	0	0 0
	MO	11	1	0	1	0 0
Assessing healthcare presentations	Total	41	1	0	1	1 0
	Nurses	30	1	0	0	0 0
	MO	11	0	0	1	1 0
Accompany / escort doctors	Total	39	1	0	1	3 0
	Nurses	26	1	0	1	3 0
	MO	13	0	0	0	0 0
Provide first aid /	Total	32	6	0	6	0 0
emergency procedures	Nurses	21	6	0	4	0 0
	MO	11	0	0	2	0 0
Provide triage for doctors clinic	Total	31	4	0	5	3 1
	Nurses	23	1	0	3	3 1
	MO	8	3	0	2	0 0
Referral management	Total	30	4	0	4	3 3
	Nurses	21	4	0	3	1 2
	MO	9	0	0	1	2 1
Liaise with other health	Total	28	8	0	7	1 0
profs and organisations	Nurses	23	5	0	3	0 0
	MO	5	3	0	4	1 0
Provide wound care / management	Total	28	5	2	8	1 0
	Nurses	23	4	1	3	0 0
	MO	5	1	1	5	1 0
Communicate test results to GP	Total	26	9	1	7	1 0
	Nurses	20	6	0	5	0 0
	MO	6	3	1	2	1 0
Substance misuse related care	Total	25	7	0	7	2 3
	Nurses	20	6	0	4	0 1
	MO	5	1	0	3	2 2
Ordering and maintenance	Total	24	17	1	1	0 1
of non-controlled drugs	Nurses	19	12	0	0	0 0
	MO	5	5	1	1	0 1
Stocks/stores management	Total	24	12	2	1	5 0
	Nurses	17	12	0	0	2 0
	MO	7	2	1	0	3 0

Note: Total (N= 44); nurses (n=31), medical orderly (n=13).

6.4.2. Clinical tasks performed with intermediate frequency

Table 6.3 presents those activities carried out with intermediate frequency.
Those tasks involving direct patient contact were:

- Diabetic assessment and management
- Taking urine samples
- Chronic disease management *
- Monitoring vital signs
- Clinical report writing
- Informal / formal counselling **
- Communicate test results to prisoners
- Mental healthcare ~
- Men's healthcare ~~
- Health education and promotion x
- Assisting with minor procedures xx.

Those tasks not involving direct patient contact were:

- Ordering and maintenance of controlled drugs
- Updating clinical knowledge.

Medical orderlies reported being involved in clinical report writing, informal / formal counselling, mental healthcare and health education / health promotion less frequently than nurses but these differences were not statistically significant.

* The most commonly encountered chronic diseases were identified as: diabetes, asthma, cardiac disease, HIV infection, COPD, hepatitis C, leg ulcers, schizophrenia, epilepsy, arthritis and cancer.

** Included: casual and brief interventions, general healthcare advice, informal talks when providing medication, nicotine replacement and diabetes management.

~ Included: assisting the psychiatrist, providing a 'listening ear', counselling prisoners experiencing difficulties adjusting to incarceration, referrals to the psychiatric team, observation of inmates on the wings and discussion with prison officers, informal discussions outside psychiatric teams, supervising medication adherence, monitoring medication effectiveness, suicide awareness, self harm management, counselling for eating disorders and assessment for psychiatric referral.

~~ Included: organising PSA blood tests, preventative advice, referral to STD clinics, weight and dietary advice and smoking cessation programmes.

X Included: smoking cessation, providing information leaflets, advice on request, detoxification group, unstructured advice is given on a daily basis on a range of topics, advice on medications, advice on diabetes, advice to prisoners on methadone programmes and advice on STDs.

XXIncluded: dressings, suture removal, ear syringing, removal of skin tags / moles, ingrowing toenails and eye care.

Table 6.3. Clinical tasks performed with intermediate frequency by respondents (ranked in order of frequency).

Activity Nurse (n=31) MO = medical orderly (n=13)	Daily	Weekly	Monthly	Occasionally	Not at all	Not Known
Taking urine samples	Total	23	13	2	4	2 0
	Nurses	16	8	2	3	2 0
	MO	7	5	0	1	0 0
Diabetes assessment / management	Total	23	2	1	13	4 1
	Nurses	18	2	1	8	1 1
	MO	5	0	0	5	3 0
Chronic disease management	Total	22	2	2	11	3 4
	Nurses	20	1	1	6	0 3
	MO	2	1	1	5	3 1
Monitor vital signs	Total	21	10	0	11	1 1
	Nurses	14	8	0	8	0 1
	MO	7	2	0	3	1 0
Clinical reports	Total	20	4	4	5	8 3
	Nurses	18	3	3	3	2 2
	MO	2	1	1	2	6 1
Undertake informal / formal counselling	Total	20	4	1	11	7 1
	Nurses	18	2	0	8	3 0
	MO	2	2	1	3	4 1
Communicate test results to prisoners	Total	18	12	0	11	2 1
	Nurses	13	10	`0	7	0 1
	MO	5	2	0	4	2 0
Mental health related care	Total	15	13	1	11	2 2
	Nurses	13	11	0	6	1 0
	MO	2	2	1	5	1 2
Men's health	Total	15	5	0	9	9 5
	Nurses	10	5	0	6	5 5
	MO	5	3	0	3	4 0
Provide health education and promotion	Total	14	6	1	15	7 1
	Nurses	13	4	1	11	2 0
	MO	1	2	0	4	5 1
Assist with minor procedures	Total	13	9	1	16	5 0
	Nurses	10	8	0	10	3 0
	MO	3	1	1	6	2 0
Ordering and maintenance of controlled drugs	Total	12	18	3	8	2 1
	Nurses	7	15	2	6	1 0
	MO	5	3	1	2	1 0
Updating clinical knowledge	Total	10	10	3	12	7 2
	Nurses	7	9	3	10	1 1
	MO	3	1	0	2	6 1

Note: Total (N= 44); Nurse (n=31), medical orderly (n=13).

6.4.3. Least frequently performed clinical tasks

Table 6.4. presents those activities carried out with a low degree of frequency, which for the purpose of this analysis, were considered as those tasks for which more than 50% of nurses and medical orderlies carried out these activities occasionally or not at all.

Those tasks involving direct patient contact were:

- Addressing social needs *
- Provide oxygen / nebuliser therapy
- Diet / weight management
- Infectious disease to include STDs
- Pulmonary assessments
- Phlebotomy
- Vaccination / immunisation
- Remove sutures
- Participate in structured health screening **
- Women's health.

Those tasks not involving direct patient contact were:

- Undertake case management
- Escort the dentist
- Attend and participate in clinical team meetings
- Assist with research / clinical audits
- Attend policy and procedure meetings

In relation to a number of the activities in Table 6.4 such as attending clinical team meetings, policy and procedure meetings or a vaccination or phlebotomy clinic, it is possible these activities would only take place on a weekly or monthly basis. However, 21 (48%) reported never attending policy and procedure meetings and 17 (39%) reported never attending clinical team meetings.

* Included: general advice, liaison with welfare services, referrals for probation and welfare and contacting external agencies for issues such as housing, family issues etc.

* * Included: cholesterol checks, checks on staff, BP checks on staff, hepatitis A and B vaccination programmes, INR clinics, other blood clinics.

6.4.4. Other clinical tasks and activities

When asked to identify other activities that were undertaken that were not present on the questionnaire the following were listed:

- Insert sutures when required
- Organising security arrangements with the prison officers for various clinics such as psychiatrist clinics, methadone clinics etc
- Requesting contractors to carry out repairs
- Ordering stationery, supplies etc.

Table 6.4. Clinical tasks performed least frequently by respondents (ranked in order of frequency).

Activity Nurse (n=31) MO = medical orderly (n=13)	Daily	Weekly	Monthly	Occasionally	Not at all	Not Known
Social needs	Total	9	6	2	12	141
	Nurses	9	6	0	7	8 1
	MO	2	0	0	5	6 0
Provide oxygen / nebuliser therapy	Total	8	5	2	24	5 0
	Nurses	5	4	1	19	2 0
	MO	3	1	1	5	3 0
Diet / Weight management	Total	8	3	3	21	9 0
	Nurses	7	3	2	16	3 0
	MO	1	0	1	5	6 0
Undertake case management	Total	7	3	4	11	181
	Nurses	5	1	3	9	130
	MO	2	2	1	2	5 1
Infectious disease to include STD	Total	6	10	1	16	101
	Nurses	5	9	1	9	7 0
	MO	1	1	0	7	3 1
Pulmonary assessments	Total	4	5	2	16	161
	Nurses	4	4	2	13	7 1
	MO	0	1	0	3	9 0
Phlebotomy	Total	4	0	0	5	332
	Nurses	4	0	0	5	211
	MO	0	0	0	0	121
Vaccination / immunisation	Total	3	6	2	14	181
	Nurses	3	5	2	13	7 1
	MO	0	1	0	1	110
Escort the dentist	Total	2	10	0	6	260
	Nurses	1	5	0	4	210
	MO	1	5	0	2	5 0
Attend/participate in clinical team meetings	Total	1	10	3	12	171
	Nurses	0	9	3	6	121
	MO	1	1	0	6	5 0
Remove sutures	Total	1	11	6	24	2 0
	Nurses	0	10	4	17	0 0
	MO	1	1	2	7	2 0
Participate in structured health screening	Total	1	2	1	14	242
	Nurses	1	2	1	8	181
	MO	0	0	0	6	6 1
Women's health	Total	1	1	0	1	338
	Nurses	1	1	0	1	108
	MO	0	0	0	0	130
Assist with research / clinical audits	Total	0	2	0	17	232
	Nurses	0	1	0	11	181
	MO	0	1	0	6	5 1
Attend policy and procedure meetings	Total	0	0	3	18	212
	Nurses	0	0	3	12	151
	MO	0	0	0	6	6 1

6.5. Professional knowledge and skills

Seven (16%) agreed or strongly agreed that their existing skills were being used to their full potential. Seven (16%) also agreed or strongly agreed that their existing knowledge was being used to its full potential.

Respondents were presented with an alphabetical list of 21 clinical skills and asked to indicate the importance of each skill in their current role using a 5 point scale, where 1 = 'not at all important' and 5 = 'essential skill'. Table 6.4 ranks these skills in descending order of importance.

A majority of respondents identified 'advocacy', 'communication', 'care management', 'clinical assessment', 'clinical knowledge acquisition', or 'conflict management' as essential skills to their role. Key differences between nurses and medical orderlies were 'clinical assessment' and 'clinical knowledge acquisition' were rated higher by nurses while 'counselling', 'conflict management and 'administration' were rated higher by medical orderlies.

When asked to identify areas in which further education was required in order to carry out one's professional role more competently, addiction, CPR training, and mental health were identified as priority areas by nurses and CPR training and emergency procedures were identified as priority areas by medical orderlies (see table 6.5).

Table 6.4. Importance of clinical skills to current role.

Skill N = nurse (n=31) MO = medical orderly (n=13)	Importance of skills in current role 5 (essential)		4		3		2		1 (not at all important)	
	N	MO	N	MO	N	MO	N	MO	N	MO
Advocacy	31		5		4		0		1	
	22	9	5	0	3	1	0	0	0	1
Communication	30		7		2		0		1	
	21	9	5	2	2	0	0	0	1	0
Care management	25		9		0		3		4	
	16	9	9	0	0	0	3	0	2	2
Clinical assessment	25		8		2		1		4	
	20	5	5	3	2	0	1	0	1	3
Clinical knowledge acquisition	25		6		6		0		3	
	21	6	6	0	3	3	0	0	1	2
Conflict management	24		7		4		2		3	
	16	8	6	1	4	0	1	1	2	1
Health promotion	21		7		4		5		2	
	16	5	6	1	2	2	3	2	1	1
Health screening	21		7		5		1		5	
	16	5	6	1	3	2	1	0	2	3
Self performance evaluation	21		7		5		2		5	
	15	6	6	1	3	2	2	0	3	2
Counselling	20		12		5		1		2	
	11	9	11	1	5	0	1	0	1	1
Education	20		7		8		2		2	
	13	7	4	3	8	0	2	0	1	1
Risk assessment	19		10		7		1		3	
	13	6	9	1	5	2	1	0	1	2
Information Technology	18		9		7		4		2	
	11	7	7	2	6	1	4	0	1	1
Care planning	17		14		3		1		6	
	11	6	13	1	2	1	1	0	3	3
Nursing care intervention	17		11		9		1		2	
	14	3	7	4	6	3	1	0	1	1
Organisational	16		12		8		1		3	
	10	6	9	3	7	1	1	0	2	1
Case management	14		13		5		3		4	
	11	3	10	3	4	1	3	0	3	1
General management	14		11		10		3		2	
	8	6	9	2	8	3	3	0	1	1
Group facilitation	14		8		8		5		3	
	9	5	6	2	6	2	4	1	2	1
Leadership	14		14		7		2		3	
	10	4	11	3	4	3	2	0	2	1
Administration / clerical	13		7		7		5		8	
	5	8	7	0	5	2	5	0	7	1

Table 6.5. Areas where additional education was needed to carry out role more competently.

Identified area	*Total*	*Nurses (n=31)*	*Medical orderlies (n=13)*
Addiction	16	16	0
Regular CPR training	14	9	5
Mental health	14	14	0
Infectious diseases	11	9	2
Wound management	11	9	2
STDs/sexual health	10	10	0
Counselling skills	9	8	1
Emergency procedure updates	8	3	5
Chronic diseases (diabetes, asthma)	7	6	1
General nursing skills (refresher course)	5	5	0
Phlebotomy	5	4	1
Health promotion	4	4	0
ICT skills	4	2	2
Dietary advice	3	3	0
Pharmacology updates	3	3	0
Conflict management	2	2	0
Legal issues	2	2	0
Communication skills	1	1	0
Management skills	1	1	0
Mens health	1	1	0
Womens health	1	1	0

6.6. Professional role development

Respondents identified 20 roles which they would like to undertake in the next 3-5 years.

Among nurses, the most commonly identified future roles were:

- delivering nurse-led clinics (10 nurses)
- health promotion (eight)
- management (five)
- phlebotomy (four)
- addiction care (four)

Other future roles included: sexually transmitted disease clinics, mental health clinics, emergency care, diabetes management, infectious diseases, wound management, asthma, practice nursing, women's health, education, research, counselling and smoking cessation.

Medical orderlies identified counselling (two) and paramedic (one) as roles they would like to undertake in the next 3-5 years.

Respondents identified nine areas where additional support / training would be needed in carrying out their identified future roles. Among nurses, the most commonly identified areas were:

- Additional Continuing Professional Development (CPD) (17)
- More staff (five)
- Educate management in the role of nurses (five)
- Internet access (four)

Other areas that were identified by nurses included: education in developing nurse-led clinics, management training, being recognised as part of the healthcare team, having a mentor in the areas of research, management and IT and further IT training.

Among medical orderlies, five (38%) indicated they required additional CPD, one person indicated the need for further IT training and one person indicated the need to be recognised as part of the healthcare team.

6.7. Nursing practice development

Twenty-three nurses (74% of nurse respondents) indicated there was scope for the development of Clinical Nurse Specialist (CNS) roles in the IPS in the following areas of practice:

- mental health (12)
- infectious diseases (nine)
- chronic disease management (nine)
- addiction (eight)
- emergency care / minor injuries (five)
- sexual health (five)

Other areas that were identified included: health promotion, wound management, smoking cessation, research, practice nursing and women's health.

Five nurses (16% of nurse respondents) indicated there was not scope for the development of Clinical Nurse Specialist (CNS) role in the IPS and reasons for this included: lack of support from management, lack of support from doctors, too constrained by prison rules and no nurse management structure.

Sixteen nurses (52% of nurse respondents) indicated there was scope for the development of Advanced Nurse Practitioner (ANP) role in the IPS. Four (25%) identified addiction as an area in which an ANP role could be developed and other areas that were identified included: infectious diseases, mental health, health promotion, emergency care/minor injuries, sexual health and women's health.

Ten nurses (32% of nurse respondents) indicated there was not scope for the development of ANP role in the IPS and reasons for this included: lack of support from management, lack of support from doctors and the area was too small.

Respondents were asked to identify 'barriers to the development of a high quality comprehensive nursing service in the IPS' (see Table 6.6.). Nurses identified main barriers as 'lack of nursing management structure', 'lack of understanding of nurses' role', 'prison management' and 'absence of structured professional development'. Medical orderlies identified the main barriers as 'prison management', 'absence of structured professional development' and 'budgetary constraints'.

Table 6.6. Perceived barriers to the development of a high quality nursing service.

Perceived barriers N = nurse (n=31) Medical orderly (n=13)	***Total***	***Nurses***	***Medical orderlies***
Prison management	22	16	6
No structured professional development	21	15	6
Lack of nursing management structure	20	20	0
Lack of understanding of nurses role (governors)	19	17	2
Lack of staff	12	10	2
Role poorly defined	10	10	0
Budgetary constraints	8	5	3
Lack of autonomy	6	6	0
Job title of nurse officer	5	5	0
Access to prisoners	4	4	0
Medical orderly – nurse conflict	3	2	1
No library or internet access	2	2	0
Poor perception or concept of prisoner	2	1	1
Poor healthcare facilities	2	2	0
Isolation of nursing	1	1	0
Language barrier	1	0	1
Lack of staff involvement with visiting healthcare teams	1	0	1
No organisation of skill mix	1	1	0
Lack of unity between professional bodies	1	1	0
Prison Officers Association	1	1	0

6.8. Synopsis

The response rate was 32%. Nurses reported a wide range of professional experience and many had formal qualifications. Although many reported involvement in continuing professional development, a need for formal professional development plans was identified. The clinical role of nurses encompasses a wide range of tasks, with addiction, mental health, chronic illness, infectious diseases and health promotion identified as core areas of prison nursing practice. Advocacy, communication, care management, clinical assessment, clinical knowledge acquisition and conflict management were identified as core skills by nurses. Addiction, CPR training, and mental health were identified as priority areas where additional education was needed to carry out their role more competently. Nurses reported spending considerable time in non-clinical activity and a number of roles which perhaps should be more central to nursing practice were reported as being performed infrequently.

The role of medical orderlies is also wide-ranging and includes a large number of clinical tasks involving direct patient contact. Advocacy, communication, care management, counselling, conflict management and administration were identified as core skills by medical orderlies, while CPR training and emergency procedures were identified as priority areas where additional education was needed to carry out their role more competently.

Nurses and medical orderlies both indicated their existing skills and knowledge were not being used to their full potential.

Nurses identified organisational, management and professional development issues as major barriers to development of prison nursing and medical orderlies identified similar issues as barriers to the development of prison healthcare.

Chapter 7: A mixed-methods study of the role of nurses in prison healthcare in Ireland (III): Qualitative results

7.1. Overview

Individual themes were identified from the focus groups and semi-structured interviews and these were grouped into six thematic categories:

- Health needs of the prison population
- Definition of nursing role
- Factors that facilitate nursing practice in prisons
- Continuing Professional Development
- Role of security personnel
- Prison healthcare infrastructure

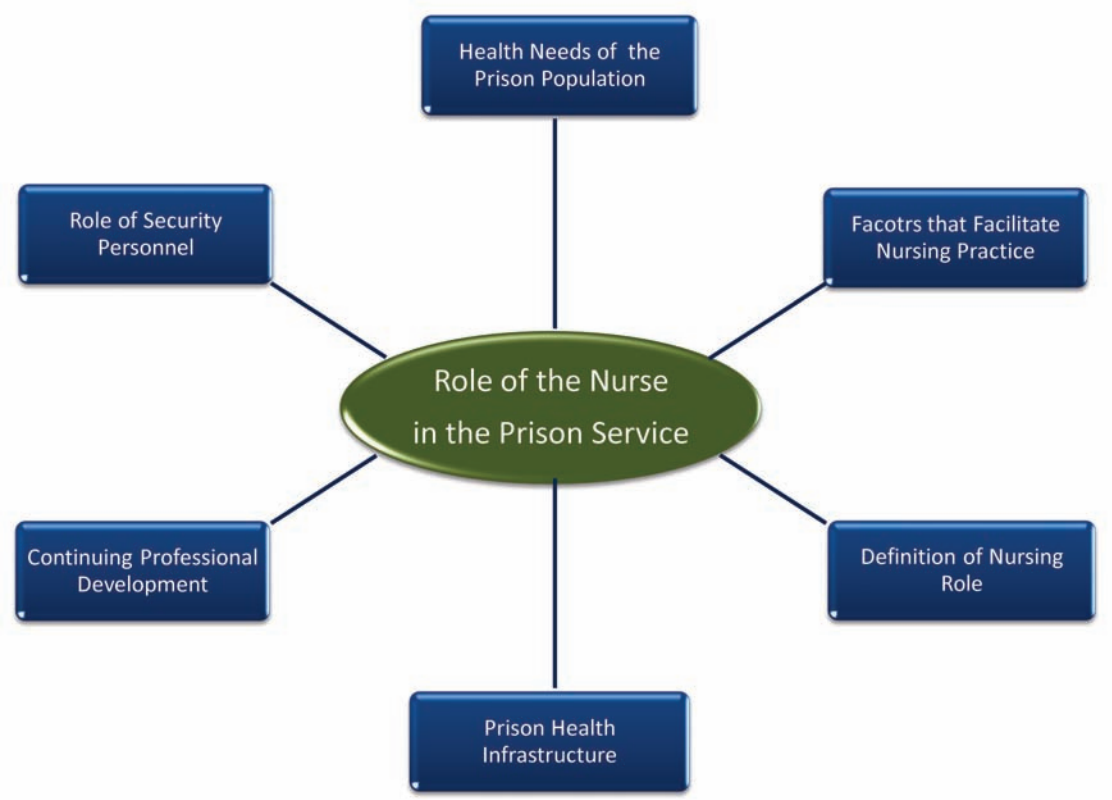
The thematic categories were then used to construct a theoretical framework to describe the role of nurses in healthcare delivery in the Irish Prison Service and the factors that influence, facilitate or act as barriers to that role (see Figure 7.1).

This chapter presents data on each thematic category and its constituent themes.

There are a number of quotes used to support the qualitative findings. The following letters enclosed in brackets after each quote denotes data from one of the following groups:

- [P] Prisoners
- [PM] Prison management
- [HP] Personnel that provide healthcare to include any persons either direct employees of the prison service or those from external organisations that provide care
- [HD] Healthcare directorate
- [O] Others to include representatives of agencies that influence prison health strategy and policy or the union (POA)

Figure 7.1 Theoretical Framework Describing Nurse's Role



7.2. Thematic category #1: Health needs of the prison population

Addiction, mental health, health promotion, education and prevention and infectious diseases were the dominant themes within this category and were referred to in all the interviews / focus groups. Other themes identified included chronic diseases and primary care.

Each of the dominant themes are described in greater detail. Aspects of care provision, concerns and everyday activities relating to each theme are outlined as imparted by the participants of the interviews and focus groups.

7.2.1. Addiction

Addiction and its consequences were commonly identified health needs. Prisoners reported widespread initiation and continued illicit substance use in prisons, with boredom, mental health problems and widespread availability of illicit substances identified as enabling factors.

"I know two or three people that never took drugs before until they came in here and now they've a horrible problem and they've to go to the nurse looking for help for methadone to say well you weren't getting it coming in, you're not getting it now so they've to go through cold turkey without ever intervening so when you do go for help they refuse." [p]

The effect of prison on pre-existing problem drug use was identified, with prison either acting as a positive or negative influence in that regard.

"I just got worse in prison, I did for my first six seven or eight months four or five, ten bags a day like in prison plus 40mls of phy, that's a big prison habit - £50 a day you know?" [P]

"I had to come into prison to address my problems as well yeah. It took me a while to get to the medical unit but that's what done it for me cause if I wasn't in prison I'd still be on drugs today, I'm still on methadone anyhow" [P]

The most commonly identified illicit substances were cannabis, benzodiazepines, and heroin. Problem alcohol use was identified as an important health issue among prisoners, although it was not reported as a commonly used substance in prisons. Availability of substances was reported to vary within individual prisons.

"...[wing x] would be heroin and ...[wing x] ... would be hash...it depends on what part of the jail you're in because ... [wing x] is just a crazy wing and they're just left to their own devices" [P]

Prisoners reported that illicit substance use is largely ignored. Prisoners and nurses reported that illicit benzodiazepine use in particular can be poorly managed and nurses reported problems dealing with benzodiazepine-dependent prisoners, including: managing withdrawals (especially seizures) and dealing with benzodiazepine-associated aggressive behaviour.

"People are illicitly taking benzos and there is fitting going on, there are things going on that are related to benzos that people are not paying attention to whatsoever because it's illicit benzo and we have to acknowledge the fact that there is this illicit benzo use going on." [HP]

An inconsistency in the provision of addiction services between prisons was highlighted, with interventions / services (eg methadone treatment) available in some but not all prisons. It was highlighted that in some prisons where methadone treatment is available, prisoners that present with an opiate addiction and are not on methadone treatment in the community, can be placed on a waiting list and the majority will continue to smoke or inject heroin.

"I've seen people coming into prison with a heroin addiction and they go looking for methadone and the doctor will ask them were you on methadone outside and they'll say no and that'll be it they wouldn't get their methadone because if you weren't on it outside you're not getting it in here". [P]

With the exception of Arbour Hill, prisoners reported that heroin is used and available in most prisons. Specialist addiction services are available in many of the Dublin prisons and established opiate addiction is the main criteria for methadone treatment by the in-reach team, with other addictions addressed by doctors working in the prison service. Many of the participant groups identified the need to more comprehensively address misuse of other substances and addiction treatment interventions.

"I would say about drug treatment we should be able to meet or offer something to anybody coming in with problematic and dependent use of any drug, not just opiates ... what I would like is a complete drug and alcohol treatment service that has access [to] evidence based interventions, pharmacological and psychosocial and could use them where there's an evidence base to support them in the prison setting." [HP]

Prisoners reported that the medical unit in Mountjoy is the only prison in the country where prisoners can detoxify successfully, albeit with a low chance of success. Prisoners observed that not all healthcare staff have an understanding of addiction and its treatment and identified a need for healthcare staff to receive specific training in addiction treatment. Prisoners reported how an addiction problem can make prisoners manipulative and difficult to manage, but reported how discipline staff can treat prisoners differently or badly at times because they have a recognised addiction problem. Prisoners also highlighted the importance of peer support.

"Know what to do, to know how to treat it, we got treated like scumbags on it you know, so there's no sympathy there, you know medical people they're supposed to be on a humane level they're supposed to be able to help you instead of being kind of fobbed off." [P]

Counselling services are limited. Healthcare staff report a lack of consistency in the various treatments available, there appears to be some confusion in relation to approaches to detoxification, methadone dose and access to treatment. Nurses have identified a need for more training and education in the area of addiction and the need for a formalised education programme. Addiction specialists have also identified the need for education and training for nurses that work in the service and regularly encounter prisoners with an addiction problem.

"That also brings up one of the other things that lacking in my view which is any sort of formalized education programme, one of the things that's very obvious in one of the locations I work where colleagues came from a general nursing background is there wasn't particularly any, not necessarily awareness but any understanding of what a methadone substitution therapy was supposed to be doing, so nursing colleagues were very focused initially and still to a degree on methadone as a sanction, methadone as punishment and were very happy to be part of an environment where those, what they wanted from the specialist team was to start reducing people's doses in response to dirty urines." [HP]

In prisons with established methadone treatment services, the administration of methadone appears to get priority over all other care. Discipline staff can be regimental regarding administration and view methadone almost as a behavioural measure.

"I think again, the whole focus in the prison at the minute and has been for a long time is around drug treatment, big priority and I know in [Prison A], the officers nearly would have a canary at the thoughts, you know, they [the prisoners] wouldn't get their methadone on time, and I mean the whole jail runs around the methadone, the whole jail." [HP]

Discharge planning and improved links with community services is an area that needs to be addressed in relation to improving addiction care. Prisoners feel that if discharge planning was improved, the recidivism rate would decrease.

"A lot of people are let out of them gates - no clinic, no doctor, nowhere to live, nothing ... there's nothing provided for you once you're let out them gates ... that's why a lot of people come back in cause they've to go out shoplift again for drugs, shoplift to try and get a B&B ... I think before you should be released they should try to have them things organised - the place, the methadone clinic, the doctor, something you know." [P]

7.2.2. Mental health

Mental health was a significant health need identified by all participant groups. Several groups, including prisoners, reported that there are prisoners with significant mental health problems who should possibly not be in the prison system. Healthcare staff report that they encounter prisoners who have not attended community psychiatric services previously, yet who present to the service with acute conditions such as schizophrenia or mania that led to their incarceration. The mental health needs of prisoners in some of the landings that accommodate mentally unwell prisoners in individual prisons were equated to those of patients in acute psychiatric wards.
In addition, mental health needs of prisoners were identified as being especially challenging: dual diagnosis (the co-existence of a mental health and substance use disorder for an individual) was identified as common among prisoners and self harm / suicide prevention were also identified as key issues.

The 'committal assessment' is the primary mechanism by which a mental illness can be detected. Otherwise, the prisoner would present to a member of the healthcare team or an officer with a mental health issue. Prison officers have an important role in detecting, observing and reporting changes in individual prisoner's mental health. Officers are on the landings or prison wings at all times, whereas healthcare staff are not. Multidisciplinary team meetings are another important means of detecting mental health problems.

Nurses and prisoners reported that recognition of mental health problems is challenging, particularly when it manifests as behaviour disturbances, with the result that delays in diagnosis and treatment can occur:

"Where people are psychiatrically unwell, being disciplined and punished you know and the officer didn't realise that they weren't actually misbehaving, they were mentally ill." [HP]

The importance of the prison officer in detecting mental health problems among prisoners was highlighted:

"I think the value of the officer at times is definitely not valued or not recognised. Some of them are so tuned in, particularly the people who are dealing with those in isolation or in the pads" [HP]

An overall improvement in delivery of prison mental health services in recent years was identified by all participant groups, although the need for continued improvement was also highlighted.

Mental health problems can be mismanaged from several perspectives and this was conveyed by several participant groups.

There are no specific prison nursing posts dedicated to the care of mentally unwell prisoners. Nurses reported deficits in how mental health is managed by healthcare staff. Nurses identified a need for education and training in the area of mental health, especially for those nurses who had no previous training or professional experience in the area of mental health. This was also identified by service providers from external agencies.

"It is also noticeable that the nurses who are employed have A) an absence of psychiatric training and B) they receive very little in-house training and that is a problem" [HP]

A requirement for a dedicated mental health clinical practice development resource within prison nursing was identified. Nurses rely on colleagues who are trained in the area of mental health in relation to assessment and clinical decision making. There are no rostering structures or work systems in place to allow for the effective utilisation of nursing knowledge, expertise or skills to individuals with specific needs or / and care groups of patients: e.g. mentally ill, addiction, etc.provision for skill mix in the service. A particular need to train staff in mental health, especially clinical assessment was identified.

The mental health component of the committal assessment on the Prisoner Medical Record System needs to be improved considerably.

The level of intervention from outside services is variable. The Central Mental Hospital (CMH) in-reach team manage much of the mental healthcare in the Dublin and Portlaoise prisons and where such in-reach teams operate, nurses reported management of mental health problems to be more straightforward. CMH staff reported that some prisons are more difficult in which to operate due to organisational issues such as availability of security staff to accompany prisoners.

The need for the CMH in-reach team to be provided with additional resources (especially in-patient beds) that are equivalent to community mental health services was identified. Timely and appropriate mental health interventions can support the prison service in managing risk, risk of suicide, risk of harm to self and to other prisoners and staff.

Advocacy was identified as an important skill when dealing with prisoners with a mental health problem in the prison service.

"I think that advocacy skills is a big one especially with vulnerable prisoners…sometimes staff, a minority of staff don't always understand mental illness, call him a stook or whatever, I think sometimes you do need to be that bit assertive in that area…" [P]

Prisoners with personality disorders were identified by governors and healthcare staff as difficult to manage from a health and security perspective:

"in which we have a significant percentage of people who would certainly be in that category, overlapping between criminality and mental illness, and then other difficulties as well around, I suppose behaviour difficulties that often don't be seen as medical but they, they're certainly on the periphery of it and you know yourself certainly the confusion sometimes that exists between whether it is a management problem or a medical problem" [PM]

Prisoners identified weaknesses in the current committal assessment with regard to detecting mental health problems and that some prisoners should not be in prison due to a mental illness.

"They ask exact the same questions…I don't think the bloke is going to say, "well yeah, I'm depressed out of me head…I'm missing me bird and I'm upset out of my head and I feel like killing myself"…you know, they don't say that, do you know what I mean…but honestly, like, that's one side of it…" [P]

"People that shouldn't be in the jail cause they're not right in the head I mean they have the mental age of twelve or thirteen and they're thirty and forty and they're not getting seriously looked after." [P]

There is a stigma attached to mental health for many prisoners and one could be deemed weak and vulnerable if they are known to have a mental health problem.

To this end, prisoners highlighted that mental health problems are under-reported and indicated prisoners who are familiar with the prison healthcare system do not report mental health symptoms during the committal assessment, as to do so would result in their being put in a 'pads' or 'strip cells'. Prisoners suggested that there should be a separate wing for new committals where healthcare needs could be comprehensively addressed. Nurses and prisoners reported inappropriate use of and adverse effects of 'pads'.

"loads of psychiatric problems…depression, yeah…they don't listen to the psychiatric problems when you're coming into prison…they ask you if you have any psychiatric problems and if you tell them that you do they automatically put you in a strip cell so if your feeling suicidal then, you're definitely going to be feeling worse…" [P]

Depression was reported as common, especially among women prisoners. Boredom, the response to incarceration and substance misuse were identified as contributing factors to developing depression while in prison.

"…they're suffering with depression…it's a culture shock…they're stuck in a cell twenty-four hours a day…" [P]

All participant groups indicated that nursing posts specific to mental health would be beneficial to prisoner health and the prison service.

"The needs would be better served if there were a specific identified member of the nursing staff who was responsible for mental health, that has happened from time to time in various prisons but due to economic constraints and a lack of political will they have not been followed through and invariably falls down and as I'm aware of the prisons that I've been to now, there is no mental health lead nurse in any of the clinics" [HP]

Discharge planning and improved links with community services is an area that needs to be addressed in relation to mental healthcare. Observation units, in which prisoners with, or at risk of, suspected mental illness, would make it easier to mange mental illness among prisoners. Some examples of best practice in this regard in the IPS were identified.

7.2.3. Health promotion, education and prevention

All groups identified health promotion, education and prevention as an area that could be developed to better address the health needs of prisoners. Nurses, medical orderlies, teachers and officers working in prison gyms provide a wide range of health promotion, education and prevention interventions at present, although the absence of a formal structure was identified as a major limitation of these interventions.

"...about 95-96% of the population smoke, we do very little, if anything at all, around health awareness on that, challenging people and educating people about the consequences of that, all that sort of stuff. There's a lot of stuff about exercise, there's a lot of stuff about diet, a lot of that, I would say good sound preventative medicine and education awareness..." [PM]

It was suggested that time in prison presents an important opportunity to engage prisoners with health services, especially those that deliver health promotion interventions.

"I think we should be proactive with an incarcerated group of people that are probably more vulnerable than the ordinary citizen on the outside that would take less care of their care, here we have an opportunity where they are in with us for 3,6, 9 months or greater and we should be more proactive with their healthcare" [HD]

Health staff and governors reported knowledge and awareness of health issues is poor among prisoners and all participant groups acknowledged that prisoners need to be encouraged to take responsibility for and control of their healthcare.

"So, I would say a lot of expertise in that area (is needed), around trying to raise awareness and trying to prevent and help prisoners, not just themselves but help them with their families as well to do things that would actually have practices and habits that would be good and healthy, rather than the way they are. We are dealing with a very significant sub-culture of people that generally don't have the sort of healthcare education awareness that other people have" [HD]

Governors and healthcare providers acknowledged that prison healthcare is currently reactive in its focus and should therefore become more proactive.

Although many nurses recognised health promotion and education was part of their role, they acknowledged this was carried out on an individual basis and without a formalised structure.

All participant groups felt health information for prisoners should address basic issues (e.g. good hygiene practices) and should be delivered in a coordinated manner, involving all prison staff and in consultation with the prisoners.

"... we should be more proactive in ... preventative medicine, rather than just reacting to the health of the prisoners as they come in." [HP]

"I believe it (health education) is not going to be useful because unless we get it in the context of their lives and I believe we don't understand. We don't understand it and to provide a theoretical class on hepatitis or asthma or anything else quite frankly I don't think it's useful, it's only going to be if you can put it into context in their own lives how does this Hep B affect them or how could it affect them. So you know I think to change anyone's behaviour, any of those people's behaviour you really have to be asking them what do you want to know about? It would have to be very much structured in a way that they decided..." [HP]

Most participant groups agreed that health promotion strategies and prevention interventions should be identified and developed, but that additional resources would be necessary if this was to be meaningful.

7.2.4. Infectious diseases

Human Immunodeficiency Virus (HIV) and hepatitis C (HCV) infection are both more common among prisoners than among the general adult population and especially among prisoners who inject drugs. Participants identified that screening for these infections could be improved as only prisoners who are considered at high risk of infection are screened, that is, prisoners who are assessed and managed by the addiction services 'in-reach team', which include doctors and nurses with a special interest dedicated in addiction.

"The issue about bloodborne viral screening, while it's addressed and minuted is for a point in the future and for the best part of the last six to eight months we've not been in a position to do it except on an individualized priority basis, i.e. where we have an immediate suspicion that somebody's at high risk and is requesting bloodborne screening." [HP]

Infectious diseases medical care is generally provided by specialist secondary care services and an infectious disease 'in-reach' service has commenced in two Dublin prisons. Management and healthcare staff considered this service had a positive impact to date and recognised that encouraging prisoners with infectious diseases to engage with this service was important.

Very few prisoners receive treatment for hepatitis C while in prison and the need for expansion of hepatitis C treatment among prisoners was highlighted.

"...hepatitis C treatment will probably represent a huge burden of care. I think everything will be affected really by coming in and properly screening and starting treatment programmes within the prison. I think however, even though there is a huge burden with chronic Hepatitis C, I think it can be, it might not be as huge a burden as you might anticipate because there's an awful lot of people that won't really be able to engage in the treatment because of their ongoing substance abuse problems or other psychological problems, so really there's a lot fewer people that are truly sort of appropriate for treatment." [HP]

Prisoners reported that HIV management in prisons had improved considerably in recent years, although they identified some aspects of its management where further advances could be made, with deficits in medication management being identified as one such area.

Nurses reported that some prisoners did not sufficiently recognise health implications of hepatitis C infection and this was often due to a lack of awareness on the prisoners behalf.

"Hepatitis C, HIV, there are a huge amount of prisoners who don't care about Hepatitis C do they, there needs to be more follow up with their care, there needs to be somebody in that area that can just manage that area of Hepatitis C in the prison." [HP]

Prisoners reported a lack of health education regarding bloodborne viruses in general and a lack of education and explanation following diagnosis while in prison.

"No, nothing like that. Just said you're hepatitis positive, gave me the leaflet that's it. She said she'd try to get me to a hospital to see how far I'm gone but I'm still waiting so I know nothing about it like. I'd love for someone to sit down and explain to me well you're going to be sick or you're not going to be sick, this is going to happen to you, that's going to happen to you... I know nothing about it, I don't know the first thing of it" [HP]

One prisoner who had received some one to one education on bloodborne viruses felt it had been very beneficial and reported an improvement in his understanding of the transmission and treatment of bloodborne viruses.

7.2.5. Chronic illness

Asthma, diabetes, cancer and heart disease were the chronic illnesses most frequently identified. Respiratory conditions are particularly common among prisoners. A substantial proportion smoke tobacco and many have a history of smoking other substances such as cannabis and heroin.

Management of chronic illness in the prison service could be improved. A prison sentence is a good opportunity to intervene in an inadequately addressed or unaddressed chronic illness where the person may not have engaged with services in the community. Encouraging prisoners to engage with treatment is an important aspect of care delivery.

Nurses felt they should be encouraged to specialise or develop expertise in areas such as asthma, diabetes etc, particularly in prisons with larger nursing teams.

7.2.6. Primary care

The importance of a comprehensive primary care service in addressing the holistic health needs of prisoners was highlighted:

"Primary care ... should be your linchpin that underpins everything else that's provided." [HD]

The role of the GP working in the prison service is different in many respects to the role of a GP in the community. Opportunities for the development of this role, particularly with respect to health promotion and chronic disease management were identified:

"There is more than just seeing the client for a five minute interview just because he's presenting with something we should be out there proactively engaging with them health education and screening and all the rest and I feel a lot of our doctors aren't doing that at the moment." [HP]

The need for reform of primary care within the prison service was highlighted. In particular, the need for a clinically accountable and comprehensive primary care service that effectively addresses the health needs of prisoners and coordinates access to and provision of more specialised clinical services was identified.

"Doctors coming in with very little coordination and supervision; there's a lot of vagueness at the moment, you see these are not medical officers in the old sense ... because they don't carry the responsibility of medical officers. They just come in and provide GP services and that's fine but..." [PM]

"I would think that for a complex like Mountjoy it should be operated like a group [general medical] practice with support among like from the medical side with support among the doctors and that there should be a lead clinician, there should be a senior doctor who is full-time in the prison service who has some kind of a higher qualification maybe in prison healthcare or some kind of a research interest that's driving research and you know driving improvements in the service because at the moment it's really piecemeal with people coming in and out working part-time, working elsewhere and there's no one doctor really driving quality or improvements in the service and that's what I would see the future is on a lead clinician basis so that people are not working on their own and that they have that support structure and there's continuing medical education organised within the prison service and that doesn't exist at the moment and it would really lead itself you know we could have a lead clinician in the Mountjoy complex you know pulling all the strands, pulling all the doctors together and I think it should work similarly for nurses I mean at the moment there are just the staff nurses working in all the prisons and then there's a chief nursing officer and nothing in between and I think leadership needs to be brought in to the prison medical service to really drive improvements because at the moment everything is just operating separately and there's no collective drive." [HP]

7.3. Thematic category #2: Definition of nursing role

All participant groups (including nurses) had difficulty articulating the role of the nurse in the prison service. The role was described in terms of specific tasks or workload, with little consideration given to professional practice addressing health needs.

"It's a task and you must have it done by a certain time and that's it, and nobody really cares whether somebody's mental health issue has to be looked after or somebody is in a 'pad' and they are actually very unwell ... I don't care about any prison, it's the same all over. As long as the smooth running of the prison is facilitated by healthcare, that's fine, and don't cause any problems, but the minute you try to change that, that's when you become a problem and healthcare becomes a problem, because we are nurses, we are looking for something we shouldn't be looking for." [HP]

Nurses reported their role involved what they considered inappropriate duties, specifically duties relating to discipline, which included: collecting prisoners, escorting other healthcare professionals and collecting urines that are not clinically indicated.

Nurses also reported they are requested to work additional hours to fill in for deficits in the roster of discipline staff, with the result that an over supply of nurses can happen on some days and a converse shortfall of nurses on duty at other times. The amount of time in clerical and administrative duties was described as excessive. Nurses also report that they provide a lot of 'occupational health' for prison staff as there is no dedicated occupational health service.

Nurses reported they sometimes felt under pressure from prison management to perform discipline-related duties and indicated the nursing role was viewed by some discipline staff as being to support the smooth running of the prison as opposed to meeting the healthcare needs of the prison population, with a consequent blurring of discipline and healthcare roles.

"...we are asked things, you know, and there are a few times when you try to explain that you can compromise your own registration, but I think they [discipline staff] sort of see our role as being for them rather than for the prisoners." [HP]

Nurses' terms and conditions of employment can further complicate the blurring of discipline and healthcare roles. The need for greater clarification of the role of nurses in prisons was identified as a priority issue by nurses, the healthcare directorate and governors. Nurses, the healthcare directorate and prison management reported that prison management and discipline staff did not understand the role of the nurse. Lack of a local healthcare management structure, nurses' terms and conditions of employment, lack of an organisational structure when nurses were introduced into the system, the task-oriented nature of their work and most importantly lack of role clarity and definition were identified as important contributing factors to this confusion.

"The first challenge is the core ambivalence in the prison system and management about what a nurse is, that has to be defined" [HP]

"We brought them in without defining their role, without saying 'listen we have medical orderlies, we now have nurses, what is the role and function of the nurses.' We didn't do it in a structured way" [HD]

When asked about the nurses' role, prison governors identified a number of tasks that nurses perform but did not outline their role in the organisation.

"I would say we would not have a good understanding of the role of the nurse. If you're looking at it from purely an operational point of view …and I suppose as the Governor your first priority is for the smooth running of the prison and other things would come secondary…whereas I can understand professionally nurses coming in have standards that they have to uphold and sometimes these may not always fit in with the operation or smooth running of the prison." [PM]

A number of problems that resulted from the lack of role definition were identified. These included: interdisciplinary conflicts, increased levels of work related stress, decreased levels of job satisfaction, lack of respect by other prison staff for their professionalism, inefficient working and general confusion and blurring of discipline and healthcare roles.

"The issue of role definition has to be addressed, it causes huge conflict for nurses, it causes difficulty in terms of delivery of care and it is causing difficulties in and among prison staff, discipline staff…there is no actual respect for their professionalism and that's a huge issue and I think part of that is to do with role definition…they are pushed into practices that are at odds with their professional guidelines because the system doesn't facilitate the practices properly. I think that is causing huge issues for nurses within the system" [HD]

"Well I don't know what I'm doing so how can you show someone else what they're doing…there is an element of that there because it's very badly defined you know" [HP]

One Governor commented that to facilitate the smooth running of the service *"all staff need education in what they should be doing and their role in the organisation should be defined and understood by all".* Nurses also conveyed the importance of prison staff understanding and respecting each ones role.

7.4. Thematic category #3: Factors that facilitate nursing practice in prisons

7.4.1. Access to healthcare

The absence of a formalised structure in which prisoners can access nurses and / or medical orderlies was identified as an important barrier to accessing healthcare by prisoners*.

"There are nurses yeah but like you wouldn't see them around the landings or anything ... if they're sent for by an officer you might see one of them" [P]

As a result, most clinical care is reactive to specific complaints and healthcare staff identified this as a barrier to quality healthcare delivery.

"Very often it would be on a needs basis, it would be reactive as opposed to proactive. If there is something wrong with a prisoner or if they come to you requesting help or requesting medical attention or during times like giving out medications or attending to wounds, it would be more reactive" [HP]

Nurses highlighted the importance of communication between healthcare staff and prison officers on the landings, with the prison officer often the first person who can report any change in a prisoner's health or clinical condition.

"Yeah but you see their roles are important to the nurses because they know that they are on the landing the whole time and if they are concerned or if you are concerned, they would be the ones that would know the prisoner inside out or a change in their behaviour wouldn't they, you know, so it's good to keep the lines of communication open between the class officer and the surgery...we get maybe seventy calls a day (from class officers)" [HP]

Prisoners reported that improved accessibility of healthcare staff would encourage them to be more forthcoming with their health concerns. Prisoners highlighted variability in the care that is provided for individual medical problems, and this variability is dependent on the prison officers and healthcare staff that are on duty at the time of the problem and on the prison itself.

* Health care staff are rarely present on landings in most prisons and therefore opportunities for prisoners to present are restricted. Prisoners can either approach nurses while they are dispensing medications or alternatively must approach a prison officer of 'Class Officer' or 'Assistant Chief Officer' grade, in the event they wish to consult with a nurse or doctor.

"no matter what you want when you're in jail, you have to go and ask your class officer or an ACO can I see a medic today. You could be dying from a heart attack but you have to see him first and then he has to go out of his way to go and see the medic" [P]

"It depends who you see like on the day and is it a good officer or if it's a bad officer it depends who is on, what shift, you could be lucky" [P]

While prisoners acknowledged that prisoners may present with simulated symptoms, they highlighted that for the most part, prisoners present with genuine complaints and this should be recognised by health staff and prison officers. Prisoners reported that at times they have to be extremely proactive about their own healthcare and some reported having to threaten legal action to receive appropriate care.

"The best thing you can do here if you desperately want to see the dentist or the doctor is talking with your solicitor but ... I had to do that once cause I had a broken wrist and I was in so much pain and they didn't want to give me any painkillers so I was asking for a doctor for three days and finally I said look if I don't see him today I'm going to call my solicitor and two hours later I was here with the doctor" [P]

Prisoners indicated that on entering prison, little information is provided regarding health services in prison or how to access them. This information would minimise anxiety associated with committal. They also conveyed that interaction with healthcare staff after the 'committal assessment' is minimal.

"...you don't even know what's available when you're in prison until you get an illness..." [P]

"They don't even know you're here if you don't say it. If you just stay in your cell, go out to the yard and don't approach them they won't even know you're here". [P]

7.4.2. Committal assessment

Nurses outlined concerns regarding committal assessments*, including deficiencies in the instruments used during the assessment, external pressures influencing the assessment, and the need for follow up assessments in some cases.

* Committal assessments are conducted by nurses or medical orderlies when prisoners first enter prison. Their purpose is to identify any pressing medical issues and / or chronic illnesses requiring ongoing treatment.

Nurses reported the assessment instrument should be revised to allow for greater detail and this was especially so in the case of assessments carried out on the prison health information system (PMRS). Nurses observed the content of assessment instrument is dominated by addiction issues and therefore medical history should be afforded an increase in relative emphasis.

"For the medical history, there is only enough space the same as a text message, you know, you run out, you don't have enough characters so you know you have to be very economical with your wording with the result that you can leave out lots of very important information." [HP]

Health staff highlighted that these issues, and the individual that is conducting the committal assessment, can affect its quality and thoroughness. Although they felt the majority of serious health issues are identified during the committal assessment, they felt this should be formally quantified.

"I think a lot depends on who's actually doing it as well, it depends whether a nurse does it or whether a medic does it, it depends on where you work and how comprehensive and un-comprehensive." [HP]

Nurses highlighted the need for formal training in conducting 'committal assessments' and that this training should include mental health assessment. Nurses and medical orderlies reported receiving no formal training in conducting committal assessments and learned informally from colleagues.

Time pressures and poor facilities were also cited as areas of concern in conducting 'committal assessments'.

"We are caught for time. I'd love to have more time to do a proper committal. I'd love to bring the committal over to me and sit down for say half an hour and do a proper committal interview. But depending on the kind of day that the committals come in and the staff that we have…we don't get time to put in a proper committal." [HP]

Prisoners indicated they felt the 'committal assessment' was not very comprehensive, did not sufficiently elicit their concerns and was also a lost opportunity to advise prisoners of prison health services. They also suggested a follow up assessment may be clinically indicated in cases where prisoners were acutely unwell on committal, due to a mental health issue or withdrawal from alcohol or drugs on committal and this currently does not always happen.

"This is what happens right, will you stop for a minute. If you come into prison and walk up to the desk, <What's your name?> Joe bloggs. <Are you on drugs?> Yes or No. <Have you any diseases?> Yes or No. <Can you read or write?> No. Right bum up to B-wing, B-wing… that's it, that's exactly what happens." [P]

"I've only had it once, one assessment and I mean they ask you questions but I mean I was coming down off the drink at the time as well and I couldn't even think clearly" [P]

7.4.3. Care planning and review

The need for a more comprehensive care process following committal was identified by nurses, governors and the healthcare directorate, with a structured care plan in place following the committal assessment instead of the existing reactive model of care.

"there should be an induction process for everyone coming into prison, and part of that induction process should include medical in a pretty broad sense, that people spend some time going through various channels with nurses and doctors and other specialists to look at their healthcare needs and their healthcare knowledge and all that sort of stuff and that after induction, assessments or whatever else would be required would be part of a programme. That does not happen at the moment as you know which is a major weakness, fine they are seen by the doctor but, that depends on the doctor it depends on time it depends on a whole lot of things and you know lots of people can go and maybe be seen and almost definitely seen at a committal stage but they could go then for a long period if not their entire sentence and not be seen again." [PM]

The variable extent to which nurses advise on the management of individual prisoners, with respect to their accommodation and level of continued observation, was also highlighted. In some prisons, nurses have a major role in these decisions, whereas in others, this is minimal.

"In some prisons … the nurses will have a huge input into how that person is managed both in terms of accommodation and observation, if they have concerns at committal they can say oh I think that person needs to go to the vulnerable unit to see a psychiatrist or whatever. Or seen by the doctor and that the referral happens to take place. Unfortunately that is not the standard throughout the system. In some cases the nurses may not even get to see or do a committal interview until the person has already been accommodated and if they make recommendations regarding how or where they should be accommodated largely they will be ignored" [HD]

7.5. Thematic category #4: Continuing Professional Development

7.5.1. Professional development for nurses

Nurses, medical orderlies, the healthcare directorate and other healthcare professionals all indicated improvements in professional development structures were necessary. Nurses and medical orderlies indicated professional development was not recognised as a priority by the prison service and that no appraisal system was in place to identify and address skill and competency deficits. Nurses indicated that such structures were particularly important given the wide range and scope of prison nursing and would increase their confidence in their clinical abilities. The healthcare directorate and nurses highlighted competency identification, definition, achievement and maintenance were important imprison nurses' professional development.

"[there is] no appraisal whatsoever, no clinical appraisal, professional assessment of your skill or okay areas, people aren't efficient in some skills so how are you going to update that, there is no process so there has to be, definitely, that has to be a major thing to be dealt with." [HP]

"...and it increases your confidence because we did the first responders course and I actually did feel a lot more confident after doing that course." [HP]

While all groups acknowledged the healthcare directorate support individual professional development endeavours, the benefits of a more formalised structure were recognised. Access to professional development was reported to be variable, with the support of individual governors a key enabler and lack of role definition, lack of a healthcare management structure, rostered working arrangements identified as the barriers.

"you know, a lot of people have said that, you know that's why it would be great to have management who comes in and they can hopefully do appraisals and people can, you know, I think it's very important for people to set objectives in their work environment, it's good for your own morale and staff morale, you know to, you know, nursing is a developmental profession isn't it...expanding roles..." [HP]

The healthcare directorate outlined the need for flexibility and increased capacity in the system to accommodate professional development needs.

"...flexibility within the system to meet those needs that is a huge challenge, if you haven't got staff to provide your day-to-day services there's absolutely no way any manager and I wouldn't do it either myself will release people for training because your priority is actually face-to-face contact and getting your service delivered." [HD]

Nurses highlighted that professional development was the responsibility of the individual as well as the organisation. The absence of provision for learning in the workplace and of internet access was cited as particular deficits.

"Access to best practice ... if you want to look something up you basically would have to do it at home on your own computer which I don't have time to do." [HP]

Professional development was also highlighted as an important issue for other professional groups in the prisons (eg prison officers, medical orderlies, doctors).

"...for the primary healthcare physicians in terms of meetings arranged or continuing medical education so while people are delivering a service there isn't anything putting that service together and offering support or education about the specific healthcare needs of prisons that's from the medical side" [HP]

7.5.2. Skills and identified learning needs

Nurses, medical orderlies, governors and prisoners all recognised the importance of communication skills in the nurse's role and this included listening skills and interpersonal, interprofessional and interagency communication.

"how you communicate with the officers, how you communicate with the prisoners, you have to be able to handle prisoners and you have to be able to communicate with hospitals and GPs who come in as well" [HP]

Prisoners also highlighted the need for special training in communicating with prisoners, especially in dealing with challenging behaviours.

"… well we are a different breed of people…to anyone on the outside we are classed as a sub-race ... it's the prisoners…we're just one class of people…I mean, we know we're all individuals and there's certain kind of people…there's some lovely people and then there's some scumbags…don't get me wrong…there's some low people in prison…but, you have to learn to differentiate between them…" [P]

Nurses considered awareness of the nursing scope of practice (and its limits), providing emergency care and responding to crisis situations as key skills and competencies and therefore advocated considerable prior nursing experience was desirable for prison nurses. Nurses also identified advocacy and assertiveness, clinical decision making / examination skills and maintaining a professional approach to practice as key skills.

All groups identified the importance of nurses being able to appreciate prisoners' social backgrounds and meaningfully engage with them through appropriate communication.

Prisoners reported different approaches to treatment of specific health issues depending on the prison and felt this was due to variability in staff training, knowledge or skills.

"you have to always remember yes you are there for security reasons, you have to remember that yes, you are part of the bigger picture, you have to be very professional in every single thing you do because there is such a small number of us…that in itself is one of the things that gets lost very quickly in the prison service and it's not a deliberate thing. It's because we don't have anybody there to represent us, again to pull it together, to liaise with each other, all that sort of thing" [HP]

"…awareness gives you a lot more because as I said you're always learning because these guys are fascinating…they have so much ways you know I've seen stuff they've done …and you learn all the time…it opens up many worlds you know because a code of silence is just you know is there with them all the time you know" [HP]

Nurses and medical orderlies suggested specialised training be developed in the following areas:

- Assessment
- Mental health
- Infectious diseases
- Addiction
- Cardio Pulmonary Resuscitation
- First aid
- Interdisciplinary working in prison environments
- Wound care
- Examination skills
- Clinical decision making
- Chronic diseases
- Pharmacological interventions
- Health education, promotion and prevention
- Parenting
- Palliative care.

Nurses also highlighted a need for a mentoring programme following induction training and indicated such a programme would help nurses adapt to their new role.

"I think it might be nice though to have a system that when new nurses do start maybe for them to have a mentor that they can go to for the first three months or six months because you forget, it takes so long to settle into the prison environment, it's different to a hospital". [HP]

7.6. Thematic category #5: Role of security personnel

7.6.1. Prison officers

Nurses reported that prison officers have a significant role to play in healthcare delivery. Officers are on the landing at all times and generally report any changes in a prisoner's health status or behaviour to nurses or medical orderlies. If a prisoner wishes to see a member of the healthcare team s/he generally has to approach an officer first. Nurses indicated good lines of communication with prison officers are essential to the provision of quality healthcare in prisons.

"Their roles are important to the nurses because they are on the landing the whole time and if they are concerned or if you are concerned, they would be the ones that would know the prisoner inside out or a change in their behaviour wouldn't they, you know, so it's good to keep the lines of communication open between the class officer and the surgery…we get maybe seventy calls a day" [HP]

Officers also support special clinics and programmes by collecting and escorting prisoners. Healthcare staff identified that ensuring prison officers understand the purpose of a clinic was essential to its success.

"having people who have experience and are sensible and have some idea what an addiction treatment programme or a methadone programme is trying to do makes a very big difference in the day-to-day running of either the methadone dispensing in the morning or the medical or for that matter nurse led clinics in the afternoon" [HP]

Nurses reported a variable awareness of health issues among prison officers but acknowledged they receive little training in healthcare. Prisoners reported that while some officers are astute, humane and respect confidentiality, others are not and cited specific incidents where officers discussed their healthcare conditions with other officers and prisoners, in some cases trivialising their medical issues.

"I have to say the landing I'm on a lot of the officers are very, very good and actually care about some of the prisoners and they'll come over and say "your man doesn't look too hot" and you know "there is something wrong…" [P]

"Well I think officers should be kept out of healthcare cause you don't want them standing listening to your, if you have a problem that you don't want to bring up in front of them, you don't know who they are telling" [P]

Nurses felt the role of the officer in addressing prisoners' health should be recognised and clearly defined.

"*I think the value of the officer at times is definitely not valued or not recognised. Some of them are so tuned in, particularly the people who are dealing with those in isolation or in the pads, they come along and say listen I think he is slipping ....have a chat…" [HP]*

Nurses and other healthcare staff indicated there should be some level of training in relation to healthcare for officers. Nurses and other healthcare staff reported that experienced officers facilitate earlier intervention in specific health problems. Such earlier intervention can substantially reduce the scale of the security and clinical response that is required.

"…we would have been in an awful worse position…very stressful… but only for the staff, nine times out of ten, staff would know somebody was kicking off in the sense that, maybe they had met them before, knew their drug history, knew their psychiatric history, just knew by looking at somebody that they weren't well" [HP]

7.6.2. Role of governors

Governors are responsible and accountable for the provision of healthcare in each prison. Nurses reported that governors who are interested in and support healthcare facilitate improved healthcare delivery. The regularity with which prison governors move posts can impact negatively on prison healthcare, through lack of continuity.

"Even if you are lucky enough to get a governor that is some bit interested in healthcare, next thing he is promoted, he is gone … they'll get someone else in his place who has no interest you know which is a problem too but you know that's the nature of the beast" [HP]

Nurses day to day reporting relationship is to governors. While nurses recognised this was appropriate from a security perspective, nurses and other healthcare staff indicated this was inappropriate from a clinical perspective.

"And that can lead to a bit of mistrust. For instance, we are actually governed by governor's orders except if it's a legal order but sometimes there can be an ethical dilemma or there can be a nursing practice dilemma…" [HP]

Governors indicated they would welcome the role of a healthcare manager to manage the day to day running of healthcare in the prison service. Governors reported that healthcare is one of the many aspects of managing a prison for which they are responsible and they generally don't have the clinical knowledge, expertise or time to become involved in many aspects of healthcare provision.

All governors indicated they were supportive of reforms in prison healthcare that led to equitable service for prisoners.

"...but I am dependent on people with healthcare expertise to inform me about [healthcare concerns] as I say most governors in fact, most of the governors in our system are not medically qualified so we are dependent on others, yes we are responsible for the smooth running of the prisons, no we have no clinical or medical experience and that's why we are totally dependent, I feel there is a gap there for a manager at senior level, chief officer level or whatever to co-ordinate the whole medical issues around the prison, I think that is a priority" [PM]

7.7. Thematic category #6: Prison healthcare infrastructure

7.7.1. Administrative support

All groups indicated administrative support for clinical staff was lacking, with nurses and other healthcare professionals indicating administration duties were both time-consuming and an inefficient use of resources.

"It can take an awful lot of the nurse's time just to answer phones and call up to make appointments that really somebody else could be doing and I think that would be much more time efficient ...I'd also see somebody (reviewing clinical records) ... making sure that vaccination lists were up-to-date, you know somebody who was ready for their second Hepatitis shot or something like that. I think that would be a very efficient use of resources quite invaluable." [HP]

7.7.2. Service evaluation and monitoring

Nurses, governors, the healthcare directorate, and other healthcare professionals reported concerns that monitoring and evaluation procedures were not in place and that a culture of quality-driven health service delivery should be supported.

"I think it's very hard to tell to be honest because who's looking at it, who's assessing it, who's recording it? ...There's not a system there, there is no way of recording that...how many pass through the system...stuff like that" [PM]

Governors indicated they rely on the integrity of the professionals providing healthcare to ensure that healthcare provision is to an acceptable standard. Consulting with healthcare staff and complaints from prisoners are the primary mechanisms by which healthcare delivery in prisons is assessed. Healthcare is only one aspect of governors' responsibilities and usually they do not have the clinical knowledge, expertise or time to become involved in many aspects of healthcare provision. In addition, they do not have access to clinical records because of confidentiality issues.

"whilst I am the manager of the institution I don't have access to the medical records, if a doctor tells me yes I am carrying out everything as per the healthcare standards, I have to take his word for it, there is no way I can monitor or evaluate it myself so either we have external evaluators coming in or we have the written key performance indicators so we can measure against them" [PM]

Governors suggested that adequate health needs assessment through regular consultation, introducing a healthcare management structure and involving the HSE in monitoring and evaluating service delivery were priorities to address existing deficiencies in evaluation and monitoring.

"I would be advocating that that (consultation with prisoners) would be part of what would be required...would be constantly evaluating and measuring and analysing your prison population and responding accordingly to what the issues are" [PM]

7.7.3. Facilities

Concerns regarding the physical environment were reported by nurses, other healthcare professionals, governors and the healthcare directorate. Limited space, inadequate provision of equipment, poor physical condition of the particular healthcare areas and concerns regarding cleanliness were identified as particular concerns.

"Rooms, locations, support, again being arguably inadequate, they're historically based as to what might have been deemed appropriate decades ago, but they still exist in a prison environment when the community has moved on" [HD]

7.7.4. Organisational communication

Healthcare staff reported vertical communication channels within the organisation were neither clearly defined nor open. The manner in which prison management communicate with healthcare staff is generally by means of 'orders' and healthcare staff reported they find this disconcerting because their prior experience has been in clinical environments where communication is more personal. Healthcare staff also reported that sometimes these 'orders' were incongruous with professional and ethical practice. A level of mistrust between management and healthcare staff was also reported.

"For instance we are actually governed by governor's orders except if it's a legal order but sometimes there can be an ethical dilemma or there can be a nursing practice dilemma……. he was requested to do it and refused to do it so he was deemed to be refusing a governor's order as opposed to making an ethical or moral judgement on a situation that was clearly not acceptable" [HP]

Communication among healthcare staff themselves although unstructured was reported as good. Nurses can communicate with each other through the intranet although this is infrequent. The importance of inter professional communication (especially with prison officers) was highlighted by all groups and multidisciplinary team meetings were identified as a potentially useful strategy in that regard.

"I mean I find it very frustrating, no matter what we try to do, nobody actually thinks of informing the prison officers of what we are doing. I go to meetings and everybody from this level up knows what's going on but nobody from that level down knows what's going on and then they wonder why we get resentment because they are never included. It's not all-inclusive" [HP]

7.7.5. Role of the HSE

All participant groups conveyed that the HSE should be involved in prison healthcare in some capacity, with many participants indicating the HSE should have ultimate responsibility for prison healthcare. Concerns were reported by all participant groups in relation to the lack of a formalised structured interface between the IPS and the HSE.

"Whatever happens on the outside and who is responsible overall for healthcare on the outside should be equally responsible for what happens in prison on the inside…" [PM]

A number of reasons were advanced for HSE involvement by the participant groups and these included:

- Boundaries regarding healthcare and security would be more transparent ;
- A more consistent and equitable approach to healthcare provision throughout the system;
- It would allow for a more comprehensive seamless, continuing healthcare delivery structure for those being cared for in the prison service and requiring follow up in the community;
- It would remove some of the mistrust prisoners may have in relation to healthcare staff as prisoners can perceive them to be part of the prison system;
- Standards could be monitored and improved;
- Health would be the responsibility of the HSE and security would be the responsibility of the Department of Justice, Equality and Law Reform.

"I think that would have the facility then of designating health, community health norms, infrastructural norms, service norms as being the guiding principles for you know healthcare provided in the custodial environment because I think that essentially by way of standards and policy statements the desirability would be that we provide people in custody with broadly equivalent levels of healthcare to people of similar means in the community" [HD]

"that would be another reason why I would be an advocate of a more central role of HSE in that it would certainly remove some of that mistrust that you'd have because they believe at the moment, most of the prisoners that the doctors and the nurses includes all parts of the system and to some degree they are and that one of the difficulties we have that eh they are part of the system and prisoners see them as part of the system and therefore there is a significant element of mistrust that prisoners" [PM]

"I think that it'd be very helpful for prisoner healthcare to have somebody overseeing what actually goes on and just so that there is a kind of continuity or a proper standard of service that is aspired to and you know hopefully attained and I think that somebody from public health perspective overseeing that would be good, somebody or I suppose a quality assurance type perspective, I think that would be good. It would also I think help in the professionalism with the nurses and doctors involved in the prison to have you know I suppose quite a tangible healthcare standard and fairly similar, without being kind of draconian but a you know broadly similar approach to all the different aspects of healthcare and you know protocols within the prison system so that you know you could move from prison to prison and be happy oh this is the general way we approach things and there probably is a bit of continuity that way, a bit of conformity that way but I think that could be improved upon and the healthcare status would already you know have those to lineate it, but I suppose maybe a more, maybe something a bit more structured for how to keep attaining those" [PM]

"I believe coming out of that [HSE involvement] it would also raise standards. I think there would be more accountability in the quality of standards you would have more cohesion and coordination as well and I believe that the quality of healthcare would be measurable then on a par with on the outside. We say it should on a par with the outside but we are not doing it the same as on the outside" [HD]

"Oh I think that the healthcare should be taken away from the Department of Justice altogether and I think it should be completely run from the HSE because the Department of Justice's priority is with custody and security and all other elements within the prison service comes secondary to that and if you're employed by the Department of Justice then you know that's the way it works, security is their number one issue whereas I think if health was coming from the HSE it would be just a different focus and there would be quality of care that wouldn't be secondary to any other issues it would be just purely quality of care" [HP]

7.7.6. Healthcare management

The absence of a comprehensive healthcare management structure was reported by all participant groups as a considerable deficit in the service. Nurses reported there is no one to represent their professional concerns and that more complex clinical decision making can be problematic due to the lack of a manager. Nursing managers would support clinical decision making among nurses who reported feeling professionally isolated at times and could clarify the role of nurses in particular prisons, where necessary.

"I mean at the moment there are just the staff nurses working in all the prisons and then there's a chief nursing officer and nothing in between and I think leadership needs to be brought in to the prison medical service to really drive improvements because at the moment everything is just operating separately and there's no collective drive" [HP]

Nurses highlighted that the presence of a manager could prevent and / or resolve problems arising from their interdisciplinary relationships. Nurses and the healthcare directorate also indicated a clear management structure would support the introduction of new service innovations.

"There is a huge potential for nurses to impact on the delivery of healthcare. How it's delivered, the quality of what's delivered and the accountability…that can't happen in the current situation. Lack of supervision, there's no planning for in terms of needs of the prisoners and matching needs particular skill sets…the whole area of skill-mix…" [HD]

Nurses and other healthcare professionals indicated it was inappropriate for healthcare professionals' clinical role to be managed by non-clinical managers and that the absence of a clinical appraisal system was not consistent with quality health service delivery. Governors, the healthcare directorate and in-reach care providers reported that a health management structure would greatly improve coordination and continuity of care as the current shift system does not support this. In addition, it was identified that a health management structure would facilitate better implementation of healthcare standards and enhance communication especially between senior management and nurses.

"At the moment you have people who are non-nursing deciding if you are a proficient practitioner or not, that's wrong" [HP]

"…a concern of mine and a concern of the medical staff here that we don't have a coordinating person…there's no continuity there, there's nobody there even Monday to Friday 8 to 5" [PM]

Governors indicated they would welcome the role of a healthcare manager in managing the day to day running of healthcare in the prison service and recognised this area was one where they did not possess the necessary knowledge, skill, qualifications or time. Nurses and other healthcare professionals identified the regularity with which governors move posts as a barrier to continuity in healthcare delivery.

7.7.7. Discharge planning

All participant groups indicated discharge planning occurs on an inconsistent basis. Discharge planning is not a specific role of the service, is not a role of any healthcare professional and is not supported by any policy or procedures. Prisoners reported that their discharge is generally unplanned and reported feeling anxious prior to discharge (particularly those serving longer sentences).

"A lot of people are let out of them gates no clinic, no doctor, nowhere to live, nothing that's why they…they've to go back using drugs they've to sleep in a B&B…there's nothing provided for you; once you're let out them gates they don't care after that…that's why a lot of people come back in cause they've to go out shoplift again for drugs, shoplift to try and get a B&B or …I think before you should be released they should try to have them things organised the place the methadone clinic the doctor something you know" [P]

The healthcare directorate expressed concerns regarding the reintegration of prisoners into the community and healthcare staff reported they are not always informed by prison management when a prisoner is due to be released and therefore cannot appropriately plan for their discharge. The reactive nature of care provision in the service was also cited as a prohibitive factor in discharge planning.

"…they're told when to sleep, when to eat, when to shower, they are medicated on a regime basis inappropriately because healthcare is delivered in very small time windows that fits the prison regime, rather than the actual prisoner. And then you discharge them maybe after fifteen years of prison regime and expect them to be able to function normally again within in a community environment it doesn't make any sense" [HD]

"Again on a semi-reactive basis where prison healthcare tends to fail as I've said already is on proactive healthcare, interventionalist rather than reactive and also on the effective throughput of people returning to the community. People come to the end of a period in prison, even healthcare doesn't always know when that's going to happen because sometimes people historically have been almost unplanned release but even where you know somebody is going out effective true care in terms of ensuring that health links are made with a provider in the community is ad-hoc, it sometimes works, but it doesn't work on a systematic basis and its problematic particularly if somebody doesn't have a GP, doesn't have…they are very problematic…" [HD]

All participant groups agreed the issue of discharge planning should be addressed and that a structured, coordinated discharge planning system where prisoners' healthcare needs are met in the community after imprisonment would lead to a reduction in recidivism.

"Unless they address the issues around prison health, these people are going back into the community they have to be linked they have to be dealt with because if they're not they're actually going to be one of the major reasons why we're not getting the problems in public health whether its HIV, Hepatitis C or antisocial behaviour as a consequence of a mental illness. They won't be addressed…there has to be some sort of joined work, joined thinking and joined planning." [HD]

7.8. Synopsis

Qualitative analysis allowed the development of a theoretical framework to describe the role of nurses in healthcare delivery in the IPS and the factors that influence, facilitate or act as barriers to that role. Six themes were identified:

- Health needs of the prison population, with addiction, mental health, health promotion, infectious diseases, chronic illness (asthma, diabetes, cancer and heart disease) and primary care key issues in this regard.
- Definition of nursing role, especially a need for greater understanding and clarity of the role. The requirement to review skill mix to ensure the effective utilisation of the nursing skills and competencies and accountability to non-clinical staff on professional issues.
- Factors that facilitate nursing practice in prisons, including prisoners' access to healthcare, the role of the 'committal assessment' in nursing practice and care planning
- Continuing Professional Development, with specific learning needs identified as: communication skills, awareness of the nursing scope of practice, emergency care / crisis incident management, advocacy / assertiveness, clinical decision making / examination and professionalism as well as clinical issues such as mental health, addiction, infectious diseases, chronic illness and health promotion.
- Role of security personnel, especially of prison officers and governors and how this role impacts on nursing practice.
- Prison healthcare infrastructure, including: administration, service evaluation and monitoring, physical environment, organisational communication, the HSE role healthcare management and discharge planning.

Chapter 8: Key findings

8.1. Key findings

Nursing in prisons in Ireland is a relatively recent service innovation and the findings and recommendations of this report should be viewed in this context. Prior to the introduction of nurses to the IPS in 1999, healthcare was delivered by 'medical orderlies' who are prison officers with some health training. At the time of this report being prepared, 88 nurses and 50 medical orderlies were working in the IPS, although it is IPS policy that no new medical orderly posts will be appointed. Nurses and medical orderlies provide health care to 9711 people entering prison each year (11934 committals), of whom 16% are under 21 years of age, 12% are female and 70% have a prison sentence that is more than two years.

Healthcare (and nursing) in prisons in Ireland is supported by a clearly-defined legal basis for prison health care (the 'Prison Rules') and the IPS therefore has statutory responsibility for prison healthcare. This project set out to examine ways of maximising the effectiveness of nursing interventions and care in the management of prisoner health, to identify what supports are required and to inform a strategy that facilitates the effective utilisation of nurses skills and competencies in the management and efficient delivery of quality healthcare in this system.

The findings in this report have not been identified in individual prisons but across the prison system from a national perspective. The data was collected from all of the prisons nationally and gives a comprehensive analysis of the health needs of this population. The analysis of current nursing practice in prisons in this report compared to the health needs of prisoners has highlighted a significant number of gaps relating to healthcare delivery and its management. The gaps identified through this analysis reflect the unmet health needs and the potential opportunities that exist to deliver a comprehensive healthcare service. Such a service is dependent on identified infrastructural, organisational, professional, management and leadership supports being in place.

As nurses are the largest healthcare workforce, the most constant and predominant healthcare providers within the IPS, this analysis provides a framework for the development of nursing roles and practices that reflects the health needs of the prison population:

This study outlines a theoretical framework within which the role of nursing in the IPS should be considered and this contains six major themes that impact on nursing in prisons:

- The health needs of the prison population include five major clinical issues (addiction, chronic illness, health promotion, infectious diseases and mental health) and in view of this diversity of health needs, a more comprehensive primary care service is needed.
- The prison nursing role should be more clearly defined and this theme includes issues such as greater clarity in the nurse's role, consideration should be given to the appropriateness (or not) of tasks regularly conducted by nurses and nurse's reporting relationships, in particular their accountability to non-clinical staff.
- Factors that facilitate nursing practice in prisons which include facilitating easier access to healthcare by prisoners, the importance of (and need for improvements in) the 'committal assessment' in nursing practice and the need for formal care plans in prison healthcare.
- Continuing Professional Development includes specific learning needs such as: communication skills, awareness of the nursing scope of practice, emergency care / crisis incident management, advocacy / assertiveness, clinical decision making / examination and professionalism. Learning needs also need to address the five major clinical issues (addiction, chronic illness, health promotion, infectious diseases and mental health).
- Role of security personnel, especially of prison officers and governors and how this role impacts on nursing practice.
- Prison healthcare infrastructure, includes issues such as: administration, service evaluation and monitoring, the impact of physical environment, organisational communication, the HSE role and healthcare management.

While this framework was developed by the qualitative research activity conducted within the project, the major themes it contains concur with those identified as priority issues by the quantitative research activity. This study also highlights that although their role may have diminished somewhat since nurses were introduced to prison healthcare, medical orderlies still make an immense contribution to prison healthcare.

The theoretical framework developed to describe the role of the nurse provides the foundation for the discussion.

8.2. Relationship to previous work

The health needs of prisoners in Ireland are similar to what has been documented in prison healthcare literature from other settings, which has also highlighted the importance of addiction [18], chronic illness [28 74], health promotion [31], infectious diseases [19-22] and mental health [12-14]. Our literature review also highlights the importance of women's health [27 28] and young person's health [29] in prison healthcare and these issues were also identified as important in our study, although to a lesser extent.

Our study highlights the benefits of a comprehensive primary care service to address the complex health needs of prisoners. Although the potential benefits of such a service are recognised in the literature [41], at the time of publication we have been unable to find published data describing the impact of a prison-based primary care service on prisoner health outcomes.

This study also highlights a number of issues relating to the professional role of prison nurses. While some of these issues, especially the diverse and challenging nature of prison nursing practice, the importance of the committal assessment and the benefits of structured care plans have all been previously identified as important in prison nursing [43 48 50 51], issues such as the expectation that nurses will conduct non-nursing tasks and concerns surrounding clinical accountability to non-clinical management have not been widely reported.

We have also highlighted the importance of professional development for nurses and identified a number of specific learning needs that should be at the core of any future professional development initiatives, both of which are consistent with previous work on prison nursing [53 55].

We described a number of issues relating to nursing practice in the prison environment and how this impacts on professional practice. Specifically, we have described the role of security professions and documented the importance of the organizational context and physical environment to prison nursing. These issues have been reported previously, with a partnership approach to prison healthcare delivery that involves collaboration between prison services and health services clearly an important framework within which many problem issues can be addressed [39 43].

Chapter 9: Discussion and recommendations

9.1. Role development

9.1.1. Health needs of the prison population

The health needs of prisoners are complex and wide ranging. Common health needs among prisoners include:

- addiction
- chronic illness
- health promotion
- infectious diseases
- mental health.

There are a number of other less prevalent healthcare needs that reflect the wide-ranging health needs of the general population. Two population groups that require special attention in the prison healthcare system are women and young people.

Considerable opportunity exists to increase nursing interventions focusing on the above areas. Care needs for different prisons will vary as they reflect differing demographics, health status and health needs of the prison population. A systematic analysis of the health needs of the prison population should inform the development of nursing roles to enable nurses to respond to health needs of the population they serve.
There is currently no tool or process specific to this purpose.

Recommendation: A prison health surveillance system is developed to document and monitor the health needs of the prison population.

Recommendation: The health needs of prisoners inform the development of nursing and other health services to this population.

9.1.2. Models of service delivery

The current model of health service delivery in the Irish Prison Service is task orientated, appears to be entrenched in prison regime and has undergone minimal change since nurses began working in the prison service. This has resulted in limited flexibility in work practices, little scope for innovation and has limited role development.

Much of the care provision in the IPS was reported as reactive to presenting conditions. Minimal proactive care such as structured health screening or health promotion, prevention or education programmes were reported. Project participants indicated that time in prison presents an important opportunity to engage prisoners with health services.

Several factors have increased the potential to develop more flexible responsive nursing roles to include: demographic/epidemiological changes in population, the increasing demand for health services, growth in nursing and midwifery knowledge, health economics, cultural and legal changes and more complex and technologically advanced health interventions.

The development of nurses roles in the prison service may occur as a result of:

- Identified needs of prisoners
- An increased endeavour to bring about a more proactive healthcare service in the IPS
- Increased interdisciplinary collaboration
- New models of service provision such as the introduction of nurse led services
- Newly developed and existing areas of nursing practice not currently in use in the IPS
- Health promotion, prevention and education opportunities
- The need to expand nursing roles to meet identified needs
- Increased specialisation in nursing and midwifery
- Advanced level of nursing and midwifery practice

Recommendation: There is an evaluation of current healthcare provision in the IPS to ensure the health needs of prisoners are being met.

Recommendation: The role of prison nurses should integrate with any new service delivery frameworks through initiatives such as multidisciplinary / interdisciplinary care, structured / shared care protocols, clinical audit and education / training.

9.1.3 Current prison nursing role

Prison nurses' roles are wide ranging and extend to several domains of clinical practice. The documented range of clinical activities nurses carry out and the number of potential extended and expanded roles identified indicate the breadth and diversity of the prison nursing role.

There is a lack of clarity regarding the role of the nurse, their responsibilities and their accountability for practice in the prison service on the part of governors, security personnel, other healthcare professionals, prisoners and among nurses themselves.

Nurses reported spending considerable time in non-clinical activity while a number of roles more central to nursing practice were reported as being performed more infrequently. There is no defined process to review the role of prison nurses or to support research activity with regards to this and role development in the prison service.

Nurses are the largest healthcare workforce and the most constant and predominant healthcare providers within the IPS. The potential for improving prisoner health through the role development of nurses is significant. The need to review and define the role of prison nurses to meet the healthcare needs of the prison population is imperative.

Recommendation: The role of prison nurses in healthcare provision should be explicitly defined and reviewed on an on-going basis to ensure it is appropriate to the health needs of the prison population.

Recommendation: The role of prison nurses is communicated to and understood by all prison staff at corporate and operational level.

Recommendation: The role of prison nurses should integrate with any new service delivery frameworks through initiatives such as multidisciplinary / interdisciplinary care, structured / shared care protocols, clinical audit and education / training.

9.1.4. Specialist and Advanced Practice

The National Council for the Professional Development of Nursing and Midwifery published a framework for the development of levels of clinical expertise through designated specialist and advanced nursing practice positions [75] [76]. The importance of the role of Clinical Nurse Specialists and Advanced Nurse Practitioners is well recognised and their important contribution to high quality client/patient care within the Irish health services.

The potential for Clinical Nurse Specialist and Advanced Nurse Practitioner roles in the IPS is recognised by the majority of project participants particularly in the areas of addiction, mental health, chronic disease management and infectious diseases. Currently there are no Clinical Nurse Specialist or Advanced Nurse Practitioner roles in the IPS.

As referred to in chapter 6 several reasons were given as to why there was not scope for the development of these roles in the IPS to include: lack of support from management, lack of support from doctors, too constrained by prison rules / systems and no nurse/healthcare management structure to support the development of specialist and advanced roles.

Barriers to the development of more comprehensive nursing service that also impact on the development of specialist and advanced practice include a general lack of understanding of nurses' role and inadequate continuing professional development supports.

Also cited was the potential overlap in the role of the specialist and the generalist nurse. This may indicate an insufficient understanding of the contribution of specialist or advanced practice to patient / client care.

Potential unquestionably exists within the IPS to develop specialist or advanced nursing roles. The general role of the prison nurse must be defined, clarified and understood in addition to basic organisational issues being addressed before the IPS examines the need for specialist and advanced practice in the service.
The development of these roles must happen in the context of identified service need and interdisciplinary collaboration both within the IPS and with external agencies.

Recommendation: The IPS conducts a needs analysis to determine areas of care where specialist or advanced nursing practice is required to deliver high quality care.

Recommendation: The National Council for the Professional Development of Nursing and Midwifery provide guidance and support to prison management and their staff regarding the development of nursing and midwifery roles.

9.2. Scope of Nursing and Midwifery Practice Framework

As referred to in chapter 4 all nurses practicing in Ireland are professionally and legally obliged to practice within An Bord Altranais' 'Scope of Nursing and Midwifery Practice Framework'. The 'nursing and midwifery scope of practice' refers to the 'range of roles, functions, responsibilities and activities, which a registered nurse is educated, competent, and has authority to perform'[65].

The scope of practice for nurses and midwives in Ireland is determined by legislation, EU directives, international developments, social policy, national and local guidelines, education and individual levels of competence.

Competence, accountability and autonomy, continuing professional development, support for professional nursing and midwifery practice, delegation and emergency situations are factors to be considered when determining 'scope of practice'.

To be competent, accountable and autonomous, participate in appropriate continuing professional development activity, delegate or be delegated to a nurse must have a clear understanding of their role and responsibilities and what skills and competencies are necessary to fulfil that role and meet the health needs of the population they are providing care for.

While each nurse is accountable for their own practice and decisions made in determining their scope of practice certain supports are necessary to assist the nurse in determining their scope of practice.

Nurses must be aware of national guidelines that impact on practice.

This can prove challenging in the IPS as nurses are isolated from the wider health workforce and do not work under the auspices of the HSE or the Department of Health and Children. In relation to local guidelines, healthcare standards have been developed to guide the provision of health services in the IPS. However more detailed local policies and procedures need to be in place to guide nursing practice to the prison population.

It is important to look at the experience, educational preparation and clinical competence of nurses. The IPS has a responsibility to access the professional development needs of their staff and to provide appropriate support for staff to enable them to practice to high standards. There are minimal continuing professional development activities available to prison nurses.

All nurses working in the IPS previously worked in a community or hospital setting. The transfer of nursing skills from these settings to the prison setting of custodial care can demand a higher level of clinical decision making and practice given the diversity of health needs and nurses being the primary healthcare presence in the majority of prisons. It is imperative that nurses in the prison service utilise the 'Scope of Nursing and Midwifery Practice Framework' to determine and expand their practice to become more competent, reflective practitioners, developing expertise and skills to meet the health needs of the prison population in an holistic manner.

Managers from a healthcare and security perspective in the IPS need to ensure that there are systems in place that will provide support for nurses and midwives in determining and expanding their scope of practice. This is of paramount importance.

Recommendation: Prison management at corporate and local level are aware of, and ensure that nurses are aware of and work within the professional and legal obligations of the scope of nursing and midwifery practice.

Recommendation: Nurses are supported to:

- Evaluate practice to ensure they are educated, competent and have the authority to carry out their range of roles, functions, responsibilities and activities.
- Review, describe and expand their scope of practice to meet the health needs of the prison population.

Guidelines, policies and protocols:

Recommendation: Existing local and national policies, procedures, protocols and guidelines are employed in the IPS to support practice.

Recommendation: In areas where there is an absence of relevant policies, procedures, protocols and guidelines to support practice these should be developed collaboratively with practicing nurses and other health professionals.

9.3. Requirements for role development

9.3.1. Clinical governance

Clinical governance may be defined as 'a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' [77]. There are four main elements to clinical governance to include:

- Clear lines of responsibility and accountability for the overall quality of clinical care
- Clear policies aimed at managing risk (risk to patients, risk to practitioners, and risk to the organisation)
- Procedures for all professional groups to identify and remedy poor performance
- A comprehensive programme of quality improvement activities including
    - Clinical guidelines/evidence based practice
    - Continuing Professional Development
    - Clinical audit
    - Effective monitoring of clinical care
    - Research and development
    - Appropriate use of patient information

Project participants reported significant deficits in relation to the majority of the above elements of clinical governance and their constituents. Many of these need to be addressed in the IPS as a priority.

Quality management systems that ensure continuous audit, evaluation and subsequent improvement of service delivery to the prison population should become an integral aspect of future service development.

Provision to enable prisoners to be involved in the design, delivery and evaluation of services should be explored. Within prison nursing clear lines of responsibility and accountability for the overall quality of nursing care, a comprehensive programme of quality improvement activities and clear policies aimed at managing risk should be developed.

In Ireland many of the related policy and regulatory considerations in relation to excellence in clinical governance are exclusively aimed at the Health Service Executive. These should recognise and include the IPS.

Recommendation: Integrated quality assurance mechanisms, capable of providing regular evaluation and monitoring of prison healthcare, should be introduced to the IPS.

Recommendation: A mechanism is advanced to facilitate the involvement of prisoners in the design, delivery and evaluation of healthcare services.

Recommendation: The Irish Prison Service should be included in any national developments regarding clinical governance.

9.3.2. Management

Several concerns regarding the lack of a nursing management structure were reported by nurses and a number of project participants to include; lack of clinical leadership, lack of professional representation, lack of leadership and guidance in more complex clinical cases, poor communication channels between nurses and senior management, poor care coordination, no management presence to oversee implementation of standards or implement clinical appraisal systems for healthcare staff, difficulty resolving interdisciplinary issues, difficulty introducing service innovations, difficulty conveying their role to security personnel and difficulty carrying out their roles and responsibilities.

During the lifetime of this project, a management structure was established so that each major prison 'complex' (The 'Mountjoy complex' to include Mountjoy prison, the Dochas Centre, the Training Unit and St Patricks, The 'Portlaoise complex' to include the Midlands and Portlaoise prisons and the 'Cloverhill/Wheatfield complex') will have a nursing manager. In addition, each of the closed prisons will have a nursing manager.

Within each prison as specified in the 'prison rules' it is the governor who is responsible for the overall management and quality of prison healthcare and it is his or her duty to see that prisoners receive good healthcare. It is therefore essential that healthcare and nursing managers work closely with and are part of the senior management team of the prison.

The recently introduced management roles should facilitate prison nursing services in the provision of visionary direction for the development of services and the professional development and management of staff.

Recommendation: The concerns identified in relation to the lack of a nursing management structure are addressed by the recently introduced healthcare and nursing managers.

Recommendation: Across the IPS, and within each prison, healthcare management should work collaboratively and in partnership with prison management at corporate and local level to address the findings of this report and to drive the implementation of its recommendations.

9.3.3. Leadership

Strong visionary leadership is needed to build modern, dependable health services within prisons and to inspire and sustain the commitment of all those involved in providing healthcare. This is particularly the case within the IPS with the need to improve quality and practice through clinical governance and provide effective management of clinical services and corporate functions.

The IPS needs corporate leaders at a healthcare and security directorate level who can systemically establish agreed direction and purpose; inspire, motivate and empower teams around common goals; and produce real improvements in clinical practice,

quality and healthcare services. Nursing is one interdependent component of healthcare in the prison system. The development of nursing in this context is inextricably dependent on such leadership at corporate level.

It was recognised by all project participants that significant opportunities exist to improve prison healthcare. Concurrent to this is the recognition that senior prison management both at directorate and local level must consider healthcare to be an integral aspect of incarceration.

A defined strategy for healthcare provision in the IPS clearly communicated to and understood by all prison staff, supported and driven by senior management is essential to the core delivery and integration of prison healthcare in the prison system.

Recommendation: Healthcare is considered an integral aspect of incarceration by those responsible for the planning and provision of services.

Recommendation: A strategic plan is developed for prison healthcare in consultation with key stakeholders nationally.

9.3.4. Workforce planning

The aim of workforce planning is to identify how many nurses are required, when, where and with what skills.

Nurses indicated their existing skills and knowledge were not being used to their full potential regardless of a wide range of professional experience and qualifications being reported. There is currently no provision to assess the skills, knowledge and experience of nurses working in the IPS and organise nursing teams that meet the health needs of the particular prison population.

These findings therefore highlight the limited ability of nursing services to respond to the broad ranging needs of prisoners. Opportunities for increasing the effective utilisation of the range of skills and experience of nurses working in the IPS are considerable. Implementing workforce planning is essential for the future development of nursing services given the diverse healthcare needs of the prison population.

Recommendation: Workforce planning is undertaken in the IPS to ensure there are an appropriate number of nurses in the right place, at the right time, with the right skills to provide care to the prison population.

Recommendation: The prison service effectively utilise the skills and knowledge of nurses within the service and organise nursing teams that meet the health needs of the particular prison population.

Recommendation: Skills, knowledge and experience in the principal identified health needs of the prison population should be considered at recruitment.

9.3.5. Professional issues

9.3.5.1. Skills and competencies

The competencies and the knowledge skills and attitude, needed by nurses working in prisons are similar to those providing care in other environments. What is different is the environment and the therapeutic relationship between the prisoner and the nurse can present additional challenges.

Nurses reported that the breath and diversity of prison nursing requires nurses to have skills and competencies in a broad range of areas. The skills and competencies required by nurses working in the IPS are not clearly understood by nurses and are not clearly articulated by their employers.

The requirement to describe and develop skills and competencies for prison nursing is fundamental to its development. In relation to skill and competency development, an inventory of skills and how to achieve and maintain competence in those skills must be developed reflecting the health needs of the prison population and the role and responsibilities nurses carry out in the service.

Competency development is more multifaceted. A competency is more than knowledge and skills. It involves the ability to meet complex demands by drawing on and mobilising psychosocial resources (including skills and attitudes) in a particular context.

For example the ability to communicate effectively may draw on the individual's knowledge of language and attitudes towards those with whom he or she is communicating with [78].

Identifying and defining skills and competencies is needed to provide links between individual and organisational requirements and to provide recognition of development and learning in whatever organisation it takes place.

From the project a number of skills and competencies emerged and were primarily in relation to:

- Advocacy and assertiveness
- Assessment
- Clinical decision making
- Clinical knowledge acquisition
- Communication particularly communication with the prison population in addition to communication with security personnel and outside agencies
- Conflict management
- Emergency care and responding to crisis situations
- Examination skills
- Interdisciplinary working in a prison environment
- Maintaining a professional approach to practice
- Health education, prevention and promotion
- Management of addiction care
- Management of mental health care
- Management of chronic illnesses care
- Management of infectious diseases care
- Management of women's health
- Pharmacological interventions
- Primary care

There are many clinical tasks (see chapter 6) that require specific competencies and skills and associated level of training and education to achieve these that nurses currently carry out. There is currently no mechanism to assess nurses competence in the workplace in the IPS.

Recommendation: Further work is needed to identify the core skills and competencies for prison nursing. These should be determined by both the health needs of prisoners and by wider developments in healthcare which support multidisciplinary care teams.

Recommendation: A competency framework for prison nursing is developed and the competencies used to inform the design of nursing roles, induction for those roles and continuous professional development.

9.3.5.2. Continuing professional development

Continuing professional development is hugely important in the development of a workforce. The individual nurse has a responsibility to develop themselves as a professional and organisations have a responsibility to access the professional development needs of their staff and to provide appropriate support for staff to enable them to practice to high standards.

Activities that may contribute to a nurse's professional development include formal education programmes, reflective practice, journal clubs, case conferencing, clinical supervision, learning sets, preceptorship, mentorship, workshops, distance learning, professional conferences accessing and sourcing information.

The considerable variability in reported CPD activity, the absence of defined competencies to fulfil prison nursing roles and the absence of formal professional development programmes are a cause for concern. Similarly there was considerable variability in reported CPD activity among medical orderlies. The lack of education facilities and basic resources such as internet access is also concerning.

There is a clear requirement for a flexible, integrated system of education. Prison nursing CPD programmes should reflect service need. This should be achieved through collaboration and partnership between education providers, service planners and the prison healthcare service.

The lack of professional development structures was perceived as a principal barrier to the development of a high quality nursing and healthcare service. Important opportunities for professional development exist at individual and service level and addressing this broad issue will realise an expanded range of clinical services.

Recommendation: An education framework for prison nursing is developed with consideration being given to developing a national postgraduate training programme in prison nursing.

Recommendation: A mechanism is established to enable professional development plans to be developed with staff.

Recommendation: A dedicated post in clinical practice development to support prison management in the planning and delivery of the continuing professional development needs of nurses is established.

Recommendation: Management at local and strategic level support the professional development of all staff.

Recommendation: The ongoing professional development needs of prison nurses should be addressed by appropriate mechanisms. These mechanisms should be geographically inclusive, allowing nurses from all 14 prisons to participate using distance / online learning strategies.

Recommendation: The IPS establishes formal links with education providers. Flexible approaches to learning such as distance / online learning strategies are explored given the geographical spread of the prisons.

Recommendation: Education facilities such as internet access, training / study areas are provided across the IPS.

9.3.6. Factors that facilitate nursing practice

To enable nurses to practice to a higher standard there are fundamental issues that must be addressed in the IPS. Such issues identified in this project are access to prisoners, initial assessment on committal and care planning.

9.3.6.1. Access to healthcare

It is difficult to provide nursing services to a high standard if access to a client group is limited or restricted. This project has shown that limited access to prisoners particularly in closed prisons restricts nursing practice and facilitates a more reactive approach to the provision of healthcare. Furthermore this can result in prisoners being less forthcoming with their healthcare concerns if they have to present and communicate through security staff.

This is an issue that can be addressed with consultation and planning by healthcare and security staff in the IPS with regards to security policies and procedures in individual prisons.

Recommendation: Formalised structures to improve prisoners interface with and access to nurses are developed in conjunction with prison management.

9.3.6.2. Care planning and initial assessment

Comprehensive assessment and care planning is an essential part of healthcare. Nursing documentation to include initial assessment and care plans are imperative to facilitate communication, promote good nursing care and meet professional and legal standards [79].

Through documentation nurses communicate to other nurses and care providers their assessments about the status of patients / clients, nursing interventions that are carried out and the results of these interventions. Comprehensive assessment and care planning increases the likelihood that a prisoner will receive a consistent, informed and quality nursing service. It also decreases the potential for miscommunication and errors.

9.3.6.2.1. Initial assessment

An initial assessment is completed for each prisoner on committal to the IPS. Many concerns were reported in relation to the process including deficiencies in the instruments used during the assessment, lack of training regarding aspects of assessing prisoners particularly those with mental health issues, external pressures influencing the assessment, and the need for follow up assessments in some cases.

Recommendation: The current 'committal assessment' process is revised to facilitate:

- The development of a more comprehensive nursing assessment tool
- The development of formal training in conducting assessments with a particular focus on the area of mental health for nurses with no training in this area
- The provision of adequate facilities and time to conduct the assessment
- The provision of information to prisoners on prison health services and an opportunity to address any immediate health concerns that present
- The provision of guidance to security staff in relation to accommodation and level of observation appropriate to presenting health concerns

9.3.6.2.2. Care planning

Care plans encourage nurses to assess client progress and evaluate which interventions are effective and which are ineffective, and identify and document changes to the plan of care as needed. Documentation can be a valuable source of data for making decisions with regards to resource management as well as facilitating nursing research, all of which have the potential to improve the quality of nursing practice and client care. Individual nurses can use outcome information to reflect on their practice and make needed changes based on evidence.

Care planning is a valuable method for demonstrating that, within the nurse-client relationship, the nurse has applied nursing knowledge, skills and judgement according to professional standards. The nurse's documentation reflects the care the patient / client has received and may be used as evidence in legal proceedings such as law suits, coroners' inquests, and disciplinary hearings through professional regulatory bodies. In a court of law the client's health record serves as the legal record of the care provided.

There is no care planning or systematic review process in place to follow on from the initial assessment. Much of the care is subsequently reactive to presenting conditions following committal.

Recommendation: Formal nursing care plans are introduced.

Recommendation: Care plans are devised in collaboration with the prisoner.

9.4. Professional and workplace culture

9.4.1. The roles of care and custody

The prison environment, one which is controlled by environmental factors such as prison regime, security and prison culture is not a conventional setting in which to provide healthcare. Nurses reported that their nursing education and professional experience had prepared them to practice in certain areas and ways but they had been acculturated into a more restrictive way of practicing. Many reported that it took a considerable length of time to adapt to working in the prison environment.

Balancing the therapeutic healthcare role against that of custody and discipline was reported as challenging. Nurses reported that one can without being aware socialise into the behaviour and role of security staff and forget the values that underpin nursing. Furthermore it was identified that the title of 'nurse officer' implies that security tasks are part of a prison nurses' role.

The majority of nurses consider themselves professionally isolated and marginalised as a professional group both in the prison service and by the broader profession and health workforce. They reported minimal interaction with other healthcare professionals working outside of the prison service and minimal interaction with other nurses working in the service even those working in the same prison.

Such acculturation into restrictive practice, role confusion and professional isolation can have a damaging effect on the provision of nursing services, its development and the perception and acceptance of the profession in the organisation.

It was put forward by nurses that a formalised support structure would enable them to be better supported, gain a better understanding of the prison environment and be less likely to experience any confusion regarding their role in the organisation.

The custody versus care roles in prison is a contentious issue. The reality is that nurses are providing care in a custodial setting and have to integrate their responsibilities. This is not a simple task and requires a certain level of professionalism and understanding. The prison system will always have security as its priority. This does not mean that the health and wellbeing of prisoners should not also be a priority.

Recommendation: Formal mechanisms to support professional networking should be pursued at both local and national level.

Recommendation: A formalised process of support such as clinical supervision is available to all nurses.

9.4.2. Role of security personnel

Prison staff, especially prison officers, are generally (with the exception of the committal assessment) the first point of contact for prisoners with health issues. In addition prison officers are often responsible for observing and reporting changes in a prisoner's health status to healthcare staff.

The presence of security staff is essential for healthcare professionals to carry out their roles and responsibilities in the prison service. The significant contribution of security staff to the efficient and safe delivery of healthcare was recognised by project participants.

However at times incidents which involve an inappropriate response on the part of security staff to health issues presented by prisoners were reported. This can lead to distress, confrontation between healthcare and security staff and most importantly, adverse health outcomes for prisoners.

In the prison workplace nurses have to work within their scope of practice as set out by An Bord Altranais and some security colleagues are not always aware of this.

To prison officers the provision of particular nursing interventions such as educating a prisoner in relation to a new diagnosis or spending a substantial amount of time completing a complex committal assessment may appear to disturb prison routines and regimes. A disparity in roles can subsequently lead to interdisciplinary conflict. This conflict is not always managed and can be destructive in the work environment.

Clarity surrounding the role of security staff in healthcare therefore is needed. This role should be clearly defined in terms of communication with nursing and medical staff, confidentiality, and clear procedures in relation to managing prisoner health issues.

Recommendation: The role of security staff in prison healthcare should be clearly defined, communicated to and understood by all prison staff.

Recommendation: Consideration should be given to formal training in issues related to prison healthcare forming part of prison officers' and prison managers' training and development.

9.4.3. Medical orderlies

Medical orderlies make a valuable contribution to prison healthcare delivery. Their role involves a large number of 'clinical tasks' that involve direct patient contact. However, their lack of formal medical training is a cause for some concern in this regard and role clarification and formalised training is a priority.

Recommendation: The role of medical orderlies in prison healthcare delivery is reviewed as a priority, with consideration given to establishing an accredited training programme if this grade is to be continued.

9.5. Prison healthcare infrastructure development

9.5.1. Administrative support

The level of administrative assistance to support healthcare provision in the service was reported by many as poor and an inefficient use of resources. Nurses in particular have to dedicate what was reported as an excessive amount of time on administration / clerical duties. Administrative personnel would enable a more organised, consistent and coordinated approach to administrative functions. This would facilitate nurses and other healthcare staff to better utilise their skills, knowledge and experience.

Recommendation: Increased access to administrative / clerical assistance to support the provision of healthcare in the service is provided.

9.5.2. Facilities

Inadequate physical environments in which to deliver healthcare were reported. The development and delivery of health interventions (such as health promotion programmes, phlebotomy clinics or health screening clinics) require adequate, suitable space that is clean, warm and appropriate. In many prisons sourcing suitable space is difficult or the available facilities are inadequate and limit the range of potential services that could be delivered to the prison population.

Recommendation: Current healthcare facilities are reviewed in terms of adequate space, physical condition, provision of equipment and hygiene.

Recommendation: Healthcare staff inform the design and planning of healthcare facilities. The healthcare needs of the population in the particular prison should also be incorporated.

9.5.3. Discharge planning

Although central to continuity of care, discharge planning was reported as inefficient, uncoordinated and disjointed, with the result prisoners may receive inappropriate follow up of medical problems in the community. This is a particular concern in the case of mental illness and problem drug use, where undiagnosed / untreated illness can perpetuate the risk to the person and to others and potential for a cycle of repeated criminal activity. A structured, coordinated discharge planning system where prisoners' healthcare needs are met in the community after imprisonment may reduce this risk and potential repeated criminal activity.

Recommendation: A structured, coordinated interdisciplinary discharge planning system where prisoners health and other needs are met in the community following discharge is developed.

Recommendation: Discharge planning is incorporated into the role of health professionals in the service.

9.5.4. Communication

Healthcare staff reported communication channels within the organisation were neither clearly defined nor open.

Effective communication is a significant factor affecting work place culture and staff input into service delivery. Lack of effective communication contributes to grievances, perceptions of isolation, inefficiency and resistance to change and continuous improvement [80].

Communication should be three way: up, down and across. This requires a mix of formal and informal methods from briefings and team meetings to intranets and newsletters and to an agreed and documented understanding regarding the culture within which managers and staff interact in everyday service delivery.

Recommendation: Communication strategies are improved in the IPS to facilitate communication channels that are clearly defined and open.

9.6. Role of the HSE

The IPS has a statutory responsibility for prison healthcare. While this statutory recognition of prison healthcare is welcome, the priority for the IPS will always be safe and secure custody. The potential role of the HSE in prison healthcare has been recognised and while initiatives to progress this issue have been pursued, the HSE still remains peripheral to prison healthcare delivery.

A number of reasons were advanced for HSE involvement by the participant groups and these included:

- Boundaries regarding healthcare and security would be more transparent ;
- A more consistent and equitable approach to healthcare provision throughout the system;
- It would allow for a more comprehensive seamless, continuing healthcare delivery structure for those being cared for in the prison service and requiring follow up in the community;
- It would remove some of the mistrust prisoners may have in relation to healthcare staff as prisoners can perceive them to be part of the prison system;
- Standards could be monitored and improved;
- Health would be the responsibility of the HSE and security would be the responsibility of the Department of Justice, Equality and Law Reform.

Achieving a healthcare system in Irish prisons equivalent to healthcare in the community poses a significant but important challenge. It is difficult to envisage how this will be achieved without the HSE having a central role in healthcare in the IPS. The role of the HSE in healthcare in Ireland mandates it should be a key agency in overseeing and delivering healthcare across the IPS.

Concurrent to formalising the role of the HSE is the need to formalise the role of the Department of Health and Children which is at the fore of health service provision in Ireland in relation to prison healthcare.

Recommendation: A formal partnership between the IPS and the HSE is established.

Recommendation: The role of the Department of Health and Children is clarified in relation to:

- Advising on the strategic development of the prison health system including policy and legislation
- Evaluating the performance of health and social services to this population and
- Working with other sectors to enhance prisoners health and wellbeing

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CO-FUNDED BY

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