The Culture of Night Nursing

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Dissertation Submitted in Partial Fulfillment of the

Requirements for the Degree,

Doctor of Philosophy in Nursing

April 3, 2015

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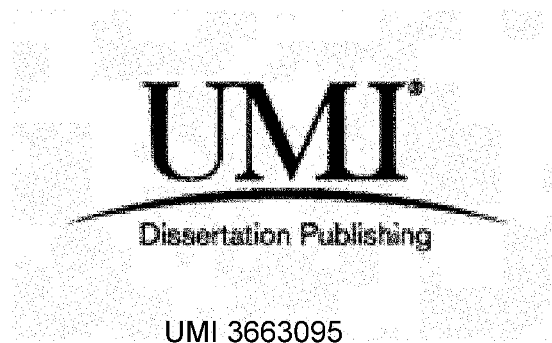

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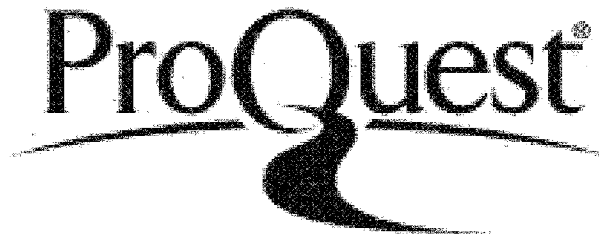

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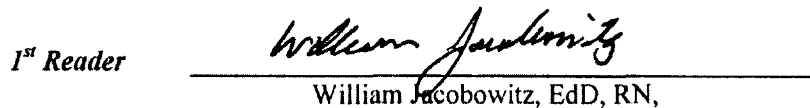

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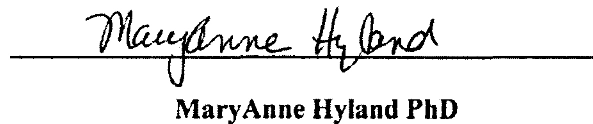

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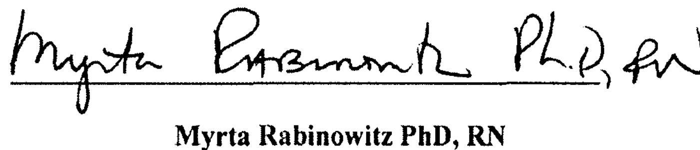

Myrta Rabinowitz PhD, RN

Acknowledgments

This dissertation was an accomplishment that could not be undertaken alone. I would like to thank Dr. Patricia Donohue-Porter and the rest of the faculty of Adelphi University for instilling in me a renewed outlook on the science of nursing through the rigorous, thought provoking coursework in the PhD program.

I would especially like to thank my chairperson, Dr. Jane White, for providing me with the guidance, mentorship, advice, direction, encouragement and discipline needed to develop and complete my research study. Her wisdom and experience were an invaluable support to me throughout this journey.

I would like to thank my husband, Kevin, and my children, Kelsi, Darci, Karli, and Delani for supporting me , allowing me the time to focus and write, and tolerating the stress that surfaced on occasion. Without their understanding, I would not have been successful.

I would like to thank my parents, siblings, coworkers, fellow classmates and faculty at Adelphi who have all been a source of encouragement over the years, and to whom I plan to pay it forward.

Thank you to all!

The Culture of Night Nursing

Debra Grice-Swenson

Abstract

Healthcare, hospital environments, and the nursing workforce have been a focus of late in both the professional literature and public media especially in the wake of the Institute of Medicine's reports *Keeping Patients Safe-Transforming the Work Environment of Nurses* (IOM, 2004) and *The Future of Nursing-Leading Change Advancing Health* (IOM, 2011). These reports address patient safety and workforce issues such as staffing, organizational culture, and workforce characteristics. Very little research has been undertaken on the culture of night nursing or the roles, experiences and characteristics of night nurses. Therefore, a study of night nursing, using a qualitative ethnographic methodology, was chosen to address this gap. Because sub- cultures can influence the larger culture, knowledge regarding their unique characteristics and attributes becomes critically important especially in the culture of a large hospital.

The purpose of this study was to develop a description of night nursing as a subculture within the larger culture of nursing care and nursing practice that exists in a hospital setting. Data were collected during the researcher's 100 hours of participant observations on five differing nursing units in two hospitals, using semi-structured transcribed interviews with eight nurse informants on these same units, and through an analysis of relevant hospital documents. A synthesis of the collected data identified a subculture of night nursing with shared domains or attributes such as unique roles, rituals, hierarchies, and insider/outsider perspectives.

The final description included four themes that were extrapolated from the synthesized data: (1) night nursing is characterized by camaraderie and teamwork; (2) the environment of a night nurse is conducive to the development of critical thinking; (3) night nurses engage in a constant reflection about sleep; and (4) night nurses share a feeling of being undervalued.

The findings from this study have implications for administrators who must be aware of and understand the needs of night nurses especially related to being valued and included. For nurse educators, important implications center on preparing students for the uniqueness of the role of the night nurse, and planning formal educational offerings during the night shift for nurses. Further research is warranted using quantitative methods to validate and explore the themes and domain descriptions identified in this study.

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CHAPTER I

INTRODUCTION

Background of the Problem

To many, the mention of night nursing in a hospital often conjures up images of dimly lit hallways, very few people and hushed voices. Little has been written about a hospital at night, or what nursing care at night is like, yet half of a patient's time in the hospital is spent under the care of a night nurse. Night shift work is not uncommon in the nursing profession. It has been described as heroic in that it requires a great responsibility, vigilance and alertness to watch over patients who are often at night time in their most vulnerable states (Lamara, 1981). However, night nursing is an area that has not been extensively studied.

Healthcare, hospital environments and the nursing workforce have been a focus of late in both the professional literature and media, especially in the wake of the Institute of Medicine's reports: *Keeping Patients Safe-Transforming the Work Environment of Nurses* (IOM, 2004) and *The Future of Nursing-Leading Change Advancing Health* (IOM, 2011). These reports address patient safety and workforce issues such as environmental safety, staffing, organizational culture and workforce characteristics. The 2004 report, *Keeping Patients Safe--Transforming the Work Environment of Nurses*, identified four components of organizations that must be addressed in order to provide for safety of patients: (a) management practices; (b) work processes; (c) workforce capability; and (d) organizational culture (p.250). Based on these four components, the IOM report presented 18 recommendations to which healthcare organizations should strive to meet in order to create a safer environment for healthcare workers and patients. One of the recommendations is that federal agencies and private foundations support research in areas that will provide healthcare organizations with the information they need to strengthen nurse work

environments, specifically "studies and development of methods to better describe, both qualitatively and quantitatively, the work nurses perform in different care settings…and development and testing of methods to help night shift workers compensate for fatigue…" (IOM, 2004, p.257).

The 2011 IOM report- *The Future of Nursing: Leading Change, Advancing Health,* identified the lack of reliable data on the nursing workforce as a barrier to transforming the nursing profession. "Strategic health care workforce planning…is hampered by the lack of sufficiently reliable and granular data on, for example, the numbers and types of health professionals currently employed, where they are employed and in what roles, and what types of activities they perform" (IOM,2011,p.8). Much has been written about the difficulties faced when graduating nurses transition from an educational setting to the real work environment. This report also calls for innovations in education of new nurses so that transitioning from the educational arena into the professional role may be less problematic. This will require a more detailed knowledge of what is occurring in the clinical settings.

If society seeks to ensure safe, culturally sensitive care in nursing environments, then the characteristics of the nursing workforce, the settings in which they provide care, and the nature of their work all need to be considered (IOM, 2004; 2011). Nursing care at night is one specific setting that should be considered. There are many aspects of night nursing that are unique and require special knowledge and attention (McMahon, 1992). It is difficult to describe and explore this uniqueness without entering into the night setting. One research method that could be used to explore night nursing is ethnography.

Ethnography, while one of the oldest qualitative research methodologies is a relatively newer methodology used in nursing research, and until recently, was only undertaken by nurse

anthropologists. Its appeal to nurse researchers today is based on its comprehensive focus on the people of the culture being studied, much like nursing's focus on holistic care (Leininger, 1998). Ethnography has been defined as " the systematic process of observing, detailing, describing, documenting and analyzing the life-ways or particular patterns of a culture (or subculture) in order to grasp the life-ways or patterns of the people in their familiar environment" (Leininger, 1998, p. 35)

Ethnography has been described as the science that studies the ways of life of humankind (Vidich & Lyman, 2003). It is a general study of the culture of a specific group of people and is characterized by its methods of data collection: immersion in the field, participant observation, and in-depth interviews. Culture refers to "the totality of all the learned and transmitted behaviors of a particular group of people" (Leininger, 1970, p. 21). Night nurses can be considered a subculture of the larger hospital workforce.

Very little nursing research has focused on the role of the nurse working at night. The only comprehensive research study found was a literature synthesis undertaken in England (Kemp, 1984).The general conclusions that Kemp arrived at from her review were that (a) permanent night workers suffer from chronic sleep deprivation; (b) working at night is not a normal pattern and requires an adjustment that is not attainable by everyone; (c) night nursing has a history of being used as a rite of passage for nursing students; (d) the problem of staffing what is considered an unpopular shift continues to exist; and (e) that the supervisory role of the night nurse, including the observation of sleeping patients, is often unrecognized and undervalued (Kemp, 1984). Kemp's review identified advantages of working nights perceived by nurses as "autonomy, responsibility, freedom from interference and interruption, and time to talk to and learn about patients." (p. 220). The disadvantages of working nights were identified as

"isolation, lack of information and consultation, deprivation in rest and eating facilities, and a general sense of being undervalued." (p. 220).

Most of the recent research on night nursing has focused on the physical ramifications of working nights (Fietze, Knoop, Glos, Holzhausen, Peter, & Penzel, 2009; Pietroiusti et al., 2010); the educational opportunities available for night nurses (Johansson, Oleni, & Fridlund, 2004; Mayes & Schott-Baer, 2010); and the impact that working nights has on job satisfaction (Bartholomeyczik et al., 1992; Kalisch & Lee, 2009). No studies have specifically described the role of a night nurse and the environment in which he or she works when night nursing is viewed as a subculture.

Significance of the Study

A study on night nursing would offer significant contributions to the science and profession of nursing. Night nursing is often the first assignment novice nurses are given when they complete an orientation and are officially "on their own". Not only are they transitioning into a new profession, they are transitioning into a new work pattern that is physically and psychologically unknown to them. If the nursing profession wants to ensure that qualified nurses are working in the hospital setting, it is important to be aware of such work environment issues as transitioning and socialization to night nursing. Nurse educators would be enlightened by the results of such a study and would be able to incorporate the findings into practicum experiences of students.

A study on night nursing would inspire nurse researchers to continue exploring the experiences and perceptions of practicing nurses in various settings. Such research would enhance the understanding of the quality of work-life and working environments of professional nurses. "Failure to address the issue of the quality of the work and professional life of the

practicing nurse may ultimately lead to intensifying the shortage of professional nurses available to meet healthcare needs" (Yancy, 2005, p. 220).

Evidence-based practice to improve patient outcomes and health care delivery has become the mantra of health care organizations, with much of the focus on quantitative research and surveys. Much of the evidence relied on is quantitative. However, it is very difficult to portray the patient and work environment of a health care organization in a quantitative format because of its dynamic nature, perpetually changing and evolving. On the other hand, evidence that is obtained by qualitative methods may warrant further investigation for evidence. However as Schein (1996) notes, "If we go back into the field and observe carefully what goes on when organizations attempt to improve their operations in response to new data from the economic, political, and technological environment, we discover the critical role that culture and subcultures play in this process" (p.236). Some subcultures can be more influential than the organization's main culture (Bellou, 2008).Understanding the origin of and acknowledging the existence of cultures and subcultures within an acute healthcare setting would benefit all those involved in the work environment and also the patient experience. Thus, to understand night nursing as a subculture, an ethnographic study was proposed.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This study focuses on the culture of night nursing. The literature that supports the study is presented, focusing on broad topics because with ethnography, as with other qualitative methods, it is not known what domains, themes, or descriptions will emerge from the investigation. Therefore researching these *a priori* is not undertaken. However a more in -depth literature review is completed later, after the findings emerge, in order to understand the findings (domains, themes) and their importance and after a description of the subculture is formulated by the researcher. In this way, the study's findings can then be compared to specific literature on what is known theoretically and has been found in the research literature on night nursing. Therefore for this chapter, topics of role and role theory, role and socialization, role and culture, and relevant research on night nursing are presented. Because there was a dearth of literature on socialization of nurses to night work, relevant research on socialization in other professions is also presented.

Role Theory

This study addresses the role of the nurse in a particular context- an acute care setting at night. In order to fully understand and be able to describe the role of a night nurse, a review of the literature on role and role theory was undertaken. Role theory is multidimensional in that it derives its origins from various behavioral sciences. The original construct, role, is derived from the world of theatre, and is defined as "a part one plays or is assigned in a drama" (Conway, 1978, p.17). Behavioral scientists have used the construct and developed subsequent theories or frameworks using two distinct approaches: a functionalist approach, which assumes that roles are

fixed positions in society, and an interactionist approach, which assumes that roles are established through one's interactions with others within society (Conway, 1978).

The interactionist approach is the one most congruent with this proposed study. It derives from the worldview of symbolic interactionism, and posits that roles are learned during social interaction (Hurley, 1978). Roles are either ascribed or achieved; ascribed roles are based on educational background or occupation (Hurley, 1978, p.53).

Sociologist Erving Goffman's work on roles and social interaction has had a significant influence on research. He defined a social role as "the enactment of rights and duties attached to a given status" (Goffman, 1959, p.16). Goffman viewed social interaction as a dramaturgical performance and posited that every individual is performing as an actor when in the presence of others, and can assume various roles, both consciously and subconsciously. "Sometimes the traditions of an individual's role will lead him to give a well-designed impression of a particular kind and yet he may be neither consciously nor unconsciously disposed to create such an impression" (Goffman, 1959, p. 6). Goffman further noted that when an individual takes on a role that has already been established by society, he will find that certain expectations of how he should behave have already been put in place. It is up to the individual to learn the scripts for each part or role that he enacts. This study intends to describe the part or the social role that a night nurse enacts.

Role and Socialization

The roles an individual assumes are known to develop during the socialization process. Socialization has been defined by sociologist Orville Brim as "a process of learning through which an individual is prepared with varying degrees of success, to meet the requirements laid down by other members of society for his behavior in a variety of settings", and as "the process

by which persons acquire the knowledge, skills, and dispositions that make them more or less able members of their society" (in Hurley, 1978, p.34). Goffman (1959) views this process as the ability of the individual to learn enough pieces of the part to be able to fill the role.

Research on Role and Socialization in Nursing

A review of the literature revealed several studies conducted on role and socialization in nursing. Aspects of role, such as perception, reality, and blurring have been labeled differently by the specific researchers who study role; however, a great deal of nursing research converges to some degree with the topic of role transition of newly graduating nurses from the education arena into employment. Some of the first research in this area was conducted by Corwin (1961) and Kramer (1968). Ronald Corwin studied the discrepancies of role perception and role reality in newly graduated nurses and concluded that a discrepancy in role conception was inevitable based on the fact that role itself is such an abstract concept. "Conceptions of role learned in training schools do not comprehend the full complexities of work experience" (Corwin, 1961, p.604). Marlene Kramer (1968) conducted studies on the discrepancies in role conceptions of new nurses, in particular role deprivation and role disillusionment; she also concluded that nurses who are trained in a school setting will encounter role conflict when they enter the bureaucratic setting of employment. This phenomenon is also known as "reality shock".

More recent studies have continued to explore the socialization of new nurses into the profession as well as role-related concepts such as *role stress* and *role ambiguity* (Chang and Hancock, 2003). Chang and Hancock concluded that role ambiguity was the most influencing factor in role stress for new graduate nurses. One study of note on socialization of new nurses

into the profession (Horsburgh, 1989) identified the adjustment to shiftwork as being a significant hurdle for new nurses to overcome.

Roles and Culture

Roles and social interaction constitute a significant aspect of any culture. Culture has been defined by social psychologist Edgar Schein (2004) as " both a dynamic phenomenon that surrounds us at all times, being constantly enacted and created by our interactions with others and shaped by leadership behavior, and a set of structures, routines, rules, and norms that guide and constrain behavior" (p.1). Schein compared the culture of a group to the personality of an individual remarking that a culture has the often-discrete power to influence the behavior of the members of a group in the same way that an individual's personality or character can influence one's behavior. Group culture results when members of the group develop norms that gradually become shared assumptions. Any group that has a shared history can thus develop a culture, and if it is a group within an organization, it is known as a subculture.

Schein (2004) posits that there are cultural forces that operate in groups; however, these forces cannot be analyzed unless they are studied from a cultural perspective. Studying a group from a cultural perspective influences the discovery of assumptions about the group that are very powerful, yet are invisible to a casual observer. Schein developed a framework for analyzing the culture of a group that entails studying the group at three levels: the level of its artifacts, the level of its beliefs and values, and the level of its basic underlying assumptions.

Strategies researchers might use to help identify cultural aspects at each level include ascertaining what new members to a group are taught, observing and interviewing regular members of the group, and examining how time is used in the group. Schein (2004) believes that "time poses a social order, and the manner in which things are handled in time conveys status

and intention. That is, the pacing of events, the rhythms of life, the sequence in which things are done, and the duration of events all become subject to symbolic interpretation (p.162). How a group uses space and how the members of the group relate to one another are additional areas that reveal assumptions of a subculture.

Research on the Role of a Night Nurse

The role of the night nurse has been fictionally portrayed in novels and the media as one of adventure, mystery and danger. In the earliest known depiction of a night nurse, Sarah Gamp was described as an alcoholic night watcher in the 1849 novel *Martin Chuzzlewhit* by Charles Dickens. She became a stereotype for a "bad" nurse, also known as a "gamp" (Helmstadter, 1994). Cherry Ames was the name of a young nurse portrayed in a series of novels by Julie Tatham (1950) about her career path from student nurse to supervisor. In the novel *Cherry Ames: Night Supervisor,* the nurse, Cherry, has the position of the lone night supervisor in a rural hospital and becomes a detective as she uncovers an embezzlement scheme run by one of the patients in the hospital. Another example of a media portrayal of night nursing was seen in the 1931 movie *Night Nurse,* in which a newly trained nurse is hired as a private night nurse for two children. She becomes involved in a shady scheme involving child abuse and murder plots. There was also a comic book series entitled *Night Nurse,* written in 1972-73. It was comprised of four issues that followed the adventure and drama in the lives of three nurses who lived together and worked the night shift together in a New York City hospital. One of the nurses, Linda Carter, eventually became a superhero night nurse in a subsequent *Marval Comics* series. While intrigue and excitement has been the focus of the night nurse portrayed in media, the actual nursing role of the night nurse has not been the focus of fiction in the media.

A review of the literature on studies focused specifically on night nurses' roles revealed a paucity of research. The only comprehensive research study found in the literature, a synthesis, was undertaken in England and published in 1984 by Kemp. In that study, Kemp reviewed 250 articles, books and reports, predominantly from Britain and North America, and found two major weaknesses in the research reports: 1) that very few of the studies were conducted during the night; and 2) that very few of the participants were women, despite the fact that the majority of nurses were female at that time.

The general conclusions that Kemp arrived at from her review were that (a) permanent night workers suffer from chronic sleep deprivation; (b) working at night is not a normal pattern and requires an adjustment that is not attainable by everyone; (c) night nursing has a history of being used as a rite of passage for nursing students; (d) the problem of staffing what is considered an unpopular shift continues to exist; and (e) that the supervisory role of the night nurse, including the observation of sleeping patients, is often unrecognized and undervalued (Kemp, 1984). Kemp's review identified advantages of working nights perceived by nurses to be "autonomy, responsibility, freedom from interference and interruption, time to talk to and learn about patients" (p. 220). The disadvantages of working nights were identified by them as "isolation, lack of information and consultation, deprivation in rest and eating facilities, and a general sense of being undervalued" (p. 220).

More recent research on the role of night nurses has focused on the physical ramifications of working nights (Fietze, Knoop, Glos, Holzhausen, Peter, & Penzel, 2009; Pietroiusti et al., 2010), the educational opportunities available for night nurses (Johansson, Oleni, & Fridlund, 2004; Mayes & Schott-Baer, 2010), and the impact that working nights has on job satisfaction (Bartholomeyczik et al., 1992; Kalisch & Lee, 2009).

Peitroiuṣti et al. (2010) found that the physical ramifications of night healthcare workers included a higher incidence of metabolic syndrome, which has been linked with cardiac disease. The presence of metabolic syndrome, which is defined as a combination of moderate visceral obesity, dyslipidemia, abnormal blood pressure and abnormal glucose levels, is known to significantly increases a person's risk of developing not only heart disease, but also diabetes and stroke (Pietroiusti et. al, 2010) .This quantitative study was conducted in Italy on a large sample of night shift (n=402) and day shift (n=336) nurses to investigate the incidence of metabolic syndrome among night shift healthcare workers; the researchers concluded there is a risk of developing metabolic syndrome associated with night shift work in nursing. The explained association is that working night shifts predisposes one to disruptions in circadian rhythms and sleep deprivation, which has been shown to have a causal effect on the individual components of metabolic syndrome. Another physical ramification found to be increased in nightshift nurses was an increase in hip and wrist fractures posited to be the result of decreased melatonin production from being exposed to more light than dayshift workers (Feskanich, Hankinson, & Schernhammer, 2008).

The educational aspects affecting night nurses have been researched from various perspectives and have revealed conflicting information. Some studies have concluded that night nurses receive less education than day nurses (Barriball & While, 1996; Johansson, Oleni, & Fridlund, 2004). A study in Sweden on night nursing was undertaken to develop an instrument to measure satisfaction with night nursing care (Johansson, Olney & Fridlund, 2004), the Night Nursing Care Instrument (NNCI). This instrument, which has been tested and shown to have adequate reliability and validity, has been designed to measure certain aspects of night care such as nursing interventions, medical interventions, and evaluation of satisfaction of nursing care.

Following the instrument development, in a subsequent study using it, the researchers found that there was a statistically significant difference between the patients' perceptions and nurses' assessments regarding the patients' rest at night. Many nurses did not notice that their patients were not getting enough rest (Oleni, Johansson, & Fridlund, 2008). In addition to developing an instrument to measure nursing care at night- the *Night Nursing Care Instrument* (NNCI), these researchers found that night nurses receive less education than their counterparts on the day shift. Clarifying this, another study undertaken in Sweden on learning opportunities for night nurses concurred, concluding that while there was less formal education available for night nurses, there are certain opportunities that could be used for learning at night, although not formal, such as report time and assessment rounds(Campbell, Nilsson, & Andersson, 2008). It can be concluded, although based on minimal research in one country, that formal education opportunities for night nurses are not the norm and that learning can occur mainly through informal means.

Sleep as a physiological problem for night nurses has been the focus in some studies. A study on the effect of the first night rotation for student nurses demonstrated that their sleep cycles were minimally affected on their first rotation (Fietze et al., 2009). However, other studies involving new nurses concluded the opposite: that working the night shift is not an easy experience for student nurses (McKenna & French, 2009). This finding was corroborated by West, Ahern, Byrnes & Kwanted (2006) who found in their study of new graduate nurses, that sleep disturbance was a major source of job dissatisfaction in the first twelve months of their employment.

Other research on the role of the night nurses includes studies that have addressed job satisfaction of night nurses related to teamwork and camaraderie. One study found that nurses

who work permanent night shifts are much more content than those who rotate between day shift and night shift (Bartholomeyczik et al., 1992). Another study that investigated characteristics of hospital nurses and their relationship to teamwork found that those working on the night shift had higher teamwork scores (Kalisch & Lee, 2009). This finding was attributed to the fact that there are fewer nurses working at night and thus an impetus for more teamwork is necessary. Other studies concur that there is a greater sense of camaraderie on the night shift (Nilsson, Campbell, & Pilhammer, 2008).

Little research has been undertaken on the work-life balance of nurses specifically working at night. Literature on work-life balance indicates that job satisfaction, tolerance of shiftwork, and retention can be related to a worker's ability to balance family and work demands (Pisarki & Barbour, 2014; Saksvik-Lehouillier et al., 2012). The phenomenon of work life conflict is described as that which occurs when the demands of one's work roles are not compatible with the demands of one's non-work roles (Pisarki et al., 2006). Compared with day shift workers, night shift workers often experience poorer mental health and stress related to their non-work responsibilities (Winwood, Winefield, & Lushington, 2006). Many nurses choose the night shift in order to be available during the day for the many responsibilities they face related to child care or personal obligations (Gallew & Mu, 2004).Thus the balance may not be an issue with them as working nights may help to balance the aspects of their roles.

Research on Nursing and Culture

Nursing research on organizational culture first appeared in 1986 (Scott-Findlay and Estabrooks, 2006). In a literature review, Scott-Findlay and Estabrooks (2006) examined 29 studies completed by nurses and found that while there has been an increase in the number of

studies on organizational culture in nursing, there is certainly room for more, specifically those that offer an interpretive perspective.

The phenomenon of a *nursing culture* has been identified and studied by nurse researchers when investigating individual nursing units, or specialty units, such as the operating room (Riley & Manius, 2009), the intensive care unit (Stores & Mc Murray, 2008),medical, surgical, intensive care and emergency units (Mallidou, Cummings, Estabrooks and Giovannetti, 2010), rehabilitation units (Coeling and Simms, 1996), a trauma unit (Tutton, Seers and Langstaff, 2007) and a stroke unit (Mather, Then, & Seneviratne, 2009). These studies reinforced the premise that subcultures do exist in acute care hospitals, and that subcultures are often delineated by specialty unit, and can have a significant impact on work environment, the organizational culture, and patient outcomes.

Only two studies in the literature addressed the broader perspective of nursing's role in the subculture of night nursing. Brooks and MacDonald (2000) completed an ethnographic study that compared the subculture of night nurses with the subculture of day nurses in a hospital in the UK, and concluded that there was in fact a subculture of night nurses in which nurses said they felt marginalized, misunderstood, and underappreciated. The researchers suggested that the existence of such subcultures provided a source of conflict, or schism, that was enlightening and one to which the organization should address. The second study was a qualitative content analysis in Iran focusing on the work experiences of night shift nurses (Nasrabadi, Seif, Latifi, Rasoolzadeh, & Emami, 2009). The Iranian researchers identified the perception of night nursing as a negative social image because, in their culture, women were expected to be home at night. There were no studies found conducted in the United States on night nursing that could be

compared with these two investigations, one important indication of a gap in the literature on the culture of night nursing in the United States.

Relevant Studies on Role and Socialization in Other Professions

The phenomena of role conception, professional socialization and shiftwork are not unique to nursing and have been studied in other professions, including physicians (Becker, Geer, Hughes & Strauss, 1961), teachers (Fantilli & McDougall, 2009; Nasser-Abu Alhija & Fresko, 2010), social workers (Miller, 2010), police officers (Julseth, Ruiz, & Hummer, 2011), air traffic controllers (Signal, Gander, Anderson, & Brash, 2009), and train operators (Holland, 2006).

Becker, Geer, Hughes and Strauss (1961) published *The Boys in White*, a seminal study on the socialization of medical students. In that study, a subculture of medical students was described in which the students underwent a role transformation that was peer led and involved learning how to act in order to avoid conflict with their professors and progress through the program. Studies on the socialization of teachers into the profession (Fantilli & McDougall, 2009; Nasser-Abu Alhija & Fresko, 2010) described the difficulties that novice teachers face as they transition into the profession, such as assimilating into the culture of the organization, communicating with parents of students, and having to manage a full workload immediately upon hire without the guidance of a mentor or induction period. A similar study on the socialization process of social workers (Miller, 2010) identified a lack of a framework to guide the newly graduated student in the socialization process of becoming a social worker, and attributed that to a high vacancy rate in social worker positions. Studies on police officers, air traffic controllers and train operators have studied the impact of shiftwork on quality of life

(Holland, 2006; Julseth, Ruiz, & Hummer, 2011; Signal, Gander, Anderson, & Brash, 2009) and found shiftwork (working at night) to be a factor in increased stress levels and work-home conflicts, as well as a possibly contributing to physical ailments such as cardiovascular disease and digestive problems, and to difficulty staying awake and alert during the night shift.

The Effect of the Nursing Environment on Nurses

All cultures and sub-cultures exist within a physical environment, or context, which affects and is affected by its members. There is a significant amount of literature on the nurse's work environment and how it may affect the nurse's role, job satisfaction and retention. Numerous articles have highlighted the importance of specific characteristics for a positive work environment, such as teamwork, leadership, autonomy, workload, clarity of role, recognition, physical design of work environment and availability of supplies, flexible scheduling , organizational policies, and opportunities for professional development (Lake & Friese, 2006; Schalk et al., 2010; Wu, Chi, Chen, Wang &Jin, 2010). In one report, characteristics such as authentic leadership, skilled communication and participation in decision making were identified as significant factors in a positive nursing work environment (Shiray, 2006). In a systematic review of interventions to improve the work environment of nurses, authors found that although several interventions to improve the work environment were identified, very few interventions were in fact implemented, and very few outcomes of the reported specific interventions were actually identified in publications (Schalk, Biji, Halfens, Hollands and Cummings, 2010).

Redesigning nursing work environments to alleviate nurses' stress has received attention in the nursing literature in response to a document published by the American Association of Critical Care Nurses that identified standards for sustaining healthy work environments (AACN,

2005). The six standards identified are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition and authentic leadership. Additional types of redesigns noted have been structural, such as to add lighting, or widen hallways on nursing units. The move toward more efficient environments for nurses has centered on electronic health records and personal computers on wheels that can go with the nurse from room to room, and "pods" outside of each patient's room with necessary supplies, and mobile medication carts that can be stored in each patient's room (Braswell & Duggar, 2006; Sensmeier, 2006).

While there has not been specific research on the working physical environment of a night nurse, authors have called for such research to be conducted in light of the recent focus on patient mortality and adverse outcomes that occur during "off-peak" times in acute care settings (Hamilton, Mathur, Gemeinhardt, Eschiti & Campbell, 2010). Off-peak periods have been identified as weekends and nights, and, for nurses, such periods incorporate 64% of the time nurses work. While many other factors may contribute to the incidence of off-peak mortality rates, the work environment during off-peak times has not been examined.

Summary and Critique

Few studies were found in the literature that explained night nursing as a sub-culture or added to an understanding of night nursing as a subculture. Reported nursing investigations on subcultures were undertaken using a specialty unit as the context rather than a specific shift. Studies that were reviewed on night nursing focused on nurses' education, job satisfaction, or the role of the new graduate at night. Two relevant studies concluded that teamwork and

camaraderie were more prevalent on the night shift positing this might be the result of fewer staff.

One important conclusion drawn from this literature review is that the subculture of night nursing is rarely examined yet may be a potentially rich and necessary area for study. Such studies are warranted especially because of recent calls for research in areas that will provide healthcare organizations with the information they need to strengthen nurse work environments, specifically "studies and development of methods to better describe, both qualitatively and quantitatively, the work nurses perform in different care settings" (IOM,2004, 2011). Thus, a qualitative study is proposed to address night nursing.

A qualitative study is used when the researcher wants to understand how people or groups work in their natural environment and how they make sense of their worlds in their own words (Lincoln and Guba, 1985). A researcher may study an entire culture or what might be considered a sub-culture or part of the larger culture; a subculture usually has many similarities to the larger culture but often has important differences. A specific unit or a specific shift can be considered as sub-cultures within hospital nursing. Because there is a dearth of research findings on night nursing, a broad perspective of this subculture would provide a first step in understanding how night nurses work and how they make sense of their world. One such methodology used to study a culture or subculture is ethnography. Therefore, this study used this qualitative methodology to describe the subculture of night nursing.

The research questions proposed for this study were:

(1) What is the role of a night nurse in a hospital?

(2) What does a typical night entail for a night nurse?

(3) What are the shared behaviors, norms, rituals, communication, hierarchies, and nursing care patterns in the hospital at night?

CHAPTER III

METHODOLOGY

Philosophical Perspective

Ethnography was used as the methodology for this study. Its origins are in anthropology and can be traced back to the 15th and 16th centuries when Western missionaries and explorers sought to discover the non-Western cultures they thought were primitive and with less civilized people (Vidich & Lyman, 2003). As history evolved, and primitive cultures became more difficult to find to study, the focus of ethnography shifted to a more narrow study of groups of people who shared the same race, ethnicity, socioeconomic status or religion.

Ethnography has its underpinnings in the constructivist-interpretive paradigm, which falls within the ontology of relativism, the epistemology of interpretivism, and the methodology of naturalism (Denzin & Lincoln, 2003). Some of the major assumptions in a constructivist paradigm are that: (a) meanings are constructed by people as they engage with the world they are interpreting; (b) people make sense of their world based on their historical and social perspectives; and (c) meaning is always social and comes from interaction with a community (Creswell, 2009). Ethnography has been used in nursing research to explore sub-cultures and provide descriptions that influence the development of hypotheses for further study.

Study Design

Ethnography is an effective way to describe and provide an understanding of night nursing, as little is known about night nursing as a culture. Madeleine Leininger (1970, 1998), a nurse anthropologist, contributed a significant amount of literature on the topic of this methodology and its use in nursing research. Ethnographic research enables nurse researchers to

explore the patterns, rituals, beliefs and life ways of people in a natural setting by entering into the environment of the group they are studying. The final product of ethnography is a holistic narrative, or cultural portrait of the group being studied, with the views and interpretation of the participants (emic) as well as the researcher's views (etic) portrayed (Leininger, 1970).

Of the several variations of ethnography used in research, mini-ethnographies and *ethno-nursing* are two types that have evolved to incorporate nursing specific purposes for conducting ethnographic research. A mini ethnography is one that is as intense and thorough in data collection and analysis as a general or macro-ethnography but is performed in a more focused narrower field. It is also referred to as a focused ethnography (Leininger, 1998; Speziale & Carpenter, 2008). Ethnonursing was developed by nurse anthropologist Madeleine Leininger in the 1960's, and incorporates the study and analysis of a chosen culture's viewpoints and beliefs about nursing care and nursing care behavior (Leininger, 1998). Leininger was greatly influenced in her development of ethnonursing by fellow anthropology classmate James Spradley, who later became renowned for his ethnographic studies. Leininger's approach to ethnography is to specifically focus on the perception and meaning of nursing care and health related issues from the perspectives of those receiving the care as well as those providing the care. Ethnonursing incorporates both the "emic" and "etic" views in the research process (Leininger, 1998).

Leininger(1998) identified eight reasons that would lead a nurse researcher to select ethnography or ethnonursing as the research method of choice, when: (a) there is very limited or no knowledge about a phenomenon; (b) the researcher is looking for a broad worldview of a particular phenomenon or lifestyles of a particular culture; (c) the researcher wants to answer new types of questions that have not yet been asked or examined; (d) the researcher wants to understand meanings of things in their context; (e) the researcher wants to generate theories or

hypotheses;(f) the researcher wants to compare aspects of nursing care across cultures;(g) the researcher wants to identify patterns that occur in a certain culture or group of people; and (h) the researcher wants to describe in detail events or phenomena that are not amenable to other types of research.

Ethnography is appropriate when the research goals are to describe how a cultural group works and to explore the beliefs, language, behaviors and issues such as power, resistance and dominance, or when the literature lacks information about a specific group and how it works (Creswell, 2003). The subculture of night nursing fits these criteria for exploration.

Regardless of the type of ethnographic approach used, there are six fundamental characteristics of ethnography that have been cited: (a) the researcher as the instrument, (b) fieldwork, (c) cyclic nature of data collection and analysis, (d) focus on culture, (e) immersion in the culture and (f) reflexivity (Speziale & Carpenter, 2008). Reflexivity, the ability to examine one's own processes as a researcher during the research, is an especially important quality for a nurse ethnographer to possess and is usually captured through journaling, as well as the ability to appropriately enter the field of study, remain, and exit (Leininger, 1998).

This study was guided by the methods of ethnonursing, as developed by Leininger and the *Developmental Research Sequence* developed by Spradley (1979; 1980). The study involved identifying a domain of inquiry, exploring literature for research on the domain of inquiry, preparing research instruments, plans and approvals, identifying and choosing people to be studied, such as key informants and general informants, observing, participating, interviewing and validating data obtained (Leininger, 1998).

The Field and Informants

The setting or field for this study was an acute care hospital during the night shift. The social situations observed by the researcher included a variety of nursing units in the hospitals. The informants were chosen from among the staff on each of the observed nursing units. The key informants were a few select nurses who had worked the permanent night shift for at least two years, were knowledgeable about the hospital and considered representatives of the night shift, and thus had the potential to provide the richest data (Leininger, 1998). The key informants were purposively selected during the field observations or through a recommendation by the Chief Nursing Officers (identified as *gatekeepers*). Key informants were given an information sheet explaining the study and requesting their participation (Appendix A). Key informants led the researcher to additional *general informants* (Higginbottom, 2004). General informants were also knowledgeable about night nursing, but not as experienced as the key informants. Initial plans were to select five key informants and not more than 25 general informants.

Data Collection, Methods, and Analysis

Spradley's (1979, 1980) Developmental Research Sequence (DRS) provided the framework for the data collection and data analysis in this study. The steps in the sequence are: (1) Locating a social situation/locating an informant; (2) Doing participant observation/interviewing an informant; (3) Making an ethnographic record; (4) Making descriptive observations/asking descriptive questions; (5) Analyzing ethnographic interviews; (6) Making a domain analysis; (7) Making focused observations/asking structural questions; (8) Making a taxonomic analysis; (9) Making selected observations/asking contrast questions; (10) Making a componential analysis; (11) Discovering cultural themes/taking a cultural inventory;

and (12) writing the ethnography (Spradley, 1979, 1980). Within this process, the researcher is considered the instrument. Data collection took place in the field. The "field" constituted a select number of units in Hospital 1 and Hospital 2. The data consisted of field notes, memos, reflexive journal entries by the researcher, transcripts of several in-depth interviews of key informants and general informants, and a collection of documents such as position descriptions, policies, meeting minutes, vision statements and procedures for content analysis (Hsieh& Shannon, 2005).

Participant Observation in the Field

The main goal of participant observation was to locate a social situation in which there were activities that occured regularly and recurrently (Spradley, 1980). In addition to Spradley's D.R.S., Leininger's stranger-friend model of entering and remaining in the field were used to guide the participant observation in this study. Leininger (1998) reversed the order of the more commonly known "participant-observation" method and changed it to" observer-participant" method, which she proposes is a more logical way of identifying with the steps. There are four phases in the observation participant method: (a) primarily observation; (b) primarily observation with some participation; (c) primarily participation with some observation; and (d) reflective observations. The written field notes taken during these observations constituted a major portion of the data collection and required the researcher to be astute to capture on paper what was seen and heard. Three principles that the researcher kept in mind during observations were: (1) the language identification principle; (2) the verbatim principle; and (3) the concrete principle (Spradley, 1980).

The language identification principle accounts for the fact that there will be more than one language included in the field notes: that of the researcher and that of the informants. In order to facilitate data analysis, the researcher labeled all field note entries with the language identified in parentheses next to it (Spradley, 1980).

The verbatim principle accounts for the need to identify terms and phrases that are heard while in the field. These phrases, or "folk terms" used by the informants may be helpful in generating additional research questions for subsequent observations (Spradley, 1980). For this study, these phrases or words were recorded in quotations with the language identified in parentheses.

The concrete principle accounts for the need to write concise field notes. It was impossible to write down every word heard and every activity seen. The researcher thus used concrete language when writing, using key words and phrases and then expanded on them at the end of the observation period. Large index cards were used to record observations, however only incorporated were brief phrases, half-sentences, and key words that provided enough information to be able to fill in more details at the end of the day (Spradley, 1980).

The researcher searched for activities that appeared to be similar or were repeated several times. "Repetition, both of field observations and concrete descriptions in your field notes, is one of the surest ways to see the complexity of a seemingly simple social situation" (Spradley, 1980, p.70-71). The researcher's observations were guided by questions, which were descriptive, focused, or selective, and required a separate observation, data collection and analysis for each type of question.

Descriptive questions are broad in nature and are appropriate for initial observations, when the researcher does not know much about the social situation. Spradley (1980) labels these

questions as either "grand tour" or "mini tour". The grand tour questions were very general and the mini tour questions were more specific in that they focused on one part of an activity and asked for details. The researcher used a matrix developed by Spradley (1980, p. 82-83) of nine major dimensions that encompass social situations to guide the written field notes. These dimensions include space, actors, activity, objects, acts, events, time, goal and feeling. The researcher asked descriptive questions about and observed each of these dimensions, filling in the matrix.

Data analysis of the descriptive question- based field notes is called a domain analysis, and began as soon as the initial observations were complete, so that the next phase of observation could be planned. The domain analysis included reviewing all field notes, memos, and reflexive journal entries to look for patterns in any of the dimensions that were described. Patterns will identify cultural meanings in the social situations being observed (Spradley, 1980). A cultural domain is defined by Spradley (1980) as the basic unit of any culture, and is comprised of categories of meaning that include even smaller categories. The domain is identified by a cover term, included terms, and semantic relationship.

The researcher began the search for cultural domains in the data by following the steps of "(1) selecting a single semantic relationship;(2) preparing a domain analysis worksheet; (3) selecting a small sample of field note entries; (4) searching for possible cover terms and included terms that appropriately fit the semantic relationship; (5) repeating the search with other semantic relationships; and (6) making a list of all the identified domains," (Spradley, 1980, p. 99). The researcher used large index cards to organize each domain worksheet.

The researcher re- entered the field to perform more focused observations guided by more focused questions. These questions stemmed from one or more of the cultural domains that

were identified and analyzed in the descriptive observations. The researcher focused more specifically on observing the semantic relationships of a domain with its cover term and used a matrix of structural questions, such as "what are all the steps in a particular activity?" or "what are all the roles that nurses have in this setting?" The structural questions were repeated so that several observations could be based on one structural question, and provide depth to the data (Spradley, 1980).

The field notes, memos, and reflexive journal entries from the focused observations were analyzed by making a taxonomic analysis (Spradley, 1980). This analysis was different from the initial domain analysis in that it probed into the relationships between all the included terms in a particular domain and how they were related to the whole domain (Spradley, 1980). The steps of the taxonomic analysis included (1) selecting a domain for further analysis; (2) looking for similarities based on the same semantic relationship; (3) looking for additional included terms; (4) searching for larger, more inclusive domains that might include the domain being analyzed; (5) constructing a tentative taxonomy; (6) making additional focused observations; and (7) constructing a complete taxonomy (Spradley, 1980, p.116-119). The researcher constructed a taxonomy for each domain selected with the goal of discovering relationships among the parts of the subculture being studied.

The next phase of observations in the field focused on selective observations. These observations led the researcher to finding the differences between the cultural categories previously identified. Finding these differences required the researcher to ask contrast questions of the informants, such as" how are these things different?" or "what is the difference between this activity and that activity". This process took place with each domain, with the ultimate goal of discovering what Spradley (1980) refers to as "dimensions of contrast".

The researcher then began a componential analysis of all the contrasts that had been identified in the selective observations. Spradley (1980) defines componential analysis as "the systematic search for the attributes (components of meaning) associated with cultural categories…" (p. 131). Contrasts are in essence attributes, or components of meaning for each category in a cultural domain. The researcher followed the steps of componential analysis including: (1) selecting a domain for analysis; (2) making an inventory of contrasts; (3) preparing a paradigm worksheet; (4) identifying dimensions of contrast that have binary values; (5) combining closely related dimensions of contrast into ones that have multiple values, (6) preparing contrast questions for missing attributes; (7) conducting selective observations to discover missing information; and (8) preparing a completed paradigm (Spradley, 1980).

Interviewing

During the observation phase, the researcher developed a rapport with the informants in each clinical area, and was able to identify key informants who might consent to interviews. Leininger's interview techniques include three types of interviews : (a) open-ended (unstructured) interviews, which use open-ended stem questions to elicit information from the informants, and are very helpful in collecting detailed, rich 'emic' data; (b) closed (structured) interviews, which are used when the researcher wants specific responses for a specific area, such as demographic data, and are not used very frequently in qualitative research; and (c) semi-structured interviews, which use a combination of open-ended and closed questions, and are helpful when the researcher wants unstructured responses in a specific domain of interest, Leininger, 1998). Effective lead-in questions that a researcher can use during interviews included "Tell me about how you came to be a night nurse." or "I would like to hear about what

you do on a normal night". The researcher used a semi-structured interview format, guided by Spradley's (1980) Developmental Research Sequence. The ethnographic interviews were thus characterized by the elements of (1) greetings; (2) giving ethnographic explanations; (3) asking ethnographic questions; (4) asymmetrical turn taking; (5) expressing interest; (6) expressing cultural ignorance;(7) repeating;(8) restating informant's terms; (9) incorporating informant's terms, (10) creating hypothetical situations; (11) asking friendly questions; and (12) taking leave (Spradley,1980). Each interview took place in a private setting.

The researcher audiotaped the interviews with a small digital voice recorder placed discreetly during the interview so as not to make the informants self conscious regarding audio-taping. The informants were reminded that they were free to decline to answer any questions with which they were uncomfortable. During the interviews the researcher strove to keep the informants relaxed and she listened carefully for key words, phrases and statements about night nursing (Leininger, 1998). It was also important for the researcher to validate and clarify responses during the interview to confirm informants' statements.

The transcripts of the formal interviews along with the corresponding field notes, memos and reflexive journal entries were analyzed in the same way as the participant observation data were analyzed, starting with a domain analysis and progressing to a taxonomic analysis. Additional interviews with some informants that were originally planned to capture missing data or to ask new questions were not necessary.

Discovering Cultural Themes

The researcher then moved to the next step of the DRS, which is discovering cultural themes. A cultural theme is defined by Spradley (1980) as "any principle recurrent in a number

of domains, tacit or explicit, and serving as a relationship among subsystems of cultural meaning" (p.141). The researcher went back over the data and looked at all the dimensions of contrast in each of the identified domains, and searched for a general recurring theme. She made a componential analysis of the names of all the domains that were identified during previous analyses and searched for general relationships among them. The researcher then made a schematic diagram of some of the domains and themes to look for generalizations that could be inferred about the subculture of night nursing (Spradley, 1980).

In the next step of analysis, the researcher took a "cultural inventory" and organized all the data in preparation for writing the ethnography. The goal of an ethnographic research study is to produce a narrative replete with "thick "description, which has been described as a story so descriptive and complex that the readers can actually understand what is occurring as they read (Geertz, as cited in Munhall, 2007).

Protection of Human Subjects

The rights of each informant were addressed with specific attention to the ethical considerations of autonomy, confidentiality and anonymity. Necessary procedures and paperwork required to enter the field for research purposes was sought and obtained from the institutional review boards of Hospital "1" and Hospital "2" after IRB approval was obtained from the researcher's university. A letter was sent to the Chief Nursing Officer of Hospital "1" requesting approval for entering the field and assistance in soliciting volunteers to participate in the study (Appendix B). All staff members on each unit where participant observations took place were made aware of the study and informed of their rights not to be observed if they so chose. Attention was paid to Spradley's (1980) statement "No matter how unobtrusive,

ethnographic research always pries into the life of informants…it reveals information that can be used to affirm their rights, interests, and sensitivities or violate them. All informants must have the protection of saying things 'off the record' that never find their way into the ethnographer's field notes" (p. 22).

Written informed consent was obtained from each informant prior to commencing the study and observation (Appendix C) and again before each interview (Appendix D) Participants had the option of refusing to respond to any question(s) they were not comfortable answering, as well as the option to withdraw from the study at any point in time. All recordings were transcribed by the researcher and all transcripts were numerically coded to avoid personal information on transcripts. The researcher kept all data in a locked file cabinet in an area that was only accessible to her. Data on the participants were reported using pseudonyms.

Methodological Rigor

Methodological rigor in a qualitative study has been identified as achieved if *credibility, transferability, dependability and confirmability* are achieved (Lincoln & Guba, 1985). Leininger (1998) also added the criteron of saturation, which refers to the exhaustive use of informants and data collection until no new information is found in context, which means that the findings are understandable to the informants within their context; she stresses that no new information is assessed through observing recurrent patterning in the data, which refers to the repeated instances of patterns occurring over time. In this study the researcher strove to achieve *credibility* through her prolonged engagement in the field, frequent debriefings with co-researchers or mentors, triangulation during data transcription (observation and interview data), keeping memos, field notes, and a reflexive journal. *Transferability* is determined by the ability

of other researchers to identify aspects of this study that may be transferable to a similar population in another setting and this is usually accomplished, as was the case in this study, by thick descriptions of data obtained. *Auditability* as a process denotes *confirmability and dependability and* was achieved by developing a "paper trail", or examples indicating the way the data were analyzed step by step and able to be traced and confirmed by those reading the study's findings. Thus, the researcher considered her approach as rigorous, enhancing confidence in the study's findings.

CHAPTER IV

PRESENTATION OF STUDY FINDINGS

The purpose of this study was to examine and describe the subculture of night nursing in a hospital setting. An ethnographic approach was utilized to answer the questions (1) what is it like to be a night nurse? (2) What does a typical night at work entail? (3) What are the behaviors, roles, rituals, and nursing care patterns in a hospital at night that are patterned and identified as part of a culture description? Data were collected through participant observations on five different nursing units in two hospitals, semi-structured interviews with eight informants, and an analysis of hospital documents. The observational phase occurred first followed by interviews. Field notes, interview transcripts and various documents in the hospitals were analyzed to identify categories, domains and patterns common to night nurses. This chapter includes a description of the physical settings in which the participant observations were conducted, a description of how entry was achieved into the settings, participants' demographic data, and a summary of the actual process used for the observations and interviews. The analysis of all of the data is then presented using domains and themes as outlined by Spradley (1980). To maintain confidentiality, the names of each hospital, each nursing unit, and each participant have been omitted and codes have been used.

The Study's Physical Setting

The two hospitals included in this study are non-profit community based acute care hospitals located in a suburban area. Hospital 1 is a 231-bed hospital that provides the services of emergency medicine, pediatrics, labor and delivery, neonatal intensive care, adult medical-

surgical care, intensive care and coronary care, physical rehabilitation and adult chemical dependency rehabilitation. Hospital 2 is a 248-bed hospital that provides the services of emergency medicine, adult medical surgical care, intensive care and coronary care, physical rehabilitation and psychiatric care. The nursing units represented in this study included Unit A in Hospital 1, and Units B, C, D and E in Hospital 2 (see Table 1).

Table 1

Summary of Characteristics of Units

Name of Unit	**Type of Patient Population**	**Total number of beds**	**Average number of nurses working each night**
Unit A	Critical Care	12	6
Unit B	Med-surg	30	7
Unit C	Oncology	36	8
Unit D	Med-surg	48	8
Unit E	Critical Care	12	6

Unit A in Hospital 1 is located on the ground floor. It is accessible by an elevator bank located on the first floor of the hospital, as well as by a staircase. There is a long walk with a few turns from the elevator bank to the doors of the unit so reading the signs and following arrows was important on the first visit there. There are two sets of electronic doors leading into the unit, the first of which requires a swipe card to enter. Any visitors would be required to press a button that would alert the staff inside to let them in. The unit is set up like a large rectangle with three sides of the outer perimeter of the rectangle containing the patient rooms, and then an inner

rectangle enclosed within the outer rectangle that contains the nursing stations, medication room and supply rooms. The rectangle is then figuratively divided into two sections, the ICU on the left side and the CCU on the right side. Each patient cubicle is a private room with glass windows and curtains. The nurses tend to sit on the side of the inner rectangle that is closest to where their patients are located.

Unit B in Hospital 2 is located on the second floor of the hospital. It is accessible by elevator or staircase. The elevator doors open up directly in front of the nursing station. The nursing station is in the center of the unit and patient hallways surround two sides of the nursing station; two hallways project out from the front of the nursing station, one on an angle to the right and one straight ahead.

Unit C is also located on the second floor of Hospital 2. This is a 36-bed unit that contains predominantly oncology patients. There is a central nursing station with three hallways of patient rooms fanning out from the front of the nurses' station like the spokes of a wheel. There is a small room off to the side of the nursing station with a table and chairs, refrigerator, microwave and coffee pot that the nursing staff uses for breaks and meetings. In this room there is also a large bulletin board that displays flyers, announcements, upcoming events, etc.

Unit D in Hospital 2 is located on the third floor. It is one of the largest units in the hospital and according to the participants, one of the most challenging to work on, due to the medically complex needs of its patients. The unit is located directly above Unit B, so it is similar in layout. The elevator doors open up right in front of the nursing station. The nursing station is surrounded on three sides with hallways of patient rooms, the right, the left and the back. There are also two hallways that project out in front of the nursing station.

Unit E is located on the 2nd floor of hospital 2. It is a critical care unit that is composed of 12 beds. The unit is shaped like an upside down "U". There is a waiting room outside the entrance doors to the unit that begins where the hallway of unit B ends, so one can look down the hall from the nursing station of Unit B and see the entry doors for Unit E. There are electronic doors that enter into the unit and the first patient room is on the left-hand side as one passes through the doors. The patient rooms continued around the perimeter of the unit and the nursing station is to the right in the middle of the upside down "U". This was the smallest unit in which the researcher observed and was the quietest overall, most likely because it was enclosed and had fewer patients and fewer staff members than the other units in the study.

Entry into the Setting

After receiving IRB approval from the university to conduct this study, the researcher pursued IRB approval from the hospitals in which the actual research would take place. After approvals, the researcher contacted the Chief Nursing Officers (Gatekeepers) of three hospitals and asked to meet with them to discuss the proposed research. The Chief Nursing Officers of two of the hospitals invited the researcher to come and present the research proposal at their Nursing Research Council Meetings. The researcher attended meetings at both hospitals to explain the study to nursing directors, nurse managers and assistant nurse managers. The researcher then contacted nurse managers who had expressed an interest in the study and arranged to present the study to the night nurses at staff meetings. Informational letters with the researcher's contact information were also left with the nurse managers as flyers to display on the unit or to distribute to their night staff (Appendix A). All necessary required clearances through human resources,

employee health and security were obtained from each hospital. The process of preparing for actual entry into the settings for data collection took approximately four months to complete.

For one hospital, gaining access each time to observe or interview, upon arrival to the settings, was cumbersome. The researcher had to enter one hospital through the emergency department after 9 p.m. and have a security officer confirm her arrival with the staff on the unit before "swiping" her through the doors to the main hospital. If the researcher was leaving the hospital during these hours, she would have to call the security department and be swiped back into the emergency department to leave the hospital. Entry into the other hospital was easier as the main entrance was open all night; however, a security officer was present in the lobby to screen visitors before allowing entry onto the hospital's units. Observations were planned as the first step with interviews following.

Methods of Data Collection

The methods of data collection included: participant observations of night nurses at work in their natural settings, semi-structured interviews conducted in private settings, and a review of hospital documents related to night nursing. The sample for this study included nine registered nurses who were currently working the night shift in either of two hospitals.

Recruitment

After obtaining IRB approval from the two hospitals, the recruitment followed the outline cited in "Entry" section. The first two participants contacted the researcher by e-mail / text message to volunteer to be in the study. When the researcher scheduled and conducted the initial observations with each of the first two participants, she was able to recruit an additional

participant from each hospital when she was introduced to the staff and explained why she was there observing his/her colleague. The next five participants were similarly recruited by snowball technique, that is a referral from a participant. At the completion of the first or second observations, each participant was invited to be interviewed by the researcher at a later mutually agreeable date and time. Interviews were to take place following the observation phase.

Table 2 depicts the participants' demographic information. Of the nine nurses who participated in the observations, two were male and seven were female. The average age of the participants was 41 years. The participants had been nurses for an average of 18 years, and had been night nurses for an average of 14 years. The least amount of time employed as a night nurse was three years. Seven of the participants were married with children, two were married without children, and one was not married and had no children. The highest level of nursing education completed by the participants was a Master's Degree for two of the participants, a Bachelor's Degree for three of the participants, an Associate's Degree for three of the participants, and a Diploma for one of the participants. Three of the participants worked on a critical care unit, three worked on a medical-surgical unit, two worked on an oncology unit and one, an educator, worked with all units in the hospital. Eight of the nine participants also agreed to be interviewed.

A total of 25 observations were completed over a five -month time span totaling approximately 100 hours. Each observation was three to four hours in length and occurred at different times between the hours of 7:00 p.m. and 8:30 a.m. Formal semi structured interviews took place during the same five month time-frame and were conducted privately with eight of the nine participants who had initially volunteered and had been observed. Hospital documents, including orientation manuals, unit schedules, policy and procedure manuals and newsletters

were examined by the researcher on the hospital units throughout the five month timeframe, during the observation sessions.

Table 2

Participants' Demographic Information

Informant Pseudonym	Age	Sex	Marital Status	Children	Highest Level of Nursing Education	Area of Work	Year in Nurs.	Years in Nurs. at Night
Bill	66	M	M	Yes	Diploma	Critical Care	47	45
Claire	41	F	M	Yes	BS	Critical Care	18	10
Joan	42	F	M	Yes	AS	Med-Surg	22	21
Melanie	56	F	M	Yes	AS	Med-surg	34	26
Tracy	30	F	M	No	AS	Oncology	3	3
Jean	29	F	M	No	BS	Oncology	6	6
Frank	35	M	M	Yes	MS	Med-surg	10	9
Elaine	26	F	S	No	BS	Critical Care	4	4
Sulema	45	F	M	Yes	MS	Education	26	4

The Observations

The first observations with each participant were a bit awkward for both the researcher and the participants. For the researcher, there was the stress of wondering how she could initially break the ice with the participant, and then be discrete enough to observe without interfering with any other activities going on at the time. For the participants, they appeared to be a little nervous and uneasy initially. They were very direct in asking the researcher exactly what she wanted to know and what they should do.

The researcher attempted to make each participant feel at ease by explaining the purpose of the study again during the informed consent process, which took place in a private area of the nursing station. The researcher emphasized that she would step away if requested to do so at any point during the observations, and that any information that the participant did not want included in the observations would be omitted. The researcher offered the analogy of orienting a new nurse to nights to give the participants a more concrete idea of how they should proceed with their routine.

The researcher then accompanied participants as they went about their normal activities. If the informant was going into a patient's room, the patient was told who the researcher was and why she was there, and was asked if they were agreeable to having the researcher present. In all such cases, the patients gave their permission for the researcher to be there. One patient actually told the researcher to "make sure you write in your report that night nurses work very hard!" as the researcher helped transport him in his bed to another unit in the hospital. There were a few instances during the observations in which sensitive patient and/or family issues were involved, and the researcher was advised that it would be better if she did not go into the patient rooms, and she obliged.

In addition to accompanying the participants as they went about their routines, the researcher would assist with non-direct patient care activities such as getting water or ice, or helping to transport patients on stretchers or beds from the emergency room to their units. During the observations, the researcher would ask the participants general questions about what they were doing, what their usual routine was, if this particular night was a typical night, what the staffing patterns were like on their unit, etc. If the participants were scheduled to distribute medications during the observations, the researcher would leave them and sit at the nursing

station so as not to be a distraction during medication administration. The researcher would take that time to chat with other staff members, who were curious about her study, or she would jot down memos and field notes in her notebook. This was also an opportunity for the researcher to read nursing manuals, staff meeting minutes, and flyers that were available on the unit.

The observations became less anxiety- provoking for the researcher as they progressed. The staff members in both hospitals were welcoming and friendly. The researcher found it easy to engage in conversation with the staff members that were not in the study as well. One nurse approached the researcher to ask if she could be in the study, but she did not meet the criteria of a night nurse, so was ineligible. Each observation lasted between three and four hours; the researcher did not want to become too intrusive or drag out the observations too long, so she would be sensitive to the actions and demeanor of each participant and would end the observations if the participant seemed to have had enough.

The overall routine of the shift was very similar in all five units that were observed. Table 3 outlines specific activities observed within time frames. The first few hours of the shift went very quickly. There were a lot of people around, including staff and visitors, as well as a very high level of sensory stimulation: conversations, phones ringing steadily, patient call bells sounding, equipment alarms on intravenous pumps, telemetry monitors and other patient devices alarming with a variety of chirps and staccato gongs, and voices coming from all directions.

Change of shift report between the day shift and the night shift RN's took place either in the hallway outside patient rooms, or in a central nursing station, and temporarily took up much of the space in all of the units observed. The researcher noted that interruptions to this ritual of exchanging handoff report were frequent, and sometimes prevented the nurse that was going off duty from leaving on time. Once the night nurses had received handoff report, they spent the next

few hours greeting their assigned patients, administering medications, and completing patient assessments. Their goal was to optimize their patients' ability to get as much uninterrupted sleep as possible during the night.

Close to midnight, on the units the level of sensory stimulation notably decreased as well as the number of people. The nurses used the next few hours to check for new orders for their patients, read updates on charts, and prepare for their morning routines. This portion of the night allowed the nurses to sit at their computers to chart, or sit and talk with their coworkers, some to go out for something to eat, or to take a break. The morning routines began at around 5:00am and continued until the nurses stopped to give handoff report to the incoming day shift nurses.

The last few hours of the shift, from about 5:30 a.m. until 7:30 a.m., were as busy and full of sensory stimulation as the first few hours were. Groups of doctors would arrive to make rounds on their patients, ask the nurses questions about how the patient's night went, and relay the new orders or plan for that day. Operating room and escort personnel would arrive with stretchers to pick up patients for surgery or tests. Dietary personnel would come with breakfast trucks and pass out trays to those patients who could eat. The nurse managers and assistant nurse managers would arrive and ask how the night went, and get updates from the night staff regarding potential discharges and patient movement so that the cycle would begin anew.

Table 3

Summary of Activities Observed During Night

7:00p.m.-12m.n.	12m.n.-5a.m.	5a.m.-8: 30a.m.
• Get assignment • Take report • Make initial rounds • Administer prn meds. • Administer scheduled medications • Vital signs • Physical assessments • Check for all necessary medications for remainder of night • Receive patients back from recovery room after surgery • Admit new patients from emergency room • Accept new transfer patients	• Check if all meds charted • Check for new orders • Check for new lab results • Read patients' charts • Document care plans, patient progress notes • Admit new patients from the ED • Accept new transfer patients from other units in hospital • Attend staff daily roundup • Take a break • Cover nurses' patients during their break	• Begin waking patients for medications • Vital signs • Treatments, • Dressing changes • Draw blood tests • Set patients up for breakfast • Administer insulin • Finish charting • Make a.m. rounds with doctors • Prepare to give report

The Interviews

It was during the observations that the researcher was able to recruit volunteers to be interviewed. All nine participants that had agreed to be observed were receptive to the idea of being interviewed, and all volunteered. However, one participant could not be interviewed because she was going out on an extended medical leave. The interviews were scheduled

individually with each participant and were conducted in a private location at a mutually agreeable time. Some of the interviews took place in a private area on the unit where they worked, and occurred during a break time. Some took place in an office in the hospital, and others took place in a coffee shop. An informed consent (Appendix D) was obtained prior to each interview and the researcher informed the participants that they had the option of stopping the interview at any point, or declining to answer any questions that they did not feel comfortable answering. Seven of the eight interviews were audio taped and transcribed. Transcriptions were analyzed using Content Analysis (Hsieh & Shannon, 2005). Line- by- line, phrases were coded. Phrases were then categorized and finally categories through reduction became themes.

The Semi -structured Interview Guide appears in Appendix E. The first question asked of each participant in the interviews was "How did you arrive at where you are now?" Every participant described his or her initial arrival to the night shift as involuntary. There were usually no openings on the day shift and as new graduates they were offered night shift positions as their only option. Some of the participants eventually obtained positions on another shift, either days or evenings, but ended up coming back to the night shift by choice. They said that they liked the atmosphere on the night shift better, or they needed to work the night shift hours for personal or family obligations. Additional interview questions pertained to their role as a night nurse, further probes about some of the observations that the researcher had noted their relationships with their colleagues, role stressors, characteristics of night nurses, and advice they would give to potential new graduate night nurses.

As the participants described their roles as night nurses, they validated the researcher's summary of the activities she had seen during her observations of them. When discussing their work environment and relationships with each other, the participants were very appreciative of

their co-worker relationships despite as they said, the working in an environment was not always ideal. In speaking about the importance of teamwork at night one participant remarked:

> "At times we kid around and say we are only here because the day people don't want to be, but I think that the teamwork of the night shift is very different from the day shift".

Characteristics of night nurses identified during the interviews included: a more 'laid back' personality, able to 'go with the flow', able to troubleshoot and critically think, confident, autonomous, equipped with a clinically strong skill set after being on nights for a period of time, team players and friends. One participant remarked:

> "I think night nurses are more independent, they're more the trouble shooter-type, they're more the fixers...night nurses devise great things to make things work...like we'll take a connector from here and a connector from there and we'll make it work...they're usually very independent. If you weren't independent, I'd think you'd be more afraid to be on nights because you don't have all that support that you have during the day...they are also planners they're more organized."

They described some role stressors such as not being able to get enough sleep, lack of resources, less opportunities for formal educational offerings, managing confused patients, and having to call doctors at home at night. All of those interviewed admitted that they often thought about sleep, specifically wondering if and when they would be able to sleep during the day so that they would be ready for their next night at work. Several of the participants proudly declared that they had become quite proficient at sleeping anywhere, as one remarked: "I would sleep all day if I could...I can sleep anytime, anywhere".

Sleep was also the main topic of all the participants when asked what advice they would give to new nurses coming on to the night shift. A participant who had worked nights for many years replied:

> "Advice for new night RN's? Let your friends and family know that you will be sleeping during the day. I had to call some of my friends at 3 am just to say hi to get my point across to a few. Eat right and take a vitamin daily. Drink lots of water while you are working, keeps you hydrated. Eye shades if you can sleep with them on or darkening curtains for your bedroom, and take the phone out of your bedroom unless you are waiting for someone very important to call!"

Another participant added:

> "A year…you gotta give it a year. You have to really give it a shot and see how hard of a shift it really is…how hard it is to stay awake. You will become more autonomous and build your confidence so you have to stick it out for at least a year!"

Some of the more experienced nurses reminisced about how night nursing used to be, and how different it was now. One nurse recalled:

> "When I first started, many years ago…you were done with your meds by 10 o'clock, you were done with your charting by 12 midnight…and we used to play Pictionary until like 5 o'clock when we were gonna start up again…**Now** you could **never** do that!"

Another less experienced night nurse added:

> "I'll never forget when I was orienting to nights…I had my preceptor…she's been on nights for twenty years…and she told me that she missed so many family

> events while working nights and I was like 'why?' I think my generation is different that way...we ask people to switch with us all the time if something comes up, but that generation...they think that whatever your schedule is, that's what it is, you don't switch".

The stressor of having to interact with or wake doctors at home at night was mentioned as one of the things about night nursing that has **not** changed over the years. One participant remarked:

> "A lot of the new nurses are afraid of dealing with the doctors during the day...that's a big stressor for them and they don't have as much of that at night. They might have to call a doctor, but that's not the same as five doctors showing up at once wanting to know this and that, and wanting you to come help with a procedure. The new nurses are nervous around the doctors. I remember when I was nervous too. You're scared that you're not gonna have the right answer and you're gonna look like an idiot! At night we get very few doctors that come in the middle of the night but if you need to call them, you do."

As noted, all interviews were transcribed by the researcher and content-analyzed line by line to identify look for common patterns, categories and themes. Eight initial categories or domains identified in the raw data of the interview transcripts were: Entry into the subculture, Role Stressors for night nurses, Work Environment, Insider/Outsider Contrasts, Characteristics of Night Nurses, Historical Perspectives, Myths/Rituals, and Things They Wish They Could Change (see Appendix F for all eight domains and examples of the initial phrases coded). Following this, themes were identified and described and are presented in the next section on the analysis and synthesis of the data collected.

Table 4

Examples of Two Domains from Analysis of Transcripts

Domain 1: Entry in the Subculture	**Domain 2 : Role Stressors for night Nurses**
Voluntary	Physical effects of sleep discordance, impact on personal life
No choice	Managing confused patients
Rite of passage for new graduates	Lack of resources
Newcomers embraced	Less opportunities for formal educational offerings
"Everyone has to do it"	Having to call doctors at night

Review of Documents

The researcher asked at each hospital if there were any specific policy manuals or orientation manuals specific for night nurses, but there were none specific to the night shift. All policy manuals were generic and the hospital documents that were found during the observations did not focus on a particular shift. Meeting schedules were posted on the nursing units for all of the Nursing Councils, and the researcher noted that they were scheduled between the hours of 9 a.m. and 3 p.m. The times these were held made it very difficult for night nurses to attend the meetings, which were mentioned as source of frustration by some of the participants. However, the researcher noticed one flyer in one of the hospitals that announced that a night nursing council was being newly formed, with meetings scheduled during the night shift. The document review reinforced the fact that there are limited resources available for night nurses.

Analysis and Synthesis of the Collected Data

The purpose of this study was to describe the subculture of night nurses. Data collection and analysis occurred over a period of seven months. Field notes and memos written during the observations, transcripts of the semi-structured interviews and hospital documents were read and re-read, line by line in order to identify recurring patterns and aspects of culture that night nurses displayed. When an issue or a topic was identified as frequently occurring in either the field notes or interviews, it was sorted out of the data, written in a column on the side, and highlighted. Later in the analysis each highlighted phrase was transferred onto an index card, labeled and grouped together with similar pieces of data.

Synthesis was then undertaken with all of the data. Each group was then clustered and relabeled as a broader category or domain. The domains identified then included characteristics of a night nurse, relationships, historical perspectives and myths of night nursing, insider/outsider status, work environment, and frustrations.

The Ebb and Flow of Night Nursing

After reflecting on and analyzing the data from the 25 observations, the eight interviews, and the documents on the units, the best way to describe the activities that occur at night in an acute care setting would be to compare them to the ebb and flow of the ocean. Just as the ocean has periods of incoming crashing waves followed by a quiet retreat of the tide, and then a resurgence of incoming crashing waves, the nightshift in a hospital has similar ebbs and flows: there were periods or flurries of intense activity and high noise levels at the beginning of the shift, followed by a period of waning noise and less activity, only to be followed by a resurgence of noise and flurries of activity once again.

Controlled chaos, 7:00 p.m-12 m.n . The first four hours of a night nurse's work were comprised of a rapid flow of activity. The shift began with an exchange of report on his/her assigned patients. These reports occurred at the nursing station or outside each patient's room, and were followed by walking rounds on each of the patients assigned. The amount of noise generated on each of the units at this change of shift time period was by far the loudest of all observations. The nursing stations were abuzz with phones ringing, patient call lights ringing, voices over the intercoms from the nurses' stations, overhead paging of physicians, rapid responses, and codes. As one participant stated in an interview:

> "Usually the first four hours of the shift is about patient movement and turnover and we try to get that down by midnight…more for the patients' sakes than anything else, because after that it becomes disruptive to them. And if there's something that has to be done for the patient before morning you have to fit that into the first four hours of your shift…I feel like you kind of have that time constraint almost, because there are some patients that actually sleep at night."

These first four hours of the night shift involved movement of *everyone*, staff and patients alike. It was the part of the night that passed the quickest for them, and when the nurses appeared to be the most overwhelmed.

Regroup, recharge and review, 12 m.n.-5 a.m. Around midnight, the pace on the nursing units began to slow down and the noise level began to decrease. This is where the ebb of the night seemed to begin. The amount of people present on the units also began to dwindle. Unit clerks or secretaries who had been answering the phones, directing family members, physicians and patients where to go and who to go to, went off duty between 11:30 and 12 m.n. Most family

members had left for the night by 11:00 p.m. Many ancillary departments, such as central supply, pharmacy, and dietary were not open overnight so there were no deliveries to the units. Other than the overnight intensivist, the overnight hospitalist, a physician's assistant (PA) and Emergency Room doctors, there were usually no doctors on the units. On most units, the lights in the hallways were turned down at this time. As one participant remarked during an observation session "the hallway lights are dimmed around midnight and you feel like the whole atmosphere of the unit kind of quiets down a little bit."

There was limited access in and out of the hospitals during these hours. The hallways in between patient units in both hospitals were quite empty at this time of night and the researcher had an eerie feeling walking through them on the way to the nursing units. One would almost surmise there were no patients or staff in the buildings as you walked through them, the sound of your footsteps the only audible noise.

Any sounds during these few hours seemed to be amplified, especially the voices of nursing staff. Even conversations in low voices sounded loud and emanated into the empty hallways and into patient rooms. As an observer, but also as a member of this subculture, the researcher could understand why patients think the hospital is noisy at night. There were short periods of time during which it was so quiet one could hear a pin drop, and then a patient call light, a bed alarm, a phone call, an overhead announcement of a patient emergency, or a cardiac monitor alarm would break the silence and startle everyone into action.

This period of time gave the night nurse a chance to regroup. Because patient care records have evolved to almost entirely electronic, having access to a computer and a chair is a priority for any nurse. One clear advantage to working at night was that computer access was much easier than on day shift. Each nurse could have a computer and not have to share. In

addition to the computers at the nursing stations, there were also computers mounted on wheeled medication carts in each patient hallway, randomly parked outside patient rooms. The nurses could then roll the cart from room to room and use the computer and patient scanner to help administer medications. These computers were also available to be used for charting and reviewing the electronic health records because there were rolling chairs in the hallway that allowed the nurses to sit and be closer to their patients. The researcher noted that on most units, the hallway computers did not seem to be used as much as the ones at the nursing stations. Most nurses seemed to prefer to be near each other, even if they were not involved in conversation.

The majority of scheduled medications had been administered by this time so the night nurse would check to see that all were charted for. Each patient's record was also accessed electronically to determine if any new orders had been placed since the start of the shift, or if any laboratory results had been entered. The nurse would also read through the notes in the patients' charts to get more detailed information about their plan of care, what consults were performed, what was planned for the future , what the discharge disposition would be, etc. The nurse would also try to complete the required vital signs, assessments, documentation, and care plan charting during this time.

The calmness during this period of the night was occasionally interrupted by a patient's call bell, a bed alarm or the telephone. There were frequent emergency room admissions during the middle of the night, so if a nurse had an empty room in his/her assignment that night, he or she knew that they would most likely get a new patient before the morning.

Revival and resumption of organized chaos 5 a.m.-8:30 a.m. The flow of the night shift resurged at around 5a.m. The last three hours of the night nurse's shift ended in much the same way it had started: in a hustle and bustle manner with high noise and activity levels. The

awakening of patients and arrival of day staff members would start off quietly and then rapidly crescendo up to high noise and activity as the night nurses prepared to give report and leave. Morning activities began at about 5:00 a.m. with lights being brightened and patients being woken up for medication administration, vital sign checks, blood sugar checks, blood tests to be drawn, dressings or treatments, A.M. care, being prepped for surgery or procedures. The first signs of daylight would become evident through the windows in patient rooms and that seemed to instill a last spurt of energy into the weary night nurses. No matter how seasoned a night nurse was, or how much sleep was obtained the day before, staying awake all night was never easy. The fight against circadian rhythms did not appear to be easy for anyone. During the observations several of the nurses remarked that they were waiting for their "second wind" to come after the quieter portion of the night was ending and the morning hustle was about to begin. The researcher noted the contrast even more so as the day staff members came in with their coffee in hand, fresh and ready to start their day and the night staff members looked pale, tired and red-eyed.

Cultural Attributes

The data analysis revealed that some of the categories and patterns the night nurses share as a group are attributes of a culture, such as entry, specified roles, rituals, hierarchies, and insider/outsider perspectives. The data reinforced the description of night nursing as a subculture.

Entry into the Sub-Culture

Entry into the subculture of night nursing takes place in either of two ways: by condition of employment or by voluntary choice. During the interviews, every participant referred to the fact that as a new graduate nurse, they did not have a choice of shifts to work when they entered the workforce. One participant stated:

> "I don't think anything prepares you for nights. When you first graduate, it's your only option…you just have to do it…I didn't know what to expect when I came to nights and I just did it." Another participant commented: "There are always more people who would rather work the day shift than the night shift so we do get a good influx of new graduates."

However, as they became acclimated to working the night shift the participants in this study chose to stay on nights because it suited their personal lives and because they liked the teamwork and camaraderie. One participant remarked:

> "I fell in love with nights so I stayed on nights even when I changed hospitals. When I came here I chose nights. Currently there are day positions available on this unit but I'll stay on nights".

One of the more experienced participants expressed how she enjoyed getting the new graduates onto the night shift:

> "I think the night shift embraces them. We coddle them and I think they feel safer. The nurse manager will ask them if they want to go to days and they'll say 'No, I'm good' so I think they like nights".

Role of a Night Nurse

The role of a night nurse is very patient-centered and encompasses both physical and emotional care. What was once considered a predominantly supervisory role of monitoring sleeping patients of course is no longer true. While sleep is encouraged for patients, there are many interruptions. Some medications are ordered to be given at specific time intervals and require patients to be awakened to administer them. There are treatments that need to be complete at regularly spaced intervals as well, such as breathing treatments with a nebulizer,

dressing changes, or peritoneal dialysis exchanges to name a few. New patients are admitted to the hospital 24 hours a day through the emergency room, and operating rooms run well into the late evening for scheduled surgeries, and during the night for emergency surgeries. Therefore at any time during the night a sleeping patient might be awakened by the arrival of a roommate. In the intensive care units, some patients were awakened to be moved to a different unit in the hospital because another more acute patient needed to be transferred to intensive care and there were no empty beds. When asked if patients ever complain that they didn't get enough sleep at night, one participant replied:

> "Oh yeah, a lot them do…a lot of them have been here before and they will say 'I'm in the hospital so I know I'm not gonna get any sleep'…they kind of do lose control of their schedule".

Physical care: The observations reinforced the fact that many hospitalized patients are in need of total physical care, around the clock. While this was to be expected in the Intensive Care units because many patients are sedated and connected to ventilators or have invasive lines and monitors, there were many patients on the general med-surg floors that were not independent in their activities of daily living (ADLs) and thus required full assistance with personal care in addition to treatments that were part of their reason for being in the hospital. The night nurses in the critical care units performed A.M. care on all of their patients, and on the med-surg units, a majority of patients were given A.M. care by the night shift nurses and nursing attendants. There were no physical therapists on duty during the night so the nursing staff had to work together to get patients into and out of bed as needed. On days, the role of the physical therapists was to assist patients out of bed and help them ambulate, but at night, the nurses and nursing assistants worked together to assume that role.

Medication administration: Medication administration is a very central part of the role of all nurses in acute care settings, and it was observed that it took up a major portion of the nurses' nights. The researcher was well aware of the importance of this activity and was very careful during observations not to interrupt them. The medication administration times at night are traditionally 10 p.m., 12.m.n., 2 a.m., 6 a.m. and 8 a.m. Each nurse on a typical med-surg floor could potentially administer as many as 100 medications in a single 12-hour shift. The researcher made an additional memo in her field notes that addressed how frequently nurses were interrupted during the medication administration process, and wondered if this could be a contributing factor to medication administration errors.

Emotional care: Many of the participants referred to spending time with their patients at night to provide emotional support, teach, and to just get to know them. One participant remarked:

> "I find that I give a lot of emotional support at night. Sometimes the patients have just found out they have cancer and the doctor doesn't have the best bedside manner and he'll just walk out of the room after telling someone bad news…so there's a lot of consoling that we do."

The researcher noted that very few patients slept for long, uninterrupted periods of time. If they didn't wake up on their own at some point during the night, they were awakened by their nurse for medications or treatments, by another patient, or by noise.

Many elderly patients experienced what is commonly called "sun-downing" at night, *Sundowning Syndrome* is a "circadian" (daily rhythm) disturbance in which agitation and activity increase, rather than slow down, as the day wanes (Kim, 2005). It is an unexplained type of transient delirium that happens to patients most frequently at night, and manifests when it becomes dark or when they wake up from sleep confused and agitated. In their confusion they

often try to climb out of bed and leave the hospital. Sometimes they are awake for an entire night. This is a significant stressor for the night staff because the sun-downing patient tries to climb out of bed, yells out, and because of confusion is often combative with the staff that is trying to help re-orient him/her. Taking care of patients like this is a challenge and poses a potential safety risk. Typically these patients need to have a nurse or nursing assistant sit by their bedside to try and calm them down and to provide constant observation to prevent them from falling or pulling out drains or IV catheters. One participant remarked during an interview:

> "So many patients sundown at night…one of our nurses suggested that we get all the flashlights in the unit and shine them in those patients' rooms so they would think it was daytime…then maybe they wouldn't sundown! One time when I gave report to the day nurse and said what a horrible night I had with my patient, the day nurse said 'oh really? She was fine for me yesterday'…so I wanted to scream then…I was spent…it's exhausting!"

Bed alarms are one strategy used to let the staff know when a confused patient attempts to get out of bed. The alarms are programmed to play music when the patient tries to leave the bed. The researcher observed the staff on several occasions jumping up and running toward the music in hopes of reaching the patient before he or she fell.

Rituals

Rituals, along with myths, are aspects of symbolism that contribute to the character of a culture or an organization. Symbolism helps members of a group understand the values and meanings of different aspects of their culture (Dandridge, Mitroff & Joyce, 1980). Myths, which are considered verbal symbols, and rituals, which are considered action symbols, play a significant part in the day-to-day functioning of a culture. Rituals and routines are quite common

in cultures and night nurses shared some as well. As described earlier, entry into the subculture of night nursing has itself become a ritual or a rite of passage for new nurses. Very few nurses who work in acute care settings have entered the workplace without starting on the night shift, or being placed on a night shift rotation as soon as orientation is completed. Receiving and giving "hand-off -report "were the first ritual of a nurse's shift and the last ritual before he/she went off duty

The researcher noted a consistent routine, or order of tasks for the night nurses on each of the units, regardless of the type of unit. All of the participants made reference to their "routines" and how their night would be very stressful if their routine was disrupted. When a patient emergency or an admission interrupted their routines, it was difficult for the nurses to regroup and get back on track. One ritual noted was: a gathering together in the lounge to eat when there was a lull in the activity, usually between 1 and 3 a.m. Very often someone would bring in a home-baked dessert or someone would go out and do a "food run" at 2 a.m. to whatever fast-food place was open. Another ritual the night nurses frequently performed was sitting together at the nursing station and brainstorming with each other about school. Interestingly, the majority of the nurses and several nursing assistants were attending school to attain a higher degree in nursing or their first nursing degree. They rarely left their units for break, so they would use their break time to give advice to each other about classes and assignments. Another ritual observed in one hospital was a nightly huddle, or "daily lineup" as it was called. At some point during the night, the staff would gather at the nursing station and listen to the assistant nurse manager, who would update them with messages from the nurse manager, or review new initiatives or policies that were coming into place, or discuss current issues on the unit.

Hierarchies

As in most health care settings the formal hierarchy of patient care decisions rests with the highest licensed independent practitioner (LIP) available, most often a physician. At night the same holds true. An intensivist, also known as a critical care attending physician, was the highest level of physician in the hospitals at night. He/she would be stationed in the critical care units, but was available to see patients on other units if consulted, and was the physician on site that responded to all patient emergencies, such as rapid responses or codes (cardiac/respiratory arrests) in the hospital. There were also nurse practitioners and physician assistants in the hospitals to admit new patients and to handle other non-emergent patient issues. Attending physicians were not routinely around at night unless they were called in for an emergency, or were performing surgery. The researcher noted a universal reluctance by all to have to call an attending physician in the middle of the night. There was a sense of apprehension in having to wake someone up at home, and as they said, be the potential recipient of anger, as well as a sense of failure in that they could not fix whatever the issue was about that they were now calling an attending physician at home. During more than one of the observations, the researcher observed the staff debating over who was going to make the phone call to a physician because they knew the particular physician had a reputation of being angry when called in the middle of the night.

The hierarchies on the nursing units appeared to be consistent among all units included in this study. There was a chain of communication on the nursing units that the nursing staff followed. The nursing assistants reported to the RN's and the RN's reported to a charge nurse, who could be an assistant nurse manager or one of their peers who had been designated as charge nurse for the night. The charge nurses and assistant nurse managers reported to a night supervisor who made rounds on each unit during the night. The hierarchy, however, was not as evident

during patient care. The researcher noted during many observations that all the night staff were willing to answer call bells, run toward the music of bed alarms and help each other with patient care, regardless of what their title was or whose patient it was. There was also a notable appreciation by the nurses of the nurses' aides. During an interview a veteran nurse stated:" I try to team up my stronger more nurturing aides with my new nurses, 'cause they're your backbone. If you have a good aide you're not gonna sink!"

Insider/Outsider Perspective

The phenomenon of insiders versus outsiders was not overtly stated by any of the participants but was a recurring pattern that emerged from the data as it was analyzed. There was a frequent use of the collective "they" by the study participants when referring to individuals who t did not work nights or to others who worked nights but did not work on their unit. One participant remarked during an interview "Sometimes I wish I could go on days and feel like a normal person". Another participant similarly referred to day shift nurses as "having a normal routine, which is not what we have". All of the participants readily admitted that the day shift was busy, but they agreed that it was a different busy. One participant tried to discern the difference:

> "They have to deal with all the doctors during the day, and the patients' families are around more during the day. I believe that the day shift nurses are fragmented. They are more distracted by other issues. We are busy too…on some nights the staff do not take a break…and if they do, they don't leave the unit."

Another participant commented: "There is a perception where they think everybody (the patients) sleeps at night and we have all this time so they will say 'why wasn't this done? or 'why wasn't that done?'…and as we all know that's not the case."

The researcher sensed a negative tone, possibly one of resentment, when the participants spoke about outsiders to the night shift. Therefore, she probed further by asking the participants if there was tension between the day shift nurses and the night shift nurses on their units. Each participant acknowledged that there was sometimes tension between the two shifts, usually over the next shift not coming in on time or over tasks that were not completed by the other shift and were being passed on to the oncoming shift. One participant had been a night nurse for many years and remembered that the night shift historically was responsible for a lot of extra tasks like restocking the medication room and the treatment carts because they had more free time. "Night shift nurses were always like the maids." Another participant remarked that there was less tension between the two shifts after they started to meet with each other and do peer-reviews. One participant said she sensed that the day shift was envious of the bond that the night shift had:

> "We are like a community at night, even from floor to floor. We know each other and if we need help someone from another floor will come and help...on days they don't have that interaction with the other floors. We go away together once a year, we plan little activities together and the day shift envies it...they say it. We do have some day shift nurses who like to join us on our activities. They are "night shift wannabees" we call them...because of their family life they can't work the night shift."

The researcher heard from many of the participants that they felt most people can't understand what it's like to work nights unless they have done it before.

Identification of Themes

As the domains and categories emerged from the data, and were analyzed the researcher searched for cultural themes, more of a synthesis. A cultural theme helps to connect the domains

of a cultural scene together and portrays a more holistic representation of the culture being described. Spradley (1980) defined cultural themes as "any principle recurrent in a number of domains, tacit or explicit, and serving as a relationship among subsystems of cultural meaning" (p. 141). Themes usually take the form of an assertion and are generalizations about the patterns that make up the culture.

Themes that were discovered in this study were: (1) Camaraderie and teamwork are the pillars of night nursing; (2) Learning to think critically abounds on the night shift; (3) Sleep mindedness permeates night nursing; and (4) Night nurses are undervalued. Each is described with supporting information gleaned from observations of the interviews.

Theme 1: Camaraderie and Teamwork: The Pillars of Night Nursing

Camaraderie and teamwork were evident throughout the research study in the observations and were mentioned by all participants during the interviews as positive attributes of night nursing. One participant remarked:

> "…there's something about it…the culture on nights…you know the way everybody works together as a team. We all kind of rely on one another a little bit more."

During the observations, it was noted that nurses and nursing assistants would often ask each other if help was needed with anything if they were at a quiet point in their own assignment. If a bed alarm sounded, more than one person would jump up and go to the patient's room, regardless of whose patient it was. If a unit was receiving an onslaught of new admissions or transfers, the charge nurse would talk to the nurses and they would come up with a plan together of who was taking each new patient. During an observation one night, one of the participant's

patients became unstable and a Rapid Response Team was called. The staff came from all around the unit to offer assistance with the patient until the members of the team arrived. One person ran to get needed supplies, another nurse offered to check on the nurse's other patients, and another person got a portable monitor and oxygen so the patient could be safely transferred to the ICU. No one was idle and when it was over, they all thanked each other and went back to their own assignments. One participant remarked during an interview:

> I find that on the nights we're stressed the most, it's almost like we get closer…there have been nights where you know, you got three codes going on or four rapids (rapid response teams) or you have a patient that's really sick…it takes like two of you to take care of…and I find that you pull together *so* tight and you work together *so* well…and when you leave in the morning you're like 'Wow, that was great! Everybody did good together."

Theme 2: Learning to Critically Think Abounds on the Night Shift

Critical thinking has been identified in nursing as a gold standard of nursing care and a characteristic of an expert nurse. The night shift seems to be especially conducive for new nurses to develop or improve their critical thinking skills, and problem solving skills, primarily because of limited resources available to them to discuss patient care and/or clinical situations. They are faced with no other options than to figure it out with what resources they have available. One participant remarked during an interview:

> "I find that the skill of a night shift nurse is far greater than the day shift because out of necessity you develop better skills…you can't call anybody to put your NG tube in or start your IV."

Another participant added regarding autonomy:

> "I think night nurses are more independent…they're more the trouble-shooter type. I have found night nurses devise great things to make things work…that drain has a leak, what can we do to improvise to make things work since we don't have the stockroom people here…we use our critical thinking to make things work, you know?"

Theme 3: Sleep Mindedness Permeates Night Nursing

A pivotal difference between day shift workers and night shift workers is their sleeping patterns. Sleep is a universally pervasive topic among night shift workers and true to form, it was brought up on a nightly basis at some point on every unit during the observations. Comments such as "How much sleep did you get today?" or "I couldn't take a nap today and this is my first of 3(shifts)!" or "I have so much to do on my way home from work in the morning I don't know when I'm going to sleep." were part of the normal night to night conversations. One participant remarked in an interview:

> "I feel like we obsess about our sleep! I don't hear day people asking each other how much sleep they got…you know?" Another participant added:
>
> "I think there is always that background fatigue…that you almost can't pay back anymore…there are still times where I'll fall asleep anywhere…sleeping is one of the most important things!"

Sleep deprivation seemed to be a common complaint among the participants. Several of them mentioned that while they had more flexibility in scheduling appointments and running errands during the daytime hours, it was at the expense of sleep. One participant stated:

> "When you work nights you get in the habit of doing things on your way

> home…you're stopping at the store, you're stopping at the post office, doing your banking, you pick and choose how many hours you are going to allow yourself to sleep; whereas on dayshift when you get off work at 8pm there's not as much that you can do. When I worked days I found that I couldn't get anything done…especially doctor appointments, but on nights if you have to make an appointment…
>
> alright I'll make it this day, I can make it in the morning, be home by noon, I can sleep for four hours…you make this whole process up!"

Night Nurses are Undervalued

Historically, night nurses have had the reputation of being "less busy" than the day nurses and have often been referred to as "babysitters". The veteran night nurses agreed that these assumptions might have had some credence years ago, but that now they were not true at all. The newer night nurses were aware of these "myths" and commented on how disheartening those made them feel. When asked if she felt like the day shift had an understanding of what goes on at night, one participant replied:

> " I feel like maybe people that worked nights before do, but the people that never worked nights think that we just sit here and eat a lollipop or something or just eat all night…I don't know."

The observations conducted for this study did not support those notions. Some nights, there was so much activity going on that it did not even seem like it was the middle of the night. One participant remarked: "We usually get more admissions in the evening and night time than they do on the day shift." Another participant added during an interview:

> "I think the day shift doesn't always understand a lot of what the night shift does. They think we are babysitting at night, which is kind of upsetting. Even the PA's or NP's on call at night...they will say things can wait until the morning, but why shouldn't we address it now when we know it's happening? That's very frustrating!"

Additional sources of frustration that led to feelings of being undervalued for some of the participants were the lack of formalized education at night and lack of nurse manager presence at night. One participant lamented:

> "We were supposed to have our first staff development meeting for the night shift last Thursday but it got canceled. It's really hard for us to get to any council meetings for the hospital because they happen on the day shift. We have been advocating having meetings at night, even with the nurse managers...we have a great nurse manager but she never comes in to meet with us during the night. That's one thing that drives me crazy. It's just a quick 'hello' in the morning and then 'goodbye'. It would be nice for us to be recognized...that's all!"

Summary of a Subculture: Night Nursing

Based on an analysis of observations and interviews and a synthesis of all data gathered for this study, night nursing was viewed as a subculture of the larger culture of nursing, or nursing practice, because shared patterns of behavior emerged from the data that reflected specific subculture attributes such as a mode of entry, specified roles, rituals, hierarchies and insider /outsider perspectives. Some of the prominent aspects of this sub culture that emerged were that there was an ebb and flow of night shift work, there was a significant focus on the importance of camaraderie and teamwork, the opportunities for enhancing the role and learning to critically

think are numerous on the night shift, sleep patterns play an important role in one's ability to adapt and thrive on the night shift, and there is an overall feeling of being undervalued among night shift nurses. Despite the frustrations, a large number of nurses continue to work on the night shift by choice. One participant stated:

> "It turned out that I like the night shift and as long as I am physically able to do nights I think I will. My friends and family have adjusted to me sleeping during the day, and that has helped too. Another participant summarized:
>
> "Night people seem more content to me…a little sleep-deprived sometimes, a little grumpy sometimes, but overall I think that we are just happier people because we are in our own little zone!"

CHAPTER V

SUMMARY, DISCUSSION, IMPLICATIONS, RECOMMENDATIONS AND CONCLUSIONS

This chapter begins with a summary of the methods utilized and findings for this study. Following this, a discussion of the findings and how these relate to other literature and published studies is presented, with specific emphasis on the uncovered subculture of night nursing with its respective domains and themes identified. Implications for nursing practice, education and administration are then presented, followed by recommendations for future research. Finally, conclusions from this study's findings are described.

Study Summary

The purpose of this study was to examine and describe the subculture of night nursing in a hospital setting. An ethnographic methodology was utilized to answer the main questions of (1) What is it like to be a night nurse? (2) What does a typical night at work entail? (3) What are the behaviors, roles, rituals and nursing care patterns in a hospital at night that serve as a culture description? Data were collected through participant observations on five different nursing units in two hospitals, semi-structured interviews with eight informants, and content analysis of transcribed interviews and hospital documents.

After obtaining IRB approval for this study from the researcher's university, recruitment of participants and entry into two hospital settings occurred over a seven-month period, from August of 2012 until February 2013. The researcher contacted Chief Nursing Officers at each hospital and arranged for meetings with them and their staff to describe the research study. IRB approval was obtained from each hospital, and recruitment of participants commenced. The

researcher attended staff meetings with night nurses in each hospital to explain the study, and left informational letters on several nursing units that explained the research study.

Once a prospective participant contacted the researcher to volunteer, an initial meeting was set up at the participant's workplace, and informed consent was obtained for observations to begin. A total of 25 observations were completed over a five-month time span from February 2013 through July 2013. Semi-structured interviews took place during the same five-month time frame with eight of the nine participants. The interviews were conducted after the first or second observations of each participant, and took place in a private location. An additional informed consent was obtained prior to each interview, and all interviews were transcribed shortly after completion. Hospital documents, including orientation manuals, unit schedules, newsletters, and policy and procedure manuals were examined by the researcher throughout the five-month time frame. Content analysis was utilized for hospital documents, the field notes that were written during the observations, memos that were written during the interviews, and the verbatim transcripts of the interviews.

The researcher met with a faculty advisor regularly during the data collection period to review field notes and memos, and then after the first two interviews to review proper content analysis techniques and coding. The data were analyzed line by line to look for common patterns, categories and themes. Eight initial domains were identified from the raw data of the interview transcripts: *Entry into the subculture, Role stressors for Night Nurses, Work Environment, Insider/Outsider Contrasts, Characteristics of Night Nurses, Historical Perspectives, Myths/Rituals, and Aspects They Wished They Could Change.*

After reflecting on and further analyzing the data, the researcher identified the activities that occurred in the nightly lives of night nurses as similar to the *Ebb and Flow of the Ocean.*

Just as the ocean has periods of incoming crashing waves followed by a quiet retreat of the tide, and then a resurgence of incoming crashing waves, the nightshift in a hospital has similar ebbs and flows: There were periods or flurries of intense activity and high noise levels at the beginning of the shift, followed by a period of waning noise and less activity, only to be followed by a resurgence of noise and flurries of activity once again.

Further data analysis refined the eight initial cultural domains into five categories and shared patterns among night nurses which incorporated attributes of a culture, such as *entry, roles, rituals, hierarchies, and insider/outsider perspectives*. As these attributes were further analyzed , four cultural themes, or generalizations about the patterns that made up this culture (Spradley, 1980) were identified: (1) Camaraderie and teamwork are the pillars of night nursing; (2) Learning to think critically abounds on the night shift; (3) Sleep mindedness permeates night nursing; and (4) Night nurses are undervalued.

Study Limitations

Although rigor was maintained throughout this qualitative study by adhering to the constructs of credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985), there were some limitations and therefore the findings should be viewed within these stated limitations. The participants in this study were registered nurses who work at night, yet there were other staff members excluded from the study who work at night, such as unlicensed assistive personnel- nursing assistants, and patient care technicians. Including all unit participants may have provided a different understanding of night nursing. While participants were assured of confidentiality, because of the openness of the observation situations, some participants may have been guarded in their interactions. Although every effort was made to

ensure privacy during the interviews, some of the interviews were conducted on the units where the participants worked, and it is not known if this context for the interviews might have influenced the responses of the participants.

Discussion

The purpose of this discussion is to compare the study's findings to what is known regarding a subculture's characteristics, and describe how the themes from an analysis and synthesis of the study's data fit with relevant literature. Supporting that night nursing is a subculture of nursing in a hospital setting adds to the discipline's knowledge. This discussion section will first cover the study's limitations and then present a comparison of the study's findings to related literature, explaining similarities and differences. The discussion begins with a comparison of the study's findings on night nursing as a culture to other cultural studies in nursing. This includes comparing the major cultural domains of the present study's findings: roles, rituals, hierarchies and insider/outsider perspectives with findings from selected relevant studies. The overall *Ebb and Flow* framework is discussed next *vis a vis* other work -related patterns noted in the published literature. The discussion will then include a section on the major themes identified in the study and juxtapose these with published literature on the topic: *Camaraderie and teamwork*, C*ritical thinking as a focus*, S*leep and sleep mindedness*, and the *Undervalued of* this specific role in nursing that of the night nurse. Finally, the methodology for the study is reviewed and critiqued regarding its usefulness and limitations for studying night nursing.

Night Nursing as a Subculture

Research on occupations and professions has a long history in the United States and can be traced back to the Chicago School of Sociology. Beginning in the 1920s, sociologist Everett Hughes conducted research that explored how occupations evolve into professions and he became know as the father of the cultural study of work (Harper & Lawson, 2003). His work paved the way for others to study occupations in a culturally minded way, by using qualitative methodologies such as observations, immersion in the work settings, and with in-depth interviews.

This study sought to describe the role of the night nurse and to determine if night nursing could be described as a subculture. Culture has been defined by social psychologist Edgar Schein as " both a dynamic phenomenon that surrounds us at all times, being constantly enacted and created by our interactions with others and shaped by leadership behavior, and a set of structures, routines, rules, and norms that guide and constrain behavior" (Schein,2004, p.1). Schein compares the culture of a group to the personality of an individual in that a culture has the often-discrete power to influence the behavior of the members of a group in the same way that an individual's personality or character can influence one's behavior. The phenomenon of group culture results when members of the group develop norms that gradually become shared assumptions. Any group that has a shared history can thus develop a culture, and if it is a group within an organization, it becomes a subculture.

Subcultures have been described as containing elements of the main culture, such as core values, practices and behaviors, but also having distinctive characteristics of their own (Bellou, 2008). Nurse anthropologist Madeleine Leininger (1997) defined subcultures of nursing as groups of nurses with distinctive values and life ways that differ from the mainstream of nursing.

This study identified night nursing as a subculture of the larger culture of hospital professional nursing.

Cultural Studies in Nursing

While there are reported research studies on night nursing, there have been very few investigations that explored night nursing from a cultural perspective; of the few found, none were conducted in the Unites States. An ethnographic study conducted in the United Kingdom (Brooks, 1999) on night nurses identified similar themes to the present study: namely that night nurses can be viewed as a subculture within the larger culture of the nursing profession, that they share a unique camaraderie, and that they perceive themselves as being undervalued and misunderstood. A significant difference between the present study and Brooks' UK study is that there were strong feelings of pessimism, marginalization and powerlessness attributed to night nurses in the UK study. The hospital setting in which Brook's study was conducted was contemplating abolishing the permanent night shift in nursing and changing to a rotating shift system. This may have had an impact on the results of the study in that the participants may have been anticipating their apparent "demise" and felt powerless to prevent it from happening.

While the night nurses in the present study identified a feeling of being undervalued, they did not exhibit strong feelings of pessimism about their roles in relation to feeling undervalued. There seemed to be a reluctant acceptance of the fact that this was the price they paid for choosing to stay on the night shift, and that they would make the best of it.

Additional studies on night nursing have utilized qualitative methodology such as phenomenology (Gallew & Mu, 2004), focus group interviews (Jahromi, Moattari, & Sharif, 2013) and semi-structured interviews with content analysis (Campbell, Nilsson & Andersson, 2008; Nasrabadi, Seif, Latifi, Rasoolzadeh, & Emami, 2009) to explore the experiences of night

nurses. Gallew and Mu's study (2004) described the lived experience of eleven night nurses in two hospitals in Midwestern United States, and they concluded that although night nurses face many obstacles and challenges in balancing their work and personal lives, they continue to work at night.

Two studies conducted in Iran (Jahromi , Moattari & Sharif, 2013; Nasrabadi et al., 2009) identified themes similar to two of the themes in the present study: socio-cultural impacts of night work , and night shift work as an opportunity for gaining more experience and better learning. The socio-cultural impacts of night work had a more significant impact on the night nurses in the Iran studies because of a strong cultural belief that "family-oriented people should not be away from their homes at night, especially young women and mothers"(Jahromi, Moattari & Sharif, 2013, p. 171). These nurses expressed sentiments of shame and embarrassment that they had to work nights; however, for many of the participants, there was no choice---because they were recently graduated nurses or they had lower seniority, they were required to work the night shift. Despite the negative socio-cultural impacts of working nights the participants in both the present study and the Iran studies attributed their increased learning and professional autonomy to working at night.

Roles and Night Nursing

As presented earlier, a review of the literature revealed several studies conducted on roles in nursing with much focus on the entry into the role after pre-licensure education, and on socialization into the nursing profession. Researchers in nursing have labeled many aspects of a role differently, however, they all agree that there is some degree of disconnect between the role of the nurse in the educational arena and the role of the nurse in professional practice. Earlier seminal research in the area of the role of nurses was conducted by Corwin (1961) and Kramer

(1968). Ronald Corwin studied the discrepancies of role perception and role reality in newly graduated nurses and concluded that a discrepancy in role conception was inevitable because the role itself is such an abstract concept. "Conceptions of role learned in training schools do not comprehend the full complexities of work experience" (Corwin, 1961, p.604). Marlene Kramer (1968) conducted studies on the discrepancies in role conceptions of new nurses, in particular role deprivation and role disillusionment, and also concluded that nurses who are trained in a school setting will encounter role conflict when they enter the bureaucratic setting of employment. This phenomenon was called "reality shock" by Kramer and continues to influence other literature and studies on the transition of new graduate nurses from the educational arena into the practice arena, as well their role acquisition and related role transitions.

Since Kramer's studies, research has continued to explore the socialization of new nurses into the profession (Clouder, 2003; Horsburgh, 1989; Howkins & Ewens, 1999; Martin & Wilson, 2011;Yancy, 2005) as well as to describe role-related concepts such as role stress and role ambiguity (Chang & Hancock, 2003), role discrepancy (Takase, Maude & Manias, 2006), and role tension in nursing and its impact on retention, burnout and intent to leave the profession (Pisarki & Barbour, 2014; Price, 2008). More recent research has denoted a change from a focus on "socialization" into the role of nursing to a focus on "formation" of new nurses within their development. In a recent seminal work, *Educating Nurses: A Call for Radical Transformation* (Benner, Sutphen, Leonard & Day, 2010) the authors emphasize a more holistic approach to socializing into the nursing profession. They assert that becoming a good nurse involves not only learning the technical aspects of the role, but also learning how to develop therapeutic relationships, how to think ethically and morally, and most importantly how to develop the "self" through reflection.

In the present study, night nurses did not express role blurring or role confusion as described in recent research but they all believed that their roles were different from those of their dayshift colleagues. One might speculate that the nurses participating in this study were not for the most part new graduates and therefore probably had achieved a comfort level as nurses. However, they did describe frustration in trying to achieve a satisfactory balance between the role expectations of their professional lives and those of their private lives. This concept of work life conflict has been discussed in the literature as well (Pisarki & Barbour, 2014).

Rituals and Night Nursing

The existence of rituals in nursing has been explored in past research in an effort to determine if the ritualistic activities nurses perform have any negative consequences for patients (Holland, 1993). Rituals differ from traditions in that rituals have more to do with the actions of the nurse in practice as opposed to traditions that help solidify a profession or group. They are an example of cultural forms or ideologies that members of a cultural group use to give meaning to what they do or what they represent to the rest of society (Dandridge, Mitroff & Joyce, 1980. Rituals have been defined as "relatively simple combinations of repetitive behaviors, often carried out without much thought, and often relatively brief in duration" (Trice & Beyer, 1993, p.107). Thus some literature has addressed rituals in a pejorative way-The present study identified some rituals but it was not apparent that these were in any way detrimental to patient care. The nurses participated in such rituals as intershift report, patient rounds with the intensivist in the critical care unit, hourly rounds on patients during the night, and gathering together to eat during a break time. The participants also referred to the fact that most new nurses had to work nights as a "rite of passage" which implied that it had become a ritual in the transition of a new nurse to the profession. In this study only three participants were graduates within their first three

years of employment, but they still remembered that working the night shift was something every new nurse had to do.

One of the hospitals in the study was seeking staff input for a new uniform for the nursing staff, which symbolized another ritual common in cultures---that of taking off the clothing of an outsider to wear the clothing, or uniform of an insider (Holland, 1993).In this study the nurses wore scrubs, all wore the same color, but were being asked for input on a nursing department jacket that would have a symbolic image and logo on the sleeve that represented their model of nursing practice.

Hierarchies in Nursing

Historically, the nursing profession has existed in a hierarchical structure since its inception. At first, the most significant hierarchical relationship cited was the often labeled the "subservient position" to physicians. Within the hospital setting, hierarchies also exist in nursing based on position and job title such as the staff nurse, senior staff nurse, assistant nurse managers, nurse managers and supervisors.

Negotiating hierarchical power has been identified as a source of stress for many nurses (McGibbon, Peter & Gallop, 2010). There has been an increasing number of research studies on the work climate of nurses, and the nurse-physician relationship has been associated with negative nursing outcomes such as moral distress (McGibbon, Peter & Gallop, 2010; Mealer et al., 2009) and burnout (Edward & Hercelinsky, 2007; Mackintosh & Sandall, 2010). Registered nurses may hold the lower position than do physicians in this hierarchy, however, the fact that they are with the patients 24 hours a day, assessing and making decisions about whether or not to call the physician if the patient needs an intervention or other treatments, causes them to view themselves as more important to the care of the patient in the hospital setting (Bridges et al.,

2012). Relevant to this study is the cited dilemma of calling a physician during the night, one who is viewed as intimidating (Daiski, 2003; Mackintosh & Sandall, 2010). An intimidating or negative relationship between a physician and a nurse has been identified as a factor in a nurse's decision of when to call a physician (Nilsson, Campbell, & Andersson, 2008).Nurses have reported that often the on-call doctor at night is not familiar with the patient, which increases the nurse's stress in trying to communicate the patient's needs.

In the present study, although hierarchies based on role and title existed in the acute care setting at night, the lines between them were sometimes blurred. There was not always a distinct display of hierarchies delineated for example by title or tasks assigned to a given role. On many occasions, nurses would perform tasks that had been delegated to assistive personnel and all staff members regardless of title, would respond to bed alarms or emergency situations.

The hierarchies were more evident, however, when the need arose to notify a physician at home in the middle of the night about a change in a patient's condition; there was a definite reluctance to be the nurse that made the phone call. The nurses often negotiated among themselves who was going to make the phone call, because as they related, they didn't want to be yelled at for disturbing a physician in the middle of the night. The physicians they discussed in fact had a reputation for being abrupt or angry when disturbed at night. Interestingly, some of the participants reported that for some nurses, working the night shift was more appealing because of the limited interaction with physicians. Additionally, by virtue of their role in the decision-making process for patients, such as writing orders for others to follow, physicians are viewed as being in a more powerful position within the hierarchy of patient care.

Insider/Outsider Perspectives in Nursing

As is the case in most cultures, there is an individual self-identification of belonging to a group, as well as a group self-identification of being a member of a collective unit where everyone accepted by the group is an insider and everyone else is considered an outsider. Entry into the nursing profession involves passing a licensure exam, and it is that license that is the first step in the transformation of an outsider into an insider in the larger culture of nursing. Upon hire into a new job, there is an orientation to the unit and to the way things are done, further instilling a sense of being an insider. Research on subcultures in organizations has identified the tendency for subcultures to develop ethnocentricity, in which their way of doing things becomes "the only way" or the "right way" and leads to possible conflicts with outsiders (vanMaanen & Barley, 1984).

In the present study, the participants collectively viewed themselves as night nurses, more so than individually identifying themselves based on the type of unit they worked on, such as a critical care nurse, or an oncology nurse, or a medical-surgical nurse. They identified a common bond that all night nurses share, and this bond was willingly extended to anyone that worked nights, regardless of what type of unit they worked on. They welcomed new night nurses into their world because they expected them to become part of their insider culture. There were frequent referrals to the "outsiders" who were jokingly labeled as "normal people, not like us". When the night nurses spoke of feeling disconnected from the daily happenings in their hospitals, or left out of the loop, they seemed to band together even more strongly , which made the insider/outsider perspectives more palpable.

Work Environment of a Night Nurse

The environment domain in the present study was described as "The Ebb and Flow of Night Nursing" because of the *almost* predictable rhythm of work flow during the night.

Even though the ebb and flow was predictable and apparent on most nights during which observations took place, there were nights when the "ebb" was interrupted. For example, on one unit, a confused patient became quite combative and loud in the middle of the night and woke up the roommate as well as other patients on the unit; on another night, the nurse manager had come in to meet with the night staff at midnight, thinking that it would be conducive to meet then. The meeting was interrupted by a patient fall, a blood transfusion reaction with another patient, and a rapid response team situation with a third patient, so the meeting was quite fragmented. On some nights, patients would be admitted from the Emergency room to a unit at all hours throughout the night. On other nights patients would be transferred into or out of the intensive care unit to accommodate emergency patient situations. This potential for unpredictability in the work environment of a nurse has been discussed in the literature; a two- part study on the impact of technology on the workflow of nurses concluded that there is often no "flow" in nurse workflow and that nurses rarely complete one activity before having to switch to another (Cornell et al, 2010).

There have been of late an increasing number of studies on the workflow of nurses and their work environment in acute care settings in an effort to understand the complexity of nursing work and to improve patient care outcomes (Pelletier & Duffield, 2003; Ebright, Patterson, Chalko, & Render, 2003). Many hospitals are faced with cutting costs while continuing to provide high quality patient care, and are examining the work flow processes in more detail than before (Potter et al., 2004). The workflow of nursing in acute care settings is difficult to define

and measure (Cornell et al., 2010). The research that has been undertaken has found that most nurses perform multiple tasks simultaneously and with interruptions, making it difficult to develop a tool that will accurately measure work flow processes. As many organizations strive to incorporate quality improvement approaches such as "value-added care" and "lean design" into their patient care areas, they need to ascertain the best way possible to measure not only the physical tasks that nurses do, but the cognitive processes that nurses utilize to make a multitude of spontaneous, unforeseen decisions.

Camaraderie and Teamwork are the Pillars of Night Nursing

This study identified a theme of camaraderie and teamwork among night nurses. Researchers have found that in some occupational groups, the members become so enmeshed in their relationships and roles in their work that it permeates into their personal lives (Gerstl, in Trice & Beyer, 1993). vanMaanen and Barley (1984) called these groups 'occupational communities', and identified five characteristics that members share: (1) a consciousness of kind; (2) reference groups; (3) unusual emotional demands; (4) enhanced self-images and social identities in their work; and (5) extension into non-work life.

Consciousness of kind refers to the notion that the members in the group identify themselves as part of the group and part of the occupation. Sometimes the self-identification is inevitable because of structural boundaries in place; in this study the participants are working at night, which is unlike most of the rest of society, so they are more apt to identify with each other in their isolation (Trice & Beyer, 1993).

The characteristic -reference groups refers to the ways in which members of an occupation share beliefs, values and norms. In an occupational community, members of a group look to one another for support and assurance that what they are doing is acceptable to their co-

workers. This was evident in the present study in that each unit had a way of doing things and had orientation programs in place for all new members to the units.

Unusual emotional demands in an occupational community tend to create a bond among its members because they learn to help each other by venting their emotions, and trying to help each other not get overwhelmed in carrying out their duties (vanMaanen & Barley, 1984). Teamwork and emotional support of each other was witnessed frequently during the observations in this study, especially when one nurse was more overwhelmed with a particular assignment than others, or in emergency situations. The participants in this study frequently mentioned that the camaraderie and teamwork were what made them able to make it through a tough night. One nurse remarked that the tougher the night was, the closer they became with each other.

Enhanced self-images and social identities often occur in occupations that provide valuable services to society, such as nursing. Members of an occupational community whose work has a direct effect on the health and welfare of others are said to feel important. Participants in this study remarked how fulfilling it was for them to comfort patients who woke up in the middle of the night afraid or confused. They also described feelings of satisfaction when they were able to advocate on a patient's behalf during emergency situations.

The fifth characteristic of an occupational community-extension into non-work life-refers to the notion that members of certain occupations spend non-work time together and in some cases and even live near each other. The reality that the participants in this study worked at night virtually set them up to socialize with each other during non-work time because they were likely the only ones off from work during the daytime. But many participants referred to their coworkers as family and spoke of strong friendships that formed as a result of their work relationships. Participants vacationed together and celebrated family occasions together.

Factors that encourage and affect teamwork have been the subject of several research studies in light of the Institute of Medicine's (IOM, 2000) study *To Err is Human,* which links teamwork to safer patient care (Brewer, 2006; Kalisch & Lee, 2009; Wheelan, Burchill & Tilin, 2003). Kalisch and Lee's study (2009) on teamwork, staffing and schedules in acute care settings found that the night shift had the highest scores in teamwork. This may also be because there are fewer people around and a necessity to get the job done.

Critical Thinking as a Value

The theme that critical thinking is more readily learned, developed and utilized on the night shift was derived from the general opinion of all participants in this study that they learned how to critically think by working at night. Critical thinking, as described by Benner (1984), is a thought process that evolves as new nurse transitions from a novice nurse to an expert nurse in clinical decision making. Benner's model of critical thinking identified three levels of clinical expertise: (1) novice, (2) advanced beginner and 3) expert, saw novice to expert as important role transitions in nursing.

Education at night was described as being different than it was for nurses on other shifts. There were very few or no formal educational programs offered during the hours that night nurses worked. Most educational programs were offered during the day, so night shift nurses would have to stay after their shift to attend them. Thus much of the acquired education was a type of experiential learning in which nurses learned from each other during specific experiences that occurred.

Very little research has been conducted on the education of night nurses. The research that has been reported concluded that nurses who work at night rely primarily on critical thinking in the moment and acquisition of skills as they go, because they have fewer support staff and

resources than nurses working during the day (Mayes & Schott-Baer, 2010). Some nurses described their work at night as more autonomous, and that they were able to learn more skills at night (Jahromi, Moattari & Sharif, 2013). Often, the primary sources of knowledge for night nurses are the patients and the changes in condition that they undergo during the night (Campbell, Nilsson & Andersson, 2008). Peer-to-peer programs in which the night staff teach each other have been successful in some health care settings and have contributed to camaraderie and communication on the night shift (Flagg & Sparks, 2003). The present study supported these notions in the literature, that is, that night nurses must ultimately trust their own judgment, experience and knowledge when faced with learning to think critically and at the same time use peers for learning (Jahromi, Moattari & Sharif, 2013). Some of the more experienced participants reminisced about how much they learned when they began work on the night shift. One remembered that she did more EKG's and started more IV's in one week on nights than she had in six months working on the day shift. Another participant said that all of his assessment skills and critical thinking skills were learned while working on the night shift.

Sleep and Sleep Mindedness

It is difficult to hear the words "nightshift" and "work" without immediately thinking of sleep, so it was not surprising that the topic of sleep was discussed at some point during the observations in all settings of this study, and in every interview. Quality of sleep, amount of sleep, and how many interruptions to sleep were topics regularly discussed among the participants and their coworkers. Accordingly, most research on night nursing has focused on some aspects of sleep, such as strategies to adapt to sleeping during the day (Gallew & Mu, 2004). Sleep has been identified as the main aspect of a night shift worker that is disturbed (Boughattas et al., 2014) and has received a lot of focus in the literature. A study on the effect of

the first night rotation for student nurses demonstrated that their sleep cycles were minimally affected on their first rotation (Fietze et al., 2009). However, other studies involving new nurses concluded the opposite, that night shift is not an easy experience for student nurses (Horsborgh, 1989; McKenna & French, 2009). This finding was corroborated by West, Ahern, Byrnes and Kwanted (2006) who found in their study of new graduate nurses that sleep disturbance was a major source of job dissatisfaction and disruption of their personal lives in the first twelve months of employment. Fatigue caused by lack of sleep was identified as a factor in the work life conflict often experienced by shift workers, especially those that work the overnight shift (Pisarki & Barbour, 2014). Night shift nurses have been noted to make sacrifices in order to fulfill their life-roles as well as have meaningful work-roles (Gallew & Mu, 2004).

The present study's findings were similar to the study undertaken by Gallew and Mu (2004), in which night nurses experience interrupted sleep during the day, often because others did not realize that they were waking someone up in the middle of the day, or because of their personal responsibilities in their other roles. Many nurses, especially the newer ones, experienced feelings of guilt, bemoaning the fact that they were sleeping during the time when the "rest of the world" was awake, especially when their families or significant others did not know what it was like to stay awake all night and did not understand that they needed to sleep. The nurses that had been working nights longer admitted that they also felt guilty sometimes when they couldn't attend some family functions because they were working or sleeping, but they believed that their families and friends had become used to it now and accepted it more readily. Many of the participants remarked that their families got used to their "grouchiness and being tired". Talking about sleep seemed to be an outlet for them to vent, as well as receive

reassurance that they were not alone in their failed attempts to achieve quality sleep during the day, as well as participate in their other roles outside of work.

Feelings of Being Undervalued in a Specific Role

Despite the identification of positive themes that emerged in this study, such as increased camaraderie, teamwork and increased critical thinking skills, there remained an element of disappointment and resignation voiced by the participants. They discussed that outside the circle of their night shift colleagues, there was little value placed on their roles as night nurses. The theme of feeling undervalued in the role of the night nurse has been described in other research and dates back to the 1930's in the United States. A very early research study, in 1932, that explored the night shift environment in hospitals in which nursing students staffed the wards at night, concluded that: "nursing at night is one of the hardest, the least honored, the most neglected, and yet the most important division of the service." (Pfefferkorn, 1932, p. 1179). In one UK report that synthesized publications and findings on night nursing, Kemp (1984) concluded that that the supervisory role of the night nurse, including the observation of sleeping patients, is often unrecognized and undervalued. The long standing "myth "that patients in the hospital sleep all night and that the nurses sit around and knit, or eat bon-bons, or even sleep themselves has perhaps perpetuated the notion of night nurses being undervalued. Bradford and Harvey's (1972) definition of a myth is "an ill-founded and untested belief which powerfully affects the way in which organization members behave and respond." (1972, p. 245). Some myths are dysfunctional and so deep-rooted that it is very difficult to dispel them (Bradford & Harvey, 1972).

All of the participants in the present study expressed disappointment that so many of their peers on other shifts, as well as friends and family members, did not understand what they do at

night. They also expressed feelings of discouragement when, after an extremely busy or difficult night, when they tried to explain it to the oncoming shift, it was not acknowledged or appreciated and almost discounted that things could be that busy at night. One participant described an interaction she had with a physician when she notified him of a change in a patient's condition in the middle of the night. He told her that whatever needed to be done for the patient could wait for the morning. So the participant said she hung up the phone, all the while thinking "Then why am I here at night monitoring the patients if I'm going to be told it can wait until the morning, why don't we take care of it now?" Many of the participants voiced their frustration in not being able to adequately describe the situations that they were involved in at night because as one participant stated "No one would believe that this is really happening in the middle of the night, unless they were here to experience it!"

Summary of Discussion

This study is one of very few conducted on night nursing and brings to light the existence of a subculture of nurses within the larger culture of nursing. Night nurses collectively share cultural attributes such as roles, rituals, hierarchies and insider/outsider perspectives. The work environment of a night nurse is like the ebb and flow of the ocean with waves crashing on the shore, followed by a calm receding of the tide, and then a resurgence of the waves crashing on the shore. The subculture of night nursing is characterized by camaraderie and teamwork, an environment that is conducive to the development of critical thinking, a constant reflection about sleep, and a feeling of being undervalued. The study findings support some of the research discussed in the literature on aspects of night nursing such as sleep disturbances, high teamwork scores among night nurses, limited opportunities for formal education at night, and a view held

that night nurses are not as valued as their peers on the day shift. However, the study findings did not support the literature that suggests that the night shift in a hospital is quiet, or that patient outcomes may be worse on weekends and nights. The study findings highlight that despite the many negative health outcomes reported in the literature that are associated with working at night, many nurses choose to work at night and like it.

Implications

The findings from this study have implications for nursing in the areas of nursing practice, nursing education and nursing administration and are presented in the following section.

Nursing Practice

This study suggests that much work is needed in the nursing practice arena to improve the work environment of night nurses. Nurse managers need to be visible to, accessible to, and in touch with their night nurses so that they are aware of any difficulties that new nurses are experiencing in their transition to nights. The socialization into the role of a new nurse is stressful to begin with, and if a new nurse is scheduled to work on the night shift, that presents an additional stress to take into consideration.

The work environment on every unit in acute care settings should be regularly assessed. Nurses need to carefully and thoroughly examine their current routines and workflow on both the day shift and the night shift. They may find that holding on to certain rituals and outdated practices may no longer meet the needs of the environment at night, and if so, they should be given the responsibility to change them.

Nurse managers should capitalize on the teamwork and camaraderie that appears to develop and thrive on the night shift. Encouraging and providing the resources necessary for the

formation of nursing practice councils or research committees that meet on the night shift would enable groups with high cohesiveness to brainstorm ideas and initiate quality improvements. Regularly scheduled meetings between the day shift and night shifts would perhaps encourage more collegiality and communication between the shifts, and allow sharing of strategies that could be used to foster more teamwork between shifts.

The conclusion that learning to critically think may occur earlier and more dramatically on the night shift warrants supporting and encouraging it. The staffing patterns at night need to be carefully examined and adjusted as necessary to ensure that a safe quantity of staff and appropriate mix of skill sets are working on a nightly basis. Learning to critically think and clinically reason usually requires a role model or experienced clinician to assist with and oversee the process; thus having a mix of senior clinicians and novice nurses every night will enable that learning to take place.

The issue of fatigue and sleep quality in night nurses cannot be ignored. Research has shown that fatigue plays a critical role in medication errors and decision-making as well as in low job satisfaction (Kunert, King, & Kolkhorst, 2007). The IOM (2004) concluded that no amount of training can overcome the detrimental effects on work performance that are caused by fatigue, sleep loss and sleepiness caused by variations in circadian rhythms. It is also one of the main reasons that nurses are not able to tolerate working the night shift (Jansen et al., 2003). The schedules of night shift nurses should ensure a minimum of two nights off in between scheduled shifts on to allow optimum recovery of sleep levels. Napping during break times for night nurses, especially during the known peak of circadian rhythm sleepiness, between 2 a.m .and 4 a.m., should be permitted and encouraged in acute care settings. The benefits of short naps, as well as

the adherence to scheduled breaks during the night shift might help to improve alertness and reduce the incidence of fatigue-induced errors.

Nursing Education

This study adds to the current literature that a gap remains between education and practice for new nurses, particularly in the area of night nursing. Nurse educators need to prepare nursing students for the high probability that if they choose to work in an acute care setting, they will work the night shift. Clinical rotations might be offered on the night shift so that students can better understand what the role of a night nurse is like as well as experience what it is like to stay awake all night at work.

Course work in the pre-licensure setting should include strategies to deal with patient care issues that occur more frequently at night, such as anxiety, delirium, and potential for falls. Formal learning about assertive communication skills, delegation, team building and collaboration should also be emphasized throughout the coursework.

Nursing education departments in acute care settings should offer formal educational activities that take place during the night shift, not before or after it. Scheduling should be planned in advance so that adequate staffing can be scheduled to accommodate "covering" the patient care units while staff attends the educational offerings. In addition to hospital-wide mandatory educational offerings, there should be educational offerings that offer strategies on handling clinical patient related issues that occur frequently at night, such as falls, anxiety, sleeping difficulties, "sun-downing", acute delirium etc. Additional educational offerings for nurses could include strategies on how to adjust to working the night shift.

Nursing Administration

This study identified a feeling of disconnectedness between night nurses and nursing administration. Many participants remarked that they did not have knowledge of changes that occurred in their institutions and said they felt "out of the loop". Nursing administrators need to be more aware of occupational complexity and diversity within the organization as well as the multiple levels of communication that occur within departments and between departments in the organization . Organizational initiatives and rationales for decisions that are made need to be more transparent to all members of the organization on all shifts. Formal communication arenas between administration and the night shift should be instituted on a regular basis. Night shift nurses should be actively recruited to be involved in nursing department decision-making and in practice or policy changes.

There is also a need for administrators to recognize and appreciate that night nursing is a subculture, and that belonging to such a subculture is not necessarily a negative phenomenon. In fact as noted in this study, the participants saw many positive aspects of night nursing, especially their expertise in critical thinking and their cohesiveness as a team. Most decisions for hospitals and other health care organizations are made by those who do not work on the night shift. This study brings to light that night nurses are aware of this and believe that it contributes to their feelings of being undervalued. When shift workers sense that they are respected, appreciated and included, they manifest greater satisfaction with and commitment to their jobs (Claffey, 2006).

Recommendations for Further Research

This study found that night nursing is in fact a subculture and the findings highlight positive and negative aspects of belonging to the subculture of night nursing and of being a night

nurse. It also provides directions for future research. There is limited research and one published instrument that have been published and can be used in studying night nursing; these have not been widely disseminated: The Nursing Teamwork Study (NTS) and the Night Nursing Care Instrument (NNCI). Research similar to the NTS can be conducted to compare teamwork across various units in acute care settings, and to make recommendations for possible changes. The NNCI can be used to evaluate the patient- nurse relationships across different units on the night shift and identify areas for quality improvement. Qualitative inquiry to further explore the dynamics of inter-shift relationships between nurses on nights and those on days, and identifying the barriers that impede development of more positive relationships may lead to improvements in relationships between shifts.

More research on the nursing practice environment of a night nurse is recommended. Research has shown that few hospitals have favorable nursing practice environments (Lake & Friese, 2006).Most of the current research on the work environment in nursing has focused on trying to improve the safety of patients and reduce errors by examining workflow processes using human factors engineering (HFE), the study of how human beings interact with environments and equipment in performing tasks. The findings from such research may not be useful because the workflow of nursing is knowledge-based and nonlinear and therefore, it is very difficult to observe and measure quantitatively (Potter et al., 2004). Ethnographic methodologies in combination with the quantitative HFE methods would enable researchers to study the total nursing process at night, which includes both covert cognitive behaviors as well as overt physical activities.

Ethnographic methodologies would provide valuable insight when organizations seek to redesign healthcare environments. Immersion in the field, observations and interviews would

supply redesign planners with data that describe how healthcare providers organize and structure information cognitively, how and what they think when they are faced with complex situations, and what types of environmental conditions affect their decision making (Ebright, Patterson, Chalko, & Render, 2003).

Conclusions

This study identified a subculture of nursing-night nursing. Important aspects of the study's findings when compared with the literature revealed that night nursing is different than day nursing and deserves to be valued and recognized as such. Increased awareness of the differences between the two shifts and willingness to explore the possibility of changing historically based staffing and workflow patterns may have a significant impact on improving patient and nursing outcomes.

Subcultures are important to identify and study because as a collective subgroup of a larger culture, they learn to establish their own ways of doing things and often believe that the way they work together is the "only way" or the "best way" to act or behave. Subcultures are often present in every layer and division of an organization and can either weaken or strengthen the culture of the larger group as a whole. Those in the subcultures with strong self-identities have the potential to become ethnocentric and this may impede further growth for the larger culture. However, acknowledging other subcultures within an organization and having a willingness to examine each other's ways of thinking and doing can encourage innovation and collaboration at all levels.

Future research, both qualitative and quantitative, may be able to discover new knowledge and reveal evidence that can lead to improvements in both patient care and nursing outcomes at night. Cultural approaches to the study of groups and organizations help uncover a

full range of meanings that lie in normal, routine activities. This study also brings to light the richness of data that can be obtained when using an ethnographic methodology.

"Ethnography offers all of us a chance to step outside our narrow cultural backgrounds, to set aside our socially inherited ethnocentrism, if only for a brief period, and to apprehend the world from the viewpoint of other human beings who live by different meaning systems." (Spradley, 1984, p. vii).

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APPENDIX A
Informational Letter to Prospective Participants

Dear Colleague:

I am a PhD candidate in the School of Nursing at Adelphi University. I am also a night nurse. I am recruiting nurses to participate in a research study about night nursing and the role of a night nurse. You are eligible to participate if you are a nurse who currently works on the night shift and interested in participating. Your participation would consist of allowing me to observe you as you work on your unit for time periods of 3 hours at a time on up to 3 different occasions and possibly participating in one or two 45 minute interviews that would be audio-taped.

During the observations, I will be watching while either sitting in the nurses' station listening and observing your night activities, or accompanying you for short periods of time as you go about your nightly routine. I will be writing notes, known as "field notes" periodically during the periods of observation. Your identity will be masked in the notes by assigning you a numerical code as an added protection to provide confidentiality. I will be the only person to possess the codes that identify you and these will be stored in a locked file cabinet in my home. These notes may include brief descriptions of activities that you are performing, interactions that are occurring, or reminders for me to ask questions about in the future. You will have the opportunity to review the field notes that I have written about you and clarify or suggest revisions or deletions. During the observations, I may also accompany you into a patient room or on patient transport if you and the patient are agreeable to it. In addition to taking notes, I may ask you informal questions about various aspects of your role, but will try to be as unobtrusive in questioning you as possible. At the end of the study, in reporting the observations for my study, formally, any information I provide to readers will not in any way identify you as the nurse I observed.

You may also be invited to be interviewed, formally. The interviews will take place on one or two separate occasions in a private area, and will involve answering questions about what it is like to be a night nurse and your experiences in that role. The interviews will be audio-taped and then transcribed and will be 45 minutes in duration. All attempts will be made to maintain your confidentiality by not using any personal information in interview transcripts. All interview data will be stored in a locked file cabinet that will only be accessible by me.

If you volunteer to participate in this study, you may choose to drop out at any time or choose not to answer any questions that you do not wish to answer, or choose not to be audio taped, without any consequences for your choices or withdrawal from participating.

A benefit of participating in this study will be the knowledge that you have contributed to the enlightenment of your colleagues, hospital administrators and nurse educators about what night nursing is like. If you are selected to be interviewed, you will receive a $10 gift card for either Dunkin Donuts or Starbucks as a token of appreciation for your participation in the interview(s).

If you would like to participate in this study or have further questions please call/text me at (631) 332-0151 or e-mail me at debragrice@mail.adelphi.edu with your contact information, telephone number and /or e-mail.

Sincerely,

Debra Grice-Swenson, RN, PhD(c)

APPENDIX B

Letter to Chief Nursing Officer of Hospital

Dear Chief Nursing Officer, (Name)

I am currently a PhD candidate at Adelphi University in the School of Nursing. I am in the process of developing a research study on night nursing and am requesting your assistance.

My dissertation will be an ethnographic exploration of the culture of night nursing. I would like to undertake this research in your hospital by participating in observations of night nurses on a minimum of 3 nursing units at night, for 3 hour blocks of time for up to three times, interviewing night nurses, and analyzing hospital documents relevant to night shift nursing. The entire period of data collection would take no longer than 4 months. My study has received approval by the IRB at Adelphi University.

If this study sounds feasible for your institution, I would like to make an appointment to meet with you at your convenience to further discuss my proposed research and necessary steps for proceeding with this study.

My dissertation committee chairperson is Dr. Jane White, and she can be reached at Adelphi University School of Nursing (516) 877-4599.

Thank you for your consideration.

Sincerely,

Debra Grice-Swenson, RN, PhD (c)

(631) 332-0151

debragrice@mail.adelphi.edu

APPENDIX C

Consent Form for Participant Observation

Adelphi University Informed Consent

IRB Protocol Title: Night Nursing: A Portrait of a Subculture

Principal Investigator: Debra Grice-Swenson RN, PhD(c)
Co-Investigator: N/A

Research Purpose

The purpose of this research study is to examine and describe the subculture of night nursing in a hospital setting. The questions that will guide the study are:

(1) What is it like to be a night nurse?

(2) What does a typical night at work entail?

(3) What are the behaviors, roles, rituals, communication, and nursing care? patterns in the hospital at night?

Description of the Research
This research study will utilize a qualitative ethnographic design in which you will be observed as a study participant on your unit, and may participate in semi-structured interviews which will be conducted by me, the researcher. If you agree to the observations, you will also be observed while you work for blocks of time of up to three hours, for up to three times, throughout the research study. If you do not wish to be observed at any point in time, you will not be observed, or I, the researcher, will wait until a more convenient time. I will be sitting in a place to observe that will not be obtrusive. I will be writing notes, known as "field notes," periodically during the observations. These notes may include brief descriptions of activities that you are performing, interactions with others that are occurring, or reminders to me, the researcher, to ask questions about these observations in the future.

Your identity will be masked in the notes by not using your name and by assigning you a numerical code as an added protection for confidentiality. You will have the opportunity to review the field notes that I have written about you and have the opportunity to clarify or suggest revisions or deletions. In addition to observation, I may accompany you into a patient room or on a patient transport if you and the patient are agreeable with it. The researcher, although also a nurse, will not intervene in direct patient care unless a patient is experiencing a life-threatening event or is at risk of harm and no other qualified staff members are present.

You may also be asked to participate in up to 2 audio-taped interviews that I will be conducting in a private location; these will be approximately 45 minutes in duration for each, consisting of questions about you and your role as a night nurse. If you are contacted and agree to an

interview, a separate consent form will be included for your review and signature. You may decline to answer any questions that you do not wish to answer and are free to stop the interview or decide not to participate in the study at any point in time.

Potential Risks

Because the data collection will involve casual observation of public professional behavior of you, a participant, it is believed that the study poses minimal risk to you as a study participant.

However, there is the potential of increased stress if you are nervous about you being observed, interviewed or your identity being revealed. The researcher will strive to be as unobtrusive as possible during the field observations. Confidentiality of your participation in the study is **not** possible whenever the researcher observes you when there are other unit staff members in the vicinity who may witness this. I will emphasize throughout the study that all your personal information will be coded and your name will not appear on any notes, or transcripts of the interviews to preserve confidentiality.

You may, as stated earlier, decline to be observed at any point during the study, as well as decline to answer any questions during an interview that you do not wish to answer. Any observations that you do not want included in the field notes will be removed at the time you review the notes with me, the researcher.

Potential Benefits

The potential benefits for your participation in this study include the knowledge that you have contributed to research that has enlightened others about night nursing.

Costs/Compensation

If you are selected to be interviewed, you will receive a $10 gift card for either Dunkin Donuts or Starbucks as a token of appreciation for your participation in this study.

Additional Information

If you wish to receive an abstract of this study you will receive one if you provide me with your contact information

Contact Persons

If you have any questions, at any time, about this research, or want to discuss any possible study-related injuries, please contact **Debra Grice-Swenson** at telephone number **(631) 332-0151**.

Confidentiality

The confidentiality about you and your institution will be maintained, however your confidentiality as a participant in this research study may not be assured within your institution. Your colleagues may know that you are participating in this research, but your identity will not be revealed in any of my field notes or interview transcripts. Numerical codes will be used to identify you in any written or recorded data. I will be the only person to possess the key to your coded identity and it will be stored under lock and key on the researcher's premises. Your identity as a participant in this research study will also be kept confidential in any publication of the results of this study. The

information obtained during this research (research records) will be kept confidential to the extent permitted by law. However, the final report may be reviewed by your employer, government agencies (such as the Department of Health and Human Services), the agency sponsoring this research, individuals who are authorized to monitor or audit the research, or the Institutional Review Board (the committee that oversees all research in human subjects at Adelphi University) if required by applicable laws or regulations. The material will be maintained for **up to 7 years and then destroyed**.

All records, kept confidential, will be locked away in an area that is only accessible to me, the researcher. All personal identifiable information will be coded on transcripts and all identifiable data will be destroyed at the end of the study. The only individuals who will have access to the coded research data will be the researcher, members of the dissertation committee, and a transcriptionist who will not know your identity.

Voluntary Participation

Participation in this study is voluntary. If you decide not to participate, this will not affect you or your employment in any way. Any new information that develops during this study, which might affect your decision to participate, will be given to you immediately.

A signed copy of this consent form will be given to you.

Institutional Review Board Approval

This research has been reviewed and approved by the Adelphi University Institutional Review Board. If you have any questions, concerns or comments, please contact Dr. Julie Altman, 516-877-4344 or altman@adelphi.edu.

Signatures:

Person Obtaining Consent/Researcher

Print Name________________Signature__________________Date_______

Study Participant

Print Name________________Signature____________________Date_______

APPENDIX D

Consent Form for Participant Interview

Adelphi University Informed Consent

IRB Protocol Title: Night Nursing: A Portrait of a Subculture

Principal Investigator: Debra Grice-Swenson RN, PhD(c)
Co-Investigator: N/A

Research Purpose

The purpose of this research study is to examine and describe the subculture of night nursing in a hospital setting. The questions that will guide the study are:

(1) What is it like to be a night nurse?

(2) What does a typical night at work entail?

(3) What are the behaviors, roles, rituals, communication, and nursing care? patterns in the hospital at night?

Description of the Research
This research study will utilize a qualitative ethnographic design in which you will be observed as a study participant on your unit, and asked to participate in semi-structured interviews which will be conducted by me, the researcher. This consent applies to the interview portion of the study.

You have been asked to participate in up to 2 audio-taped interviews that I will be conducting in a private location; these will be approximately 45 minutes in duration for each, consisting of questions about you and your role as a night nurse. You may decline to answer any questions that you do not wish to answer and are free to stop the interview or decide not to participate in the study at any point in time.

Potential Risks
It is believed that the study poses minimal risk to you as a study participant.
However, there is the potential of increased stress if you are nervous about being interviewed or your identity being revealed. I will emphasize throughout the study that all your personal information will be coded and your name will not appear on any notes, or transcripts of the interviews to preserve confidentiality.
You may decline to answer any questions during an interview that you do not wish to answer.

Potential Benefits
The potential benefits for your participation in this study include the knowledge that you have contributed to research that has enlightened others about night nursing.

Costs/Compensation
For each interview, you will receive a $10 gift card for either Dunkin Donuts or Starbucks as a token of appreciation for your participation in this study.

Additional Information
If you wish to receive an abstract of this study you will receive one if you provide me with your contact information

Contact Persons
If you have any questions, at any time, about this research, or want to discuss any possible study-related injuries, please contact **Debra Grice-Swenson** at telephone number **(631) 332-0151**.

Confidentiality
The confidentiality about you and your institution will be maintained, however your confidentiality as a participant in this research study may not be assured within your institution. Your colleagues may know that you are participating in this research, but your identity will not be revealed in any of my field notes or interview transcripts. Numerical codes will be used to identify you in any written or recorded data. I will be the only person to possess the key to your coded identity and it will be stored under lock and key on the researcher's premises. Your identity as a participant in this research study will also be kept confidential in any publication of the results of this study. The information obtained during this research (research records) will be kept confidential to the extent permitted by law. However, the final report may be reviewed by your employer, government agencies (such as the Department of Health and Human Services), the agency sponsoring this research, individuals who are authorized to monitor or audit the research, or the Institutional Review Board (the committee that oversees all research in human subjects at Adelphi University) if required by applicable laws or regulations. The material will be maintained for **up to 7 years and then destroyed**.

All records, kept confidential, will be locked away in an area that is only accessible to me, the researcher. All personal identifiable information will be coded on transcripts and all identifiable data will be destroyed at the end of the study. The only individuals who will have access to the coded research data will be the researcher, members of the dissertation committee, and a transcriptionist who will not know your identity.

Voluntary Participation
Participation in this study is voluntary. If you decide not to participate, this will not affect you or your employment in any way. Any new information that develops during this study, which might affect your decision to participate, will be given to you immediately.

A signed copy of this consent form will be given to you.

Institutional Review Board Approval

This research has been reviewed and approved by the Adelphi University Institutional Review Board. If you have any questions, concerns or comments, please contact Dr. Julie Altman, 516-877-4344 or altman@adelphi.edu.

Signatures:

Person Obtaining Consent/Researcher

Print Name________________Signature__________________Date_______

Study Participant
Print Name________________Signature____________________Date_______

Consent for audio recording

My participation in the interview will be audio recorded. I consent to the recording of my voice for this interview. The recording will be used for research purposes and the data will be treated in the same manner as the aforementioned data.
Signature of Participant _______________________Date________________

APPENDIX E

Semi-structured Interview Guide

These questions are examples and actual questions will be similar but based on the analysis of the observations because the interviews are intended to clarify and extend information gleaned from the observations as well as from documents reviewed

1. Tell me about how you arrived at where you are now on ...... unit working the night shift

   Possible probes: Who or what influenced your decision to work nights?

   Was there a choice in this decision?

   What factors supported your decision to work nights?

   What has influenced staying on nights?

   What are your feelings about working nights now and what were they when you first started working nights?

2. What comes to mind when you hear the term "night nurse"?
3. Tell me about what a typical night would be like for you.
4. What do you like most and what do you like least about being a night nurse?
5. How would you describe the nursing care that you provide at night?
6. What advice would you give to a new nurse coming onto the night shift?

Appendix F

Initial Domains From Analysis of Interview Transcripts

Domain # 1 **Entry into the Subculture**	**Domain # 2** **Role Stressors for Night Nurses**
Phrases/Patterns from Interviews:	***Phrases/Patterns from Interviews:***
Voluntary	Physical effects of sleep discordance
"No choice"	Lack of resources
Rite of passage for new graduates	Less opportunities for formal educational offerings
Newcomers embraced	Having to call doctors at night
"Everyone has to do it"	Managing confused patients
Domain# 3 **Work Environment of Night Nurses**	**Domain # 4** **Insider/Outsider Contrasts**
Phrases/Patterns from Interviews:	***Phrases /Patterns from Interviews:***
Different kind of busyness. "On days, sometimes the patients are off the floor a lot for tests...it's crazy trying to get things done! At night they are usually on the unit and need a lot of care."	Frequent use of "they" and "us"
Limited number of people around. "Less chefs in the kitchen!"	Perception that nobody helps on the day shift. "You don't have the same kind of looking out for each other type of bond on day shift."
Lower noise level "Less confusion"	"We are not 'normal' like the day shift people"
Darker	Permeable boundary between days and nights but there can be a sense of tension
No cafeteria	
Domain #5 **Shared Characteristics/ Assumptions**	**Domain #6** **Historical Perspectives/Myths**
Phrases/Patterns from Interviews:	***Phrases/Patterns from Interviews:***
"Happier on nights"	More acute patients now than in the past
"More laid back"	Busier now than in the past. "It used to be different but now...the OR...they could be doing surgery all night sometimes!"
Increased critical thinking	Larger patient load in the past because "That's just how it was"
Teamwork	"Nights was so easy...you could take 2 hour breaks back then"
Camaraderie "You depend on each other"	Some think that nurses sit around all night

	and eat
Troubleshooters	Some think that the patients sleep all night
"Everybody is really cohesive and we work well together"	
Strong skill set	
Domain #7 **Things They Wish They Could Change**	**Domain # 8** **Rituals**
Phrases/Patterns from Interviews	***Phrases/Patterns from Interviews***
Would like to see formal teaching on a regular basis during the night as opposed to staying after their shift in the morning when they are tired and off duty	"Everyone has to do it once, it's a rite of passage"
An elevation in leadership status for those who fill in as assistant nurse managers and charge nurses	Handoff report
A consistent nurse: patient ratio	Daily line-up
More understanding from others of what they do at night	Sharing food together/ making "food runs" or "coffee runs"
	Gathering at nurses' station to talk about school
	Performing AM care on patients