Walkrounds in Practice: Corrupting or Enhancing a Quality Improvement Intervention? A Qualitative Study

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Article-at-a-Glance

Background—Walkrounds, introduced as Leadership (or Executive) WalkRounds,™ are a widely advocated model for increasing leadership engagement in patient safety to improve safety culture, but evidence for their effectiveness is mixed. In the English National Health Service (NHS), hospitals have been strongly encouraged to make use of methods closely based on the walkrounds approach. A study was conducted to explore how walkrounds are used in practice and to identify variations in implementation that might mediate their impact on safety and culture.

Methods—The data, collected from 82 semistructured interviews in the English NHS, were drawn from two components of a wider study of culture and behavior around quality and safety in the English system. Analysis was based on the constant comparative method.

Findings—Our analysis highlights how local, pragmatic adjustments to the walkrounds approach could radically alter its character and the way in which it is received by those at the front line. The modification and expansion of walkrounds to increase the scope of knowledge produced could increase the value that executives draw from them. However, it risks replacing the main objectives of walkrounds—specific, actionable knowledge about safety issues, and a more positive safety culture and relationship between ward and board—with a form of surveillance that could alienate frontline staff and produce fallible insights.

Conclusion—The study's findings suggest some plausible explanations for the mixed evidence for walkrounds' effectiveness in creating a safety culture. On a practical level, they point to critical questions that executives must ask themselves in practicing interventions of this nature to ensure that adaptations align rather than conflict with the intervention's model of change.

Recent years have seen growing emphasis on encouraging leaders to learn what is happening on the "shop floor," actively participate in addressing local problems, and energize staff to align with core organizational objectives. Techniques such as "GembaWalks" and "Management by Walking Around"[1,2] have become widely used in business.[3] In the health care sector, an especially influential and widely used approach is that of Leadership (or Executive) WalkRounds,™ which were developed by Alan Frankel and colleagues at the Institute for Healthcare Improvement (IHI) in the early 2000s.[4–8] *Walkrounds* (as they are also known) are intended to provide a structure for staff involved in care delivery to surface safety concerns, have them recognized by senior staff, and ensure they are addressed by providing "an informal method for leaders to talk with front-line staff about safety issues in the organization"[9] and as the following:

> … a tool to connect senior leaders with people working on the front line—both as a way to educate senior leadership about safety issues and to signal to front-line workers the senior leaders' commitment to creating a culture of safety.[9]

The walkrounds approach involves visits by senior executives to different areas of hospitals where, guided by a toolkit comprising a set of instructions and a prompt guide, they engage in structured conversations with frontline staff.[9] Issues identified in the course of these visits are then supposed to be followed up with concrete action. The approach might thus be characterized as aiming to bring together the "sharp end" of care delivery at the front line with the "blunt end" of organizational leadership and administration,[10] emphasizing connectivity between different levels of the organizational hierarchy and the education of senior executives. Walkrounds should, in principle, translate into multiple small-scale improvements tailored to frontline staff's needs.[6,11,12]

The IHI approach—which we term the "espoused model"—has been widely adopted in the United States and elsewhere.[1,13–16] Its value is argued to lie in its potential for improving safety culture,[12,17] encouraging the upward transfer of expertise from the front line to the executive, enabling "horizontal" knowledge sharing,[6,11,13,18] and averting a blame culture.[4,11,13] IHI's toolkit for walkrounds recommends rigorous implementation closely following the model as designed: It includes a script for those executing walkrounds to follow and provides several prescriptions for what walkrounds should and should not do (for example, all information discussed should remain confidential; walkrounds should be conducted at least once a week for a whole year; the focus should be on systems, not individuals).[9] The only issue left to local judgment is whether walkrounds should be announced or unannounced.[9]

Despite their increasing popularity, consistent evidence of the effectiveness of walkrounds is elusive.[13,19–21] Some recent work has begun to challenge the claimed benefits of walkrounds, suggesting that in practice they may have perverse, unintended effects. For example, instead of promoting frontline staff empowerment and flattening the organizational

hierarchy, walkrounds may, it has been suggested, reinforce existing power differentials. [1,14,15,19] The potential of walkrounds to act as an eye-opener and a source of unique insight into clinical areas[11,14] for hospital executives may be undermined by their own failure to act on the problems that they find[20] or by the tendency of staff to "be on their best behavior."[15] The walkround may thus transform into a public relations exercise that overshadows other functions.[21,22] As a consequence, some frontline staff have described walkrounds as disruptive "seagull management," in which managers "fly in, make a lot of noise, dump on everyone, then fly out."[14(p. 38)]

One possibility is that the unintended effects arise because the model is modified as it is implemented. Organizational theory and evaluation science have both shown that programs involving a social or behavioral component have an irreducible tendency to adapt and mutate.[23,24] Although problems in ensuring "fidelity" to the espoused model of walkrounds have been reported,[7] less clear is what particular forms the departures and distortions might take and why they might emerge. Using interview accounts from senior executives and local administrators in areas hosting walkrounds, we aimed to explore the ways that walkrounds have been practiced, in an attempt to generate hypotheses about the consequences of implementation for the ability of walkrounds to achieve their intended outcomes. Our setting is the English National Health Service (NHS), where hospitals have been strongly encouraged to make use of methods closely based on the espoused model.[11,25]

Methods

Data Sources

The data drawn on in this article come from interviews conducted between 2010 and 2011 for two substudies that were part of a larger noninterventional research project exploring culture and behavior relating to quality and safety in the English NHS.[26]

First Dataset—The first dataset consisted of 107 semistructured telephone interviews with a large sample of stakeholders involved in quality and safety in the NHS—mostly, senior administrators and clinicians, as well as persons involved in health care policy and purchasing. Participants were identified via publicly available information (for example, website information about members of hospital boards*) and then through snowball sampling.[27] These interviews focused on, among other things, how participants identified issues relating to quality and safety in their organizations, how they sought to promote a positive safety culture, and what specific tools they used in pursuit of this. In line with inductive, hypothesis-generating qualitative methodology,[27] our topic guide for these interviews was general and open-ended and did not at first include specific questions about walkrounds. In early interviews, several participants alluded to the importance of walkrounds in their organizations' approaches to improving quality and safety, usually when asked about how they sought to find out about quality of care on the front line. Following discussions about emergent themes that seemed prominent in early interviews, but before

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*In the United Kingdom, hospital boards are small groups consisting of executive directors (CEO, director of finance, medical director, director of nursing; and sometimes other roles, such as deputy CEO, director of human resources, and director of informatics) and nonexecutive directors (chair and others), whose role is to hold executives to account.

formal data coding and analysis, we decided to adapt our topic guide in subsequent interviews, and address walkrounds explicitly, asking whether these were part of participants' strategies for gathering intelligence about quality and safety, and instigating change. Of 107 interviews conducted in total, 50 included discussion of walkrounds and were admitted to our analysis.

Second Dataset—The second dataset consisted of 32 semistructured individual face-to-face interviews with clinicians and administrators in three NHS hospitals where we were conducting ethnographic case studies as part of the same study.[26] These hospitals were sampled for their proactive approaches to quality and safety improvement, as assessed through publicly available information (for example, reports published by the UK's principal regulator of quality and safety, the Care Quality Commission) and through the knowledge of personal contacts. Because these case studies were undertaken after the senior stakeholder interviews, participants in these organizations were also explicitly asked about walkrounds in the course of the interviews. The participants consisted of senior executives (board-level executives and senior administrators not on the board), as well as local administrators and clinicians in wards and other areas that hosted walkrounds.

Participant Sampling and Interviews—Our 82 interview participants (Table 1, above) were not selected with a view to comparative analysis between different hospitals or modes of walkround implementation; they might best be characterized as a convenience sample that enabled access to multiple levels of strategic and operational implementation of walkrounds. As already stated, the focus on walkrounds in interviews was emergent rather than a priori, so that it was therefore participants' accounts of the design and execution of walkrounds and their effects on safety culture[5,7,9] that engaged our analytic attention. Our data therefore do not offer an adequate basis for summative evaluation, but we sought to identify possible consequences of the interviewees' divergent walkround approaches, particularly in terms of the nature of the information shared and its effect on the organization's safety culture.

Data Analysis

Data analysis, which followed completion of data collection in both substudies, used an inductive approach, drawing on "sensitizing concepts" (ideas that inform analytical direction) from the literature on walkrounds as summarized earlier.[28] An initial reading of the interview dataset led to the construction of a set of open codes—codes derived inductively from the data themselves rather than informed by the prior literature—that would capture the ways in which walkrounds were operationalized and identify the mechanisms of change that the participants themselves put forward. These codes were subsequently supplemented by a number of extra codes to capture more detailed aspects of these mechanisms and relationships between them and potential unintended consequences. For example, this response from an interview in the first dataset—"'this is your chance now to talk to patients and visitors,' and find out just the real hot feedback about what their experience is in terms of quality and safety"—was initially open-coded as "patients' views," "experience," and "frontline knowledge." The supplementary code "monitoring" was later added, because, in the context of the entire interview and datasets, walkrounds could be

understood as a means of providing additional information not available through the espoused walkrounds model.

The coding framework was further refined through discussion and rereading of coded excerpts both in the context of the original transcripts and as coded groups, leading to the development of the themes discussed in the Findings section below.

Findings

Participants reported widespread use of multiple approaches to implementing the espoused model, representing a range of alterations—with divergent and at times potentially adverse consequences for the potential of walkrounds to achieve their objectives. We now discuss these approaches and their consequences under three thematic headings, which cover (1) the various ways that walkrounds were implemented, (2) some of the apparently malign consequences that could then follow, and finally, (3) how some forms of deviation from the espoused model could enhance rather than detract from the walkrounds ethos.

1 Implementing Walkarounds

Participants with managerial responsibilities emphasized, without researcher prompting, the value of executive visits to clinical areas. They perceived that walkrounds offered an unparalleled means of allowing executives to hear about challenges that frontline staff experienced in delivering safe, high-quality care, and to signal senior leaders' commitments. The visits were seen to enable insights and awareness that were not available from standard metrics or were prone to lose their meaning or importance when channelled through the managerial hierarchy. Participants explained how the intelligence gathered through walkrounds could hasten action for "fast-track" important issues, escalating knowledge of risks quickly and "unsticking"' problems that had been in middle managers' in-trays for months, as in the following interview excerpts:

> We have a process of executive safety walkarounds. So once a week—and we have got a rota—once a week an executive will walk to a clinical area, the area will know you are coming and they have some information that says you are coming, this is what you are coming for, so gather as many people as they can together. And it is staff from all walks, it could be the ward clerk if she is available, a nurse or a junior doctor or a physio [therapist] who works on the ward, and we will be coming just to talk to you about what are the things that concern you about patient safety in your area. —Senior administrator, first dataset

> I will ask them what help we can provide to help their results, ask what support they need. If they are having trouble making something happen—not trying to bypass the management line structure but try and support moving it on quicker or unlocking things. But they are very used now to us coming on the ward, so it is not seen as you only see someone when it is bad. It is not like that at all. —Board-level executive, first dataset

Participants' accounts of walkrounds suggested, however, that several variants of the walkround were in use. Some closely resembled the espoused model, including the use of executive prompts, and clear, structured objectives:

> We do have some prompts, but really it's an opportunity for staff to share with us any concerns they might have, as well as areas of good practice. We then feed that back through [colleague]'s office and there's a pro forma that gets circulated. So what we would do there is, if we hear of a problem that's not been resolved, we'd escalate that and try and get that resolved for the individual. —Senior administrator, second dataset

Other approaches described by participants, however, seemed to deviate markedly from the espoused approach, mutating to accomplish a variety of aims. In part, this reflected the differing interests of different executives:

> Our medical director has quite a different view on his area than, say, does our finance director. Because of course they would, the finance director isn't a doctor. And it's quite interesting just to see the different questions they ask, the different things they focus on. I've done one with our HR [human resources] director, and she was asking staff if they knew about safety policies and if they knew how to raise concerns and things like that. —Administrator in nonclinical function, second dataset

Sometimes, though, a rather different set of concerns seemed to permeate the approaches taken to walkrounds, most notably the need to comply with regulatory expectations. Accordingly, while still focused on patient safety, sometimes walkrounds as implemented could change significantly in character—such that they started to resemble opportunities for surveillance and audit rather than opportunities for engagement:

> Our chairman as well goes round, he loves to take himself on walkrounds, and that is all included in our process for monitoring our continuous compliance to the Care Quality Commission's [England's statutory regulator for health care quality] essential standards that we have. —Board-level executive, first dataset

There was a sense, then, that walkrounds were not always implemented by the book but rather could become an intervention for all seasons—either seeking to accomplish more than just focused engagement on patient safety or significantly altering the nature of the encounter between executives and front line.

2   Pragmatic Adaptations—Or Distorting Deviations?

Most frequently, the alterations described by participants involved supplementing the espoused model of walkrounds as an "informal method for leaders to talk with front-line staff"9 with additional approaches to gaining intelligence about the state of care onward. Although the conversations with frontline staff prescribed by the espoused model were acknowledged as very valuable, some participants emphasized the added value of direct observations of the care environment and "chats" with a wider range of stakeholders such as patients and caregivers in obtaining a more holistic and realistic sense of the issues of quality and safety in play:

> Originally they went in and they spoke to staff and they were looking at the environment, they are talking with staff and everything, but I said, "We need to be talking to the patients, this is your chance now to talk to patients and visitors," and find out just the real hot feedback about what their experience is in terms of quality and safety. —Board-level executive, first dataset

> I can walk onto a ward and have a quick flick through the documentation. Have a look at what's at the bottom of the bed. Have a look at the way the ward is run. You know, you just get a feeling I think of how a ward or how a clinical area is being run and whether or not it's got an acute safety focus. By being there … when I've tried to implement safety walkarounds in other organizations, I've always kind of advocated that you would know everything that is moaned or spoken about. Because, you know, until you've got a collection of what all of the problems are, big or small, only then can you really understand what your real issues are. —Nonhospital stakeholder, first dataset

Besides direct observation of frontline practice, some executives even went as far as explicitly "going behind the backs" of frontline staff, again, ostensibly to obtain a more accurate picture of the realities of care than they felt they could achieve through conversation alone:

> Leadership walks. So all the executives, and some others who aren't executives but are part of the executive team…basically go and do spot checks, but we go down onto a ward, we're told where we're going, but they don't know we're coming and we have a kind of a crib sheet and an action plan, but we basically go and have a look at the environment, talk to the ward manager, get them to show us around, then we ask her to leave us alone, we go and speak to patients on the ward about their experience down there, any concerns they may have. —Senior administrator, first dataset

Executives who practiced this kind of surveillance through their walkrounds found great value in the eyewitness knowledge they felt it provided. They believed that in adding observations to conversations, they were able to get closer to the "truth" of quality and safety in particular clinical areas than through application of the espoused model alone, particularly if they arrived unannounced:

> Announced walkrounds are a good function in a big organization because it is good for the senior people to be seen. Unannounced, they are more likely to find an unsanitized version. —Senior administrator, second dataset

> It's a really unedited account and it gives the board unedited access to staff on the ground, without a report. —Senior administrator, second dataset

From the point of view of frontline staff, however, walkrounds that involved surveillance as well as interaction represented quite a different proposition—and a very different experience from the espoused model's focus on open communication and a blame-free environment,9 as evident from the following interview excerpts:

Participant: We've very rarely had our Head of Nursing for Surgery and then just one executive in the quarter, so it is not a lot. It would be nice to see someone more regularly.

Interviewer: And do they have a set agenda when they come around?

Participant: I think they are supposed to but they don't. They kind of come and look at our Productive Ward Board, our Safety Crosses [visual representations of occurrences of adverse incidents], you know, check our cupboards. —Frontline administrator, first dataset

It's very similar to a corporate environment where the chief exec will just walk down the production line and sort of visually inspect, you know, unprompted, untimed, you know, random, just to assess just multiple aspects. The motivation, the workforce, the morale, the kit, the equipment, the cleanliness. Talk to patients, find out what their views are…. They're perceived by most staff as "Oh no, what's going on here?" It's more of a negative rather than a productive element. It's more of a "Big Brother is watching over me, I'd better start," but I think that is the culture that we work in. I don't think people would be expecting a pat on the back and a thanks. They'd be expecting a rollicking for something.—Frontline clinician, second dataset

In contrast, where walkrounds were focused on conversations about safety—without the specter of Big Brother—they were received much more positively by frontline staff:

You always knew that [the CEO] was coming around, and he was very approachable, and he would kind of say, you know, "What's going on? Anything I ought to know about?" and people did tell him stuff, and he was very approachable and normal, and you know, some chief executives just sit in their office and you never see them, you wouldn't even know what they looked like, would you.— Frontline administrator, first dataset

Such contrasting accounts suggest that as walkrounds shifted away from conversation and toward inspection, one of their most important objectives—at least as articulated by the espoused model—was at risk of compromise. If walkrounds were intended to offer a vehicle for "building a culture of safety,"[9] then the sense of subjection and distrust created by the use of walkrounds for surveillance was at best unhelpful, and at worst counterproductive.

But more than this, there were also indications that the sense of "unedited" or "unsanitized" insight that executives felt their adaptations offered was illusory. As some participants reflected, even unannounced walkrounds did not offer an unmediated window on the realities of the front line—but rather a very particular view that was inherently partial and incomplete and that could be further biased by the knowledge of frontline staff that they were being observed:

I know there's a big patient safety initiative, executives will do walkabouts, but there's walking about a ward and you see a few things, but they're not, you don't really hone down on it, and you don't really understand the culture, and the challenges, and I think until you do that you can't actually change anything and

sustain it. If you want to make a change in practice and sustain it, you've got to really understand that culture and produce something that's realistic rather than something that, you know, the staff will know from the beginning if it's unachievable and you'll never switch them onto it then. —Senior administrator, first dataset

Repurposing walkrounds, then, could undermine one of their most important objectives—the promotion of an open and trusting safety culture. But it could also offer executives misleading insights into issues of quality, safety, and professional behavior at the front line. In attempting to supplement the espoused model of walkrounds with something akin to observational audit, executives risked creating an intervention that was fit for neither purpose.

3   Enhancing Walkrounds

Not all alterations of the walkround approach gave rise to such unintended consequences. Also in evidence in our data were adaptations that seemed to remain true to the spirit of walkrounds, while seeming to offer opportunities to generate a more trusting culture, even where one had not existed before.

If acts of surveillance could modify the behavior of frontline staff and result in an unrealistic picture for executives, then the same was also true of the conversations advocated by the espoused model. Particularly in cultures that were characterized by suspicion or distrust, frontline staff could be guarded in discussions with executives, or local managers might feel compelled to proffer those colleagues likely to give the "right" responses:

> It's only the nominated people that actually attend and obviously, for want of a better word, they are hand-selected, really, aren't they? There could be a tendency for managers to pick the people who will not challenge and you know, who will sort of say the agreeable things. —Administrator in nonclinical function, first dataset

There was a risk, then, that even implementing walkrounds as espoused could generate not honest, critical, and constructive insights but rather superficial and glossy accounts, as in the preceding interview excerpt, or unduly negative or hostile interactions:

> Some senior staff who do the walkabouts will ask somebody a question and because you might have gone onto the ward on a bad day, you've met a member of staff who is having a bad day…. If you just speak to one person who might be very negative and very critical and you know of course they can give a very false picture, but they can also give a very open and honest picture, and sometimes somebody like the chairman or a non-executive director actually won't know the difference between if somebody is having them on, or they are telling them a really valid piece of information. It is very difficult really but that is the purpose of the executive visits. —Senior administrator, second dataset

To this extent, neither observation nor conversation could be relied on to provide a realistic and balanced picture of frontline realities. Both constituted very particular, constructed encounters between ward and board. However, this did not mean that walkround

conversations were without value. On the contrary, the most promising approach to walkrounds—in terms of both gleaning information on patient safety and inculcating a more open safety culture—seemed to be one that *embraced* the rarefied nature of the walkround, with executives working actively to ensure that all parties were aware of the purpose of the conversation, what was to be covered, and the "terms of engagement" governing the encounter. Particularly in organizations where openness between executives and front line was not the norm, this meant making it clear that walkrounds were about learning, not about censure—and sometimes, this required going beyond the specific set of questions suggested in the espoused model:

> Our walkabouts aren't very rigid—they just encourage discussion. And it's really to encourage people to be as open and honest as possible. And specifically I can remember an example of a particular ward having problems with the concept of intentional rounding. And they didn't agree with it at all, yet the rest of the hospital were having huge success with intentional rounding, so following that we knew that we had to provide some kind of guidance to the ward sister [ward manager] what it was for her to help her lead her team. —Senior administrator, first dataset

> We have got a bit of a philosophy, that we call "putting the shirt on," because we have got a uniform of the executive team that we have got, we have a short-sleeved blue shirt with our names stitched on and the hospital balloon and all the rest of it and we call them our "out-and-about shirts." And we put those on for visibility really, I mean I think it helps in quite a few ways because people can identify you when you are out and about, if they don't know who you are, but also we feel, certainly when I am wearing mine, I feel that people approach you in a slightly different way. —Board-level executive, first dataset

Surveillance-oriented walkrounds were inherently premised on a relationship of distrust that put executives in the role of checking up on frontline staff—and correspondingly, enjoined frontline staff to hide, to cover up, or to present false assurances. Walkrounds based on conversations, by contrast, sought to foster a relationship of trust in which executives and frontline staff could have frank conversations with one another—but sometimes this required going beyond the walkround script and going to greater lengths to emphasize the "privileged" nature of the conversations, and the terms of engagement that governed them. Both approaches could give rise to concealment, but where an approach based on surveillance made concealment the natural choice, carefully framed conversations at least held the possibility of developing a more mature relationship between ward and board. In organizations with a prevailing negative culture and little previous contact between executive and front line, this could be a lengthy process:

> When I started doing that, I think there was suspicion, "What is she doing here?"—you only really saw the boss if you were in trouble. That has changed now…. There is no set time or day because I think you want to see it for what it is, good and bad, busy and quiet, when pressure is on, when pressure is off. So I think it is very easy to have a conversation with the ward staff. They know you so they are very good at letting you know things. I think they are very much more relaxed in telling you where they have concerns. —Board-level executive, second dataset

Nevertheless, through time, openness about the purpose of walkrounds, and good faith in the use of the delicate knowledge they could produce, could, it seemed, slowly create a virtuous circle.

Discussion

Walkrounds are an established practice in many English NHS hospitals, valued for how they display executive commitment to quality and safety, provide unique and holistic insight into clinical areas, and offer possibilities for speedy resolution of identified problems. However, it is evident from our data that there is much divergence in the way that walkrounds are put into practice. What we have characterized as surveillance-oriented walkrounds differ substantially from the espoused model. Although they may retain some of the core features such as safety-focused conversations with frontline staff, they are supplemented by extra forms of intelligence-gathering, such as observation of practice. Crucially, these modifications may, by making staff feel monitored and sanctioned, undermine one of the most important objectives of walkrounds: that of creating a culture of safety.[9] Walkrounds became about "checking up on, rather than listening to, staff."[29] (p. 535) Moreover, these surveillance-based walkrounds may be thwarted in gaining the authentic insights into frontline realities they seek: By reproducing an atmosphere of distrust, they risk making concealment the natural choice for frontline staff. Surveillance-based walkrounds, our analysis suggests, may be self-defeating. But the espoused model itself is no panacea; no matter how faithfully deployed, it too is limited in what it can achieve.

It is crucial that executives recognize walkrounds for what they are—a constructed, imperfect, and partial account of the challenges of quality and safety and the chance to demonstrate commitment to learning and improvement rather than a magical window on the ward that reveals what is hidden by other methods. Executives must ensure that frontline staff also understand walkrounds as a means of sharing specific knowledge rather than a soul-baring confessional box that encourages evasion or dishonesty. Such a protected, knowledge-sharing space may be a taken-for-granted feature of a positive safety culture, but rendering a space of this kind in a culture that is characterized by distrust, managerial scrutiny, and blame will be challenging. Rotteau, Shojania, and Webster, in a recent study of senior leaders' and frontline staffs' responses regarding walkrounds at two major teaching hospitals in Toronto, show that executives are not always good at creating the right atmosphere or using the knowledge offered by walkrounds to appropriate use.[21] Good intentions must be borne out by good faith in the way that executives use the intelligence produced by walkrounds; through time, walkrounds may be a useful vehicle for creating a more mature and open relationship between ward and board, although on their own— without wider efforts to create an open culture—it seems implausible that they could be sustained as islands of honesty in an ocean of distrust.

Our analysis suggests above all that care must be taken in the way in which walkrounds are executed. Interviewees indicated that the temptation to expand the remit of walkrounds is great. We argue that walkrounds should be clearly distinguished from interventions such as observational audits if their potential to broach frank discussions of delicate issues is to be retained. The social scientific literature argues that adaptation is an inevitable feature of any

implementation of complex social interventions such as walkrounds,23,30 and, certainly, unwavering adherence to the letter of the espoused walkrounds model is not required to remain faithful to their spirit. But care is needed to ensure that incremental shifts in the way they are enacted do not accumulate to create an intervention that is quite contrary to their espoused objectives. By identifying the effects of different degrees and kinds of adaptation, our study helps to plot the range of deviation from the walkrounds prototype that constitute appropriate adaptation and those that risk undermining the intervention. A crucial task in deciding on how to adapt a complex, social intervention such as walkrounds is the question of what will work in "my setting," given the contextual constraints and opportunities.23,31 With each adaptation, executives should ask themselves whether what they are doing fosters trust or reinforces suspicion, and whether in trying to maximize their sources of knowledge about life on the front line, they are stretching walkrounds so far that they risk breaking. In particular, executives might ask themselves whether announced or unannounced walkrounds are most likely to reinforce their objectives. Although this choice is left open to administrators in IHI's walkrounds protocol, our analysis suggests that unannounced walkrounds were often used by executives seeking to catch frontline staff off their guard. Certainly, if unannounced walkrounds are combined with surveillance-based approaches, there is a strong risk of debasing the learning- and culture-enhancing ethic of the intervention.

Our study has several limitations. The data were derived from two interview-based datasets, whose original focus was neither walkrounds nor their implementation. Although an iterative approach and an emergent research question are both accepted and recommended features of qualitative methodology, different findings might have emerged from a study that set out to focus on walkrounds from the start. Our qualitative methodology necessarily precludes any direct associational analysis of the relationship between approach to walkround and outcome in terms of knowledge produced or impact on organizational culture, but this should be a focus of future research. Supplementing our interviews with ethnography would also have provided further insight, particularly in terms of the consequences of respective walkround approaches for shared knowledge, relationships, and culture, and might have validated or challenged some of our more tentative findings and interpretations.

Nevertheless, these interviews offer important insights into a widespread practice. Our study hints at explanations for the rather mixed evidence base on the effectiveness of walkrounds in achieving their intended outcomes.13,19,21 Our propositions regarding the optimal approach to implementing walkrounds, which can be tested through correlational analyses, in the meantime offer important pointers for executives who wish to make optimal use of walkrounds to improve safety and culture. Above all, care must be taken in the way in which walkrounds are executed; any modifications must remain true to the principles or risk subverting the very purpose of the technique.

Acknowledgments

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Table I

Participants by Role and Substudy

	First Dataset	Second Dataset			Total
		Hospital 1	Hospital 2	Hospital 3	
Title (examples)					
Board-level executive (CEO, medical director, board chair)	10	2	1	3	16
Senior administrator not on the board (associate director, head of quality)	20	0	6	2	28
Administrator in nonclinical function (risk manager, clinical governance officer)	7	0	0	3	10
Frontline administrator or clinician (ward manager, nurse, technician)	6	6	3	6	21
Nonhospital stakeholder (purchaser, policy maker)	7	0	0	0	7
Total	50	8	10	14	82