

'I think we should just listen and get out': a qualitative exploration of views and experiences of Patient Safety Walkrounds

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ABSTRACT

Objective This article is an exploration of views and experiences of Patient Safety Walkrounds, a widely recommended strategy for identifying patient safety problems and improving safety culture.

Design and setting Qualitative analysis of semistructured, in-depth interviews with 11 senior leaders and 33 front-line staff at two major teaching hospitals with mature walkrounds programmes, collected as part of a larger mixed-methods evaluation.

Results Despite differences in the structure of the two walkrounds programmes, senior leaders at both institutions reported attitudes and behaviours that contradict the stated goals and principles of walkrounds. Senior leaders tended to regard executive visibility as an end in itself and generally did not engage with staff concerns beyond the walkrounds encounter. Some senior leaders believed they understood patient safety issues better than front-line staff and even characterised staff concerns as 'stupid'. Senior leaders acknowledged that they often controlled the conversations, delimiting what counted as patient safety problems and sometimes even steered the conversations to predetermined topics. Some front-line staff made note of these contradictions in their interviews.

Discussion/conclusions Our study found that walkrounds may inadvertently lead to counter-productive attitudes by senior leaders at odds with the recommended principles of walkrounds. The results demonstrate similar attitudes from senior leaders at two hospitals with quite different formats for walkrounds, suggesting that this pattern may exist elsewhere. Better preparation of senior leaders prior to the walkrounds may help to avoid the counter-productive attitudes and dynamics that we identified.

BACKGROUND

Patient Safety Walkrounds, also known as Executive Walkrounds or Leadership Walkrounds, has emerged as a promising strategy for identifying specific patient safety problems and, more generally, improving safety culture.¹⁻⁹ Though details vary across institutions,^{1-5 9 10} walkrounds typically involve senior leaders meeting with front-line staff to discuss patient safety concerns,⁴ in a forum that is intended to be open and blame-free. These concerns may range from practical issues (eg, equipment availability or functionality) to deeper challenges (eg, adequacy of staffing or inter-professional communication problems). Based on the open, non-hierarchical nature of the conversations, walkrounds have also been promoted to improve patient safety culture.⁸

Walkrounds offer the concrete benefit of detecting patient safety concerns not captured by other common sources of patient safety data (eg, incident reports, chart review).¹¹ Some studies have also shown modest improvements in patient safety culture associated with adoption of walkrounds.^{2 8 12} However, a recent randomised trial reported that front-line staff perception of performance improvement actually decreased with participation in walkrounds.¹³ Some research has suggested that senior leaders perceive great value in hearing from front-line staff about their safety concerns.¹⁴ Yet, a large-scale organisational intervention at four UK hospitals that included walkrounds reported disappointment by front-line staff, with participants questioning the degree to which senior leaders acted on the issues they

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identified.¹⁵ Thus, despite frequent recommendations to implement walkrounds, limited research establishes the degree to which they improve safety culture or lead to concrete improvement in specific safety problems.

We undertook a mixed-methods evaluation of walkrounds programmes at two major teaching hospitals in Canada to examine the degree to which the walkrounds programmes achieved their improvement goals. Senior leaders at the two hospitals had invested substantial personnel-hours in carrying out walkrounds and requested an evaluation of the impact achieved and identification of any weaknesses of the programmes. The mixed-methods evaluation included qualitative interviews and quantitative analysis of the types of patient safety concerns identified and addressed by the walkrounds. The types of problems identified at the two hospitals resembled those reported in the literature, with staff commonly wanting to discuss infrastructure problems (eg, equipment and physical plant issues)^{1 2 6 11} rather than teamwork, communication and other system problems more explicitly related to patient safety.

While analysing the interviews from this larger evaluation, we noted attitudes and behaviours on the parts of the senior leaders that contradict the stated goals and recommended principles of walkrounds. Therefore, we undertook a qualitative analysis focused on exploring these contradictory attitudes and behaviours by senior leaders as well as determining the degree to which front-line staff identified these attitudes and behaviours.

METHODS

This qualitative descriptive study¹⁶ sought to explore views and experiences of senior leaders and front-line staff members participating in walkrounds programmes at two major teaching hospitals in a large Canadian city. The qualitative interviews analysed in this study were conducted as part of the previously described larger mixed-methods evaluation. Both hospitals had walkrounds in place for several years but had implemented them with different features (see online supplementary appendix table 1).

Using purposive sampling,¹⁷ we recruited 11 senior leaders and 33 front-line staff (table 1). Our sampling strategy for the senior leader interviews aimed to recruit a range of participants to maximise variation.¹⁷ Thus, we recruited senior leaders with differing impressions of walkrounds (positive or negative) and

institutional roles (leadership of clinical portfolios, such as Vice President of Nursing or Medical Affairs, vs oversight of explicitly administrative functions, such as Public Relations, Information Services and Operations). We based the characterisations of senior leaders' impressions of walkrounds on consultation with patient safety officers at the two hospitals, as they had observed all the rounds and received informal statements from senior leaders indicating their views of walkrounds.

Sampling for the front-line staff interviews was based on unit walkrounds participation. Five units from each hospital were selected primarily on the recommendations of the patient safety office at each hospital based on their perception of how well the walkrounds went and the success of follow-up on the issues identified in the walkround. We also ensured that at least some of the units participated in their walkround far enough in the past to allow for follow-up and feedback following the walkround. The unit managers from each of the 10 selected units were interviewed and at the end of the interview were asked to identify two staff members who participated in the walkround and could provide insight. In total, one unit manager and two front-line staff from each unit completed interviews for the larger evaluation study. We also interviewed three patient safety specialists (one from Hospital 1 and two from Hospital 2) who helped organise and facilitate the walkrounds.

Data collection used semistructured interviews.¹⁷ One of the authors (LR) conducted all interviews between April and September 2010, with each interview ranging from 22 to 48 min in duration. Senior leaders were asked to describe how walkrounds typically unfolded, discuss their perceptions of the walkrounds, the types of patient safety concerns elicited during the meetings and reflect on how walkrounds could be improved. The front-line staff and patient safety specialists were asked to reflect on their experience in the walkround, the types of issues that were discussed and their impressions of the feedback and follow-up after the walkround. All interviews were audiotaped and professionally transcribed.

Two researchers (LR and FW) reviewed three senior leader interview transcripts independently, and a coding template was developed to code the remaining senior leader transcripts (LR). Following the thematic analysis steps outlined by Braun and Clark,¹⁸ codes were organised into overarching themes through an iterative and inductive process. Following the analysis

Table 1 Study sample

	Hospital 1	Hospital 2
Total number of senior leaders employed at each hospital	11	12
Number of senior leaders interviewed	5 (3 with clinical portfolios/backgrounds)	6 (2 with clinical portfolios/backgrounds)
Number of front-line staff interviewed	16 (including 1 patient safety specialist)	17 (including 2 patient safety specialists)

of the senior leader transcripts, we re-reviewed all interviews with staff and patient safety specialists to identify any quotations that related to the themes that emerged from the analysis of the senior leaders' interviews.

FINDINGS

Senior leaders typically echoed the generally recommended principles of walkrounds—engaging front-line staff in an open, blame-free conversation and valuing their clinical and practical expertise regarding potential patient safety problems. However, further discussion elicited attitudes and descriptions of behaviours at odds with these principles. We present three inter-related themes highlighting this disjuncture between the principles of walkrounds and senior leaders' attitudes in practice. These themes include nominal respect for front-line concerns, executive presence without engagement and controlling the conversation.

Nominal respect for front-line concerns

The literature highlights as an important goal of walkrounds the opportunity for senior leaders to hear directly from front-line staff about patient safety concerns for their unit. Eight of the senior leaders echoed this goal during the interviews. They also acknowledged the front-line staff as 'experts' for their units and provided examples of patient safety issues that were brought to their attention by staff. However, further probing elicited contradictory attitudes, ranging from merely paying lip service to front-line staff as experts to explicitly disparaging their concerns.

The following excerpt illustrates these contradicting statements. This participant initially expresses the philosophy of the hospital about learning from the front-line staff in the walkrounds.

I'm not in the frontlines, I'm not experienced. You have to walk the shoes to understand what's going on. (Senior leader 3, Hospital 2)

However, on further reflection about his experience participating in the walkrounds, he contradicted this characterisation of front-line staff as experts from whom senior leaders could learn.

The truth of the matter is I won't learn that much new because I sort of know what's going on. I know all the barnacles, I know what we need, I know what we don't have...I don't go there to learn that much anymore. (Senior leader 3, Hospital 2)

Additionally, half of the leaders described frustration with front-line staff bringing up issues that they regarded as irrelevant to patient safety. They felt that staff too often focused on environmental and physical infrastructure issues as opposed to topics more closely related to the senior leaders' understanding of patient safety.

So I often prompt to get more of the patient safety [issues] because sometimes it's a process issue that drives them crazy but the patient isn't in any harm. And I find that I would say almost 60 percent of the time that's what I'm getting. I don't think they sometimes get what patients safety is. (Senior leader 4, Hospital 1)

[W]e spend a fair amount of time on environmental and the physical which isn't what I really want to do. I would far rather we look at the process issues but ... you don't want to say 'I'm not going to look at that. I'm not interested in that'...You want to make them to feel valued about what they've pointed out. But I wish they'd stick to the process issues sometimes. (Senior leader 3, Hospital 1)

Not all senior leaders shared this perspective. Some acknowledged that concerns raised by front-line staff were clear patient safety issues for the units and provided examples of important issues identified in walkrounds they had facilitated. However, there were also examples of senior leaders characterising staff concerns as 'stupid' and 'trash'.

Although I have to admit, the last one I did, I just knocked one of the issues off because it was stupid, and went with the top two. (Senior leader 2, Hospital 1)

I got a whole bunch of trash on the table that had nothing to do with patient safety...Silly little stupid things that the [unit] manager should have been embarrassed was on the table because it's the manager's role. (Senior leader 4, Hospital 2)

Notably, both of the above quotes came from senior leaders without clinical backgrounds. Senior leaders with clinical backgrounds tended more often to acknowledge the legitimacy of issues raised by the front-line staff even when these issues did not fit with their conception of patient safety.

Executive presence without engagement

All but two of the senior leaders spoke of the importance of promoting executive visibility as a means of demonstrating organisational commitment to patient safety, consistent with the goals of walkrounds.

I think the main purpose was to demonstrate senior management leadership and commitment to patient safety. (Senior leader 5, Hospital 2)

But ...from the vantage point of trying to be leaders of influence... trying to push it down into the organization that we're serious about this [patient safety]... we needed to put our weight behind it. (Senior leader 4, Hospital 1)

However, one senior leader acknowledged wanting to appear interested for the benefit of the front-line staff rather than actually being interested.

Generally speaking, employees are quite proud of their work areas and would like to show someone

who is interested. So I do always want to appear as if I'm interested. (Senior leader 4, Hospital 1)

And, more generally, senior leaders indicated limited interest in engaging with front-line staff concerns beyond walkrounds encounters.

I give [walkrounds leader] a look and body language that says, look I think we should just listen and then accommodate and then get out. (Senior leader 3, Hospital 2)

I just basically metaphorically roll my eyes and think, okay, well, let's put it down on the list. (Senior leader 2, Hospital 1)

The interviews with the front-line staff at both hospitals suggested that staff perceived a lack of any ongoing commitment to addressing patient safety concerns beyond the initial face-to-face meeting. Many of the staff were initially excited to meet with the senior leaders and stated that they felt heard and acknowledged. However, some described becoming disillusioned with the process due to lack of resolution to the issues raised during walkrounds and the absence of follow-up communication.

To think that you put your hour, hour-and-half, however long it was, poured out your heart to discuss these issues and then nothing. (Social worker, Hospital 1)

Part of me feels like it's just an exercise. (Unit manager, Hospital 1)

Management coming to the frontlines ...is a good thing, but how that translates into patient safety I'm still not sure...the people from the Office of Patient Safety had trotted out a few motherhood statements with a big smile on their faces, thanked us and then left. (Physician, Hospital 2)

Controlling the conversation

Walkrounds aim for open, non-hierarchical communication between the front-line staff and senior leaders about patient safety issues. The following quotation is representative of the way in which many senior leaders echoed the goals of walkrounds.

And everybody introduces themselves by name and their role which I think is also important because whether you're again an executive or whether you are a service assistant, the fact that you get to say your name and your title in the same breath as everybody else is a good equalizer. (Senior leader 6, Hospital 2)

However, further discussion elicited acknowledgments by senior leaders they often control the conversations, for instance, setting the boundaries at the outset or throughout the walkrounds for what should or should not be discussed. Five senior leaders explained that they like to set out what is appropriate to discuss in the walkrounds.

I spend a lot of time trying to set out almost the terms of engagement by saying, "this is what we want to talk about specifically". (Senior leader 2, Hospital 1)

So immediately one of them [frontline staff] says what we really need here is ...extra nurses at night. So I'll say, well, you know what, I'm going to bring you back because I want to remind you that what we're really trying to identify here are some areas where I can actually deliver for you in a short period of time. And I'll acknowledge the fact that they've got staff and other issues. But there's times where we just need to move on. There's no value in us spending an hour talking about that. (Senior leader 5, Hospital 1)

Two of the senior leaders also noted the importance they placed on front-line staff maintaining a professional atmosphere.

I'm a little controlling in a sense that if I see it's getting too negative and it's losing its productivity or constructivity (sic)...Because it begins to pollute the air...I like professional environments. (Senior leader 3, Hospital 2)

This quotation not only indicates controlling these conversations as a general behaviour but also highlights the degree to which this senior leader uses a definition of professionalism (as being productive and positive) to rule out discussion of some problems that frustrate staff ('too negative' and 'polluting'). Another senior leader described one staff member as 'whining' in their description of a walkrounds interaction. One unit manager (importantly, not from the same hospital as the above quotation) specifically mentioned sensing intense pressure on front-line staff to conduct themselves in the expected manner during the walkrounds.

I think there was a lot of pressure on my staff. I could see they were so very careful in choosing their words and actually I felt bad for them because I felt like this was a lot of pressure on them. (Unit manager, Hospital 1)

While most front-line staff did not make note of senior leaders controlling the conversations, some sensed senior leaders steering the conversation towards specific patient safety concerns.

Then I guess [Facilitator] took the lead and led this very structured exercise...I felt there was a bit of a bias on their part and a desire to fixate on [patient safety issue]. (Nurse, Hospital 1)

At a recent walkaround there was a very passionate exchange around hallway patients and the inherent dangers around treating [hallway] patients. And the discussion was very limited; for whatever reason, it was very limited. And so I could sense from the body language that went on past that point that people could see that, 'Ah, well, the real issues that are important to us, perhaps this is not the right venue to discuss those.' (Patient safety specialist, Hospital 1)

It went pretty much as expected, with them deflecting and not addressing any of the issues. I mean the issue is money. It's as simple as that. I mean some concerns were brought up. I think I got the impression that we were limited. (Physician, Hospital 2)

DISCUSSION

This qualitative study described views and experiences of 11 senior leaders and 33 front-line staff members at two hospitals with quite different formats to their walkrounds programmes. Our analysis identified three interrelated themes. Though senior leaders initially echoed the general principles of walkrounds, engaging staff in an open, non-hierarchical conversation and valuing their expertise, further discussion elicited attitudes and behaviours at odds with these principles. Senior leaders had only nominal respect for the concerns of front-line staff (sometimes even explicitly disparaging them); they viewed executive visibility as an end in itself, generally not engaging with staff concerns beyond the walkrounds encounter; and they acknowledged controlling the conversations, delimiting what counted as patient safety problems and sometimes even steering the conversations to specific topics. Though most front-line staff did not comment on these attitudes, some noted the degree to which senior leaders steered the conversation and appeared to be conducting a purely administrative exercise.

Our results also indicate that senior leaders and front-line staff wish to discuss different issues during walkrounds. Senior leaders in our interviews attributed this difference to poor understanding by front-line staff of patient safety problems. While this may be true to some extent (most front-line staff have had no formal exposure to patient safety education), the observed disjuncture may reflect the different perceived needs of these two groups for effectively filling their roles within the institution. Because senior leaders wish to demonstrate their commitment to patient safety and ability to resolve front-line concerns, they avoid discussions of problems they feel they cannot solve. Based on our interviews, senior leaders adopt one of two approaches. They steer front-line staff away from issues that will require substantial resources, such as increased staffing ratios and major equipment expenses. Or, they define practical concerns, such as equipment and facilities, as not counting as 'patient safety problems'. Front-line staff, however, regard these problems as fundamental impediments to delivering basic care and therefore want them addressed before discussing higher-level concepts such as teamwork and communication. Interestingly, senior leaders with clinical backgrounds were more willing to acknowledge the importance of these front-line concerns regardless of whether these concerns conformed to their conception of patient safety.

Recently, the concept of addressing small issues that directly impact front-line staff alongside widespread institutional change initiatives has appeared in the literature.¹⁹ For example, in their description of the 'Sweat the small stuff' initiative, Moore and Buchanan¹⁹ found that addressing small safety and administrative issues reduces frustrations of front-line staff, improves quality of care and leads to better clinician-managerial relationships. The authors also suggest that such 'quick wins' can lead to further and ongoing improvements in care. This finding parallels the 'broken windows theory' in the sociology and criminology literature, which has been previously discussed in the context of healthcare and patient safety.^{20 21} The broken window theory argues that major criminal behaviours can be limited through prevention by quickly addressing small environmental issues (such as broken windows) and low-level anti-social behaviours. The same argument can be made in healthcare that quickly addressing small issues (that erode staff morale and reduce confidence in management's commitment to high-quality care) can reduce the occurrence of more serious patient safety problems.²² Senior leadership should be encouraged to prioritise both small issues that impact the daily workflow of staff, not just more substantive problems that fall more within their conception of patient safety.

Our study is not the first to question the positive effects of walkrounds on safety culture. Recently, a randomised control trial of walkrounds has called into question the walkrounds programmes' ability to enhance organisational safety culture and points to the negative implications of senior leaders' attempts at engagement when they are not followed by meaningful, ongoing relationships.¹³ Our study supports the results of this trial and provides insight into why walkrounds may fail to generate such relationships between senior leaders and front-line staff. Along the same lines, a German study described the potentially counterproductive effects of 'management by walking around' on wards and floors due to reinforcement of hierarchical relationships, with leaders asserting managerial control and establishing the expectations, norms and hospital standards during these visits.²³ A US study of 30 Veterans Affairs hospitals found that organisations showing characteristics of a hierarchical culture, specifically emphasising rules and control, "may dampen awareness of safety problems and hamper quality improvement efforts by impeding the open flow of information and stifling input from the frontline".²⁴

LIMITATIONS

The original purpose of the interviews lay in evaluating walkrounds in general, not highlighting specific senior leaders' and front-line staff views and experiences. However, the emergence of the themes we encountered during more general interviews (at

hospitals with quite different walkrounds programmes) potentially underscores their pervasiveness. Senior leaders' comments about controlling conversations and the limited understanding of front-line staff arose spontaneously in their answers about the goals, conduct and outcomes of walkrounds in general, not in response to specific questions probing their views of front-line staff. The posthoc nature of this analysis also affected the interviews with the front-line staff. We did not ask if they perceived senior leaders controlling the conversations or taking their concerns seriously. Nonetheless, some staff spontaneously commented on these issues. Had we pursued further interviews to explore staff perceptions of the relationships and power dynamics with the senior leaders, more of the staff may have commented on this topic.

The small sample size of 11 senior leaders limits the generalisability of our findings. In addition, thematic saturation occurred only for the larger evaluation, not for the present analysis. Further interviews might have added more nuanced information by asking senior leaders about the clear disconnect between attitudes they expressed and the principles underpinning walkrounds. Several factors prevented us from pursuing further interviews, including the amount of time since the initial interviews and the feasibility of engaging senior leaders in a further round of interviews, but the challenge of confronting senior leaders with indications of negative management styles seemed particularly problematic. However, even without the nuances that further interviews might have provided (eg, how senior leaders reconcile their contradictory attitudes), the themes that emerged clearly indicate attitudes and behaviours that undermine the goals of walkrounds.

CONCLUSION

The findings from this qualitative study of walkrounds highlight the potential for the emergence of counter-productive attitudes among senior leaders even when they express support for the principles of walkrounds. These attitudes likely emerge as a result of two challenges encountered by senior leaders during walkrounds. Front-line staff want to discuss issues senior leaders feel they are unable to solve and raise concrete, practical issues that senior leaders regard as too mundane and not falling within the scope of patient safety. Moreover, continually hearing the same issues brought up in multiple units can engender frustration with front-line staff.

Ensuring that senior leaders receive an orientation that prepares them to encounter these challenges may avoid the development of the contradictory attitudes elicited in our study and enhance the possibility of achieving the intended improvements in patient safety culture. Senior leaders without clinical backgrounds may particularly benefit from such orientation, given that they may not always recognise the link between

the front-line staff concerns brought up in walkrounds and the delivery of safe patient care.

Early reports of the benefits of walkrounds^{5 7 12} may reflect the strong organisational commitments to patient safety in 'early adopters' and the involvement of clinician champions in the development and execution of walkrounds. Subsequent studies have demonstrated less favourable results,^{13 15} possibly reflecting lesser organisational commitments to safety but also possibly the emergence of attitudes such as we have described. While further research into the contextual factors associated with successful walkrounds would be beneficial, orienting senior leaders to avoid the counter-productive attitudes and behaviours that can emerge may enhance the outcomes of walkrounds in whatever context they occur.

Contributors All authors meet the authorship requirements as defined by the ICJME. Specifically, all authors made substantial contribution to conception and design of the current project. LR conducted all of the data collection. LR and FW completed the analysis and interpretation of the data. KGS provided substantial input on the final interpretation of the results. All authors contributed to the draft of the article or revising it critically, and have provided final approval of the submitted version of this manuscript.

Competing interests LR is the Program Manager at the University of Toronto Centre for Quality Improvement and Patient Safety and doctoral student at the University of Toronto Institute for Health Policy Management and Evaluation. KGS is the Director of the University of Toronto Centre for Quality Improvement and Patient Safety. FW is an Education Scientist and Assistant Professor in the Department of Family and Community Medicine (DFCM) at the University of Toronto.

Ethics approval The ethics boards at both participating hospitals approved the study. The names of the two institutions' ethics boards have been omitted to preserve anonymity of the participating hospitals.

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REFERENCES

- 1 Budrevics G, O'Neill C. Changing a culture with patient safety walkarounds. *Healthc Q* 2005;8:20–5.
- 2 Campbell DA Jr, Thompson M. Patient safety rounds: description of an inexpensive but important strategy to improve the safety culture. *Am J Med Qua* 2007;22:26–33.
- 3 Richardson S, Watson S, Wrong T. Implementing leadership rounds to improve patient safety. *Healthc Manage Forum* 2007;20:38–46.
- 4 Frankel A, Graydon-Baker E, Neppel C, *et al.* Patient safety leadership walkrounds. *Jt Comm J Qual Saf* 2003;29:16–26.
- 5 Shaw KN, Lavelle J, Crescenzo K, *et al.* Creating unit-based patient safety walk-rounds in a pediatric emergency department. *Clin Pediatr Emerg Med* 2006;7:231–7.
- 6 Zimmerman R, Ip I, Daniels C, *et al.* An evaluation of patient safety leadership walkarounds. *Healthc Q* 2008;11:16–20.
- 7 Frankel A, Grillo SR, Pittman M, *et al.* Revealing and resolving patient safety defects: the impact of leadership WalkRounds on frontline caregiver assessments of patient safety. *Health Serv Res* 2008;43:2050–66.
- 8 Morello RT, Lowthian JA, Barker AL, *et al.* Strategies for improving patient safety culture in hospitals: a systematic review. *BMJ Qual Saf* 2013;22:11–18.

- 9 Rinke ML, Zimmer KP, Lehmann CU, *et al.* Patient safety rounds in a pediatric tertiary care center. *Jt Comm J Qual Patient Saf* 2008;34:5–12.
- 10 Pronovost PJ, Weast B, Bishop K, *et al.* Senior executive adopt-a-work unit: a model for safety improvement. *Jt Comm J Qual Saf* 2004;30:59–68.
- 11 Levtzion-Korach O, Frankel A, Alcalai H, *et al.* Integrating incident data from five reporting systems to assess patient safety: making sense of the elephant. *Jt Comm J Qual Patient Saf* 2010;36:402–10.
- 12 Thomas EJ, Sexton JB, Neilands TB, *et al.* The effect of executive walk rounds on nurse safety climate attitudes: a randomized trial of clinical units. *BMC Health Serv Res* 2005;5:28.
- 13 Tucker AL, Singer S. A Randomized Field Study of a Leadership WalkRounds-Based Intervention. *Harvard Business School 2013 Working Paper No. 12–113*.
- 14 Burnett S, Parand A, Benn J, *et al.* Learning about leadership from Patient Safety WalkRounds™. *Int J Clin Leadersh* 2008;16:185–92.
- 15 Benning A, Ghaleb M, Suokas A, *et al.* Large scale organisational intervention to improve patient safety in four UK hospitals: mixed method evaluation. *BMJ* 2011;342: d195.
- 16 Sandelowski M. Whatever happened to qualitative description? *Res Nurs Health* 2000;23:334–40.
- 17 Patton MQ. *Qualitative research & evaluation methods*. 3rd edn. Thousand Oaks Sage Publications, Inc, 2002.
- 18 Braun V, Clark V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
- 19 Moore C, Buchanan DA. Sweat the small stuff: a case study of small-scale change processes and consequences in acute care. *Health Serv Manage Res* 2013;26:9–17.
- 20 Baldwin DC Jr, Daugherty SR. Interprofessional conflict and medical errors: results of a national multi-specialty survey of hospital residents in the US. *J Interprof Care* 2008;22:573–86.
- 21 Dixon-Woods M. Why is patient safety so hard? A selective review of ethnographic studies. *J Health Serv Res Policy* 2010;15:11–16.
- 22 Kelling GL, Coles CM. *Fixing broken windows: restoring order and reducing crime*. New York, NY: Touchstone, 1996.
- 23 Beil-Hildebrand M. The implications of management by walking about: a case study of a German hospital. *Leadersh Health Serv* 2006;19:1–15.
- 24 Hartmann CW, Meterko M, Rosen AK, *et al.* Relationship of hospital organizational culture to patient safety climate in the Veterans Health Administration. *Med Care Res Rev* 2009;66:320–38.

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