The Implementation of Correctional Nursing Practice in Alberta: A Grounded Theory Study

Dhaliwal, Kirnvir Kaur

doctoral thesis

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The Implementation of Correctional Nursing Practice in Alberta: 
A Grounded Theory Study 

by 

Kirnvir Kaur Dhaliwal 

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Abstract

Introduction: In three Canadian provinces, offenders in provincial custody receive healthcare services from health authorities, rather than correctional services. Alberta made the care transition to the health authority in 2010. The governance of correctional healthcare services by health authorities, and not the correctional services, may be advantageous as healthcare professionals are possibly less likely to experience tension between corrections (custody) and health (caring) priorities. There is uncertainty about if and how this tension between custody and caring still exists and is experienced by Canadian registered nurses (RNs) practicing in provincial custody with healthcare governance by health authorities. Therefore, the aim of this doctoral research was to study how RNs implement their nursing practice in the Alberta provincial custody correctional system.

Method: Straussian grounded theory approach was used. Simultaneous data collection and analysis were undertaken using theoretical sampling, constant comparison, and memo writing. RNs (n = 13) engaged in semi-structured telephone interviews, focused on the experience of implementing their correctional nursing practice and providing nursing care to offenders. Data were collected until saturation occurred. Analytic coding (open, axial, and final theoretical integration) was performed to identify the core category (Caring Behind Bars) and its six subcategories around which the substantive theory was developed.

Findings: The theory of Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population. RNs possessed a foundational stance regarding what nursing practice means to them in
general. Upon entering the correctional context, RNs experienced tension between custody and caring. RNs engaged in adaptability and advocacy to address this tension and access the offender population. The provision of care required RNs to take numerous actions – interactions to provide care to offenders. The consequences of Caring Behind Bars were challenging and positive outcomes. Significance: The research resulted in the development of foundational knowledge to advance Canadian correctional nursing practice and offered potential insights into promoting offender health.

Keywords: Canada, Correctional nursing, Grounded theory
Preface

Chapter 2. Portions of the text are used from Dhaliwal and Hirst (2016) of which I am first author. Permission to use these portions of text was received via email from the Editor (Journal of Forensic Nursing), and Publisher (Wolters Kluwer) on 2019/November/12.

Chapter 3. Portions of the text are used from Dhaliwal, King-Shier, and Hirst (2019) of which I am first author. Permission to use these portions of text was received via email from the Editor (Journal of Forensic Nursing), and Publisher (Wolters Kluwer) on 2019/November/12.

Chapter 5: Portions of the text are used from Dhaliwal and Hirst (2019) of which I am first author. Permission to use these portions of text was received via email from the Publisher (Wiley) on 2019/November/15. © 2018 Wiley Periodicals, Inc.

This thesis is original, otherwise unpublished, independent work by the author, K. K. Dhaliwal. The doctoral study was approved by The Conjoint Health Research Ethics Board (CHREB), University of Calgary Ethics ID: REB18-1593 on 2018/November/08.
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**List of Common Abbreviations**

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<th>Full Form</th>
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<tr>
<td>AHS</td>
<td>Alberta Health Services</td>
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<tr>
<td>ABJSG</td>
<td>Alberta Justice and Solicitor General</td>
</tr>
<tr>
<td>CARNA</td>
<td>College and Association of Registered Nurses of Alberta</td>
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<tr>
<td>CSC</td>
<td>Correctional Service Canada</td>
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<td>GT</td>
<td>Grounded theory</td>
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<tr>
<td>RN</td>
<td>Registered nurse</td>
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<td>WHO</td>
<td>World Health Organization</td>
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List of Definitions

Caring: The implementation of correctional nursing practice including, the provision of care (Peternelj-Taylor, 2019); and “RNs are expected to attend, provide for, and take responsibility for the care of their patients through such behaviors as trust, concern, compassion, nurturing, and presence” (Maroney, 2005, p. 158).

Client: “The term client can refer to patients, residents, families, groups, communities and populations” (College and Association of Registered Nurses of Alberta, 2011, p. 2).

Custody: The correctional/corrections services duties and priorities such as, confinement and security (Peternelj-Taylor, 2019).

Implement: “Carry out, accomplish: especially to give practical effect to and ensure of actual fulfillment by concrete measures” (“Implement,” 2020, para. 1).

Implementation: “An act or instance of implementing something: the process of making something active or effective” (“Implementation”, 2020, para. 1).

Ministry of Health: “The Ministry of Health works to ensure Albertans receive the right health care services, at the right time, in the right place, provided by the right health care providers and teams. Alberta Health is responsible for: setting policy, legislation and standards for the health system in Alberta, allocating health funding, administering provincial programs such as the Alberta Health Care Insurance Plan, providing expertise on communicable disease control, and implementing and ensuring compliance with government policy. Health services are planned and delivered by Alberta Health Services. Some public health services may also be provided by private health care clinics, for example, dentists' offices” (Alberta Health, 2020, para. 12-14).
Nursing practice: “Registered nurses do one or more of the following: (a) based on an ethic of caring and the goals and circumstances of those receiving nursing services, registered nurses apply nursing knowledge, skill and judgment to (i) assist individuals, families, groups and communities to achieve their optimal physical, emotional, mental and spiritual health and wellbeing, (ii) assess, diagnose and provide treatment and interventions and make referrals, (iii) prevent or treat injury and illness, (iv) teach, counsel and advocate to enhance health and well-being, (v) coordinate, supervise, monitor and evaluate the provision of health services, (vi) teach nursing theory and practice, (vii) manage, administer and allocate resources related to health services, and (viii) engage in research related to health and the practice of nursing, and (b) provide restricted activities authorized by the regulations” (Alberta Queen’s Printer *Health Professions Act*, 2000, pp. 268–269).

Offender: An individual serving time within a correctional institution.

Registered nurse: “An applicant for registration as a regulated member on the registered nurse register must (a) have successfully completed as an education requirement either (i) on and before December 31, 2009, a diploma or baccalaureate degree in nursing from an approved nursing program undertaken in Alberta, or (ii) on and after January 1, 2010, a baccalaureate degree in nursing from an approved nursing program undertaken in Alberta, and (b) pass the registration exam” (Alberta Queen’s Printer *Health Professions Act* – Registered Nurses Profession Regulation, 2005, p. 4).

Tension: “unrest or imbalance,” and “a state of latent hostility or opposition” (“Tension,” 2020, para. 1).
Chapter 1 Introduction

Alberta transitioned the governance of provincial custody correctional healthcare services from the Ministry of Justice and Solicitor General to the Ministry of Health in 2010. The governance of correctional healthcare services by health authorities, and not the correctional services (College of Family Physicians of Canada [CFPC], 2016; Independent Review of Ontario Corrections, 2017; McLeod & Martin, 2018; Pont, Stöver, & Wolff, 2012; Pont et al., 2018; World Health Organization [WHO], 2007; WHO, 2013; WHO, 2014) may be advantageous as healthcare professionals are possibly less likely to experience tension between their corrections (custody) and health (caring) priorities (Flegel & Bouchard, 2013; Office of the Correctional Investigator [OCI], 2013; Pont et al., 2012; Pont et al., 2018; WHO, 2013). Tension can be defined as “unrest or imbalance,” and “a state of latent hostility or opposition” (“Tension,” 2020, para. 1).

Custody refers to correctional/corrections services duties and priorities such as, confinement and security (Peternelj-Taylor, 2019). Caring refers to the implementation of correctional nursing practice including, the provision of healthcare services (Peternelj-Taylor, 2019). Specifically, “RNs are expected to attend, provide for, and take responsibility for the care of their patients through such behaviors as trust, concern, compassion, nurturing, and presence” (Maroney, 2005, p. 158). A widely held assumption exists that custody and caring are adversarial rather than collaborative, and that custody must rule (Maroney, 2005); this is not surprising in that RNs practice in environments that do not prioritize health and wellbeing (See Chapter 2 Literature Review and Chapter 5 Discussion).
Improving nursing care for offenders requires more correctional nursing research (Weiskopf, 2005). Yet, there is a dearth of research in Canada, especially in the provincial custody context (Pterenelj-Taylor & Woods, 2019). Moreover, resolving the ongoing tension between custody and caring requires educational intervention and research (Maroney, 2005). There is uncertainty about if and how this tension between custody and caring still exists and is experienced by Canadian registered nurses (RNs) practicing in provincial custody with healthcare governance by health authorities. Therefore, the aim of this research was to study how RNs implement their nursing practice in the Alberta provincial custody correctional system.

**Correctional System**

Jurisdiction over correctional institutions is shared between the Canadian federal, provincial, and territorial governments (Kouyoumdjian & McIsaac, 2017; Kouyoumdjian, Schuler, Hwang, & Matheson, 2015; Kouyoumdjian, Schuler, Matheson, & Hwang, 2016). Provincially or territorially, correctional services are directed at offenders serving sentences of less than two years, and those who are detained in remand (Alberta Justice and Solicitor General [ABJSG], 2020a; Kouyoumdjian & McIsaac, 2017; Kouyoumdjian et al., 2015; Kouyoumdjian et al., 2016; Owusu-Bempah et al., 2014). Offenders admitted to correctional institutions prior to sentencing are considered detained in remand, rather than incarcerated (Kouyoumdjian et al., 2015). Federally, correctional services (i.e., Correctional Service Canada [CSC]) are directed at offenders serving sentences of two years or more (CSC, 2017a; Kouyoumdjian & McIsaac, 2017; Kouyoumdjian et al., 2015; Kouyoumdjian et al., 2016; Owusu-Bempah et al., 2014). The *Corrections and Conditional Release Act* (CCRA) is the law that regulates the CSC (CSC, 2017a).
Health Status of the Offender Population

The health status of the Canadian offender population is poor relative to the general population (Canadian Human Rights Commission [CHRC] & OCI, 2019; Flegel & Bouchard, 2013; Kouyoumdjian et al., 2016). Canadian offenders have poorer outcomes as per the data regarding the determinants of health (Kouyoumdjian et al., 2016), and poorer mental and physical health (Flegel & Bouchard, 2013). The majority of offender health research has been conducted with those in federal custody due to several reasons such as, longer periods of incarceration that provide more time to assess health and conduct research, and greater accessibility of administrative and health data as compared to those in provincial custody (Kouyoumdjian et al., 2015).

Determinants of health. “Determinants of health are the broad range of personal, social, economic and environmental factors that determine individual and population health” (Government of Canada, 2019, para. 2). Researchers have studied determinants of health for federal offenders (Martin, Dorken, Colman, McKenzie, & Simpson, 2014; Stewart, Nolan, Thompson, & Power, 2018). For example, Stewart et al. (2018) reported two determinants (i.e., early childhood development and socioeconomic status) were associated with the most physical health conditions. Federal male offenders who reported being abused during childhood were almost twice as likely to report a blood borne illness (e.g., human immunodeficiency virus/acquired immune deficiency syndrome and hepatitis C virus) as compared to those who had not been abused (Stewart et al., 2018). Federal offenders have reported socioeconomic status issues such as, unstable job history and unemployment, financial instability, and the use of social assistance (Martin et al.,
Offenders also experience homelessness and poverty (Peternelj-Taylor, 2019).

**Chronic and communicable conditions.** Researchers have studied chronic conditions experienced by federal offenders (Nolan & Stewart, 2017; Stewart et al., 2015). Yet, the data are limited regarding chronic diseases in the offender population, especially in provincial custody (Kouyoumdjian et al., 2015). Federal male offenders have identified the most common chronic health conditions as head injury, back pain, asthma, and hepatitis C virus infection (Stewart et al., 2015). Hepatitis C virus and human immunodeficiency virus testing among new admissions into federal custody increased from 37% to 78% since the years 2000 to 2014 (CSC, 2016a; CSC, 2016b). The overall trend in hepatitis C virus prevalence indicated a decline to 18.2% in 2014 (CSC, 2016a). Moreover, the overall trend in annual human immunodeficiency virus prevalence since 2007 indicated a decline to 1.19% in 2014 (CSC, 2016b). Federal offenders were diagnosed with 45 active tuberculosis cases between the years 1998 and 2014 (CSC, 2017b).

**Mental health.** Canadian correctional institutions have become repositories for individuals with mental illness (Peternelj-Taylor, 2019). Individuals who experience chronic mental illness are usually well known by the courts, correctional institutions, emergency departments, mental healthcare services, and the police (Peternelj-Taylor, 2019). Individuals with mental illness are over-represented in the criminal justice system, hence there is a higher proportion of people living with such issues in this system than in the general Canadian population (Mental Health Commission of Canada, 2012). Researchers have studied mental illness experienced by offenders in federal custody.
Federal male offenders experience higher rates of mood and psychotic disorders relative to the general population (Beaudette & Stewart, 2016). Beaudette and Stewart (2016) reported that more than 40% of federal male offenders ($n = 1110$) met the diagnostic criteria for a mental disorder other than personality or substance use disorders. Brown et al. (2015) also estimated that about 41.1% of the general provincial offender population in Ontario, evidenced current, severe symptoms of mental illness.

**Older adults.** Canadian correctional institutions are fulfilling the functions of nursing homes, hospices, or long-term care facilities (CHRC & OCI, 2019). There is no legal or policy recognition that older adults represent a vulnerable population in federal custody (CHRC & OCI, 2019). The proportion of older offenders in federal custody (50 years of age and older) is growing (CHRC & OCI, 2019). Stewart et al. (2015, 2018) reported federal male offenders, 50 years of age and older, experience higher rates of chronic conditions (e.g., cardiovascular related) than younger offenders. Moreover, these older offenders experience higher rates of other chronic conditions such as, arthritis, prostate problems, and history of cancer, as compared to younger offenders (Stewart et al., 2015). Older offenders in federal custody also appear to have high rates of depression, anxiety, and personality disorders (CSC, 2017 as cited in CHRC & OCI, 2019). Research is also required regarding older offenders in provincial custody.

**Women’s health.** Female offenders constitute a small, but growing percentage of the offender population, thus the majority of research (Nolan & Stewart, 2017) and health needs have focused on male offenders (Besney et al., 2018). Besney et al. (2018) identified that provincial female offenders experienced high rates of various health
concerns: mental illness, partner violence, substance use, sexually transmitted infection, and irregular Pap testing. Barriers to care in provincial custody include lack of comprehensive gender specific services, mistrust of providers, and fragmentation of healthcare services (Besney et al., 2018). Federal female offenders have also identified common chronic health conditions as back pain, head injury, hepatitis C virus, and asthma (Nolan & Stewart, 2017). Nolan and Stewart (2017) reported the prevalence rates of these chronic health conditions for female offenders were similar to, or higher than male offenders, yet notable exceptions were higher rates of head injury for men, and higher rates of hepatitis C virus infection for women. Federal female offenders continue to have a higher prevalence of hepatitis C virus (CSC, 2016a) and human immunodeficiency virus (CSC, 2016b) as compared to male offenders (CSC, 2016a; CSC, 2016b).

**Indigenous offenders.** Indigenous individuals are over-represented in federal custody (Besney et al., 2018; Motiuk & Hayden, 2016; OCI, 2018; Owusu-Bempah et al., 2014) and provincial custody (Besney et al., 2018; Owusu-Bempah et al., 2014). The federal Indigenous offender population has increased (OCI, 2018). Over the past decade, federal Indigenous offenders 50 years of age and older have increased (CHRC & OCI, 2019). An Indigenous Canadian may lose considerably more life-years to incarceration than a non-Indigenous Canadian (Owusu-Bempah et al., 2014). The disproportionate level of Indigenous incarceration has adverse health and social consequences (Owusu-Bempah et al., 2014).

Stewart et al. (2018) revealed that federal male offenders of Indigenous ancestry were significantly more likely than non-Indigenous offenders to have experienced poorer
health associated with all of the determinants of health. Indigenous offenders are also more likely to show more current, severe symptoms of mental illness compared to non-Indigenous offenders (Brown et al., 2015). Beaudette and Stewart (2016) reported a considerably higher rate of alcohol and substance use disorders, as well as pathological gambling and personality disorders among federal Indigenous male offenders. Federal Indigenous male offenders have also self reported higher rates of alcohol use as compared to non-Indigenous offenders (Stewart et al., 2015). In two studies, federal Indigenous female (Nolan & Stewart, 2017) and male (Stewart et al., 2015) offenders reported higher rates of hepatitis c virus as compared to their non-Indigenous counterparts. A greater proportion of federal Indigenous female offenders have reported diabetes than non-Indigenous females (Nolan & Stewart, 2017). Federal Indigenous male offenders have also reported higher rates of head injury as compared to non-Indigenous offenders (Stewart et al., 2015).

**Ethnic minorities.** Relative to the Canadian population, White and Asian offenders are under-represented in federal custody, while Black offenders are disproportionately represented (Trevethan & Rastin, 2004). Trevethan and Rastin (2004) stated that “visible minority [federal] offenders seem to be less entrenched in a criminal lifestyle than Caucasian offenders” (p. ii). Visible minority federal offenders may require different types of programs or services to have their needs met (Trevethan & Rastin, 2004). Important characteristics of Canadian offenders such as race and ethnicity are minimally known, yet are required for planning health and social services in custody, and in the community after release (Kouyoumdjian & McIsaac, 2017). An understanding of
race and ethnicity of offenders in federal and provincial custody may assist in the provision of appropriate healthcare services.

**Correctional Healthcare Services**

Kouyoumdjian et al. (2016) reported that correctional healthcare services may be delivered in three ways: by the governmental authority responsible for health; by the governmental authority responsible for correctional services; or contracted out to a private company as previously done in British Columbia. In provincial custody, federal legislation such as, the *Canada Health Act*, is applicable to healthcare delivery, and provincial or territorial legislation might also apply (Kouyoumdjian et al., 2016). When in provincial custody, offenders are usually provided healthcare services by the correctional services authority, other than in three provinces. In Alberta, the provision of correctional healthcare services is not identified as a main function of the provincial custody correctional system (ABJSG, 2020b), yet general supports are listed such as, addictions and mental health, and healthy living (ABJSG, 2020a). The lack of emphasis on correctional healthcare services may be due to the transitioned governance of correctional healthcare services from the Ministry of Justice and Solicitor General to the Ministry of Health. When in federal custody, offenders are excluded from the *Canada Health Act*, thus are not covered by provincial health authorities (OCI, 2013). As per the CCRA, CSC provides healthcare services for offenders serving time in federal custody (CSC, 2020).

All provincially sentenced and the majority of federally sentenced offenders are eventually released into the community (CFPC, 2016; Flegel & Bouchard, 2013). Therefore, a well-organized and coordinated correctional healthcare system is required
that will enable follow up from incarceration to release into the community (Flegel & Bouchard, 2013). Healthcare professionals are well positioned to deliver quality care to offenders with no or limited access to healthcare services (Flegel & Bouchard, 2013), including opportunities for RNs to promote the health and wellbeing of the offender population. The CFPC (2016) argued that quality of care within correctional institutions is below the community standards, regardless of the efforts of healthcare professionals. Therefore, the governance of correctional healthcare services by health authorities, and not the correctional services (CFPC, 2016; Independent Review of Ontario Corrections, 2017; McLeod & Martin, 2018; Pont et al., 2012; Pont et al., 2018; World Health Organization [WHO], 2007; WHO, 2013; WHO, 2014) may be advantageous for several reasons such as, to address tension between custody and caring:

- decreased chance of role conflict between corrections (custody) and health (caring) priorities (OCI, 2013; WHO, 2013) as healthcare professionals will be more exposed to the values and ethics that guide their usual practice (Flegel & Bouchard, 2013);
- decreased risk of corrections (custody) priorities overriding health (caring) priorities (OCI, 2013; Pont et al., 2012);
- decreased risk of corrections (custody) constraints inappropriately interfering with clinical independence (caring) (Pont et al., 2018; WHO, 2013);
- to improve quality of care for offenders (Pont et al., 2012; WHO, 2007; WHO, 2014);

Whether these advantages (e.g., decrease in tension between corrections [custody] and health [caring]) would be true outcomes of Canadian correctional healthcare governance by health authorities requires exploration. To date, Nova Scotia, Alberta, and British Columbia, have transitioned their provincial custody healthcare services from correctional services authorities to health authorities (Government of British Columbia News, 2017; Kouyoumdjian et al., 2016; McLeod & Martin, 2018; OCI, 2013; University of British Columbia News, 2014). To date, there is no published literature regarding the outcomes of these transitions.

**Correctional Nursing Practice**

Forensic nursing is the practice of nursing where the domains of criminal justice and healthcare intersect, which includes the branch of correctional nursing (Peternelj-Taylor, 2019). Forensic nurses who care for offenders in correctional institutions are often identified as correctional or prison nurses (Shelton, 2009; Weiskopf, 2005). In North America, forensic psychiatric nursing/correctional nursing is the “care of people who have come into conflict with the law and are in the legal process of being remanded for psychiatric assessment, or are sentenced and incarcerated and require healthcare treatment during that time” (Kent-Wilkinson, 2009, p. 208).
Nursing care within correctional institutions is provided based on professional standards, and correctional healthcare and institutional policies and procedures (Dhaliwal & Hirst, 2016). RNs practicing within Canadian correctional institutions are primary healthcare professionals (Iftene & Manson, 2013), and play a key role in providing care (“Caring in Corrections,” 2010). Nursing care is also provided by nurse practitioners. Nurse practitioners are being integrated into correctional institutions such as CSC (University of Saskatchewan News, 2017). The role of nurse practitioners in Canadian correctional institutions is novel, and requires further exploration regarding cost effectiveness, quality of care, and accessibility (University of Saskatchewan News, 2017).

Healthcare professionals are challenged to provide care in settings whose primary purposes are security and control of the institutions and offenders, which creates “role conflict and confusion, and invites ethical and professional dilemmas” (OCI, 2013, para. 29). Likewise, nurses practicing within correctional institutions must address the rival demands of custody and caring (Peternelj-Taylor, 2019). For example, for RNs practicing in federal custody (i.e., CSC) settings, the dual role of agent of care and agent of social control (Holmes, 2002; Holmes, 2005; Holmes, Perron, & Michaud, 2007) challenges the nursing concept of caring (Holmes, 2002). There is uncertainty about if and how this tension between custody and caring still exists and is experienced by Canadian RNs practicing in provincial custody with healthcare governance by health authorities. The concerns should be diminished with such governance (Flegel & Bouchard, 2013; OCI, 2013; Pont et al., 2012; Pont et al., 2018; WHO, 2013). Therefore, the aim of this
research was to study how RNs implement their nursing practice in the Alberta provincial custody correctional system.

**Chapter Summary**

Jurisdiction over correctional institutions is divided among the Canadian federal, provincial, and territorial governments. Offenders experience poorer health outcomes as compared to the general population. Correctional services authorities or health authorities govern and deliver correctional healthcare services. Alberta is one of three provinces who transitioned their governance of provincial custody correctional healthcare services from a correctional services authority to a health authority. The governance of correctional healthcare services by health authorities may be ideal for various reasons (e.g., decreased tension between custody and caring). There is uncertainty about if and how this tension between custody and caring still exists and is experienced by Canadian RNs practicing in provincial custody with healthcare governance by health authorities. As a result, the aim of this research was to study how RNs implement their nursing practice in the Alberta provincial custody correctional system.
Chapter 2 Literature Review

Researchers undertaking GT research must understand the controversy of the literature review as it may impact the research process. The initial review of the international correctional nursing literature was published in the *Journal of Forensic Nursing* (See Preface). The findings of the initial review and its updated version revealed the study problem. The problem (i.e., tension between custody and caring) was identified to support the need for this study.

**Controversy of the Literature Review**

A literature review is required to demonstrate the depth of the substantive area, including gaps in knowledge, and to justify the selected research topic and method (Xie, 2009). However, the need for a literature review in GT research has always been disputed (Charmaz, 2006). The controversy of undertaking a literature review may be best understood upon learning about the different GT approaches.

Initially, Glaser and Strauss (1967) stated “to ignore the literature of theory and fact on the area under study [is] to assure that the emergence of categories will not be contaminated by concepts more suited to different areas” (p. 37). Researchers using the Classical GT approach must avoid undertaking a literature review due to the risk of preconceived notions impeding the development of the GT (Cutcliffe, 2000; Glaser & Holton, 2004; Reay, Raffin Bouchal, & Rankin, 2016; Xie, 2009). The completion of an extensive literature review violates the basic premises of Glaser’s Classical GT approach such as, hindering theoretical sensitivity (Glaser & Holton, 2004). The literature can be reviewed later in the research process upon emergence of the GT (Cutcliffe, 2000; Glaser
Corbin and Strauss (2015) acknowledged that researchers using the Straussian GT approach bring knowledge of the technical and nontechnical literature prior to engaging in any inquiry. Charmaz (2006) agreed that researchers can use a literature review in Constructivist GT research to fulfill several objectives such as, demonstrating a grasp of the knowledge base. Researchers are advised to delay writing the literature review chapter until after data analysis (Charmaz, 2006). Yet, all authors (Charmaz, 2006; Corbin & Strauss, 2015; Glaser & Strauss, 1967) voiced the risk of over divulgence in the literature: a literature review should not “stifle creativity or strangle the theory” (Charmaz, 2006, p. 166), and researchers must not become deeply immersed and constrain the research process such as, being distracted from data analysis (Corbin & Strauss, 2015).

Researchers must rationalize the inclusion or exclusion of a literature review based on the chosen GT approach to ensure a rigorous research process. Dhaliwal and Hirst (2016) undertook the initial literature review, which provided insight regarding the issues of correctional nursing practice and revealed a lack of Canadian content. The literature review and its updated version assisted in the development of the research proposal. Moreover, a review of additional literature was used to situate the findings from this study (See Chapter 5 Discussion).

**Initial and Updated Literature Reviews**

Dhaliwal and Hirst (2016) undertook a systematic search and narrative synthesis of the published international correctional nursing literature. “The focus was on
correctional nurses portraying caring, caring for, and working with adult offenders in secure correctional environments” (Dhaliwal & Hirst, 2016, p. 6). Thirty one of the 42 identified publications were non-research, and only six non-research and two research articles provided Canadian content (Dhaliwal & Hirst, 2016). Three main themes with multiple subthemes emerged: the struggle of custody and caring; the need to be nonjudgmental towards offenders; and the importance of boundaries between nurses and offenders (Dhaliwal & Hirst, 2016).

An updated literature review was undertaken with specific time limits (November 1, 2014 to January 31, 2018). Several concluding points arose based on the new literature: the new literature aligned with the initial review findings; the tension between custody and caring continued to be a focus in the literature; the literature continued to be on the lower levels of the hierarchy of evidence such as, no clinical trials, or large-scale studies; and there was no Canadian content. The concluding points are relevant to this study: the problem (i.e., tension between custody and caring) was identified to support the need for this study in Alberta with healthcare governance by a health authority; and this study addresses the lack of Canadian correctional nursing research.

Study Problem – Tension Between Custody and Caring

Internationally, authors of corrections health and correctional nursing literature have discussed the opposition between corrections (custody) and health (caring) (Alexander-Rodriguez, 1983; Brodie, 2001; “Caring in Corrections,” 2010; Day, 1983; Dale & Woods, 2002; Dhaliwal & Hirst, 2016; Doyle, 1999; Doyle, 2003; Foster, Bell, & Jayasinghe, 2013; Holmes, 2005; Holmes et al., 2007; Jacob, 2012; Jacob, 2014; Maeve, 1997; Maeve & Vaughn, 2001; Maroney, 2005; OCI, 2013; Peternelj-Taylor, 1999;
Peternelj-Taylor & Johnson, 1995; Peternelj-Taylor & Johnson, 1996; Pont et al., 2012; Pont et al., 2018; Schoenly, 2015; Stevens, 1993; Walsh, 2009; Walsh, Freshwater, & Fisher, 2012; Weiskopf, 2005; Willmott, 1997; White & Larsson, 2012; WHO, 2007; WHO, 2013) – such discussion further reinforced the need for this study. For example, Dhaliwal and Hirst (2016) undertook the initial literature review resulting in the emergence of a primary theme entitled “the struggle of custody and caring.” Correctional nurses experience the struggle of custody and caring due to several concerns: conflicting ethical and philosophical ideologies; correctional priorities override nursing priorities; and safety and security issues (Dhaliwal & Hirst, 2016).

**Conflicting ethical and philosophical ideologies.** Correctional nursing practice is complex due to various ethical issues (Brodie, 2001; Walsh et al., 2012) such as, respecting offender autonomy in environments that are designed to restrict daily life privileges, and addressing the institutional demands of control, coercion, and security while providing care (Walsh et al., 2012). Correctional nurses may experience a loss of ownership of their practice because nursing practice philosophy focused on the promotion of health and wellbeing is compromised to mitigate or accommodate the philosophical priorities of correctional institutions (i.e., compliance, segregation, security, and discipline) (Doyle, 1999). Moreover, healthcare professionals (e.g., nurses) are not always honoured for their efforts in providing care (Maeve & Vaughn, 2001), especially when offenders are stigmatized due to mental illness (Melnikov, Elyan-Antar, Schor, Kigli-Shemesh, & Kagan, 2017) and are not viewed as valuable within society (Maeve & Vaughn, 2001). The ideological intrusion of a disciplinary philosophy is antithetical to the values of nursing practice (Doyle, 1999; Doyle, 2003).
Correctional priorities dominate nursing priorities. Aligning with the conflicting ethical and philosophical ideologies, correctional priorities often override nursing priorities (Dhaliwal & Hirst, 2016). Correctional nurses may encounter problems adapting to security procedures as these outweigh healthcare delivery (Dale & Woods, 2002). Correctional healthcare is dominated by prison architecture and “the artifice of surveillance and control” (Doyle, 2003, p. 308), which focuses on the “control of masses through the application of strict regulations” (Jacob, 2014, p. 49). As a result, nurses may experience difficulty in portraying caring towards offenders and implementing individualized care plans (Jacob, 2014).

Safety and security issues. The safety and security procedures of correctional institutions dominate healthcare delivery (Brodie, 2001; Dale & Woods, 2002; Flanagan & Flanagan, 2001). For example, correctional officers may place offenders in segregation because of disruptive behaviour that may be compromising the safety of staff and other offenders (Dhaliwal & Hirst, 2016). However, correctional nurses may believe this behaviour is due to mental illness requiring therapeutic interventions, and not segregation (Dhaliwal & Hirst, 2016). The primary purpose of correctional institutions is not healthcare delivery (Brodie, 2001), thus the unique culture of correctional environments may not always be well suited to the aspirations of nursing practice (Dale & Woods, 2002). Brodie (2001) suggested that correctional nurses may experience role strain because they are practicing in environments that do not prioritize health and well-being, which is the primary purpose of nursing practice. As a result, correctional nurses may adapt to the environments by modifying their behaviour, beliefs, and values to diminish this role strain (Brodie, 2001). In correctional institutions, therapy is mandated (i.e.,
healthcare services must be provided), yet safety and security are emphasized, and this emphasis may cause difficulty in maintaining the therapeutic culture known to nurses (Jacob, 2014).

In conclusion, correctional nurses may experience challenges in facilitating offenders’ health and well-being (Weiskopf, 2005), and must possess specialized knowledge to deliver quality care (Almost et al., 2013; Schoenly, 2015), especially when faced with tension between corrections (custody) and health (caring). The available evidence for any discipline has important implications for developing practice guidelines and clinical recommendations (Evans, 2003), and understanding and addressing challenges to advance the discipline (Dhaliwal, King-Shier, & Hirst, 2019). Yet, there is a dearth of robust research, which fails to provide an evidence base for correctional nursing practice (Almost et al., 2013; Peternelj-Taylor & Woods, 2019; Schoenly, 2015; Weiskopf, 2005), especially in Canada and the provincial custody context (Peternelj-Taylor & Woods, 2019).

The pursuit of basic research can lead to the development of specialized knowledge to advance Canadian correctional nursing practice. Basic research can aide in identifying, understanding, and addressing any problems (e.g., tension between custody and caring) experienced by Canadian RNs, and to promote offender health. There is uncertainty about if and how this tension between custody and caring still exists and is experienced by Canadian RNs practicing in provincial custody with healthcare governance by health authorities. Therefore, the aim of this research was to study how RNs implement their nursing practice in the Alberta provincial custody correctional system.
**Research Question**

The research question is “How do registered nurses implement their nursing practice in the Canadian (Alberta) provincial custody correctional system?”

**Chapter Summary**

Researchers undertaking GT research must understand the controversy of the literature review as it may impact the research process. The use of a literature review remains controversial in the Classical GT approach, yet it is more accepted in the Straussian and Constructivist GT approaches. Dhaliwal and Hirst (2016) undertook the initial literature review, which provided insight regarding the issues of correctional nursing practice and revealed a lack of Canadian content. The initial literature review and its updated version assisted in the development of the research proposal. Moreover, a review of additional literature was used to situate the findings from this study. The problem (i.e., tension between custody and caring) was identified to support the need for this study.
Chapter 3 Method

A qualitative investigation is particularly suited to correctional nursing research; thus, grounded theory (GT) was the best approach to answer the research question. Specifically, the Straussian GT approach (Corbin & Strauss, 2015) was the ideal method for this study. Some content regarding the selection of the GT approach was published in the Journal of Forensic Nursing (See Preface). The rigor of this study was assessed using the Straussian GT evaluation criteria (Corbin & Strauss, 2015).

The Suitability of Qualitative Research

Qualitative research is appropriate when topics are minimally explored (Corbin & Strauss, 2015). Qualitative investigations may reveal patterns and processes suggesting causal interpretations, which then can be systematically tested using more controlled methods of quantitative inquiry (Polit & Beck, 2017). The use of qualitative research approaches helps investigate the complexity of systems and other factors, “such as the sociopolitical context in which healthcare is regulated, funded, and provided” (Greenhalgh et al., 2016, p. 1). For example, correctional nursing practice is a complex process implemented in settings that do not prioritize the promotion of health and wellbeing, and with varying authorities (e.g., correctional services or health) governing healthcare services (Dhaliwal et al., 2019).

The exploratory nature of qualitative research also provides insights into the processes that individuals use to deal with situations that are not well understood (Benoliel, 1996). One situation requiring exploration is if and how this tension between custody and caring still exists and is experienced by Canadian RNs practicing in provincial custody with healthcare governance by health authorities. The best qualitative
research approach selected to answer the research question was GT. GT is one qualitative research approach used to understand the complexity of Canadian correctional nursing practice, and build foundational knowledge necessary to advance this specialty of nursing.

**The Suitability of Grounded Theory Research**

Barney Glaser and Anselm Strauss, sociologists, published their first GT method book in 1967 (Glaser & Strauss, 1967). The GT method is an inductive process (Streubert & Carpenter, 2011), enabling the systematic generation of a substantive theory grounded in empirical data (Walker & Myrick, 2006). “Substantive theory is grounded in research on one particular substantive area, it might be taken to apply only to that specific area” (Glaser & Strauss, 1967, p. 79). The discovery of substantive theory refers to the formulation of categories and their interrelation into a set of hypotheses for a substantive area (Glaser & Strauss, 1965), such as correctional nursing. The GT approach provides researchers with the tools to synthesize data – “it is a particular way of thinking about data” (Morse, 2009, p. 14). Researchers using a GT approach can gain deep understandings of psychosocial processes, as well as develop theories to explain what is going on (Morse, 2009; Streubert & Carpenter, 2011), why and how something happens (Corbin & Strauss, 2015), “or has happened” (Morse, 2009, p. 14). The extensive use of the GT method (Streubert & Carpenter, 2011) has led to the development of different approaches (Annells, 1996).

The current three commonly used GT approaches (Classical, Straussian, and Constructivist) retain a familial resemblance among each other due to the use of certain procedures (Kenny & Fourie, 2015) such as, simultaneous data collection and analysis
using theoretical sampling, constant comparison, memo writing, and data saturation (Glaser & Strauss, 1967). Furthermore, GT’s main philosophical underpinning is symbolic interactionism (Annells, 1996; Hall, Griffiths, & McKenna, 2013; Streubert & Carpenter, 2011). Informed by pragmatism (Charmaz, 2006), symbolic interactionism is a theory of human behaviour and an approach to inquire “about human conduct and group behaviour” (Annells, 1996, p. 380). George Mead, a social psychologist, identified a basic assumption of symbolic interactionism in that self is defined through social roles, expectations, and perspectives placed by society; “humans come to understand collective social definitions through a socializing process” (Annells, 1996, p. 381). There are three assumptions that underpin symbolic interactionism: individuals act based on the meanings that things have for them; individuals act because they have agreed on the meanings attached to things in the environment; and meanings change via an interpretive process (Benzies & Allen, 2001). Researchers must be aware of the various philosophical underpinnings of the different GT approaches to effectively use the method (Hall et al., 2013).

There are two reasons why a GT approach is paramount for building foundational knowledge to advance correctional nursing practice (Dhaliwal et al., 2019), including in Canada. First, the GT approach is used for theory development (Polit & Beck, 2017). A GT approach develops theories that explain human interaction (Hall et al., 2013), including noting changes in conditions and contexts (Holloway & Todres, 2003). The development of a substantive theory regarding the implementation of correctional nursing practice will provide a comprehensive understanding of this specialty of nursing (Dhaliwal et al., 2019); for example, “an understanding of the interaction of correctional
nurses with offenders and correctional services, and noting changes in nursing practice
due to the correctional context” (Dhaliwal et al., 2019, p. 37). Second, nursing practice is
a process, and the GT approach is process oriented (Dhaliwal et al., 2019). The use of a
GT approach can enable the generation of a theory of process, sequence, and change
pertaining to organizations, positions, and social interaction (Glaser, 1965), “thereby
enlightening the ‘how’ and ‘why’ correctional nursing practice is implemented the way it
is” (Dhaliwal et al., 2019, p. 37). The Straussian GT approach as espoused by Corbin and
Strauss (2015) was the ideal method for this study.

**The Suitability of Strauss and Corbin Grounded Theory Research**

The Straussian GT approach allows researchers to initiate the research process
with the identification of a problem and question (Annells, 1997; Corbin & Strauss, 2015;
Streubert & Carpenter, 2011). The research topic or problem may be selected from
several sources such as, an advisor or mentor, technical and nontechnical literature, and
personal and professional experience (Corbin & Strauss, 2015). The differing
philosophical underpinnings also dictate the use of literature to support the research
question (Kenny & Fourie, 2015). Researchers using the Straussian GT approach bring
knowledge of the literature prior to engaging in any inquiry (Corbin & Strauss, 2015).
Kenny and Fourie (2015) reported the acceptance of a literature review in the Straussian
GT approach aligns with post-positivistic underpinnings (Kenny & Fourie, 2015).
Researchers using the Straussian GT approach are also able to use a myriad of structured
data analysis tools (Corbin & Strauss, 2015). The Straussian GT approach (Corbin &
Strauss, 2015) and its philosophical stance allowed strategic knowledge development for
this study: ability to select a definite research topic, including posing a question and
problem; opportunities to review the literature to identify gaps requiring further knowledge development; structured data analysis; and flexibility about laying in abeyance assumptions, ideas, and knowledge (Dhaliwal et al., 2019).

**Participants**

The participant inclusion criteria included: practicing as an RN licensed by the College and Association of Registered Nurses of Alberta (CARNA); at least one year of frontline (i.e., provide direct care for adult offenders) clinical nursing practice experience; and employed in Alberta provincial custody correctional institutions under Alberta Health Services (AHS). There are eight Alberta provincial custody correctional institutions for the adult offender population, specifically four remand centres and four correctional centres (ABJSG, 2020a). The participant exclusion criteria included: RNs with less than one year of frontline experience in provincial custody correctional institutions; and RNs employed in federal custody correctional institutions. Thirteen RNs participated in this study (See Table 1 *Participant Demographic Characteristics* and Table 2 *Other RN Employment*).

**Recruitment**

In May 2018, the Provincial Director and Acting Director for AHS Corrections Health provided a Letter of Support for this study, and confirmed access to recruit participants. In November 2018, the University of Calgary Conjoint Health Research Ethics Board approved this study. Next, in November 2018, AHS (Provincial Research Administration) provided approval as well. In December 2018, the Provincial Director and Acting Director sent their initial email with the Study Invitation (See Appendix A) to healthcare managers in Alberta provincial custody correctional institutions. Healthcare
managers were asked to inform their RNs. In February 2019, these Directors re-sent the initial email to facilitate further recruitment.

Interested participants made contact via email as per the Study Invitation. Next, participant eligibility was confirmed via email based on the inclusion and exclusion criteria. Upon confirmation, the Informed Consent Form (See Appendix B) was sent to the participant via email, along with a request to make an appointment for the interview. Each Informed Consent Form was returned using email. The ethics approval and the “Obtaining and Documenting Consent Electronically CHREB Guidance Document February 2, 2018” allowed for the exchange of each Informed Consent Form via email.

**Sampling**

Purposive and snowball sampling were used at the onset of this study to start participant recruitment. Purposive sampling requires the selection of participants that will benefit the study (Polit & Beck, 2017), specifically those that met the inclusion criteria and could assist in answering the research question. Snowball sampling requires that participants refer other potential participants who meet the study inclusion criteria (Polit & Beck, 2017). Theoretical sampling (see Data Collection) was used as this study progressed.

**Data Collection**

Data collection and analysis were interrelated and simultaneous (Corbin & Strauss, 2015). Data were immediately analyzed after initial collection, and this in turn guided subsequent collection (Corbin & Strauss, 2015). The primary method of data collection was semi-structured interviews conducted via telephone as participants resided in different parts of Alberta. The interviews occurred from December 2018 to October
2019. The interviews were conducted at a date and time mutually agreeable with each participant. The interviews were audio-recorded using a digital recorder. Each interview was approximately 40 to 60 minutes in length. Each interview began by an explanation of this study, followed by obtaining informed verbal consent via reviewing the Informed Consent Form, which was audio recorded. Once informed verbal consent was obtained, the Demographic Questionnaire (See Appendix C) was completed. Next, a semi-structured preliminary interview guide (See Appendix D) was used. The field notes taken during the interviews were also considered data.

The initial semi-structured interview guide was preliminary, thus a few questions changed as data collection progressed:

- Question 1 revised post-interview one: describe what nursing practice means to you in general? Based on your frontline practice experience as a registered nurse, what is it like to implement or carry out your nursing practice in the correctional context?
- Question 4 revised post-interview three: do you use any resources to help you implement your correctional nursing practice? There were too many sub questions in the initial question.
- Questions 6 and 7 revised post-interview one and four, respectively: the word similarities was included as both questions focused only on differences.

**Theoretical sampling.** In theoretical sampling, the concepts derived from data collection and analysis guide subsequent data collection (Corbin & Strauss, 2015); the concepts are sampled, not persons (Corbin & Strauss, 2015). Researchers may go to
places, persons, and situations to gain information about the emerging concepts of interest (Corbin & Strauss, 2015). Theoretical sampling starts after the first analytic session, and continues throughout the research process (Corbin & Strauss, 2015). Corbin and Strauss (2015) recommended that researchers do not begin interviews by asking about the concepts, but allow participants to proceed at their own pace; if participants fail to bring up the concepts, then at the end of the interviews, researchers can ask questions to elicit information about the concepts of interest. Theoretical sampling began with participant four (i.e., interview four). Participants were requested to elaborate when they spoke of anything relevant to the emerging categories whether it was during the interviews, or at the end. Red coloured text was used within each transcript during transcription to identify where participants elaborated regarding the emerging categories. Theoretical sampling continued from interview four onwards to gain information about the emerging GT; this was required as theoretical sampling becomes more specific with time to fill in any gaps in the concepts (Corbin & Strauss, 2015).

**Data saturation.** Data collection was completed upon saturation – “when no new concepts are emerging” (Corbin & Strauss, 2015, p. 134). The final interview was undertaken with participant 13 to conclude data collection. Theoretical sensitivity assisted in the data saturation process. “Qualitative researchers aim for ‘sensitivity,’ or the ability to carefully listen and respect both participants and the data they provide” (Corbin & Strauss, 2015, p. 77). Theoretical sensitivity grew over the course of the data collection and analysis process (Corbin & Strauss, 2015) in which theoretical sampling was used to develop the GT. The steps to finalize the theory were also undertaken (Corbin & Strauss, 2015) to assist in data saturation (See Data Analysis). Theories are
never final or verified, they can be supported, rejected, and modified (Polit & Beck, 2017), and should be updated (Corbin & Strauss, 2015). As a result, this GT is not the ultimate explanation of correctional nursing practice.

**Data Analysis**

Demographic data were analyzed using descriptive statistics. Means and range were used to characterize the study sample based on the type of data provided (See Table 1 *Participant Demographic Characteristics* and Table 2 *Other RN Employment*). Qualitative analysis is “the act of taking data, thinking about it, and denoting concepts to stand for the analyst’s interpretation of the meaning intended by the participant” (Corbin & Strauss, 2015, p. 85). Constant comparison is the “analytic process of comparing different pieces of data against each other” (Corbin & Strauss, 2015, p. 85). Constant comparison is continuously required during analysis to determine if data are conceptually different or similar, and to be grouped accordingly (Corbin & Strauss, 2015). Analytic coding (open, axial, and final theoretical integration) using constant comparison is undertaken to develop the GT (Corbin & Strauss, 2015). Memo writing ensues after the first interview and its analysis, and is a written record of data analysis enabling the documentation of researcher thought processes, ideas, and reflections regarding the development of the final GT (Corbin & Strauss, 2015).

**Open coding.** The interviews were transcribed verbatim. During transcription, the audio recordings were replayed, and the transcribed data were read to ensure accuracy. Open coding requires a line by line analysis of each transcript (Corbin & Strauss, 2015). Each transcript was read, and any interesting lines were underlined and highlighted. During the review of each transcript, reflection upon several questions facilitated open
coding – “What is being said or done? Who is doing it? Why?” (Corbin & Strauss, 2015, p. 87). Constant comparison starts immediately with open coding. The “data [were] broken down into parts” and common concepts were identified based on the interpretations of raw data (Polit & Beck, 2017, p. 547). The common concepts were coded (labeled or named); “coding refers to denoting concepts to stand for data” (Corbin & Strauss, 2015, p. 85). Open coding is early, exploratory analysis, thus conceptual names are tentative (Corbin & Strauss, 2015) and multiple codes are possible for one piece of data. Electronic memo tables were developed to record open coding.

**Axial coding.** During axial coding, lower level codes from open coding are linked together to develop categories (Corbin & Strauss, 2015). Axial coding also helps code for context with the use of “The Paradigm” analytic tool (Corbin & Strauss, 2015). The Paradigm analytic tool encompasses three features (conditions, actions – interactions, and consequences or outcomes) to help with the development of categories and their relationships (Corbin & Strauss, 2015). Conditions answer “the questions about why, when, and how come. They refer to the perceived reasons that persons give for why things happen and the explanations that they give for why they respond…through action–interaction” (Corbin & Strauss, 2015, p. 158). “Actions–interactions are the actual responses people or groups make to the events or problematic situations that occurred in their lives” (Corbin & Strauss, 2015, p. 158). “Consequences are anticipated or actual outcomes of action and interaction” (Corbin & Strauss, 2015, p. 159). Constant comparison continues with axial coding for the development of categories and their further combination based on (dis)similarity (Corbin & Strauss, 2015). Categories also
include properties; properties are “characteristics or qualities of concepts that define, give specificity, and differentiate one concept from another” (Corbin & Strauss, 2015, p. 57).

The Paradigm analytic tool was used to undertake axial coding post-interview three. The three features of this tool were posted on a wall, and using constant comparison, the lower level open codes from interviews one to three associated with raw data were also posted on the wall. Potential emerging categories with inclusion criteria for interviews one to three were documented in a written memo, and electronically in a Microsoft Word document to keep a record of data analysis. Data collection and analysis ensued as described above for interviews four and beyond. Further memo writing assisted in axial coding.

**Final theoretical integration.** Achieving final theoretical integration requires identifying a core category and integrating the findings around this core category (Corbin & Strauss, 2015). The core category is a concept that summarizes the main ideas of the study (Corbin & Strauss, 2015). The core category must meet several criteria: abstract and broad with the greatest explanatory power to integrate all categories; appears frequently in the data; and abstract enough to conduct further research to raise the level of theory (Corbin & Strauss, 2015). Memo writing having started from the first analytic session should assist in identifying a core category, the potential links among all categories, and thereby provide ideas about the final GT (Corbin & Strauss, 2015).

The first findings write up was overly descriptive, hence the core category was not clear. Corbin and Strauss (2015) reinforced “it is not unusual for novice researchers to have difficulty arriving at a core category…they find it difficult to stand back and determine which among the many concepts represents the major theme running through
The research” (p. 189). The supervisor’s feedback confirmed the excess description, thus additional integration was required. Corbin and Strauss (2015) provided techniques to aid final theoretical integration: descriptive summary memos, conceptual summary memos, integrative diagrams, and speaking with professors or colleagues. Researchers write descriptive summary memos by synthesizing in several sentences the story line of the data, including what the research is about (Corbin & Strauss, 2015). Researchers write conceptual summary memos by providing a synopsis of the findings; the ideas are expressed using the categories, including statements of the relationships among these categories (Corbin & Strauss, 2015).

Four memos were written (what is the core category, a descriptive summary memo, and two conceptual summary memos) to facilitate final theoretical integration. The four memos resulted in the core category of Functioning Behind Bars. Next, the supervisor held a meeting to discuss the findings to date. Post meeting, another conceptual summary memo resulted in a new core category as Functioning Behind Bars was too task oriented. RNs were not focused on just tasks, nor were they functioning as robots; they engaged in numerous actions – interactions (See Chapter 4 Findings) to address the correctional conditions thus enabling the implementation of nursing practice. Further memo writing of thought processes and revisions of the findings facilitated final theoretical integration.

**Finalizing the Theory**

Researchers must take steps to finalize the GT such as, filling in poorly developed categories, trimming the theory, dealing with outlying cases, and checking for variation (Corbin & Strauss, 2015). Researchers fill in poorly developed categories by reviewing
memos or raw data and using further data collection via theoretical sampling (Corbin & Strauss, 2015). Theoretical sampling occurred with the final participant (i.e., interview 13) to gain information about the emerged categories. Researchers also trim the theory because there are concepts that do not fit or make any contributions (Corbin & Strauss, 2015). Extraneous concepts are those that were never fully developed, did not appear much in the data, or “trail off into nowhere;” these concepts can be dropped to avoid cluttering the theory (Corbin & Strauss, 2015, p. 198). A running list of extraneous raw data was developed during open coding. The running list was continuously reviewed to determine whether extraneous data were a fit with the emerging theory.

Researchers must deal with outlying cases. Outlying cases are those that fall at either extreme in the range of a concept, or seem contrary to what is going on in the emerging theory; these valuable outliers should be included as they represent alternative explanations or variation (Corbin & Strauss, 2015). Specific outlying cases are presented in the next chapter (See Chapter 4 Findings). Researchers must also check for variation in their theory, and not only imply that a theory flows from A to B to C (Corbin & Strauss, 2015). Variation was captured in the theory due to the interrelated categories, which presented a complex and dynamic view of the implementation of correctional nursing practice (See Chapter 4 Findings). Committee and supervisor feedback with subsequent memo writing assisted in finalizing the theory.

**Rigor**

Credibility of qualitative findings refers to those that are “trustworthy and believable in that they reflect participants, researchers, and readers experiences with phenomena…the explanation the theory provides is only one of many possible ‘plausible’
interpretations from data” (Corbin & Strauss, 2015, p. 346). A rigorous research process can result in more credible findings (Given, 2008). Corbin and Strauss (2015) offered evaluation criteria for researchers and reviewers using their Straussian GT approach to assess the methodological consistency, and quality and applicability of GT studies. There are various checkpoints (i.e., questions) to evaluate the methodological consistency, and quality and applicability of GT studies (Corbin & Strauss, 2015).

Researchers and reviewers can use the 16 checkpoints to evaluate the methodological consistency of GT studies (Corbin & Strauss, 2015); these checkpoints focus on the methods of the research process. The methodological details were discussed earlier (See Chapter 3 Method). Methodological consistency was enhanced by receiving the appropriate approvals to undertake this study. A qualitative research approach, specifically Straussian GT was rationalized as the ideal method to answer the research question. The population was identified using inclusion and exclusion criteria, along with details regarding recruitment and sampling strategies. Data collection and analysis were undertaken using the Straussian GT approach procedures. The process of finalizing the theory was discussed as well.

Researchers and reviewers can use the 17 checkpoints to evaluate the quality and applicability of GT studies (Corbin & Strauss, 2015); these checkpoints focus on the methods of the research process, specifically data analysis and the findings. The data analysis (See Chapter 3 Method) and findings (See Chapter 4 Findings) were discussed earlier. Caring Behind Bars is the overarching core category connecting all subcategories contributing to the formation of the theory. The subcategories all relate to this core category in some manner as conditions, actions – interactions, or consequences. The
notions of context and process were identified within these subcategories. Adequate explanations of all categories were provided. Interrelation of the categories raised the findings to a substantive theoretical level, and not merely description (Corbin & Strauss, 2015). Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population.

Corbin and Strauss (2015) supported the Glaser and Strauss (1967) idea of applicability. A GT must uphold the four criteria of applicability (Glaser & Strauss, 1967): the theory must closely fit with the substantive area in which it is used; the theory must be readily understandable by laymen concerned with this area; the theory must be general enough to be applicable to differing situations within the substantive area; and the theory must allow partial control over the daily situations as they change over time. The theory of Caring Behind Bars fits the substantive area because the data emerged from RNs practicing within correctional institutions. The existing literature aligned with the findings demonstrating that others concerned with this area may understand this theory. Furthermore, audience members attending an international correctional nursing conference provided verbal feedback regarding the notable findings; many of the attendees (i.e., correctional nurses) agreed with the findings.

The theory of Caring Behind Bars may be studied and used for applicability among different allied health and healthcare professionals practicing in Canadian federal or provincial custody institutions with varying healthcare governance, and internationally, to study whether they face different or similar conditions, actions – interactions, and consequences. The theory offers some control by introducing various conditions and subsequent actions – interactions for users to explore leading to
challenging and positive consequences. The implications and recommendations for correctional nursing practice and offender health contribute to the quality and applicability of this theory (See Chapter 6 Conclusion).

Chapter Summary

The Straussian GT approach (Corbin & Strauss, 2015) was the ideal method for this study. RNs were the best participants whose eligibility was determined by the inclusion and exclusion criteria. The process of participant recruitment was undertaken electronically. Three sampling strategies (purposive, snowball, and theoretical) were used. Data collection and analysis were interrelated and simultaneous using the procedures of GT research: theoretical sampling, constant comparison, memo writing, and data saturation. The theory was finalized using various steps (Corbin & Strauss, 2015). Lastly, rigor was assessed using the Straussian GT evaluation criteria (Corbin & Strauss, 2015).
Chapter 4 Findings

Thirteen RNs each participated in one interview with no follow up interviews required (See Table 1 Participant Demographic Characteristics and Table 2 Other RN Employment). More than half of participants self-identified as female (n = 10). Participant age ranged from 26 to 65 years with a mean of 40.92 years. All participants self-identified as White (n = 13). The majority of participants held a Bachelor of Nursing Degree as their highest level of nursing education (n = 10). The mean years of employment as an RN were 17.31 years. The 13 in depth interviews resulted in the emergence of the core category and subcategories. The core category of Caring Behind Bars is the overarching category connecting six subcategories contributing to the formation of the substantive theory. The subcategories all relate to the core category in some manner as conditions, actions – interactions, and consequences (Corbin & Strauss, 2015). A substantive theory regarding the implementation of correctional nursing practice is best understood by this core category.
Table 1. Participant Demographic Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Participants (n = 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>(n = 3)</td>
</tr>
<tr>
<td>Female</td>
<td>(n = 10)</td>
</tr>
<tr>
<td><strong>Age (Years)</strong></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>40.92</td>
</tr>
<tr>
<td>Range (Minimum – Maximum)</td>
<td>26 – 65</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td><strong>Nursing Education (Highest Level)</strong></td>
<td></td>
</tr>
<tr>
<td>Diploma (RN)</td>
<td>(n = 2)</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>(n = 10)</td>
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<tr>
<td>Master’s degree</td>
<td>(n = 1)</td>
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<tr>
<td><strong>Years Employed as RN</strong></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>17.31</td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>(n = 2)</td>
</tr>
<tr>
<td>&gt;5 years – 10 years</td>
<td>(n = 3)</td>
</tr>
<tr>
<td>&gt;10 years – 15 years</td>
<td>(n = 4)</td>
</tr>
<tr>
<td>&gt;20 years</td>
<td>(n = 4)</td>
</tr>
<tr>
<td><strong>Current Employment Status (Corrections Health)</strong></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>(n = 6)</td>
</tr>
<tr>
<td>Part-time</td>
<td>(n = 4)</td>
</tr>
<tr>
<td>Casual</td>
<td>(n = 3)</td>
</tr>
<tr>
<td><strong>Years Practicing as RN in Provincial Custody</strong></td>
<td>(n = 12)</td>
</tr>
<tr>
<td>*One participant removed because could not recall Years</td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>(n = 4)</td>
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<tr>
<td>&gt;5 years – 10 years</td>
<td>(n = 5)</td>
</tr>
<tr>
<td>&gt;10 years – 15 years</td>
<td>(n = 3)</td>
</tr>
<tr>
<td><strong>Years Practicing as RN Under Each Authority</strong></td>
<td></td>
</tr>
<tr>
<td>Correctional Services (ABJSG)¹</td>
<td></td>
</tr>
<tr>
<td>*Pre transition (2010 and earlier)</td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>(n = 4)</td>
</tr>
<tr>
<td>Health (AHS)²</td>
<td></td>
</tr>
<tr>
<td>*Post transition</td>
<td></td>
</tr>
<tr>
<td>1 – 5 years</td>
<td>(n = 4)</td>
</tr>
<tr>
<td>&gt;5 years – 10 years</td>
<td>(n = 8)</td>
</tr>
</tbody>
</table>

¹Five participants employed under both authorities; one participant removed because could not recall years.
²All participants employed under health authority; one participant removed because could not recall years.
Table 2. *Other RN Employment*

<table>
<thead>
<tr>
<th>Other RN Employment</th>
<th>Participants (n = 13)</th>
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<tbody>
<tr>
<td><strong>Current Other Nursing Employment</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>(n = 4)</td>
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</tbody>
</table>
| Other Nursing Employment | Private clinics  
Urban hospital  
Community chronic disease  
Educational Institution |
| No | (n = 9) |
| **Previous Nursing Employment Prior to Correctional Nursing** | |
| Yes | (n = 11) |
| Previous Nursing Employment | Rural and Urban hospitals (e.g., cardiac intensive care, emergency, forensic psychiatry, geriatrics, inpatient psychiatry, labor & delivery, medical units, neonatal intensive care, operating room, surgical units, travel nursing)  
Homecare  
Educational Institution |
| No | (n = 2) |
Core Category: Caring Behind Bars

The theory of Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population (See Figure 1). Caring Behind Bars (core category) is comprised of six subcategories: foundational stance, tension between custody and caring, adaptability and advocacy, offender population, provision of care, and challenging and positive outcomes. RNs possessed a foundational stance regarding what nursing practice means to them in general, prior to entering the correctional context. The foundational stance is based on three properties: nursing process, nonjudgmental approach to care, and elements of care. RNs foundational stance about nursing practice was challenged upon entering the correctional context and experiencing the conditions behind bars. Upon entering the correctional context, RNs experienced tension between custody and caring as evidenced by five correctional conditions (i.e., properties): correctional culture, conflicting attitudes, health is not always priority, correctional services operations, and physical structure of correctional institutions.

RNs engaged in adaptability and advocacy (initial actions – interactions) to address tension between custody and caring and access the offender population. RNs described the complexity of offenders in four conditions (i.e., properties): all individuals, attitudes, manipulation as survival mode, and vulnerable. The provision of care required RNs to take numerous actions – interactions to provide care to offenders. The provision of care is based on four properties: patient focused, assessment, facilitators of care, and variety of care. The consequences of Caring Behind Bars were challenging and positive
outcomes. Caring Behind Bars was challenging due to various reasons: lack of balance between corrections and health, exposure to violence, and constantly enduring dilemmas. Caring Behind Bars also resulted in positivity among RNs, such as it was amazing, exciting, fun, and interesting.

Figure 1. Caring Behind Bars.
Foundational Stance

The subcategory of foundational stance refers to the RNs views on what nursing practice means to them in general, prior to entering the correctional context. The foundational stance is based on three properties: nursing process, nonjudgmental approach to care, and elements of care. RNs foundational stance about nursing practice was challenged upon entering the correctional context and experiencing the conditions behind bars.

Nursing process. Participants identified the use of the nursing process when describing what nursing practice means to them in general. The first step of assessment repeatedly emerged as crucial in the provision of care. Most participants discussed the nursing process from a clinical lens as many possessed practice experiences in the domain of clinical practice.

Several participants identified the steps of the nursing process such as, assess, plan, intervene, and evaluate:

*nursing practice to me is [Silence] assessing the situation, to see if there’s an issue or problem, whether it is a medical or psychological or biosocial or spiritual... is there something that I can do about it. What are my options, pick the best one, move forward, and if that doesn’t work, back it up, and then start with step two, and carry on the nursing process.* (P2)

The nursing process also occurred naturally: “it just becomes a part of how you do business, like it’s your everyday, it’s not like you think about it... Everyday. Assess, plan, implement, evaluate. That’s nursing [Laughs]” (P4). Others spoke of the nursing process in relation to different contexts such as, collaboration and holistic nursing practice. For example, one participant voiced that the nursing process required collaboration to meet the needs of the population receiving care: “and then we work with
the client or patient, along with physicians, and other team members to ensure that those needs are met” (P5).

**Nonjudgmental approach to care.** Participants discussed the importance of a nonjudgmental approach to care when describing what nursing practice means to them in general. For example, one participant discussed preventing judgments towards the population receiving care: “my goal is not to judge based on anything...except if I have a fear for my life, or inherent danger” (P2). The provision of care remained at the center of focus in nursing practice, and not the backgrounds of the population receiving care. A nonjudgmental approach to care was required to provide an equivalent standard of care, as one participant stated:

> you’ll get patients who may be like extremely affluent...they should get the same exact healthcare as someone who has none of those advantages, they may come from a very, like, impoverished background, they may have a history of addiction, they may have a history of crime...in a perfect world, that person would achieve the exact same healthcare outcomes as that extremely affluent patient. And the nurse shouldn’t have, um, they may have their personal beliefs, but they can’t let those personal beliefs affect outcomes for the patient. (P5)

**Elements of care.** Participants discussed that nursing practice in general focused on several foundational elements of care: holism, health promotion, and patient focused. Several participants echoed the provision of care must be holistic. For example, one participant stated: “from birth to death, and it should be a holistic approach, and it should incorporate the client as a whole being, and the family...the assessment needs to include the mind and the body, and the spirit” (P7). Numerous participants reported the provision of care also focused on health promotion: “nursing practice is helping people, get healthy, or maintain whatever function they got...for me nursing practice is getting them to their maximum capability” (P12). Lastly, participants strived to be patient
focused by “meeting patients where they’re at,” as one participant stated: “nursing
practice is to meet the patient where they’re at on their health journey...our goal is to
improve their quality of life, or help them maintain a certain standard of quality of life
(P10).

**Tension Between Custody and Caring**

The subcategory of *tension between custody and caring* refers to the conditions
experienced by RNs upon entering the correctional context. The *tension between custody
and caring* is based on five properties: correctional culture, conflicting attitudes, health is
not always priority, correctional services operations, and physical structure of
correctional institutions. Each property conveyed the tension RNs experienced between
custody (represented by the correctional/corrections services duties and priorities) and
caring (i.e., implementing nursing practice including, the provision of care). RNs did not
experience this tension chronologically (i.e., properties were not experienced in order);
there was an interplay of properties, hence RNs can experience these in any combination.
Tension was provoked as RNs strived to care, yet this was not easily accomplished due to
the correctional context. RNs identified the existence of this tension regardless of the
governance of correctional healthcare services by the health authority (AHS).

**Correctional culture.** Participants identified the existence of a correctional
culture. Negative talk was an inevitable component of this culture. Negative talk within
correctional institutions was constant, as one participant identified: “it’s a very hard
place to work because you hear a lot of negative talk” and “you constantly live in an
atmosphere that you’re hearing human beings as regarded as pieces of dirt, pieces of
feces, you know like, less than human” (P2).
Examples of negative talk included the language used among staff. For example, one participant identified the use of profanity among staff: “lots of swearing, the officers all the time, you can hear them, f-bombs left and right, it’s their normal, it’s their culture kind of, they are not necessarily being rough people that’s just how they talk” (P3).

Negative talk was also used by offenders:

the population, tends to be quite rough...they use language that’s not professional, you know, whereas out in the hospital, or out in the community, people generally have sort of a politeness to them, in general that sense of politeness isn’t there in corrections. [Laughs]. So, you know, it’s important to remember...to accept that, and to not let it really like hurt your soul [Laughs]. (P5)

Conflicting attitudes. Participants identified the existence of two different entities within correctional institutions – corrections and health. The existence of these entities led to the conflicting attitudes among corrections and health staff. The existence of these two different entities was a potential barrier in the implementation of correctional nursing practice:

the biggest barrier is the fact that...like we aren’t with ABJSG...we’re AHS...So, the goals, let’s say, of those two organizations are very different things...the goal of ABJSG is, you know, they have to maintain care, custody, and control. So, care is the first component of that, but in my experience, it’s very much custody, is the first goal, in their mind, you know, as long as the patients are, they call them inmates, are kept in custody, and under control, that’s their first goal. (P5)

Several participants voiced that conflicting attitudes emerged among correctional officers and RNs towards offenders and the provision of care. For example, one participant stated:

fundamentally our mandates conflict, you know, their mandate is care, custody, and control, and that’s a soft ‘C’ right [Laughs], and our mandate is care, a hard ‘C’...I think it can be difficult at times because they might not understand where we’re coming from. Um, and I feel very often that they will question care. (P10)
Participants emphasized that RNs attitudes focused on caring for and helping offenders; caring and helping were beneficial in times of crisis: “if I can, or you can help them in anyway, you’re going to do that…the fact that you cared to persevere enough to help talk that person down from whatever crisis” (P2). Another participant reinforced the need for caring in correctional nursing practice:

*I do think there is a lot of room to have some, hear me out, to have that caring and care…but to say I care, I care for you, I’m going to help you, and let me help you where you’re at, you know help the client where they’re at, the whole nursing thing, try that in corrections.* (P7)

Participants reported that RNs attitudes also focused on portraying a nonjudgmental approach to care to provide a high standard of care:

*just because you have the ability to look in and see what an individual is in here for, what their charges are, don’t look at them because that will change how you provide care for that individual. And so if you need to maintain a standard of care, and um, in court you need to say that I provided the highest level of care that was possible to me…say an individual is in here because they have confinement for child sex charges, or things like that, if I knew that as a mom, that’s going to change how I interact with that person.* (P4)

Another participant agreed this approach to care was required to deliver an equivalent standard of care: “we’re not there to judge anybody for why they’re there…we want them to have equitable care to like the rest of citizens in Alberta right, like Canadians” (P10).

In contrast to these RNs attitudes, participants discussed that correctional officers questioned the need for and value of their care. For example, one participant described the impact of correctional officer attitudes on the provision of care: “*if officers don’t necessarily think that what I’m doing is worthwhile, or whatever then it can be very difficult to provide care*” (P1). One participant provided an example of correctional
officer attitudes towards an opioid dependency therapy program: “a view of the officers is you’re enabling them, you’re giving them free drugs...That’s really hard to kind of overcome...I’ve heard the response, okay well then just let them die, and that’s a very common consensus” (P13). Participants attempted to overcome such attitudes to implement correctional nursing practice: “you have to kind of overcome in your practices about how do you make this connection with them, so they understand the science behind it, the rationale, the morality [Laughs]” (P13). Unfortunately for participants, correctional officer attitudes were a potential barrier in the implementation of correctional nursing practice: “the correctional officer sort of mentality that can be a bit of a barrier to building rapport and providing care” (P11).

**Health is not always priority.** Participants acknowledged that correctional institutions are not hospitals (i.e., typical health settings), hence correctional issues were often prioritized over health. Examples of correctional issues included incarceration, safety, and security. For example, one participant stated: “I’m working in a place where it’s a prison first, and not a hospital first. Whereas, if you’re in a hospital people are there only for healthcare” (P1). Safety and security were often priority within correctional institutions versus offender health: “it’s a correctional facility first, and then he’s a patient second” (P3). Yet, safety and security measures were also warranted to keep RNs safe:

we can’t just rush in there because then we could become the victim...We could be taken hostage, we could be injured...like we’re not there to have ourselves at risk, so that we end up getting hurt where we have to go to the hospital, or worse, instead of going home. (P3)
Regardless of the prioritization of correctional issues over health and nursing care, the institutions were safer than other health settings. For example, correctional institutions were safer than hospitals: “in corrections, you know their background, you have access to that information…it’s a much safer atmosphere than entering a four bed ward where you don’t know what you’re entering into” (P2); and “I feel safer there [correctional institution] than the emergency room” (P3). No participant argued against safety and security; one reason may be the desire to be safe while practicing behind bars.

**Correctional services operations.** Participants described the correctional institutions as hierarchical, paramilitary settings in which they experienced operational constraints and restrictions: “it’s like any paramilitary organization, they have a chain of command” (P2). RNs were required to follow the rules within these settings: “in order to be able to do your job effectively, you have to accept that the rules that ABJSG, or the officers kind of lay down are the rules that you have to follow” (P1). Correctional services operational factors (i.e., officer presence, officer availability, and officer duties) were potential barriers to offender accessibility and the provision of care.

**Officer presence.** Several participants identified that working with correctional officers was a barrier in the provision of care. For example, one participant stated: “the biggest barriers would be the officers allowing us to do work, and what I mean by that is I cannot see a patient without an officer present” (P10). One participant also reinforced that correctional officers, at times, negatively impacted the provision of care:

> they’re our teammates, um, they are a barrier in access obviously in us trying to get contact with our patients, there are finite times, that work with ABJSG to be able to do all the interventions and treatments that you [Silence] and assessments that you need to do…I don’t know how to say this in a nice way but, use kids gloves in order to be able to meet your needs [Laughs] for the day. (P4)
The presence of correctional officers was an issue for maintaining offender privacy and confidentiality. For example, one participant emphasized that offenders were made aware of the lack of privacy: “with a guard present in open earshot...you have to be cognizant of confidentiality, and you make sure that the patient you’re dealing with understands that this is by no means a private conversation” (P2). Offenders were also less likely to share their health concerns in the presence of correctional officers: “I’m never gonna get quality information out of my patient. They’ll never disclose to me what’s actually bothering them cause they don’t want the COs to know” (P5).

Participants also experienced difficulties regarding information sharing with correctional officers as compared to hospitals: “whereas in the hospital...you don’t have to worry about what information can I share with them [correctional officers]” (P9).

**Officer availability and duties.** Some participants identified the lack of correctional officer availability as a barrier to offender accessibility: “half of them [correctional officers] are gone...and there’s a point that you cannot really argue because it comes down to man power, and availability” (P2). Extra nursing support did not facilitate practice either due to the lack of correctional officers. At times, correctional officer duties also challenged offender accessibility and the provision of care. Correctional officer duties included the dispersion of meal trays, execution of exercise schedules, and the maintenance of security. For example, a participant stated:

the COs also have to do certain things, like they have to feed people at certain times, and they have to exercise people at certain times...and so I don’t ever go into that situation being like nope, I need to see them right now, this is my timeline, you can’t operate in corrections like that, you have to operate on the officers timeline. (P5)
Other correctional officer duties (e.g., maintenance of security) challenged the provision of care as well. For example, one participant discussed how offenders on maximum security units were not easily accessible due to the high level of security:

they won’t bring the individual out to the MAT room, the little medical assessment treatment room...because they are too high risk...So, you have to go onto the unit to see them, so the lights are low, you’re assessing them through a door, how are you to do that and providing care and medication, and make sure that it’s appropriate and good quality care, you can’t. (P4)

Physical structure of correctional institutions. The physicality of correctional institutions was not suitable for the implementation of correctional nursing practice. Participants did not indicate this physicality contributed to the rehabilitation of offenders. The physical nature of correctional environments was not conducive to a healing environment. Several participants commented on the limited physical space: “the obvious barrier is the physical barrier...you learn very quickly how to have a conversation through the crack of a door” (P2); and “sometimes we’re just assessing them through, ah, I don’t know, a five-inch little window” (P3). Limited space also challenged the provision of care during medical emergencies: “in an emergent, code situation, an inmate cell is very small to be able to get a lot of people to do work, so that’s always a limitation” (P13). One participant emphasized how assessment rooms located on different floors challenged offender accessibility: “their [correctional institution] assessment rooms are on different floors...so you have to work harder to get to where you can see your patient” (P12). Some correctional institutions are also separated into different buildings requiring transportation of healthcare professionals and their equipment, including medications, in all types of weather.
Ultimately, the milieu within correctional institutions differed from hospitals due to the physicality:

*I could sit down with a patient, and um, have a conversation with them in a way more therapeutic milieu as opposed to like a very, you know, kind of a very rigid milieu kind of like a jail is not therapeutic, it’s confining, it’s a very, you know, like bricks, and bars, and glass, and steel, it’s not like, there is no plants, like calming music [Laughs]. (P5)*

Conditions refer to the perceived reasons that persons (e.g., RNs) give for why things happen, and the explanations they provide for why they respond via actions – interactions (Corbin & Strauss, 2015). Context is then expressed in the conditions that persons give for their actions – interactions (Corbin & Strauss, 2015). As a result, the tension between custody and caring (conditions) was the reason that RNs did what they did (i.e., took initial actions – interactions) to access the offender population.

Adaptability and Advocacy

The subcategory of *adaptability and advocacy* refers to the initial actions – interactions taken by RNs to address the tension between custody and caring.

*Adaptability and advocacy* is based on three properties: adaptability requires creativity and flexibility; and advocacy requires convincing and explaining, and rationalizing by identifying the potential consequences of not providing care. The tension between custody and caring was the reason that RNs adapted and advocated to access the offender population. Process is a notion that describes how persons adjust actions – interactions to meet the demands created by the conditions to achieve desired goals (Corbin & Strauss, 2015). RNs adjusted their *adaptability and advocacy* based on the tension between custody and caring to access offenders with the goal of providing care. RNs who
mastered addressing this tension on one day did not permanently eradicate this tension – they constantly strived to overcome this tension on a daily basis.

**Adaptability.** Participants adjusted their degree of adaptability by using creativity and flexibility whilst following the routines within correctional institutions. The majority of routines were linked to the correctional conditions. For example, correctional services operations included officer duties, which were routinely implemented during strict time periods: “everything in custody, like in the jail, it’s done on a schedule, everything is done at the officers [Silence], they have to let it happen” (P5). Other participants agreed with the adherence to strict routines: “we have certain times of the day where we’re able to see patients...So, we do have strict like kind of timeframes where we need to get our work done” (P9).

Participants used creativity to access offenders within the routines of correctional institutions: “you just have to get creative to be able to access them” (P4); and “you need to take everything that you’ve learned and go outside of the box” (P6). One participant provided an example of using creativity to access offenders:

> sometimes you have to be a little more creative with your care...so if I can’t get an officer to support me and I feel, like I need to intervene like say a pump was beeping, and if the patient was mobile I might ask the patient to bring the pump close to the door, I’ll open the servery, and I’ll fix it through the door. (P10)

Several participants used flexibility to access offenders within the routines of correctional institutions. Participants provided examples of flexibility: if offenders could not visit the healthcare units, RNs would go to offender cells; and RNs would organize their duties as per the officer schedules. One participant emphasized flexibility:

> your usual go-to route of how you would do something, ah, is typically not always straight forward. You have to always be looking out for patient care, and trying
to, not bend the rules, but ABJSG does not understand AHS policy or politics. So, or how to actually access patients. Um, and provide good quality patient care, or ethical [laughs] patient care. So, you have to always [be] willing to, try different avenues in order to be able to access your patient, and get what you need accomplished. (P4)

**Advocacy.** Participants advocated accordingly when they experienced tension between custody and caring to access offenders. For example, advocacy was crucial when correctional officers denied access:

> it’s my due diligence to ask the officer, and if I am denied to assess my patient at that time, that’s literally what my charting is. Um if I am seriously concerned for the wellbeing then you kind of go up your chain of command and do what you can to advocate for that patient. (P11)

Participants adjusted their degree of advocacy by convincing and explaining to correctional officers about why they needed to access and provide care to offenders. For example, one participant emphasized that convincing correctional officers was a tiring act: “I have to convince officers to sort of help me, sometimes, or convince them that the care I need to provide is important,” and so “it does get exhausting, I guess, when you are fighting and convincing people constantly that the work you need to do is important” (P1). Along with convincing, participants voiced the need to explain their work: “offer explanation to the officer as to what I’m needing...but doing it in a way that validates their role of keeping things safe and secure, but also opening up opportunities for me to get access to the patient” (P11).

Participants also adjusted their degree of advocacy by rationalizing to correctional officers the potential consequences of not providing care. For example, one participant stated: “I guess, will sort of rationalize it to them. So, if I can provide this care now...it’s going to be less bad later...If I don’t do it then we are going to have bigger problems
Likewise, another participant agreed about warning correctional officers of potential medical emergencies if care was not punctually provided: “if you don’t want to have a code 99, and have to respond to that in the next four hours, I actually need to see this individual now, so I can provide the care, so it doesn’t escalate” (P4). Rationalizing with potential consequences was not easy; one participant disliked this approach to advocacy: “I hate having to do that, cause like you have to do it a lot of the times. Well if we don’t do this now, it’s going to whatever…you almost have to justify the morality of something” (P13).

**Offender Population**

RNs addressed tension between custody and caring (conditions) via adaptability and advocacy (initial actions – interactions) to access the offender population. The subcategory of offender population refers to the offenders residing within correctional institutions. RNs described the complexity of the offender population in four conditions (i.e., properties): all individuals, attitudes, manipulation as survival mode, and vulnerable.

**All individuals.** Participants described that all patients are human beings in any setting including correctional institutions. A difference for participants was the knowledge of criminal histories, yet in other settings (e.g., community clinics, hospitals), these details are usually not available. For example, one participant stated: “you’re still dealing with the same patients you would see at any hospital, at any acute care setting, it’s just that you don’t know their background” (P2). Offenders are all human beings regardless of their criminal histories: “it’s the same people you’re going to see at the [hospital]…except here they all wear the same color…they’re the same individuals, they’re your neighbours” (P2). Another participant also agreed with this idea: “it doesn’t
matter what they’ve done, they are still a client, they’re your client, and they deserve respect, and if you can’t honor that then you’re in the wrong place” (P7). Nursing staff made efforts to treat offenders as individuals. For example, one participant reported educating new correctional nurses during orientation: “we say that typically in orientation, right off the hop is that this could be your brother, your cousin, your neighbour, the law does not discriminate [laughs]” (P4).

Attitudes. Participants described the attitudes expressed by offenders towards health and wellbeing in two ways. First, offenders expressed feelings of being judged by healthcare professionals and the public. Several participants identified that offenders felt judged by healthcare professionals due to previous negative experiences: “a lot of our population has a lot of issues with trusting healthcare professionals, whether it be inside of a correctional centre, or outside may be due to bad experiences” (P8). Another participant also echoed that offenders felt judged by the public: “they are put in orange jumpsuits, and they are leg shackled and hand shackled. So, I’ve had patients who will refuse very important medical appointments…they don’t want to be seen in the community under those circumstances” (P10).

Second, offenders expressed varying attitudes regarding health and wellbeing. For example, one participant reported that offenders were aware their health was a second priority: “I think when you are an inmate you realize that again you are in a prison first, and receiving healthcare second…they are a little more lenient in the care that they get” (P1). Another participant agreed that offenders were not immediately concerned with their health and wellbeing upon entering the correctional institutions: “and their first priority often is not healthcare…they’re coming to us like almost as a second thing”
Offenders lack of concern with their health and wellbeing was a potential barrier to the provision of care.

**Manipulation as survival mode.** Participants voiced that offenders presented as manipulative: “*these people don’t talk the way you think they would, they like to manipulate*” (P6); and “*I don’t want to paint them all with the same brush but there is also sometimes a level of manipulation*” (P8). Offenders demonstrated manipulative behaviour due to ulterior motives: “*the inmates always try to manipulate you, they’ll be like super friendly to you, and you realize after that it’s because they have an ulterior motive*” (P3). The ulterior motives were the desire for other items such as, food, shoes, mattresses, medications, change of living units, and transport out of the institutions:

> the patients there will do things to themselves like physically, health wise, or whatever to manipulate placement. So for example, if they want to be moved off of a unit, they will hurt themselves, so that they can go to the infirmary...or they’ll do things to intentionally cause themselves harm, so that we have to send them out to the hospital. (P3)

Upon reflection, participants concluded that offenders manipulated to survive within correctional institutions; it was a way to have their needs met. For example, one participant reflected on this idea:

> they are trying to get something, but this is their whole life, right, it’s not just in here, you know, it’s how do I get my end goal of whatever, and what do I need to do to attain that...in global AHS they believe the patient is always right, well we actually don’t have that perspective here because they are trying to get what they need to survive. (P4)

Other participants also agreed that manipulative behaviour was a survival tactic used in the community which then occurred behind bars. The scarcity of resources among offenders also triggered manipulative behaviour in which access to anything extra was
used for personal gain. Ultimately, participants were challenged to address this behaviour to provide quality care:

*I try to think a little bit more, what is the need they’re trying to meet...and to build a little bit more of a rapport instead of just immediately telling the person no you’re not getting this you’re being manipulative, and then the care stops there, the relationship stops there, the education stops there.* (P11)

**Vulnerable.** Participants described the offenders as being vulnerable. A myriad of factors contributed to this vulnerability: a lack of accessibility to healthcare services outside of correctional institutions, homelessness, marginalization, and unmet basic needs. Offenders experienced a lack of accessibility to healthcare services outside of correctional institutions: “*the mental health and the girls, um, they just need so much help, they need birth control, they need access, because when they are on the outside, they have no access*” (P3). Yet, admissions into correctional institutions provided an opportunity to meet some healthcare needs. For example, one participant echoed this opportunity: “*sometimes you’re getting better treatment than they would necessarily be on the outside may be if they’re like marginalized, if they live in a remote rural area, or if they are homeless*” (P8).

The unmet basic needs are a complex social problem among offenders, as emphasized by one participant:

*if we see the same people over and over...and they call this place their primary address, that’s a problem, that’s a social problem, that’s not them just, you know, this is my life, and I’m gonna lead a life of crime, its I can’t secure my basic needs to be able to elevate to my next level in Maslow’s Hierarchy of Needs.* (P4)

Participants did not see their offenders as any different regarding vulnerability as compared to patients in other settings. For example, one participant stated: “*a lot of high-
"risk births, are my patients here on this side, you know. So, women who have experienced no prenatal care, right, have addictions issues” (P4).

**Provision of Care**

The subcategory of provision of care refers to actions – interactions taken by RNs to provide care to offenders. The provision of care is based on four properties: patient focused, assessment, facilitators of care, and variety of care. RNs acknowledged the complexity of offenders using a patient focused lens, and then used assessment skills and facilitators of care to provide a variety of care. Process was demonstrated when RNs adjusted the provision of care (actions – interactions) based on the offender population.

**Patient focused.** Participants acknowledged the complexity of offenders by using a patient focused lens for the provision of care. Participants engaged in numerous actions – interactions to develop a patient focused lens. Gaining knowledge of the determinants of health for each offender was important to become patient focused:

>you need to know the demographics of the person...you need to know their cultural background, significantly, you need to know their mental health, their history, are they recidivism, are they brand new, what is their story, because to know that will give you an inclining into how you can approach this person. (P6)

Rapport and trust between participants and offenders were required to become patient focused: “the patients tend to be quite guarded at first until you can develop a rapport with them, and I think that’s the case of any patient...but it’s way more so in corrections” (P5). Participants also became patient focused by meeting patients where they’re at in various ways: using communication styles accepted by offenders; reviewing nursing basics such as Maslow’s Hierarchy of Needs; letting go of personal expectations
of offenders; and demonstrating empathy. For example, one participant emphasized meeting patients where they’re at using a relevant communication style:

> we have to meet our patients where they’re at, um, and if every other word they are using is either improper, or a swear word, or things like that, um for me to sit there and explain to them from a white Anglo-Saxon protestant perspective, they’re gonna tell me to go get stuffed. (P4)

**Assessment.** Participants required strong assessments skills due to the variety of care provided. Assessment included using clinical judgment to triage the severity of signs and symptoms: “you have to also know how to assess …if it’s an emergency, if it’s something like you’re calling an ambulance, or if it’s like oh this person needs to go to the hospital, but they’re stable enough to wait” (P3). Strong assessment skills were ideal to assess a variety of health issues ranging from general medical concerns to emergency situations: “you have to have a very wide, and diverse ability of assessments because you’re gonna pretty much see everything. Like in primary care, you’re the first gate keeper almost to prioritize or triage” (P13). Moreover, strong assessment skills were required because there was limited support from physicians: “the doctor is not here everyday, you actually have to make judgments and ask for treatments based on your assessment” (P12). Numerous participants also reported that assessment skills were crucial to address offenders’ manipulative behaviour: “you really have to have a good set of assessment skills because our clientele sometimes can be manipulative” (P9).

**Independent facilitators of care.** Participants engaged in independent actions – interactions to facilitate the provision of care. Independent facilitators of care included background clinical practice experience, computer programs, and educational resources. Participants specifically identified the use of computer programs and educational
resources as facilitators and resources for the implementation of correctional nursing practice.

**Background clinical practice experience.** Participants reported that background clinical practice experience facilitated the provision of care. For example, one participant echoed that prior experience was beneficial due to the variety of care provided behind bars: “so it definitely applies when you get here and you see all types of people requiring all types of care” (P3). Participants benefited from prior experience with marginalized populations and mental health: “it’s usually beneficial especially if we have people that come from any sort of acute psych unit, or forensic unit, or mental health background because a large portion of our population has an addictions or mental health issue” (P4). Other valuable background clinical practice experience included acute care: “ICU, or at least two years med-surg” (P6). Participants also benefited from emergency care experience in acute or rural settings. Emergency care experience was beneficial due to its applicable practical knowledge, and in the development of assessment and decision-making skills: “like an ER nurse would be perfect for a correctional setting because they have a broad range of knowledge, it’s very practical” (P5).

**Computer programs.** Participants used available computer programs to facilitate the provision of care. AHS computer programs (e.g., NetCare, E-Clinician, and internal website) provided health information about offenders. For example, one participant stated: “NetCare is a God sent, you know, you can find a lot of collateral information...E-Clinician has been very helpful to us as well with check up on the notes from the community” (P2). The majority of participants agreed that NetCare was helpful: “we pull up on NetCare, a list of medications, or recent admissions to ER, for what
reason, and what diagnostics were done, so it gives us an idea of the person that’s coming in” (P6). ABJSG computer programs (e.g., ORCA) provided corrections information about offenders. For example, one participant stated: “like the ORCA program, that’s hugely [Laughs] influential for helping locate patients, when is their court, how can I access them, do they have something coming up, kind of helps you plan” (P4).

**Education.** Participants recommended educational resources to facilitate the provision of care. Emergency and trauma care courses were commonly recommended: “I definitely recommend that they take education, if they can, for trauma nursing, ‘cause we do see a lot of emergencies” (P1). Other participants agreed with the benefit of pursuing emergency and trauma care courses, along with any other extra education. “trauma nursing core curriculum, any type of healthcare type of extra education or certification” (P11). There was a lack of educational resources specific to correctional nursing practice: “there isn’t a lot out there that’s easily accessible” (P2). As a result, participants desired more specific educational opportunities, yet had no choice but to seek out resources: “I would love to go to more education. It’s on us really to seek out education…it’s hard to get stuff that would be relevant here. That’s one area I think we can improve on” (P9). Other participants also voiced that educational resources were easily accessible in hospitals as compared to correctional institutions.

**Collaborative facilitators of care.** Participants engaged in collaborative actions – interactions to facilitate the provision of care. Collaborative facilitators of care included mentorship and teamwork. Participants specifically identified mentorship and teamwork as facilitators and resources for the implementation of correctional nursing practice.
Mentorship. Participants engaged in mentorship among each other to facilitate the provision of care. Participants identified the need for experienced nurses to mentor new and young nurses. For example, one participant voiced this need:

they [experienced nurses] understand how to engage our population, and how to get their job, or their tasks accomplished in a smooth way and we need to be retaining them, [Laughs], as best as possible, so that they can teach future, kind of, generation of correctional nurses. (P4)

Participants also highlighted a lack of mentorship. A few participants acknowledged the importance of mentorship and suggested this lack needed to be addressed. For example, one participant stated: “I think that’s lacking a lot…I think that’s probably the biggest piece that needs some work in corrections right now” (P8).

Teamwork. Participants engaged in teamwork with the interprofessional team to facilitate the provision of care. The interprofessional team included allied health professionals, healthcare professionals, and correctional officers. For many participants, a team-oriented environment was apparent as they used each other as resources: “we rely on each other as resources, and um, ah [Silence] we’re a really good team” (P2).

Another participant reported using the health team as a resource to overcome barriers: “I find my biggest resource is to overcome barriers are like, my team. If I’m struggling with something, I’ll go to them” (P5).

Participants collaborated with many allied health and healthcare professionals such as, mental health professionals, physicians, pharmacy teams, social workers, and transition teams: “we actually have a lot that help us to provide care to. So, examples would be like social workers, addictions counsellors, mental health team members who are either other [RNs] or psychologists, um, lab technicians” (P1). Another participant
agreed that having support from other professionals filled a knowledge gap: “having the resources, such as a specific STI clinic because then I don’t have to have like exact knowledge” (P3). Nursing staff were keen on teamwork among each other as well. A few participants acknowledged their corrections health management played a vital role in supporting interprofessional teamwork. Participants also collaborated with external resources (e.g., community transition team, university faculty).

The professional relationships among correctional officers and RNs were essential for effective teamwork. Most participants agreed with this idea. For example, one participant emphasized the importance of developing rapport with correctional officers to access offenders:

*I try to establish a good rapport with the COs. So, if you can be like friendly with the COs...and not seem adversarial to them, and sort of work on their timeline, like they’re very much in control, and you don’t try to like take that control away from them, you can, you can get them to then help you. So if you have a sick patient, and you need to get access to them...Like a very positive working relationship is critical [Laughs]. (P5)*

Teamwork among correctional officers and RNs was also paramount during medical emergencies: “if we’re ending up in a code, they are usually the first ones there, we can’t go in until they’ve made the area safe. But, they work very, very well with us” (P6).

**Variety of care.** Participants used a patient focused lens, assessment skills, and facilitators of care to provide a variety of care (i.e., correctional healthcare services) to offenders. Participants benefited from a generalist practice as very high-level intricate knowledge like intensive care nursing was not required. Therefore, the variety of care provided was similar to community nursing: “it’s almost like community nursing because
you kind of cover a wide variety, like every system in the body, we have dental stuff, we have mental health” (P3). Others agreed the variety of care provided was comparable to community and rural health: “it’s like rural, you know, anything and everything is walking through the door” (P10). The wide variety of care provided also included administrative duties: “it’s primary care with a lot of administrative processes what really kind of makes it quite challenging” (P13).

The provision of emergency and trauma care was common as well. For one participant, daily correctional nursing practice was similar to emergency nursing: “ER nursing is probably very similar on a daily basis to what we do” (P6). Other participants agreed the need for emergency and trauma care frequently arose: “there is actually a lot more kind of care provided, and a lot more emergency care provided than what people might initially expect” (P1), including the use of advanced cardiac life support skills.

**Challenging and Positive Outcomes**

“Consequences are anticipated or actual outcomes of action and interaction” (Corbin & Strauss, 2015, p. 159). The subcategory of challenging and positive outcomes refers to the outcomes of the implementation of correctional nursing practice (i.e., Caring Behind Bars). RNs expressed the consequences of Caring Behind Bars as challenging, yet positive outcomes did arise.

**Challenging.** An outcome of Caring Behind Bars was that it was challenging. Caring Behind Bars was challenging due to various reasons: lack of balance between corrections and health, exposure to violence, and constantly enduring dilemmas. For participants, Caring Behind Bars was challenging when they failed to balance corrections and health priorities:
finding that balance is really difficult for them [RN]s because they are, their history is more that they’re patients and only patients, and that comes in battle with sort of, remember these are inmates too, um, is too challenging for them in terms of being able to stay and work there. (P1)

One participant voiced that Caring Behind Bars was challenging due to the constant exposure to violence:

it is challenging, a challenging work environment. So, if you don’t have good boundaries, and a solid support system in the community, this place will eat you alive [Silence]...There is a lot of violence in this building...and people do experience trauma from responding to those codes. (P4)

Nursing staff were prone to becoming tainted by this challenging environment in which they started to see their offenders as objects. Participants discussed that Caring Behind Bars was also challenging due to constantly enduring dilemmas. Participants provided various examples of these dilemmas. For example, one participant discussed the provision of care versus correctional officer safety:

ABJSG want me to talk to them, and the guards will say no that’s it, you know, like there is no more talking. So, I have to obey that...But, ethically it’s an issue...Morally, you know, well I should just stand up to this officer, and say well screw you, I’m gonna go see him, but that would be putting them in jeopardy because now they have to go and protect. (P2)

Positive. An outcome of Caring Behind Bars was that positivity arose. Caring Behind Bars was amazing, exciting, fun, and interesting. Several participants identified these sentiments of Caring Behind Bars: “it’s probably going to be one of the most exciting career, or choices in their career” (P2); “it’s fun, interesting, every day is different, you don’t have to be perfect to work here” (P4); and “it is an absolutely amazing area to work” (P11). Caring Behind Bars also allowed continued growth and learning in the nursing role. For example, one participant stated:
it’s the biggest learning curve you’ll ever get in your life. You will find yourself challenged. You will find yourself learning, more quickly than you ever thought you could. You certainly have the ability to learn not only just from the medical team, but also from the inmates themselves. (P6)

Participants identified Caring Behind Bars as rewarding as they positively impacted offenders. Other participants also voiced the joy of nursing when addressing the needs of offenders. For example, one participant stated:

you’re in an extremely challenging place…and that you being there, and trying your best, and usually half decently giving a shi*t about people that the rest of the society doesn’t…That’s rewarding, and you know that you’re making a positive impact even though it doesn’t really feel like that. (P13)

Summary of the GT – Caring Behind Bars

The core category of Caring Behind Bars is the overarching category connecting six subcategories contributing to the formation of the theory. The notions of context and process were identified within the subcategories, all of which were conditions, actions – interactions, or consequences. A substantive theory regarding the implementation of correctional nursing practice is best understood by this core category. The theory of Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population (See Figure 1). RNs possessed a foundational stance regarding what nursing practice means to them in general. Upon entering the correctional context, RNs experienced tension between custody and caring. RNs engaged in adaptability and advocacy to address this tension and access the offender population. The provision of care required RNs to take numerous actions – interactions to provide care to offenders. The consequences of Caring Behind Bars were challenging and positive outcomes.
Other Notable Findings

Other notable findings emerged from this study, specifically the governance of corrections health. The governance of corrections health refers to the transitioned governance of correctional healthcare services and its employees from the Alberta Ministry of Justice and Solicitor General (ABJSG) to the Ministry of Health (AHS). Several RNs (n = 5) shared their experiences of the implementation of correctional nursing practice under each Ministry. The governance of corrections health is based on four properties: changes in autonomy; changes in correctional officer and RN relationships; lack of understanding of corrections health; and positive outcomes post transition to AHS.

Changes in autonomy. The level of autonomy changed post transition to AHS. Participants believed they possessed more autonomy under ABJSG. For example, a participant voiced the level of autonomy was greater prior to the transition because other allied health and healthcare professionals were not regularly available: “prior to AHS, we were very independent, so we performed all those functions” (P4). A few participants identified the level of autonomy was also greater prior to the transition due to the use of standing orders: “we used to be very autonomous...we were able to work under what was called back then standing orders from the physicians...That is not what it is now. Right now we are just puppets.” (P7).

Changes in correctional officer and RN relationships. Relationships among correctional officers and RNs changed post transition to AHS. Participants reported two reasons (communication and teamwork) for the changes in relationships; there was more communication and teamwork under ABJSG. Participants believed there was more
effective communication under ABJSG as all staff were employed under this authority:
“it’s just access to patients…we could all share information, right, we were all under ABJSG…Whereas, I can’t share patient information with ABJSG. Trying to explain something when you can’t share all the details is a bit difficult (P4).

Participants also believed there was more teamwork under ABJSG: “we don’t work together as an individual cohesive unit anymore, we are not ABJSG nurses, and that’s what we had to make them [correctional officers] understand, and we still do” (P6). Another participant agreed with this idea: “the camaraderie and the belonging is not the same, it’s two different departments that are trying to work together” (P7). As a result, the relationships among correctional officers and RNs suffered post transition to AHS: “some people at the beginning said that relations suffered between healthcare and ABJSG” (P8).

**Lack of understanding of corrections health.** Other professionals within AHS did not understand corrections health post transition to this authority. For example, one participant discussed that AHS staff in hospitals did not understand corrections health:

*the biggest barrier that we have...when we have our inmates in hospital, or we have taken over from [City Police Service] is not receiving information and being told that that’s confidential, and I’m like no it’s not, we are AHS, you are AHS, this is continuation of care.* (P6)

Another participant voiced that the new AHS policies and procedures were not suitable within correctional institutions:

*they [AHS] don’t understand where we work at all, they don’t understand our patient population, they don’t understand our colleagues, the ABJSG factor. So,*
they write these overarching provincial policies that are absolutely ludicrous to implement here with our level of care, the ratio, the staff mix, it’s impossible. So, trying to play within your own organization’s rules in a building that they don’t own is extremely difficult. (P4)

**Positive outcomes.** There were numerous positive outcomes post transition to AHS. A participant identified that one positive outcome post transition was being connected to AHS: “connecting us to like AHS, wonderful” (P4). Participants identified that improved continuity of care, and recruitment and retention of nursing staff were positive outcomes post transition: “anyone who’s AHS as long as it’s for continuity of care, it’s helped with communication, it’s helped with recruitment of nursing staff and other staff...those things are extremely important to facilitating good patient care” (P10). Follow up opportunities also improved post transition: “we have better ability now being part of the provincial governed association, to arrange follow up for these guys that are being released” (P8). New access to technology (e.g., NetCare) and simulation programs for training improved the implementation of correctional nursing practice. There was an increase in access to additional allied health and healthcare professionals:

> the resources are endless under AHS ...We’re seeing more days where we have a doctor’s clinic. We’re seeing more days where we have a psychiatrist in the facility... I think access is a little bit better as well...I definitely think it has been an improvement, and I think it’s bringing better care. (P8)

**Outlying Cases**

Outlying cases are those that fall at either extreme in the range of a concept, or seem contrary to what is going on in the emerging theory; these valuable outliers should
be included as they represent alternative explanations or variation (Corbin & Strauss, 2015). There were several cases that were contrary to the emerging data, and one extreme case. Most outlying cases pertain to the theory of Caring Behind Bars, however two cases also emerged for the governance of corrections health.

**Health is not always priority.** Contrary to the emergence of this property, exceptions existed in which health was a priority. Participants reported the prioritization of health was evident during medical emergencies. For example, two participants stated: “the biggest barrier to care is that the officers security or preference supersedes healthcare all the time unless it’s an emergency” (P10); and “it’s very much more in times of emergency, the incarcerated individual, their health becomes much more of a priority” (P13).

**Correctional services operations.** Contrary to the emergence of this property, correctional officer presence was, at times, a facilitator in the provision of care. For example, one participant stated: “they’re great facilitators because, you know, if they’re on a unit you got an extra set of eyes watching over the people, and not just about the custody, but, it’s about the care” (P2). Other participants agreed that officer presence facilitated the provision of care such as, encouraging offenders to comply with healthcare plans, and facilitating the development of rapport among RNs and offenders.

**Governance of corrections health.** Contrary to the property of changes in autonomy in which participants voiced more autonomy under ABJSG, these changes were also beneficial. For example, one participant agreed there was greater autonomy prior to the transition, yet the new policies and procedures provided more guidance for correctional nursing practice:
we were probably more independent under ABJS...if you were a nurse in a hospital and you came into corrections...you were expected to know and do all these assessments, like you had standing orders, but they probably weren’t as detailed as like our policies and protocols now...it helps nurses like understand what they’re looking for now. (P9)

Other participants agreed there was greater autonomy prior to the transition, yet now there was more regulation of correctional nursing practice contributing to safer care:

you could do whatever you wanted [Laughs]...And seeing some of the scope of the nurses, I was like I don’t think this is in scope...The autonomy did change, but in a way that I think would facilitate safer care...you’re still very autonomous, but you’re also more accountable. (P10)

The emergence of the extreme case aligned with the property of positive outcomes post transition to AHS. The extreme case was the evolution of correctional nursing practice from punitive to therapeutic. For example, one participant stated: “our practice before when we worked for the officers was more punitive in nature...based on my assessment and what I tell the officers, the patient could get in trouble, which is fundamentally against a therapeutic nurse patient relationship” (P10). Moreover, this participant emphasized that correctional services authorities should not be supervising healthcare professionals as this may strain nursing ethics and standards. The transition of the governance of corrections health positively impacted correctional nursing practice: “I would say the biggest difference now, before we had a punitive practice, and now we have a therapeutic practice” (P10).
Chapter Summary

A substantive theory regarding the implementation of correctional nursing practice is best understood by the core category of Caring Behind Bars and its six subcategories. The theory of Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population (See Figure 1). Other notable findings emerged from this study, specifically the governance of corrections health. Outlying cases presented alternative explanations and variation in the findings (Corbin & Strauss, 2015).
Chapter 5 Discussion

The existing literature was used to situate the findings; the majority of the literature is nursing focused. The findings made a novel contribution to the state of the current literature. Lastly, there were several limitations of this study.

Review of the GT – Caring Behind Bars

A substantive theory regarding the implementation of correctional nursing practice is best understood by the core category of Caring Behind Bars and its six subcategories. The theory of Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population (See Figure 1). RNs possessed a foundational stance regarding what nursing practice means to them in general. Upon entering the correctional context, RNs experienced tension between custody and caring. RNs engaged in adaptability and advocacy to address this tension and access the offender population. The provision of care required RNs to take numerous actions – interactions to provide care to offenders. The consequences of Caring Behind Bars were challenging and positive outcomes.

Situating the Findings

The existing literature was used to situate the findings. The majority of the existing literature is nursing focused. The findings provided insights to advance correctional nursing practice and promote offender health from all domains of nursing practice.

Foundational stance. The subcategory of foundational stance refers to the RNs views on what nursing practice means to them in general, prior to entering the correctional context. The foundational stance is based on three properties: nursing
process, nonjudgmental approach to care, and elements of care. Participants identified the use of the nursing process. Ida Jean Orlando developed the five steps of the nursing process in the late 1950s (Orlando, 1972 as cited in Kent-Wilkinson, 2009): assessment, diagnosis, plan, intervention, and evaluation (Kent-Wilkinson, 2009; Turkel, Ray, & Kornblatt, 2012). The nursing process is a problem-solving tool (Melin-Johansson, Palmqvist, & Rönnberg, 2017; Semachew, 2018) used to identify, prevent, and treat actual or potential health issues and promote wellness (Semachew, 2018). Authors have discussed the nursing process in a myriad of contexts: forensic nursing (Kent-Wilkinson, 2009), nurses’ intuition (Melin-Johansson et al., 2018), play therapy (Sezici, Ocakci, & Kadioglu, 2017), hospital settings (Semachew, 2018), and disaster preparedness (Bulson & Bulson, 2011).

Participants discussed the importance of a nonjudgmental approach to care, especially to provide an equivalent standard of care to all populations regardless of their backgrounds. Nursing authors have also emphasized the importance of a nonjudgmental approach to care in different contexts such as, psychiatric care (Beentjes, Goossens, & Jongerden, 2016), medically assisted death (Beuthin, Bruce, & Scaia, 2018), nurse practitioner care (Carroll, 2019), and opioid use in adolescence (Carson, 2019). Societal norms and stereotypes can impact the nursing care provided (Carson, 2019), hence the use of a nonjudgmental approach to care is crucial for many reasons: to stay connected with patients experiencing health challenges (Beentjes et al., 2016); to focus on patient needs when faced with controversial situations (Beuthin et al., 2018); and to deliver quality care by diminishing stigma and health disparities faced by vulnerable populations.
The Canadian Nurses Association (CNA) also advocated for RNs to be nonjudgmental when providing care (CNA, 2017).

Participants indicated the foundational elements of care included holism, health promotion, and patient focused. A holistic approach in nursing can refer to “whole person care” acknowledging the body, mind, and spirit (Frisch & Rabinowitsch, 2019, p. 260), and a multidimensional perspective of health (Povlsen & Borup, 2011). Nursing authors have recognized the concept of holistic care within varying nursing contexts such as, medically assisted death (Beuthin et al., 2019), nurse practitioner care (Carroll, 2019), and gerontological nursing (Berg, Hedelin, & Sarvimäki, 2005). Health promotion, illness prevention, and the enhancement of wellbeing are required in guiding healthcare system transformation (Canadian Medical Association [CMA] & CNA, 2011). Nursing authors have also cited that health promotion is a component of the nursing role (Bright & Burdett, 2019; Darch, Baillie, & Gillison, 2017; Kemppainen, Tossavainen, & Turunen, 2012; Povlsen & Borup, 2011; Ross et al., 2019; Simpson & Hass, 2019). Nurses not only prevent actual or potential health problems, but they also promote wellness (Semachew, 2018). RNs can promote health across the continuum of care, from birth to death, to improve the health and wellbeing of all Canadians (CNA, 2015).

Participants emphasized the provision of care was patient focused, specifically meeting patients where they’re at. In 2001, the Institute of Medicine recognized the need to focus on patients (i.e., patient centered care) as one of six aims to achieve quality care (as cited in Doktorchik et al., 2018). Authors have cited the importance of patient centered care regarding the domains of nursing practice such as, research (Bernstein, Getchell, & Harwood, 2019), clinical practice (Kollstedt, Fowler, & Weissman, 2019),
and education (Powers, Morris, Flynn, & Perry, 2019). Various Canadian organizations have also advocated for a patient and family centered approach to care (AHS, 2014; British Columbia Ministry of Health, 2015; CMA & CNA, 2011; Registered Nurses’ Association of Ontario [RNAO], 2015).

**Tension between custody and caring.** The subcategory of tension between custody and caring refers to the conditions experienced by RNs upon entering the correctional context. The tension between custody and caring is based on five properties: correctional culture, conflicting attitudes, health is not always priority, correctional services operations, and physical structure of correctional institutions. Each property conveyed the tension RNs experienced between custody (represented by the correctional/corrections services duties and priorities) and caring (i.e., implementing nursing practice including, the provision of care). RNs did not experience this tension chronologically (i.e., properties were not experienced in order); there was an interplay of properties, hence RNs can experience these in any combination. Tension was provoked as RNs strived to care, yet this was not easily accomplished due to the correctional context. RNs identified the existence of this tension regardless of the governance of correctional healthcare services by the health authority (AHS).

The dual roles of custody and caring as adversaries are accurate since RNs practice within secure environments (Maroney, 2005) that do not prioritize health and wellbeing (Brodie, 2001). Therefore, rhetoric of custody prior to caring is not surprising. However, caring shares an equal role in the provision of care to offenders (Maroney, 2005) as Canadian RNs are governed and regulated healthcare professionals that are
legislated to uphold and provide appropriate standards of care in all settings. Therefore, RNs must not devalue caring over custody in their practice.

Caring and custody can coexist (Maroney, 2005; Peternelj-Taylor & Johnson, 1996) and “should not be competing interests – in fact, they are two faces of the same reality” (Maroney, 2005, p. 167). RNs must attempt to strike a balance between custody and caring (Peternelj-Taylor & Johnson, 1995) while bridging the gap (Peternelj-Taylor, 1999) and positively interpreting the interface amid these two entities (Willmott, 1997). Effective interprofessional collaboration among correctional officers and RNs may diminish tension between custody and caring to advance correctional nursing practice and promote offender health. Correctional services authorities should also promote effective interprofessional collaboration among their correctional officers and RNs.

**Correctional culture.** Participants identified the existence of a correctional culture. Several authors have discussed that correctional institutions possess a unique culture (Choudry, Armstrong, & Dregan, 2017; Christensen, 2014; Dale & Woods, 2002; Steefel, 2018; White & Larsson, 2012). The punitive correctional culture (Steefel, 2018) and environment (Christensen, 2014) may not always be well suited to the aspirations of nursing practice (Dale & Woods, 2002), and are at odds with the nursing tenets of caring (Steefel, 2018), and altruistic nature of the nursing profession (Christensen, 2014). Goffman (1961) also discussed culture within total institutions (i.e., correctional institutions); these institutions do not look for cultural victory, instead they create and sustain a tension between the home world (i.e., offenders life prior to admission) and the institutional world, and “use this persistent tension as strategic leverage in the management of men” (p. 13).
Participants reported that negative talk was an inevitable component of this correctional culture. Munger, Savage, and Panosky (2015) also reported that correctional nurses are exposed to profanity and or vulgarity of corrections staff and offenders. The language used within correctional institutions is strange (Christensen, 2014) and military like (White, Jordens, & Kerridge, 2014). Offenders admitted into correctional institutions are introduced to a new vocabulary used by correctional officers and fellow offenders (Steefel, 2018). The provision of care requires an increased understanding of the correctional culture (Christensen, 2014), which can be gained via effective interprofessional collaboration among correctional officers and RNs to advance correctional nursing practice and promote offender health.

**Conflicting attitudes.** Participants identified the existence of two different entities within correctional institutions – corrections and health. Nursing authors have discussed the conflict between the entities of corrections and health (Christensen, 2014; Dale & Woods, 2002; Doyle 1999; Doyle, 2003; Hardesty, Champion, & Champion, 2007; Steefel, 2018). Correctional nursing practice mandates a paradigm shift for nurses accustomed to focusing on health, whereas within correctional institutions, the larger entity of corrections is often priority (Parrish, 2016).

The existence of these different entities led to the conflicting attitudes among corrections and health staff. Participants emphasized that RNs attitudes focused on caring for and helping offenders, whereas correctional officers questioned the need for and value of nursing care. Nursing authors have indicated that correctional officers and nurses possess conflicting ideologies (Almost et al., 2013; Doyle, 2003; Maeve & Vaughn, 2001; Smith, 2003; Solell & Smith, 2019; Weiskopf, 2005). Correctional officers are
guided by different ethical principles than nurses (Maeve & Vaughn, 2001), and not by the promotion of health and wellbeing. Correctional officers sometimes treat nurses with the same disdain as they treat offenders (Maeve, 1997). As a result, correctional officers may convey conflicting attitudes towards nurses and nursing care in various ways: question the necessity, validity, and the intrinsic worth of healthcare interventions (Doyle, 2003; White et al., 2014); question the legitimacy of a nurse’s request to attend to an offender (Almost et al., 2013); and second guess the nurse’s role (Solell & Smith, 2019).

In Weiskopf’s (2005) study, nurses reported that caring for offenders was a constant fight with correctional officers, and felt autonomous and supported based on whether officers valued healthcare, or not. The attitudes of correctional officers tend to determine who holds and exercises the power and authority for the prioritization of healthcare services (Smith, 2003). Healthcare professionals often face a dual loyalty to the correctional institutions and offender population (Pont et al., 2018); this conflict between custody and caring may negatively impact nurse autonomy and the provision of care giving rise to ethical and moral distress (Sasso, Delogu, Carrozzino, Aleo, & Bagnasco, 2018). Effective interprofessional collaboration among correctional officers and RNs may diminish conflicting attitudes to advance correctional nursing practice and promote offender health.

Participants also portrayed a nonjudgmental approach to care to provide high and equivalent standards of care to the general public. Nursing authors have agreed that judging and labeling offenders may negatively impact the care provided (Brodie, 2001; Dean, 2013; Jacob, 2012; Jacob, 2014; Rogalla, 2002; Solell & Smith, 2019) specifically,
damage to the quality and outcomes (Brodie, 2001), and such nurse behaviour is incompatible with therapeutic relationships (Rogalla, 2002). In the studies by Weiskopf (2005) and White et al. (2014), nurses and physicians reported looking beyond the offender’s past behaviour and criminal history to provide care. Maeve and Vaughn (2001) stressed that healthcare services provided “based on what a person might be charged with or convicted of, is a slippery slope that will undermine the integrity of all healthcare professionals” (p. 61). Nurses need to provide nonjudgmental quality care (Munger et al., 2015) regardless of any bias about offender backgrounds (Solell & Smith, 2019); it is not essential to know the crime to provide care (Parrish, 2016). Nurses require support to set their personal feelings aside (Dean, 2013).

**Health is not always priority.** Participants acknowledged that correctional institutions are not hospitals (i.e., typical health settings), hence correctional issues were often prioritized over health. Examples of correctional issues included incarceration, safety, and security. Nursing authors have also identified that health and wellbeing are not the primary purposes of correctional institutions (Brodie, 2001; Schoenly, 2013a), rather safety and security are prioritized (Dale & Woods, 2002; Flanagan & Flanagan, 2001; Sasso et al., 2018; Solell & Smith, 2019; White & Larsson, 2012), which may pose a challenge in the provision of care (Jacob, 2014; Pont et al., 2018). Correctional institutions “are organized to protect the community against what are felt intentional dangers to it, with the welfare of the persons thus sequestered not the immediate issue” (Goffman, 1961, pp. 4-5). Similar to the participants, Solell and Smith (2019) also revealed that nurses felt safer within correctional institutions as compared to hospitals.
RNs must effectively collaborate with correctional officers to uphold their responsibility of caring for offenders regardless if health is not always priority.

**Correctional services operations.** Participants described the correctional institutions as hierarchical, paramilitary settings in which they experienced operational constraints and restrictions. An organizational structure exists within correctional institutions (Christensen, 2014; Steefel, 2018), including a hierarchy of power (Christensen, 2014; WHO, 2014). Military like hierarchies increase the risk of correctional services interference in the clinical independence of healthcare professionals (Pont et al., 2018). Participants reported that correctional services operational factors (i.e., officer presence, officer availability, and officer duties) were potential barriers to offender accessibility and the provision of care.

Correctional institutions are very regimented (Maeve & Vaughn, 2001), thus daily activities are tightly scheduled and imposed by a system (Goffman, 1961). The schedules are dictated by security demands rather than health priorities (Sasso et al., 2018), hence the provision of care is supervised and constrained by the availability of correctional officers (White et al., 2014). The structure of daily life is under the control of correctional officers (Steefel, 2018), including nurses’ access to offenders (Christensen, 2014; Tompkins, 2016), which challenges the provision of care (Steefel, 2018). Correctional officers’ policies and procedures may hinder offender accessibility (White et al., 2014) and postpone the provision of care (Christensen, 2014). Christensen (2014) and Steefel (2018) identified similar operational factors such as, rigid schedules for meal times and exercise times, and security routines like head counts. Often times these correctional services operations prioritize security and containment above any therapeutic
consideration (Doyle, 2003). Effective interprofessional collaboration among correctional officers and RNs may diminish the strain of correctional services operations on offender accessibility and the provision of care.

**Physical structure of correctional institutions.** Participants reported the physicality of correctional institutions challenged offender accessibility and the provision of care. Participants did not indicate this physicality contributed to the rehabilitation of offenders. The physical nature of correctional environments was not conducive to a healing environment. Nursing authors have identified the physical environments of correctional institutions are characterized by secure perimeters and technology (Doyle, 2003), and developed to seclude, segregate, and confine (Doyle, 1999). “Secure perimeters, armed towers, locked doors, cells, bars, electronic surveillance, and razor wire are omnipresent reminders of the monolithic and unremitting administration of correction and criminal justice” (Doyle, 1999, p. 32). Large numbers of like-situated individuals, removed from the broader society for specific time periods, “together lead an enclosed, and formally administered round of life” (Goffman, 1961, p. xiii) with little privacy (Doyle, 2003; Schoenly, 2013a; White et al., 2014) or personal space (Doyle, 2003). The boundaries offenders place between their being and the environment are invaded (Goffman, 1961).

Healthcare units are often underequipped with a lack of appropriate space for the provision of care (Schoenly, 2013a), hence interventions may be delivered in confined physical spaces (Doyle, 2003). Correctional nurses may share over crowded conditions similar to the offenders (Doyle, 1999; Doyle, 2003; Schoenly, 2013a; White et al., 2014), and these poor working conditions (i.e., cramped, poorly lit, and unclean) may contribute
to the development of vicarious trauma (Munger et al., 2015). The provision and ethics of care may be compromised by the physicality of correctional institutions because this defines how and where offenders receive care (White et al., 2014).

**Adaptability and advocacy.** The subcategory of *adaptability and advocacy* refers to the initial actions – interactions taken by RNs to address the *tension between custody and caring*. *Adaptability and advocacy* is based on three properties: adaptability requires creativity and flexibility; and advocacy requires convincing and explaining, and rationalizing by identifying the potential consequences of not providing care. The *tension between custody and caring* was the reason that RNs adapted and advocated to access the *offender population*. RNs adjusted their *adaptability and advocacy* based on these conditions.

**Adaptability.** Participants adapted accordingly when they experienced *tension between custody and caring* to access offenders. Participants adjusted their degree of adaptability by using creativity and flexibility whilst following the routines within correctional institutions. There are strict routines within correctional institutions (Christensen, 2014; WHO, 2014), which may serve to remove some control for healthcare professionals over their work conditions (WHO, 2014). Several authors have discussed adaptability within correctional institutions, especially when strict routines are a norm (Choudry et al., 2017; Hardesty et al., 2007; Sasso et al., 2018). Nurses’ ability to adapt to correctional conditions (Choudry et al., 2017) and the needs of offenders (Sasso et al., 2018) can facilitate the implementation of nursing practice (Choudry et al., 2017). Hardesty et al. (2007) identified correctional nursing practice styles reflecting varying degrees of adaptability and functionality; the realist style was beneficial as it required
nurses to understand the custody (security) while caring (implementing nursing practice). Walsh et al. (2012) also recommended the need for creative and flexible approaches to address the tension between custody and caring.

**Advocacy.** Participants adjusted their degree of advocacy in two ways: convinced and explained to correctional officers about why they needed to access and provide care to offenders; and rationalized to correctional officers the potential consequences of not providing care. Nursing authors have emphasized the need for nurses to advocate for offenders (Hernandez-Sherwood, 2012; International Council of Nurses [ICN], 2011; Maeve & Vaughn 2001; Parrish, 2016; Rogalla, 2002; Schoenly, 2014; Solell & Smith, 2019; Weiskopf, 2005), including their own role (Solell & Smith, 2019). Nurses must advocate to maintain conditions that will facilitate caring (Maeve & Vaughn, 2001) and safe humane treatment including dignity, respect, and other necessities of life (ICN, 2011).

Advocacy does not transpire easily – nurses “constantly ‘walk the line’ between the requirements of security, healthcare, and client advocacy” (Peternelj-Taylor & Johnson, 1995, p. 14), and are challenged to promote a caring environment when safety precautions outweigh advocacy (White & Larsson, 2012). Therefore, advocacy is risk laden for nurses (Weiskopf, 2005), and may be controversial within correctional institutions (Smith, 2003). Healthcare professionals should be safeguarded as advocates for offenders (WHO, 2014), and from reprisals related to advocacy (ICN, 2011). All healthcare professionals can advocate for policy and practice changes that will eradicate barriers to correctional healthcare services access (McLeod & Martin, 2018). Advocacy is a component of the RN role; corrections health authorities must prioritize the ongoing
development of advocacy skills via education to advance correctional nursing practice and promote offender health.

**Offender population.** The subcategory of *offender population* refers to the offenders residing within correctional institutions. RNs described the complexity of the *offender population* in four conditions (i.e., properties): all individuals, attitudes, manipulation as survival mode, and vulnerable. Participants described that all patients are human beings in any setting including correctional institutions. Nursing authors also support the notion that offenders are human beings (“Caring in Corrections,” 2010; Parrish, 2016; Rogalla, 2002; Solell & Smith, 2019; Weiskopf, 2005) who may require healthcare services (“Caring in Corrections,” 2010; Rogalla, 2002), and possess the right to such services (ICN, 2011; Maeve & Vaughn, 2001).

Participants described the attitudes expressed by offenders towards health and wellbeing in two ways. First, offenders expressed feelings of being judged by healthcare professionals and the public. Several authors have discussed offender distrust towards healthcare professionals (Besney et al., 2018), including nurses (Choudry et al., 2017). There are several causes of distrust of healthcare professionals: distrust toward nurses’ work is influenced by the correctional culture such as, nurses are a part of the system (Choudry et al., 2017); the lack of professionalism is a basis for negative experiences in the community and during incarceration (Besney et al., 2018); and a lack of respect (Besney et al., 2018; Cuthbertson, Kowalewski, Edge, & Courtney, 2018). Cuthbertson et al. (2018) revealed several findings regarding offender views of healthcare professionals: poor listening and judgmental were identified as negative attributes; feelings of stigmatization arose when interacting with these professionals; and trust in physicians
among offenders was lower than community populations. Offenders may also view staff as condescending, highhanded, and mean (Goffman, 1961). Second, offenders expressed varying attitudes regarding health and wellbeing (e.g., lack of its prioritization). In a study by Choudry et al. (2017), nurses reported offenders lack of prioritization of health and wellbeing; offenders made unhealthy food choices, chose to be inactive, and did not care about health.

Participants voiced that offenders presented as manipulative with ulterior motives to attain whatever they desired. Nursing authors have identified similar causes of manipulation: fabricated healthcare concerns to avoid work assignments (Flanagan & Flanagan, 2001); “faking it” for medication (Foster et al., 2013) or food supplements (Choudry et al., 2017); diversion or entertainment (Peternelj-Taylor & Johnson, 1995); and valid healthcare needs versus wants (Day, 1983; Maroney, 2005; Sasso et al., 2018). Participants concluded that offenders manipulated to survive within correctional institutions; it was a way to have their needs met. Nursing authors have also indicated that manipulation may be used as a survival skill to meet needs (Maeve, 1997; Maroney, 2005; Schoenly, 2014). Ultimately, manipulative behaviour may compromise the way healthcare needs are met, and the ethical value of therapeutic relationships (Sasso et al., 2018).

Participants described the offenders as being vulnerable. A myriad of factors contributed to this vulnerability: a lack of accessibility to healthcare services outside of correctional institutions, homelessness, marginalization, and unmet basic needs. Nursing authors have also recognized the offenders as vulnerable (Chafin & Biddle, 2013; Christensen, 2014; Maroney, 2005; Maruca & Shelton, 2016; Schoenly, 2013a; Solell &
Smith, 2019). Other researchers have identified similar reasons for this vulnerability: poorer health outcomes as compared to the general public (Fazel & Baillargeon, 2011); stigmatization due to mental illness (Melnikov et al., 2017); lack of health education (Flanagan & Flanagan, 2001); lack of healthcare accessibility (Green, Foran, & Kouyoumdjian, 2016; Solell & Smith, 2019); and unmet health needs prior to incarceration (Green et al., 2016). Fazel and Baillargeon (2011) suggested the health disparity between offenders and the general population has been attributed to various behavioural and socioeconomic factors such as, high rates of intravenous drug use leading to the increased risk of infectious diseases, alcohol misuse, and smoking; these behaviours also raise the risk of cardiovascular disease and some cancers (Fazel & Baillargeon, 2011).

**Provision of care.** The subcategory of *provision of care* refers to actions – interactions taken by RNs to provide care to offenders. The *provision of care* is based on four properties: patient focused, assessment, facilitators of care, and variety of care. RNs acknowledged the complexity of offenders using a patient focused lens, and then used assessment skills and facilitators of care to provide a variety of care.

**Patient focused.** A participant discussed that gaining knowledge of the determinants of health for each offender was important to become patient focused. Likewise, nurses require knowledge of the complicated backgrounds of offenders (Solell & Smith, 2019) and their demographics (Schoenly, 2013a) to provide care. Participants identified the need to establish rapport and trust to become patient focused. There is a split between the large managed group (i.e., offenders) and staff (Goffman, 1961), thus nurses may experience difficulty in developing therapeutic rapport with offenders.
(Choudry et al., 2017; Jacob, 2012; Jacob, 2014; Maroney, 2005; Parrish, 2016; Sasso et al., 2018; Weiskopf, 2005). The nature of these nurse-patient relationships may impact offender health (Maeve, 1997), and the inability to establish such relationships is a potential barrier to health promotion (Choudry et al., 2017). Yet, correctional nurses can prevail to develop caring relationships (Weiskopf, 2005), and potentially experience higher levels of job satisfaction (Sasso et al., 2018).

Participants became patient focused by meeting patients where they’re at. Cuthbertson et al. (2018) and Sasso et al. (2018) emphasized the need for healthcare professionals to focus on offenders. Solell and Smith (2019) advocated for the incorporation of the McCormack and McCance Person-centred Practice Framework into correctional nursing practice. The principles of patient centered care can be applied to improve the quality of care, experience, and health outcomes for offenders (Cuthbertson et al., 2018). Correctional nurses must adapt their practice (Sasso et al., 2018) to meet their patients where they’re at. The study findings inform RNs of how to provide care that is focused upon offenders. The ongoing development of patient centered and focused care is required to advance correctional nursing practice and promote offender health.

Assessment. Participants required strong assessments skills due to the variety of care provided. Nursing assessment may be the initial point of offender contact to determine whether additional healthcare services are required (Schoenly, 2015). Nursing authors have identified the importance of assessment skills for correctional nursing practice (Flanagan & Flanagan, 2001; Parrish, 2016; Peternelj-Taylor & Woods, 2019; Sasso et al., 2018; Schoenly, 2014; Schoenly, 2015; Solell & Smith, 2019; Weiskopf, 2005; White & Larsson, 2012). Nurses require assessment skills to evaluate the
manifestation of signs and symptoms (Schoenly, 2015), and to identify and prioritize the health needs of offenders (Solell & Smith, 2019). In a Canadian study by Peternelj-Taylor and Woods (2019), most nurses placed some level of importance on a variety of assessments; the assessments rated as very important were suicide, mental health, and self-harm. A few nursing authors have also discussed the use of a rapid assessment technique for correctional nursing practice (Flanagan & Flanagan, 2001; Schoenly, 2015).

Numerous participants also reported that assessment skills were crucial to address manipulative behaviour. Several nursing authors have conferred that correctional nurses require strong assessment skills to address manipulative behaviour (Flanagan & Flanagan, 2001; Parrish, 2016; Sasso et al., 2018; Schoenly, 2014; Weiskopf, 2005). Offenders may present with actual (Schoenly, 2014), fabricated (Flanagan & Flanagan, 2001; Sasso et al., 2018; Schoenly, 2014), or exaggerated symptoms (Flanagan & Flanagan, 2001; Sasso et al., 2018). Offenders may report symptoms for secondary gain to manipulate the healthcare system for reasons other than illness (Flanagan & Flanagan, 2001). Correctional nurses may not rely on the veracity or validity of offenders’ report of symptoms (Flanagan & Flanagan, 2001) because they may not present their medical complaints honestly (Weiskopf, 2005). As a result, correctional nurses must discern between actual problems and ulterior motives (Parrish, 2016) using highly honed assessment skills (Flanagan & Flanagan, 2001; Sasso et al., 2018). Corrections health authorities must prioritize the ongoing development of assessment skills via education to advance correctional nursing practice and promote offender health.
**Independent facilitators of care.** Participants engaged in independent actions – interactions to facilitate the provision of care. Independent facilitators of care included background clinical practice experience, computer programs, and educational resources. Participants specifically identified the use of computer programs and educational resources as facilitators and resources for the implementation of correctional nursing practice.

**Background clinical practice experience.** Participants reported that background clinical practice experience facilitated the provision of care. Flanagan and Flanagan (2001, 2002) and Flanagan (2006) reported that often times nurses coming into correctional nursing possess previous clinical practice experience; in two of these studies, the majority of nurses had prior practice experience in hospitals (Flanagan & Flanagan, 2001; Flanagan, 2006). Hardesty et al. (2007) revealed that nurses with prior experience in the emergency department or mental health reported the most positive perceptions of their jobs within correctional institutions. Background clinical practice experience can contribute to the implementation of correctional nursing practice in various ways: job satisfaction and perceived stress is informed by previous experience (Flanagan & Flanagan, 2002); contribute to shaping nurse perceptions within correctional institutions (Hardesty et al., 2007); and previous experience with released offenders can pique clinicians’ interest to practice within correctional institutions (Hale, Haley, Jones, Brennan, & Brewer, 2015). From a nursing discipline lens, further knowledge development via research regarding background clinical practice experience (e.g., type and benefit) is required to advance correctional nursing practice and promote offender health.
**Computer programs.** Participants used available AHS and ABJSG computer programs to facilitate the provision of care. Contrary to the participants, several nursing authors have identified limited access to technology for correctional nurses (Almost et al., 2013; Almost et al., 2019; Christensen, 2014), yet it is required to support the provision of care (Almost et al., 2013). Limited technological resources may negatively impact the provision of care within correctional institutions (Christensen, 2014). Medical and pharmacy professionals have discussed the benefits of other types of technology (e.g., health information exchange systems and telemedicine) for corrections health (Doarn, Justis, Chaudri, & Merrell, 2005; Hinchman, Hodges, Backus, & Warholak, 2018; Young & Patel, 2015). Corrections health authorities must explore the use of changing technology in the provision of care to advance correctional nursing practice and promote offender health.

**Education.** Participants recommended educational resources to facilitate the provision of care. There was a lack of educational resources specific to correctional nursing practice. Nursing authors have also identified the lack of educational resources pertinent to correctional nursing practice (Almost et al., 2013; Peternelj-Taylor & Woods, 2019; Sasso et al., 2018). The breadth of scope is both a challenge and an attraction for correctional nurses – the challenge relates to skill development (Almost et al., 2013) because many nurses start practicing without all of the required nursing competencies (Shelton, Weiskopf, & Nicholson, 2010) and education (Maroney, 2005). Yet correctional nurses require specialized knowledge and skill (Almost et al., 2013; Schoenly, 2015), which may be gained from educational resources. The specialized knowledge and skill is beneficial for various reasons: to practice to full scope (Almost et
al., 2013); to address the complex needs of offenders (Almost et al., 2013); to safely transition into correctional institutions (Shelton et al., 2010); and to resolve ethical issues and reduce moral distress (Sasso et al., 2018). Chafin and Biddle (2013) advocated that correctional nursing leaders should provide education opportunities for their frontline nurses. From a nursing discipline lens, correctional nursing research is required to develop educational resources that can be used by frontline RNs to advance correctional nursing practice and promote offender health.

**Collaborative facilitators of care.** Participants engaged in collaborative actions – interactions to facilitate the provision of care. Collaborative facilitators of care included mentorship and teamwork. Participants specifically identified mentorship and teamwork as facilitators and resources for the implementation of correctional nursing practice.

**Mentorship.** Participants engaged in mentorship among each other to facilitate the provision of care. Nursing authors have discussed the benefits of mentorship in different nursing contexts such as, camp nursing (Laske, 2019), critical care (Kanaskie, 2006), nursing academia (Genrty & Johnson, 2019; Nowell, White, Mrklas, & Norris, 2017), and nursing graduate education (Anderson et al., 2019). Participants also highlighted a lack of mentorship. Likewise, only a few authors have discussed mentorship within the forensic nursing context (Cashin & Potter, 2006; Clements, Mugavin, & Capitano, 2005). Cashin and Potter (2006) declared that no published literature existed about mentoring in forensic environments such as correctional institutions. Clements et al. (2005) discussed the need for mentorship in forensic nursing research.

Participants identified the need for experienced nurses to mentor new and young nurses. Chafin and Biddle (2013) also identified the need to retain experienced nurses.
Experienced nurses can take on a leadership role to support other nurses via mentoring (Dhaliwal & Hirst, 2019; Parrish, 2016). Appropriate orientation processes can support new RNs within correctional institutions (Chafin & Biddle, 2013; Parrish, 2016), including the development of mentorship programs among staff and administration to increase the perception of organizational support (Flanagan, 2006). Corrections health authorities must prioritize the development and evaluation of mentorship programs to advance correctional nursing practice and promote offender health.

**Teamwork.** Participants engaged in teamwork with the interprofessional team to facilitate the provision of care. The interprofessional team included allied health professionals, healthcare professionals, and correctional officers. Several authors have cited the importance of collaboration and teamwork among professionals employed within correctional institutions (Almost et al., 2013; La Cerra et al., 2017; Leaman, Emslie, Richards, & O’Moore, 2016; Peternelj-Taylor & Woods, 2019; Schoenly, 2013b; Schoenly, 2014; Solell & Smith, 2019). Participants also collaborated with external resources (e.g., community transition team, university faculty). Schoenly (2013b) reinforced that nurses’ collaboration with professionals outside of correctional institutions is crucial as not all care can be provided behind bars.

Participants emphasized that professional relationships among correctional officers and RNs were essential for effective teamwork. Various authors have cited the importance of teamwork among corrections and health professionals: to reduce the impact of unhealthy correctional environments on the transmission of infectious diseases (ICN, 2011); to develop a common understanding of processes and priorities (Leaman et al., 2016); the implementation of correctional nursing practice depends on collaboration
with officers (Sasso et al., 2018); to navigate offenders through the system and accomplish positive health outcomes (Schoenly, 2013b); and for safety purposes (Maeve & Vaughn, 2001; Schoenly, 2014; Smith, 2003). The provision of ethical care requires teamwork among all professionals within correctional institutions (Foster et al., 2013; Pont et al., 2018), while safety and security are maintained (Foster et al., 2013). Effective interprofessional collaboration among correctional officers and RNs may promote the provision of care.

**Variety of care.** Participants used a patient focused lens, assessment skills, and facilitators of care to provide a variety of care to offenders. Nursing authors have also identified that nurses provide a variety of care to offenders such as, emergency, geriatric, maternal health, mental health, and public health (Almost et al., 2013; Shelton et al., 2010; Solell & Smith, 2019). For participants, the provision of emergency and trauma care was common as well. A few nursing authors have agreed that emergency and trauma care are common within correctional institutions (Peternelj-Taylor & Woods, 2019; Solell & Smith, 2019), and nurses identify it as a very important practice issue for their knowledge and learning to meet offender needs (Peternelj-Taylor & Woods, 2019), including an immediate training need (Flanagan & Flanagan, 2001). One participant identified that RNs engaged in administrative duties to facilitate the provision of care; likewise, Solell and Smith (2019) also reported administrative duties were a component of correctional nursing practice. Another participant voiced that RNs are primary healthcare professionals. Several nursing authors have indicated that nurses are primary healthcare professionals within correctional institutions (Flanagan & Flanagan, 2001; La Cerra et al., 2017; Muse, 2013; Solell & Smith, 2019; White & Larsson, 2012) through
which offenders access care (La Cerra et al., 2017; Muse, 2013). RNs must possess strong skill sets due to the variety of care provided behind bars. From a nursing discipline lens, further knowledge development via research about background clinical practice experience beneficial for the variety of care provided is required to advance correctional nursing practice and promote offender health. Corrections health authorities must also prioritize the ongoing development of RN skill sets to advance correctional nursing practice and promote offender health.

**Challenging and positive outcomes.** The subcategory of *challenging and positive outcomes* refers to the outcomes of the implementation of correctional nursing practice (i.e., Caring Behind Bars). Participants reported Caring Behind Bars was challenging when RNs failed to balance corrections and health priorities. The provision of care is challenging for nurses (Almost et al., 2013; Cashin & Potter, 2006; Hale et al., 2015). Several nursing authors have reported that nurses experience the challenge of finding a balance, and prioritizing between providing care and the need for security (Almost et al., 2013; “Caring in Corrections,” 2010; Maroney, 2005; Sasso et al., 2018; Weiskopf, 2005).

Participants reported that Caring Behind Bars was challenging due to the constant exposure to violence. Some nursing authors have discussed correctional nurses’ exposure to violence (Flanagan & Flanagan, 2001; Flanagan & Flanagan, 2002; Maroney, 2005; Munger et al., 2015; Schoenly, 2014). Workplace violence concerns are ever-present within correctional institutions (Schoenly, 2014), including varying degrees of violence and violent behaviour (Maroney, 2005). Munger et al. (2015) reported that exposure to violence is one factor placing correctional nurses at risk for vicarious trauma; in their
study, correctional nurses who experienced violence had lower levels of compassion satisfaction, and higher levels of secondary traumatic stress and burnout compared to those who did not experience violence. Correctional nurses may experience increased stress due to the fear of exposure to violence (Flanagan & Flanagan, 2001; Flanagan & Flanagan, 2002). Participants were prone to becoming tainted by the challenging environment in which they started to see their offenders as objects. Similarly, Alexander-Rodriguez (1983) discussed that correctional nurses must be aware of their own institutionalization to avoid negatively impacting the provision of care.

Participants indicated that Caring Behind Bars was also challenging due to constantly enduring dilemmas. The professional and ethical obligations of healthcare professionals may be challenged or compromised due to correctional policies and procedures (White et al., 2014). Nursing authors have discussed the ethical dilemmas endured by correctional nurses (Brodie, 2001; Hooten & Shipman, 2013; Maeve & Vaughn, 2001; Peternelj-Taylor, 2004; Peternelj-Taylor & Woods, 2019; Sasso et al., 2018; Solell & Smith, 2019; Walsh et al., 2012). The priorities of control, coercion, and security within correctional institutions (Walsh et al., 2012; White et al., 2014) present ethical and professional dilemmas for nurses educated to value caring as essential to nursing practice (Brodie, 2001). Correctional nurses may experience ethical dilemmas due to rules dictated by security requirements rather than the health needs of offenders (Sasso et al., 2018).

Correctional nursing practice is also complex due to other ethical issues: the inability to provide equivalent care similar to other practice settings (Sasso et al., 2018); the manipulative behaviour conveyed by offenders (Sasso et al., 2018); maintaining
offender confidentiality (Maeve & Vaughn, 2001); and respecting offender autonomy (Walsh et al., 2012). Correctional nurses may experience ethical dilemmas due to the inability to establish therapeutic relationships unlike other settings (Sasso et al., 2018), yet these nurses themselves may also engage in ‘othering’ (Peternelj-Taylor, 2004). “Othering represents an attempt to separate ‘them’ [offenders] those who are othered, from ‘us’ [correctional nurses], those who do the othering” (Peternelj-Taylor, 2004, p. 138); othering is an ethical concern that can negatively impact therapeutic relationships, including the quality of care (Peternelj-Taylor, 2004). The study findings inform RNs about the ongoing challenges they may experience upon Caring Behind Bars. Corrections health authorities must develop strategies to diminish these challenges.

An outcome of Caring Behind Bars was that positivity arose. Participants identified that Caring Behind Bars was amazing, exciting, fun, and interesting. Correctional institutions provide an exciting (Hale et al., 2015; Stevens, 1993) and interesting opportunity for clinicians to continue learning (Hale et al., 2015). Participants reported that Caring Behind Bars also allowed continued growth and learning in the nursing role. Shelton et al. (2010) reinforced a correctional nursing competency development system should provide opportunities for professional growth. Participants identified Caring Behind Bars as rewarding as they positively impacted offenders. Several nursing authors have also indicated that correctional nursing practice is rewarding (Cashin & Potter, 2006; Flanagan & Flanagan, 2002; Hale et al., 2015; Munger et al., 2015). Correctional nurses may feel rewarded when witnessing offenders becoming advocates for their own health needs (Munger et al., 2015). In a study by Chafin and Biddle (2013), most correctional nurses expressed pride in their employment.
The study findings inform RNs about the positive outcomes they may experience upon Caring Behind Bars.

**Governance of corrections health.** The *governance of corrections health* refers to the transitioned governance of correctional healthcare services and its employees from ABJSG to AHS. The *governance of corrections health* is based on four properties: changes in autonomy; changes in correctional officer and RN relationships; lack of understanding of corrections health; and positive outcomes post transition to AHS. In many countries, the authority responsible for correctional services is also responsible for offender health (Pont et al., 2018; WHO, 2019). Yet, many authors and organizations are now advocating for health authorities to govern correctional healthcare services due to various advantages (See Chapter 1 Introduction).

Similar to the transition in Alberta, the Royal College of Nursing Scotland (2016) reported about the governance transition from the Scottish Prison Service to the National Health Service Scotland. The Royal College of Nursing Scotland (2016) reported three similar findings: the relationships negatively changed among prison officers and nurses; a lack of understanding from the wider National Health Service Scotland about the role of prison health; and access to resources improved. Hayton and Boyington (2006) also reported similar positive outcomes when the governance transitioned from Her Majesty’s Prison Service to the National Health Service England and Wales: the risk of professional isolation for healthcare professionals diminished; improvement in resources and funding; and public health initiatives now included offenders. Leaman et al. (2016) reported significant improvements in the quality of care post transition to the National Health Service England and Wales. Monitoring and measuring the success of governance
transition is difficult, yet is required to evaluate the impact on health outcomes (Hayton & Boyington, 2006) and quality of care (Pont et al., 2018).

**Summary for situating the findings.** The existing literature aligned with the findings. Some gaps in knowledge arose upon situating the findings with the existing literature. Numerous topics remain minimally explored from the correctional nursing lens in Canada and elsewhere: adaptability, advocacy, patient centered care, assessment, use of background clinical practice experience, use of technology, educational resources, mentorship, positive outcomes of Caring Behind Bars, and correctional healthcare services governance models. Most of the correctional nursing literature is international, signifying the need to further study this specialty from a Canadian context.

**Limitations**

There were several limitations of this study. First, the doctoral student (KKD) possesses correctional nursing practice experience, knowledge of the literature due to previous graduate work, and international networks; these three factors potentially impacted data collection and analysis. To mitigate the personal impact on data collection and analysis, various actions were taken: there was no voluntary disclosure of personal correctional nursing practice experience to ensure participants engaged openly and willingly; there was no review of the literature during data collection and analysis; field notes were written during the interviews; and memo writing was undertaken to keep a record of thought processes. Other readers, researchers, and reviewers may analyze this data to offer new findings. Second, the small sample size may be a concern, however data collection continued until saturation was achieved. Third, participants spoke of their interactions with the interprofessional team (i.e., allied health professionals, healthcare
professionals, and correctional officers) and offenders; these participant views were limited to the data they provided. Future studies with other professionals and offenders may provide insights into their experiences within correctional institutions.

Fourth, the findings may not be fully applicable to RNs practicing within federal and provincial custody institutions with healthcare governance by correctional services authorities. Similar studies with RNs practicing within these federal and provincial custody correctional systems may be worthwhile to advance correctional nursing practice and promote offender health. Fifth, the findings are not directly applicable to other specialties of nursing due to the unique correctional context.

Chapter Summary

The theory of Caring Behind Bars refers to the process of how RNs implemented their correctional nursing practice to care for the offender population. The existing literature was used to situate the findings. Canada continues to lag behind in correctional nursing research. The study is significant because this research resulted in the development of foundational knowledge to advance Canadian correctional nursing practice and offered potential insights into promoting offender health. Lastly, there were several limitations of this study.
Chapter 6 Conclusion

The study is significant because this research resulted in the development of foundational knowledge to advance Canadian correctional nursing practice and offered potential insights into promoting offender health. Leadership in correctional nursing practice is required to advance this specialty and promote offender health. The implications and recommendations for correctional nursing practice and offender health are based on the findings and situated in the four domains of nursing practice. Effective correctional nursing leadership is required to facilitate these implications and recommendations. Some content regarding leadership in correctional nursing practice presented below is published in the journal Nursing Forum (See Preface).

Significance

The study is significant because this research resulted in the development of foundational knowledge to advance Canadian correctional nursing practice and offered potential insights into promoting offender health. The study was the first Canadian GT focused on correctional nursing practice with healthcare governance by a health authority. To date, this may be the first substantive theory focused on correctional nursing practice, particularly in Canada and the provincial custody context. The theory of Caring Behind Bars presents a complex and dynamic view of the implementation of Canadian correctional nursing practice. The theory has advanced the discipline of correctional nursing by providing knowledge that offers a richer understanding of this specialty in Canada to inform professional practice. In Canada and elsewhere, frontline RNs currently practicing within correctional institutions can use this theory to make informed choices when providing care to offenders. Canadian RNs employed within the
other domains of nursing practice (i.e., administration, education, and research) can also use this theory to advance and inform practice with the ultimate goal of promoting offender health.

Significant knowledge emerged about the existence of tension between custody and caring regardless of the governance of correctional healthcare services by the health authority (AHS). Whereas, various authors have advocated this tension may decrease with such governance models (Flegel & Bouchard, 2013; OCI, 2013; Pont et al., 2012; Pont et al., 2018; WHO, 2013). From a nursing discipline lens, the ongoing existence of this tension amidst health authority governance requires further exploration via research (e.g., its existence and strategies to reduce within varying governance models) to advance correctional nursing practice and promote offender health. Globally, there is a lack of evidence on current governance models and an urgent need for evaluation and research as improving offender health status can improve population health (McLeod et al., 2020).

The tension may be viewed as providing purposeful space to improve the relations and practices of correctional officers and RNs with the use of effective interprofessional collaboration. Significant knowledge emerged that participants moved beyond this tension by engaging in numerous actions – interactions (adaptability and advocacy) to access and care (provision of care) for offenders. The actions – interactions are highly pragmatic strategies that can be used by correctional RNs in Canada and elsewhere. From a nursing discipline lens, further knowledge development via research regarding these strategies (e.g., ongoing development and evaluation) is required to advance correctional nursing practice and promote offender health.
Significant knowledge regarding the *offender population* and *challenging and positive outcomes* informs Canadian RNs currently practicing within correctional institutions, or those interested in correctional nursing practice. Knowledge regarding the *offender population* informs RNs of the complex population under their care, and how they may proceed in developing therapeutic relationships and the provision of care. Likewise, knowledge regarding the *challenging and positive outcomes* informs RNs about the ongoing challenges and positivity they may experience upon Caring Behind Bars. From a nursing discipline lens, further knowledge development via research about these outcomes (e.g., how to diminish challenges and promote positive outcomes) is required to advance correctional nursing practice and promote offender health. Overall, the findings also inform all domains of nursing practice (administration, clinical practice, education, and research) to advance correctional nursing practice and promote offender health (See Implications and Recommendations).

The findings also offer significant opportunities for correctional institutions to be envisioned as healthy work environments. Correctional nursing practice can be advanced by more than just promoting the positive outcomes of Caring Behind Bars. “A healthy work environment is a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performance and societal outcomes” (RNAO, 2008, p.13). A healthy work environment is an outcome of the interdependence among individual (micro level), organizational (meso level), and external system (macro level) factors (RNAO, 2008). An RN’s functioning is mediated and influenced by the interaction between him/her and the environment (RNAO, 2008).
The following examples demonstrate how the findings align with various factors that impact RN practice. Physical/Structural factors (RNAO, 2008): physical work demand factors such as threats to personal safety within correctional institutions (individual micro level); organizational physical factors such as physical structure of correctional institutions (organizational meso level); and external policy factors such as correctional healthcare services governance model (system macro level).

Cognitive/Psycho/Socio/Cultural factors (RNAO, 2008): cognitive and psychosocial work demand factors such as correctional officer and RN relationships, and role strain due to tension between custody and caring (individual micro level); organizational social factors such as correctional culture (organizational meso level); and external sociocultural factors such as complexity of the offender population (system macro level).

Professional/Occupational factors (RNAO, 2008): individual nurse factors such as adaptability, foundational stance about nursing practice in general, and views and ethics about correctional nursing practice (individual micro level); organizational professional/occupational factors such as control over correctional nursing practice (organizational meso level); and external professional/occupational factors such as corrections and health policies (system macro level).

The findings presented a multitude of interplaying factors that impact RN practice, which offer significant opportunities for correctional institutions to be envisioned as healthy work environments. As a result, interventions to promote healthy work environments must be aimed at multiple factors at the individual micro, organizational meso, and external system macro levels (RNAO, 2008). The implications
and recommendations offer ways to not only promote healthy work environments, but to advance correctional nursing practice and promote offender health.

**Leadership in Correctional Nursing Practice**

“In measuring healthcare performance, factors associated with leadership styles have been strongly linked to [patient] outcomes” (Fischer, 2016, p. 2654). Leadership at the political, management, and individual professional levels is key in achieving health promoting correctional institutions (WHO, 2007). Leadership within correctional institutions is also essential to foster an ethos of upholding human rights, including the acceptance of offender dignity, respect, and self-efficacy (WHO, 2014).

The improvement of patient health outcomes requires consideration of how leadership is understood and practiced in nursing settings (Fischer, 2016). Likewise, the consideration of how leadership is understood and practiced within correctional nursing is crucial to advance this specialty and promote offender health. Several authors have discussed correctional nursing leadership (Bennett, Larry, & Tapworth, 2010; Dhaliwal & Hirst, 2019; Newman, Patterson, & Clark, 2015; Schoenly, 2013b). The authors offered beneficial insights into correctional nursing leadership such as, the use of transformational leadership is possible (Bennett et al., 2010; Dhaliwal & Hirst, 2019; Schoenly, 2013b), and one published example of a leadership intervention exists for corrections and forensic health nursing management (Newman et al., 2015).

Correctional nursing leadership is required at all levels of organizations (Schoenly, 2013b), hence leaders may possess varying levels of education, and practice in formal (e.g., senior executive, middle, and frontline management) or informal positions such as frontline nursing staff (Dhaliwal & Hirst, 2019). Correctional nursing leaders
should alter their approach according to the context (Bennett et al., 2010) such as, when faced with tension between custody and caring. Effective correctional nursing leadership may enable the provision of care equivalent to the general public (Bennett et al., 2010). Effective correctional nursing leadership is required to facilitate the implications and recommendations arising from the findings.

**Implications and Recommendations**

The potential implications and recommendations are directly based on the findings. The implications are speculative ideas (Polit & Beck, 2017), whereas the recommendations are more feasible actions, all of which are aimed to advance correctional nursing practice and promote offender health. The implications and recommendations are situated in the four domains of nursing practice: administration, clinical practice, education, and research (CARNA, 2005 as cited in CARNA, 2011). The quality and applicability of the GT (i.e., theory of Caring Behind Bars) is strengthened due to the emergence of these implications and recommendations for correctional nursing practice and offender health. Effective correctional nursing leadership is required to facilitate these implications and recommendations.

**Administration implications.** Correctional nurse administrators across Canada can engage in the transition of governance of corrections health from a correctional service authority to health authority (if required). There is rationale for this implication: international authors and organizations have advocated for the governance of corrections health by health authorities for various reasons (See Chapter 1 Introduction). Correctional nurse administrators can evaluate any barriers (Pont et al., 2018) and facilitators for the
transition, and the impact of this transition on health outcomes (Hayton & Boyington, 2006) and quality of care (Pont et al., 2018).

AHS can advise correctional nurse administrators to regularly celebrate team success within each institution. There is rationale for this implication: celebrating team success may promote the positive outcomes of Caring Behind Bars (e.g., fun, excitement, and interest). Correctional nurse administrators can celebrate team success within their financial budget.

**Education implications.** The Nursing Education Program Approval Committee (NEPAC) can advise nurse educators to provide content on correctional nursing practice during undergraduate nursing programs. There is rationale for this implication: the Canadian Nursing Students Association (2018) advocated to include this content into nursing curriculum to promote offender health. NEPAC can meet with the Academy of Canadian Executive Nurses (i.e., Deans and Directors of nursing programs) and nurse educators to discuss the integration of this content into undergraduate nursing programs.

CARNA can collaborate with correctional nurse administrators, Academy of Canadian Executive Nurses (i.e., Deans and Directors of nursing programs), and CNA to discuss the possibility of competencies for correctional nursing practice. There is rationale for this implication: Shelton et al. (2010) advocated for correctional nursing competencies to promote safe practice and quality care. CARNA can meet with correctional nurse administrators, the Deans and Directors, and CNA to discuss correctional nursing competencies and standards of practice.

**Research implications:** The Canadian Association of Schools of Nursing (CASN) can identify offenders as a vulnerable population in their National Research Priorities for
Nursing reports to promote corrections health and nursing research. There is rationale for this implication: Nursing authors have identified offenders as a vulnerable population (See Chapter 5 Discussion). CASN can consult with Canadian scholars who have undertaken corrections health and nursing research when developing their reports. The CASN Research and Scholarship Committee can review relevant international reports (e.g., WHO, ICN) and literature to support the identification of offenders as a vulnerable population.

CASN and the Canadian Nursing Students Association (CNSA) can advocate for the promotion of corrections health and nursing research to the Academy of Canadian Executive Nurses (i.e., Deans and Directors of nursing programs). There is rationale for this implication: there is a lack of Canadian correctional nursing research (Peternelj-Taylor & Woods, 2019). CASN and CNSA can meet with the Deans and Directors to discuss the integration of corrections health and nursing research into their faculty research priorities (e.g., within areas focused on advancing the nursing profession, and vulnerable populations).

**Administration recommendations.** AHS will facilitate a joint workshop with correctional nurse administrators and correctional services administrators to promote interprofessional collaboration among all staff. There is rationale for this recommendation: the joint workshop is required to foster respectful work relationships (Almost et al., 2013). There are several strategies to achieve a successful joint workshop: emphasize joint education, meetings, and orientation (Weiskopf, 2005); inclusion of correctional officers in quality improvement initiatives (Weiskopf, 2005); and provide education about professional roles and challenges (Pont et al., 2018; Weiskopf, 2005).
AHS will request that correctional nurse administrators review orientation programs to determine if effective mentorship is provided for newly hired correctional nurses. There is rationale for this recommendation: participants desired correctional nursing mentorship programs, and reviews of orientation programs may assist in the retention of nursing staff. AHS will send a memo to correctional nurse administrators requesting for the reviews. Correctional nurse administrators will respond to AHS by providing reports, including possible action to be taken.

**Clinical practice recommendations.** AHS will advise correctional nurse administrators to inform frontline nurses of the *tension between custody and caring* during hiring and annually. There is rationale for this recommendation: frontline correctional nurses must be informed of this tension to implement nursing practice. Correctional nurse administrators will collaborate with clinical nurse educators and correctional services administrators to offer education (e.g., in class, online, presentations, workshops).

Correctional nurse administrators will advise correctional nurse educators to promote the development of assessment skills of frontline nurses. There is rationale for this recommendation: nursing authors have cited the need for strong assessment skills in correctional nursing practice to address offender needs (See Chapter 5 Discussion). Clinical nurse educators will provide education (e.g., in class, online, presentations, workshops) to strengthen assessment skills.

**Education recommendations.** CARNA will promote the contribution of their provincial documents to correctional nursing practice. There is rationale for this recommendation: CARNA has the responsibility of promoting public safety. CARNA
will provide online modules and webinars on their documents in relation to correctional nursing practice.

AHS will request that clinical nurse educators develop educational resources for frontline correctional nurses to be completed with mandatory annual continuing education. There is rationale for this recommendation: participants reported that correctional nursing educational resources are limited; these are required to implement nursing practice and promote offender health. Clinical nurse educators will provide mandatory annual continuing education (e.g., in class, online, presentations, workshops).

**Research recommendation.** AHS Research and Innovation will review their research priorities to assess the promotion of corrections health and nursing research among their Strategic Clinical Networks and affiliated universities. There is rationale for this recommendation: AHS took over the governance of corrections health in 2010, thus must assess their research priorities to improve professional practice and offender health. AHS will partner with universities and ABJSG to promote corrections health and nursing research. AHS will request assistance from the relevant Strategic Clinical Networks (e.g., Addiction and Mental Health, and Population, Public and Indigenous Health).

Correctional nurses must possess specialized knowledge to deliver quality care (Almost et al., 2013; Schoenly, 2015), hence improving nursing care for offenders requires more nursing research (Schoenly, 2015; Weiskopf, 2005). Yet, there is a dearth of robust research regarding correctional nursing practice (Almost et al., 2013; Peternelj-Taylor & Woods, 2019; Schoenly, 2015; Weiskopf, 2005), including in Canada and the provincial custody context (Peternelj-Taylor & Woods, 2019). White and Larsson (2012) argued that knowledge development, specifically research and its dissemination in
correctional nursing is required to keep pace with the progression of nursing science in more traditional practice areas. Canadian RNs practicing within correctional institutions, may experience challenges (e.g., tension between custody and caring) due to the unique context such as, the correctional system and its legislation, and differing healthcare governance models and offender needs. Therefore, Canadian correctional nursing practice warrants the development of its own evidence base. Canadian correctional nursing researchers can develop specific knowledge to advance this specialty in all domains of nursing practice (Dhaliwal et al., 2019).

The theory of Caring Behind Bars makes way for further research opportunities using various methods (e.g., mixed method, qualitative, quantitative) depending on the types of questions posed. For example, gaps in knowledge arose upon situating the findings with the existing literature, specifically numerous topics remain minimally explored from the correctional nursing lens in Canada and elsewhere (See Chapter 5 Discussion). Finally, these topics, and the following, may be studied to advance correctional nursing practice and promote offender health:

- how and if nurses are able to strike a balance between corrections and health priorities to assist in decreasing the tension between custody and caring;
- the impact of transitioning the governance of corrections health on health outcomes (Hayton & Boyington, 2006) and quality of care (Pont et al., 2018);
- whether the foundational stance regarding nursing practice is changing for nurses, especially upon Caring Behind Bars; and
- the theory of Caring Behind Bars may be studied and used for applicability among different allied health and healthcare professionals practicing in Canadian
federal or provincial custody institutions with varying healthcare governance, and internationally, to study whether they face different or similar conditions, actions – interactions, and consequences.

Chapter Summary

The study is significant because this research resulted in the development of foundational knowledge to advance Canadian correctional nursing practice and offered potential insights into promoting offender health. The theory of Caring Behind Bars presents a complex and dynamic view of the implementation of correctional nursing practice. Leadership in correctional nursing practice is required to advance this specialty and promote offender health. The implications and recommendations for correctional nursing practice and offender health are based on the findings and situated in the four domains of nursing practice. Effective correctional nursing leadership is required to facilitate these implications and recommendations.
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APPENDIX A: STUDY INVITATION

A RESEARCH OPPORTUNITY FOR AHS CORRECTIONS HEALTH REGISTERED NURSES

Volunteer for a research study by sharing your thoughts about correctional nursing practice. $10.00 gift card for Starbucks® or Tim Hortons for participation.

Research needed to develop foundational knowledge to advance Canadian correctional nursing practice, and provide potential insights into promoting offender health.

IF INTERESTED PLEASE CONTACT

Kiruver Dhaliwal RN, MN
dhaliwak@ucalgary.ca
Primary Investigator: Dr. Sandra Hirst RN, PhD, GNC(C)
shirst@ucalgary.ca

Phone Numbers:
403-220-8069 (local) and 1-866-867-5055 (toll-free)

The University of Calgary Conjoint Health Research Ethics Board has approved this research study REB 18-1955
APPENDIX B: INFORMED CONSENT FORM

STANDARD CONSENT FORM

TITLE: The Implementation of Canadian Correctional Nursing Practice: A Grounded Theory Study

INVESTIGATORS: Primary Investigator: Dr. Sandra P. Hirst RN, PhD, GNC(C)
Co-Investigator: Kirnveer Dhillon RN, MN
Co-Investigator: Kathryn King-Shier RN, PhD, FESC

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about, and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully, and to understand any extra information. You will receive a copy of this form.

BACKGROUND
People are sentenced to serve time in correctional institutions [herein referred to as jails] for various reasons. Registered nurses [RN] are the main healthcare providers in jails. The primary goal of jails is not health promotion. The jails are focused on control, discipline, and security. The RNs face the tension between custody and caring. The RNs must balance the goals of jails, yet deliver quality care, and promote health. The World Health Organization says this tension may be lowered when a health authority controls healthcare services in jails. The Alberta Ministry of Health is in charge of correctional health for offenders. Offenders in provincial custody are sentenced to less than 2 years.

WHAT IS THE PURPOSE OF THE STUDY?
It is unclear if Alberta RNs face the tension between custody and caring. The purpose of this study is to answer the research question.

“How do registered nurses implement their nursing practice in the Canadian (Alberta) provincial custody correctional system?”

WHAT WOULD I HAVE TO DO?
You will be interviewed over the telephone at a time and place that works for you and the researchers. The interview will take about 45 to 60 minutes. The interview will be audio recorded. As this study continues, the interview questions may change if new concepts arise. So, one participant may be interviewed twice (if willing) to understand these new concepts.
**WHAT ARE THE RISKS?**
There are minimal to no risks related to this study. You will not be asked personal questions during the interview. You can access professional resources through your employer (Alberta Health Services), and the Canadian Mental Health Association website if participation in the interviews cause distress.

**WILL I BENEFIT IF I TAKE PART?**
There are no direct benefits if you take part in this study. The study will provide knowledge about nursing practice in jails in Canada. The study may provide insights into promoting offender health.

**DO I HAVE TO PARTICIPATE?**
Participation in this study is voluntary; you can stop at any time. If so, contact the researchers using the email addresses or phone numbers on the Study Invite. Please say that you do not want to participate in this study. Your data will be removed if you stop prior to, or during the interview. Your data cannot be removed once the interview is finished and analysis has begun due to the nature of the Grounded Theory [GT] method. The GT method uses earlier data to guide future data collection and analysis. If the researchers gain new information that may impact your participation, you will be told as soon as possible.

**WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?**
You will be given a ten-dollar Starbucks or Tim Hortons gift card for participating in this study. There are no costs you need to pay. You will only receive a gift card if you finish the interview, and not if you stop participation.

**WILL MY RECORDS BE KEPT PRIVATE?**
Electronic data will be encrypted. It will be stored on a computer with a password. An external hard drive with a password used to back up this data will be kept in a secure cabinet at the Faculty of Nursing, University of Calgary [UofC]. Paper copies of this data will be kept in a secure cabinet at the Faculty of Nursing, UofC. All electronic and paper data will be kept for five years. The data will be destroyed following the UofC Data Retention Policy. Only the researchers can access this data. Study data may be used for publishing, such as in journals. Your personal identity will be anonymized and protected.

**SIGNATURES**
Your signature on this form means that you have understood to your satisfaction the information about your participation in this study. Your signature on this form means you agree to participate as a participant. In no way does this waive your legal rights. In no way does this release the investigators or involved institutions from their legal and professional responsibilities. You can stop participating in this study at any time without penalty. If you have questions related to this study, please contact:

Dr. Hirst (403) 220-6270

ID: RBB 18-1593
Study Title: The Implementation of Canadian Correctional Nursing Practice: A Grounded Theory Study
PI: Dr. Hirst
Version number/date: Version 2/Created 2018. October. 09
Page 2 of 3
If you have questions about your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

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The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you. You can keep this form for your records and reference.

ID: REB 18-1593
Study Title: The Implementation of Canadian Correctional Nursing Practice: A Grounded Theory Study
PI: Dr. Hirst
Version number/date: Version 2/Created 2018, October, 09
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APPENDIX C: DEMOGRAPHIC QUESTIONNAIRE

Sex:
1. Male
2. Female
3. Other

Number of Years Employed in Alberta Provincial Custody Correctional Institutions:
1. 1 – 5 years
2. >5 years – 10 years
3. >10 years – 15 years
4. >15 years – 20 years
5. >20 years

Age:
Please specify:

Ethnicity:
Please specify:

How Many of Those Years Under Correctional Services (ABJSG), and or Ministry of Health (AHS):

Nursing Education:
1. Diploma
2. Bachelor’s\(^1\) degree
3. Master’s degree\(^2\)

Correctional Services
1. 1 – 5 years
2. >5 years – 10 years
3. >10 years – 15 years
4. >15 years – 20 years
5. >20 years

Ministry of Health (AHS)\(^3\)
1. 1 – 5 years
2. >5 years – 10 years
3. >10 years – 15 years

Current Other Nursing Employment:
1. Yes Please specify:
2. No

Number of Years Employed as an RN:
1. 1 – 5 years
2. >5 years – 10 years
3. >10 years – 15 years
4. >15 years – 20 years
5. >20 years

Previous Nursing Employment Prior to Correctional Nursing:
1. Yes Please specify:
2. No

Current Employment Status:
1. Full-time
2. Part-time
3. Casual

\(^1\) Bachelor of Nursing or Bachelor of Science in Nursing
\(^2\) Master of Nursing or Master of Nursing Nurse Practitioner
\(^3\) Ministry of Health (AHS) only took over correctional healthcare services in 2000. [https://www.albertahealthservices.ca/info/Page5805.aspx](https://www.albertahealthservices.ca/info/Page5805.aspx)
APPENDIX D: PRELIMINARY SEMI-STRUCTURED INTERVIEW GUIDE

Preliminary Semi-Structured Interview Guide

1. Based on your frontline practice experience as a registered nurse, what it is like to implement or carry out your nursing practice in the correctional context?

2. What barriers do you encounter in implementing your correctional nursing practice?

3. What facilitators do you encounter that help in implementing your correctional nursing practice?

4. Do you use any resources to help you implement your correctional nursing practice? Why? How do these help you? Would you recommend these resources to other registered nurses?

5. What information would you offer to registered nurses interested in correctional nursing practice?

6. What is your experience in implementing your nursing practice in the other (current or previous) practice area/s as compared to the correctional context? Are there differences? If so, what are these differences?

7. What is your experience in implementing your nursing practice when you were employed under the Correctional Services as compared to the Ministry of Health? (**Only for participants who have practiced under both Ministries**)
   - Do you notice any differences in implementing your nursing practice?