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# Dance of the Call Bells

## Using Ethnography to Evaluate Patient Satisfaction With Quality of Care

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Ethnographic methods can provide insights into patients' perceptions of quality of care. We used ethnographic methods to examine problems related to answering patient call lights on one inpatient unit in the hospital. Communication through call bells consisted of 3 interrelated components. These included answering the call bell, communicating the patient's request, and following through with the request. Results of this study provided a deeper understanding of the nuances of power and control embedded within the issue of patient-caregiver communication and empowered unit staff to find solutions to the call bell problem. **Key words:** *call bells, ethnography, quality of care, qualitative methods*

**A**NYONE who has spent time as a hospital patient knows that the call bell is the patient's "lifeline." It is perhaps one of the few means of control that patients have over their situation. When they push the call button, it is usually to summon the nurse for assistance or information. Patients expect that when they push the button, someone will answer or come to them. Conversely, busy caregivers might find answering call bells time consuming and some might even perceive patients who ring their call bells frequently as "pests." This was evident during an assess-

ment of quality of care and patient satisfaction that was conducted on a medical-surgical unit at our hospital. It became clear that patient perceptions about staff response to their call lights and staff perceptions about answering call bells were a key component of patient satisfaction on this unit.<sup>1-4</sup>

Qualitative methods, especially ethnography, are useful in gathering data about health-care quality and patient satisfaction because they provide deeper insights into patient and provider perspectives at the point of care. Ethnography can help us understand the "lived experience" of people.<sup>5</sup> For those interested in quality measurement, understanding the "personal" aspects of the healthcare experience is essential.

Ethnographers listen to what people say and observe what they do, an important perspective from which to approach the assessment of quality of care.<sup>2,6-9</sup> Ethnographic methods provide a descriptive and contextual approach to data collection. Findings also can be used as supplementary data to augment or refine information provided by survey data.

Ethnography can provide insights and understanding that quantitative methods alone might miss. This methodology can be used during project planning to help refine a

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question, used concurrently with quantitative methods to provide a mix of methods to help validate findings, and used late in a project to more deeply explore a topic brought to light by quantitative methods. Ethnography is useful in providing data on topics where little statistical differences appear to exist—differences may in fact be present, but the researcher must rely on qualitative methods to tease them out.<sup>10</sup> We illustrate the use of ethnographic methods through the examination of a real-life quality of care and patient satisfaction issue described as the “dance of the call bells,” an ethnographic report about what was happening on one of our hospital’s busy medical-surgical units.

Quality of care measurement is routinely done at many hospitals primarily using surveys. While surveys can provide helpful information and benchmarking, numbers alone cannot provide details about the experience of care. Donabedian noted that patients judge their care on the basis of their evaluation of interpersonal process such as communication, sensitivity to their needs, explanations, and friendliness of staff. He suggested that satisfaction be used as a surrogate indicator of quality because patients’ perception of quality of care is their “reality”; as such, quality can be measured through the patient’s self-report of satisfaction.<sup>11,12</sup>

The Institute of Medicine’s *Crossing the Quality Chasm* report noted that providing patient-centered care that is focused on the patient’s experience of illness and healthcare should be the goal of healthcare organizations.<sup>13</sup> Currie et al also provided insights into the personal aspects of care, pointing out that nurses and patients have differing perceptions about quality care.<sup>14</sup> Similarly, Berwick indicated that quality of care must be measured in terms of “improvement of the experiences of patients and communities and nowhere else.”<sup>15</sup> Patients and their caregivers may have different viewpoints about what is important regarding processes such as communication.<sup>2</sup> Therefore, it is essential to use methods such as ethnography that will provide the description and depth of de-

tail necessary to adequately understand these multiple interpersonal processes. Ethnography is useful in quality of care assessment because it allows investigators to hear what people say, see what they do, and make sense of the daily routine of care in a particular setting.

## ETHNOGRAPHY

Fetterman defined *ethnography* as “the art and science of describing a group or culture.” This includes the study of patterns of thought and behavior of people in the studied group.<sup>15</sup> Ethnographers try to understand a group or culture from a holistic perspective by looking at the “whole picture.” Wolcott suggested asking the question “what is going on here?” as a way of focusing ethnography.<sup>16</sup> Key components of ethnography are that it is holistic, comparative, descriptive, theory driven, and designed to provide information based on a specific question. Ethnography can be used in the clinical setting to study small micro cultures such as an inpatient unit at a hospital, or a large macro culture such as an entire department or organization. Ethnographic methods include observation, interviews, and collection of supplementary data such as photographs, measurements, mapping, patient records, and other supporting data or documents.<sup>6,16,17</sup>

Perspective is important in the ethnographic approach.<sup>2,8,18,19</sup> Ethnographers traditionally explore a topic from both the emic and etic perspectives. The emic perspective is the insider perspective—the situation from the point of view of the participants. What is the participant’s lived experience? In the clinical example we use here, the emic perspective would be the experiences of both the patient and unit staff.<sup>10</sup>

The etic perspective is that of the outsider. What does the experience of the unit look like from the point of view of the ethnographer who is not living the experience of the unit from the same vantage point as either the patients or the staff?<sup>10</sup> Ethnography uses both of these perspectives to gather a complete or holistic picture of “life” on the

unit. Questions the ethnographer may ask to organize their observations include the following: What is care like from the patient's point of view? How does a patient get needed assistance from the unit staff? What are nurses' perceptions about patient satisfaction and quality of care? How is care on the unit organized?

While the patient perspective is of major interest in quality of care assessment, the perspective of the caregivers also must be examined.<sup>14</sup> Differences in perception between patients and nurses about key aspects of patient care can help the ethnographer tease out areas where changes need to be made. In our case example, it was clear that disjunction between patient and nurse perceptions of call bells was the crux of the problem. These personal perspectives, used in conjunction with satisfaction data from other sources, such as surveys, ethnographic descriptions, and observational data, can provide insights into happenings on a daily basis. The resulting themes and supporting data can be used to contextualize care on the unit and eventually serve as benchmarks for the organization's quality improvement focus.

## OUR STUDY

The call bells study was conducted as part of a larger study on the unit that was designed to delineate the key aspects of satisfaction important to hospitalized patients. During the course of that work, it became apparent that problems related to the answering of call bells were affecting nurse-patient communication and were an essential part of the patient "experience."<sup>20</sup>

The hospital ethnographer, an RN and a doctorally prepared anthropologist, observed the central call bell console light up and saw people at the nurses' station ignoring the console. In addition, it appeared that a bit of choreography was going on about who would answer the call bells. She watched as people eyed the lit console and each other, seeing who was closest, who made the move to answer, and who avoided going near the

console. She also heard differing perspectives about call lights from staff as well as from patients. This "dance of the call bells" indicated that a disconnect was present on the unit regarding perceptions about the call bells, the patients who used them, and whose job it was to answer them.

## ETHNOGRAPHIC METHODS

The hospital ethnographer conducted this study on a 36-bed medical-surgical unit on one campus of the hospital over the course of 3 months in the spring of 2002. This project was reviewed and approved by the hospital's institutional review board as a Quality Improvement Project. Written informed consents were obtained from patients and family members interviewed, and oral consent was obtained from physicians, nurses, and other staff.

It should be pointed out that while each of the methods used in this assessment is discussed individually in this section, in practice, ethnographic data are often collected using these methods simultaneously. Observations can suggest topics for talking with staff or patients while comments from staff or patients might suggest things to watch for during observations or identify gaps in understanding that need to be resolved. Supplementary data may need to be collected to aid in unpacking the experience of working or being a patient on the unit.

## GAINING ENTRY

Cooperation for the project was obtained from the unit's nursing administrator. She introduced the ethnographer to the unit's nurse manager, who introduced the ethnographer to unit staff. This "validation" of the ethnographer and the work being done was an important first step.

## MAPPING

Mapping of the site, or in this case, the clinical unit, is done early in the project. These

maps show the details of the site including unit layout, public and private areas, high activity areas, and the position of the unit within the larger hospital system. Simple maps were drawn by the ethnographer to show the layout of the unit area. Room numbers were marked, and key areas such as the medication room, clean and dirty utility rooms, kitchen, solarium, nurses' station, and unit exits were indicated. A second map was drawn of the central nurses' station area since it is the "hub" of activity for nurses and physicians. A tape measure was used to measure the area, given some size perspective to the map.

Key items at the nurses' station were located on the map—these included the shape and layout of the counter area, location of the central call bell console, the location of the unit secretary's work area, the telemetry consoles, the location of the chart rack, and the writing area where nurses, physicians, and others could sit or stand to chart. These maps helped show the physical layout of the unit and its key areas and also were useful in communicating information about the unit layout during the reporting phase of the project.

### PHOTOGRAPHY

Photography is an important aspect of ethnography. Photos were limited to public areas and staff work areas, and no patient/visitor photographs were taken. A disposable 35-mm camera was used by the ethnographer to take photographs of the nurses' station, and the hospital photographer took photos of the central hallway and public areas of the unit in the early morning hours while these areas were free from foot traffic and patients/visitors.

The photos show the reality of the nurses' station and unit areas pictorially. Photographs were particularly helpful in documenting the status of the call bell console—the number of lights that were lit at specific times during the different shifts, who was standing near the console, who was or was not answering the lights, and other similar details. Pictures were taken at intervals during the project to capture the workflow at the nurses' station

during different times of days and shifts. The pictures also were helpful in communicating information about the layout of the nurses' station and the status of the call bell console to administrators who were unfamiliar with the unit.

### OBSERVATIONS

The hospital ethnographer conducted 60 hours of observations on all 3 shifts over a 3-month period. Observation provided information about what actually occurred on the inpatient unit. These components of the day-to-day functioning of the inpatient medical-surgical unit provided context to the patient experience.

Observations were done concurrently with interviews, mapping, and initial photography. The ethnographer walked around and observed activities on the unit in various areas, including the hallways, nurses' station, break room, and patient rooms. At first, the observations were done during various times/days to understand the daily routine of the unit. Observations were planned so they would occur over several hour time periods on different days/shifts to understand the functioning of the unit from a broad perspective. After the first 2 weeks of observations, the ethnographer had a basic understanding of the unit routine, workflow, schedules, and staff relationships.

During review of these initial data, it became apparent that issues related to call bells were a recurrent theme that needed further evaluation. The ethnographer collected call bell data in addition to information about the broader topic of the components of patient satisfaction, the original purpose of this investigation. Findings from the patient satisfaction assessment have been published elsewhere.<sup>20</sup>

To collect observational data about call bells, the ethnographer stood where she could see the nurses' station. She watched the call bell console light up, used a watch to time how long it took for someone to answer the call bell, and noted who answered (nurse, aide, unit secretary), and who ignored it. She

also looked for patterns in the ringing of the call bells, evaluating their proximity to meal times and their frequency at night and in the mid-afternoon. She examined the number lit at certain times, checked if some rooms rang more than others, and explored the possibility that patients in rooms further from the central station rang more than those closer. All of this information provided an understanding about patterns of use of the call bells.

During this observation phase, the ethnographer also walked around the unit and watched the rooms where the over-the-door call light was illuminated. She watched to see if someone went in, how long he or she stayed, and how long it took the person to return with the needed item, such as pain medication, water, or information. While in the course of walking around the unit, she encountered an older man in a hospital gown standing in the hallway asking for help. She asked him what he needed, and he explained that he had pushed the call button for a long time and when no one came, he got out of bed and walked into the hall. He thought his bell was broken. It wasn't.

## INTERVIEWS

Interviews were conducted with 23 inpatients, 9 family members, and 17 staff members, including nurses, nursing supervisors, nursing assistants, care managers, and respiratory therapists over a 3-month period. One physician was interviewed. Patient interviews captured the patient perspective of care while the physician and staff interviews provided information about their perspectives on key aspects of patient care.<sup>20,21</sup>

Interviews were conducted with patients about the general topic of satisfaction as well as questions about call bells such as "when did they use them," "were they answered promptly," and "did the person who answered follow through promptly on your request?" Interviews were conducted with nurses, nurse aides, supervisors, and the unit secretaries about the call bells. Questions included items about whose job it was to answer bells, their thoughts about patient requests, and other

similar topics. The interviews provided an understanding of the call bell issue from multiple perspectives.

## Analysis strategy

Ethnographers look at the different kinds of data—maps, photos, interview transcripts, observation notes, and satisfaction surveys (if available) to see how the data compare with that from the other sources. This cross-checking of data, triangulation, helps in corroborating and validating the findings.<sup>17</sup> For example, the maps constructed as part of this project showed the position of the nurses' station in relation to the patient rooms on the unit. Photographs documented that there were a lot of lights lit on the console as well as the presence of staff at the nurses' station ignoring the call bell console.

Observations confirmed that the nurses' station was the hub of the unit. Ethnographic observations also identified avoidance behaviors with regard to answering the patient calls on the console at the central nurses' station. Observations conducted in the "walking around" process of the ethnographic work allowed the ethnographer to observe nurse-patient interactions within patient rooms as well as in public areas such as unit hallways. She also watched and documented the time it took for calls to be answered.

Interviews with patients and staff and the observations confirmed that nurse-patient communication via call bells needed improvement. Patient satisfaction surveys were helpful in early stages of the planning in suggesting that patients were not satisfied with certain aspects of care they were receiving on the inpatient units. This process of cross-checking or triangulation of data from different sources is essential in validating findings from an ethnographic project such as this one. It is also important to feed the data back to the unit staff to ask them, "Did we get it right?"

## RESULTS

Call bells in this research consisted of 3 interrelated components that all had impact on the efficiency of communication between

unit staff and patients. These include (1) answering the call bell, (2) telling the caregiver that the patient needs something, and (3) following through with the patient request.

The first, and perhaps most problematic aspect of the call bell issue, is that of answering the light. This category includes whose job it is to answer the bells, where the light is answered (either at the nurses' station or in the room), and how long it takes for the light to be answered. Interviews with nurses, unit secretaries, and nurse aides suggested that some people in all 3 groups viewed patient call lights as an interruption to their work rather than a means of patient communication with unit staff. A nurse aide, when asked who should answer patient call lights, said, "it is important to answer call lights . . . only the nurse aides do it, but everyone should. Patients get mad when they have to wait for pain medicine or have their lights answered. Everyone should work together to get the lights answered as quickly as possible and not wait for the aides to do it."

On this same topic, some patients reported that staff answered their call lights promptly, whereas others said they waited and waited for help that never came. One example was the man who came out of his room to find a nurse after he rang and rang and no one came. Another was the man who said he had frequently asked for things by ringing his bell and was never sure if his bell would be answered or not. One man whose room was across from the nurses' station said, "One night I could hear the call bells ringing for a long time and nurses talking at the nurses' station. I felt like getting up and answering the bells just so they would stop ringing. The ringing during the night was disturbing." Conversely, several patients said that nurses and aides were in and out of the room frequently so they never had to ring the call bell to get something.

During interviews with nurses and clinical staff, it became clear that a disconnect was present among staff as to whose job it was to answer call bells. Nurses thought that nurse aides or the unit secretary should answer the call bell console. Some staff said that they were often very busy and did not have

time to stop what they were doing and answer call lights. One nurse responded to a question about call lights by saying that "patients complain if their lights are not answered promptly." She also said that "answering call lights is the nurse aide's job." Another nurse said that "answering call lights takes too long. There are not enough people to answer lights, and it is often left up to the nurse aide to do it. Usually the nurse aide is busy, so they can't always answer the light promptly." She also said, "there should be better communication and cooperation between staff." From these comments it was clear that there was confusion about whose job it was to answer call lights. Timeliness in answering the bells was sometimes a problem. The ethnographer observed variation in the amount of time a bell rang, from hardly at all to as long as 20 minutes. The average response time until a light was answered at the desk was 5 minutes.

Transmitting the information that a patient called to the appropriate patient's nurse or nurse aide is another component of the call bell issue. For example, the ethnographer observed one unit secretary answer a light at the console that had been ringing for 5 minutes by saying "someone will be right in." The secretary then sat down and resumed her work without communicating to staff that a patient had called for assistance. That same secretary then turned to the ethnographer and said, "some people don't understand." Clearly, if the fact that a patient called is not communicated once the light is answered, then follow-through on the request is problematic.

Nurses on the unit were supposed to carry phones so that the unit secretary could easily reach them if needed. Communication was further complicated on the unit from inconsistent use of the phones by the nurses. Reasons nurses gave when asked why they did not carry their phones ranged from "I could not find a charged battery" to "The phones are big and heavy." Such reasons may be legitimate but further complicate matters by limiting the ability of staff to communicate with one another about patient needs, among other things. In addition, nurse aides were not assigned to carry phones so it was often

hard to locate them if they were out of view of the desk.

The third component of the call light issue is that of follow-through on patient requests. It is not enough for the secretary, nurse, or nurse's aide to answer the light and find out what the patient needs. While call lights should always be answered promptly, it is equally important for the person answering the light to follow through on the patient request. If the patient asks for a medication or extra blanket, then he or she should promptly receive it. If the request cannot be acted on, then the patient should be told why, for example, it may be too early for the next dose of pain medication.

Patients said that often when someone answered the call bell, he or she did not follow through with the patient's request, whether it was a request for food, information, medication, or even assistance in getting out of bed to go to the bathroom. They also reported that often the response over the intercom was, "We'll send someone in," but that "someone" never appeared.

There was a perception by some staff that call bells were an inconvenience. An example is the observations by the ethnographer of numerous call lights ringing at the station console and nurses standing right there not bothering to answer them. Some nurses and aides seemed to understand that answering call bells was important, but on a busy medical-surgical unit, it was easy to view the call bells as an interruption of one's work.

Findings were reported to hospital management in a bulleted format (Table 1) and put into a series of PowerPoint slides for presentation to unit staff.

## DISCUSSION

This study illustrates how ethnography can be used to identify clinical problems such as the call bell issue and provide an understanding of the problem from the perspective of multiple stakeholders. Ethnographic assessment brought the call bell issue to the forefront and allowed staff to understand the

**Table 1.** Call lights findings summary

<p>Call light issues were the most frequently cited concern among patients interviewed in this project.</p> <p>Patients reported that delays in getting call bells answered were common.</p> <p>The response time to call lights varied greatly from a low of less than a minute to a high of 20 minutes.</p> <p>Another concern of patients was the amount of time it takes to carry out the patient's request once the light is answered.</p> <p>Some patients reported that they never got what they asked for once the call light was answered.</p> <p>Staff interview data suggest that there is disagreement among staff about whose responsibility it was to answer patient call lights.</p>
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problem and seek ways to improve patient-caregiver communication on their unit.

Nurses were eager to hear the results of the work and verified that the ethnographer "got it right." During the data presentation session, nurses were surprised to see that everyone seemed to think that answering call bells was not a priority and was someone else's job. Once staff understood the importance of call bells to patients, answering call bells promptly and courteously became a priority for everyone on the unit. They understood that whoever was nearest the console or room when the light went on should answer the light and either fulfill the request or transmit the request to the person who can handle the request. The staff took ownership of the call bell issues and brainstormed ideas about how to improve this aspect of patient care. At the same time, nurses gained an understanding about the value of ethnography in understanding key aspects of patient care.

How do ethnographic methods in general and this study in particular promote changes in nursing practice? First, we have demonstrated how an ethnographic study was conducted on an inpatient unit. This provides

a step-by-step guide to nurses who want to perform ethnography in their clinical setting. Second, our study also showed the value of the nurses' use of ethnography to understand how their patients evaluate quality of care, which in our case was through something as seemingly simple as the responsiveness of staff to requests and their prompt answering of call bells.

Our study encouraged us to focus on what the patients perceived as important and valuable and to explore further why they had those perceptions. We realized that call bells and requests to staff remain one of the few ways that patients can exercise control over their care and their existence on the unit. Frustration over delays in answering call bells was one of the most frequent comments patients made during the interviews. It appeared that many patients are hesitant to ask for any form of special consideration and thus often structure their requests within a context they think will be acceptable on the unit. We realized it was important to recognize that call bells and other requests are legitimate ways for patients both to test the responsiveness of the system to their needs and to indicate obliquely some other needs or concerns.

Another related aspect of the call bell issue is patient safety and fall prevention. The encounter that the ethnographer had in the hallway with the elderly man who got out of bed and came into the hallway to get attention when his call light went unanswered shows how critical prompt attention to call bells is in terms of patient safety. We suspect that this linkage of prompt response to patient call bells as a patient safety issue is often overlooked. This study brought this linkage to the attention of unit staff and administrators and made an indelible impression in a more powerful way than a survey alone.

Another aspect of responsiveness to patient needs that became clear through this study is that of managing patient expectations. Time constraints of staff versus patient expectations need to be balanced. The solution may involve process changes so that staff is better able to manage patient expectations. For

example, if patients are told that call bells will be answered within 5 minutes, then patients are probably less likely to get upset when they do not get an instant response. By managing expectations for certain key measures such as call bell response time, patients will know what to expect and when, and will be more satisfied with their care. We found that it is important for a hospital to develop standards for measures such as call bell response time and communicate these to patients and staff, minimizing the potential for misunderstandings.

## RECOMMENDATIONS

From the findings presented in this article, unit leadership and nursing staff developed standards related to answering the call bells. These included the following recommendations. (1) Call bells should be responded to within a defined period of time. These standards should be communicated to patients, families, and nurses so they all have similar expectations. (2) A typology should be developed for the services requested by call bells and internal standards established for how long it takes to complete those services. (3) Since patients are often concrete in their thinking, for example, they may expect that a 1 o'clock medication be delivered at 1 o'clock, not 1:05 or 1:30, careful communication should be used to shape realistic patient expectations.

## CONCLUSIONS

In this modern era of healthcare where the focus is on patient-centered care and meeting patient needs as patients perceive them, ethnographic methods are measurement tools that can capture these insights. This article has demonstrated that for certain clinical problems, such as "the dance of the call bells," ethnographic methods provide an in-depth understanding of the many facets of a topic in more detail than a survey alone would provide. Ethnographic methods provide insights into the "big

picture” of a problem and provide insights into the human perspectives. These methods also may be used with established survey and satisfaction measures to “unpack” and better understand what those surveys are measuring and how to improve those measures.

We provided a concrete clinical example of how to use ethnographic methods step by

step to understand patient care with the goal of improving patient satisfaction and quality of care. Nurse researchers should be able to use our example to replicate this study in their own hospitals. Finally, we also wanted to contribute to further understanding of the importance of the many dimensions of call bell issues to hospitalized patients and their care, safety, and satisfaction.

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