A realist informed mixed methods evaluation of Schwartz Center Rounds® in England

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Declared competing interests of authors

Professor Jill Maben, reports being a member of an advisory group 2006-2009 advising development of The Point of Care project at The King's Fund, and being a member of the Point of Care Foundation Board 2013-2014; stepping down as board member at the start of the evaluation. Professor Jeremy Dawson reports that he is a Board member of the NIHR Health Service & Delivery Research programme. Shilpa Ross, Laura Bennett report they are currently employed by The King's Fund and Catherine Foot reports she was previously employed by The King's Fund. The Point of Care Foundation, which supports the implementation of Schwartz Center Rounds® in the United Kingdom, was set up in 2013 by colleagues who were previously also employed by The King's Fund 2007-2013.

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Scientific summary

Background

Schwartz Center Rounds® (Rounds), introduced to the UK in 2009, are now run in over 150 healthcare organisations. These organisation-wide forums, which are open to all staff (clinical and non-clinical) to discuss emotional, social or ethical challenges, through staff sharing their experiences of caring for patients and families in a safe environment, are intended to help improve staff wellbeing, effectiveness of communication and engagement, and ultimately patient care. Evaluations of Rounds are sparse, though evidence from the USA and UK suggests that attending Rounds is associated with improved wellbeing and relationships with colleagues, and more empathic and compassionate patient care.

Study aims

Examine how, in which contexts and for whom, participation in Rounds affects staff wellbeing at work, social support for staff and improved relationships between staff and patients including compassion. Specifically:

- Scope the literature and map UK Rounds providers including the resource implications.
- Evaluate whether attendance at Rounds impacts on healthcare staff work engagement, and other outcomes.
- Determine staff experiences associated with Rounds.
- Establish contexts within which and mechanisms whereby Rounds influence staff wellbeing and social support.
- Evaluate any changes in relationships between staff who attend Rounds and their patients and colleagues in relation to the quality of patient care and staff experience.
- Identify any wider changes in teams/across the organisation.

Overview of methods

A mixed methods evaluation of Rounds, with contributions from our patient advisors, and informed by realist evaluation was undertaken in 2015 and 2016 in sequential integrated phases:

Phase 1: Scoping review and national mapping study

Literature was reviewed to identify mechanisms by which Rounds work and alternatives e.g action learning sets and the evidence. Profiles of Rounds providers in England were mapped, including reasons for adoption and how Rounds had been implemented including costs.

Providers in England that had adopted Rounds at the start of our evaluation (1/9/2014, n=77) were invited to participate in an online survey and interview.

Secondary data (type, size, location and quality of care indicators) were collated for providers with Rounds in England by 15 July 2015 (n=115).

Quantitative survey data were analysed descriptively, including comparing by type (NHS Trust versus Hospice) and size of provider. Secondary data were analysed using inferential statistics to explore the association between provider characteristics and timing of adoption (e.g. early versus late adopters). Qualitative data were analysed thematically using the Framework method.

Phase 2: Survey and organisational case studies

Thirteen providers were purposively sampled from Phase 1 data; ten sites for the survey, and nine for organisational case studies. Six sites participated in both.

Following a pilot study in two sites, a survey (baseline and eight-month follow-up) of staff new to Rounds ((attenders) (n=256) and non-attenders (controls) (n=233)) in ten sites (acute/mental health/community Trusts and hospices) to determine if Rounds have an impact on work engagement and wellbeing. New attenders were recruited at Rounds and non-attenders via an online survey to a random sample. The questionnaire included measures of work engagement, psychological wellbeing, self-reflection, empathy, compassion, peer support and organisational climate for support, and questions about

absenteeism and views on Rounds. The primary analysis compared regular attenders to non-attenders; supplementary analysis examined the effects of attending different numbers of Rounds.

Organisational case studies in nine sites (acute/mental health/community Trusts and hospices: six were also survey sites) to understand (i) the mechanisms by which Rounds 'work' and result in outcomes and ripple effects regarding staff wellbeing and social support and outcomes for patients; and (ii) staff experiences of attending, presenting at and facilitating Rounds. The nine sites were purposively sampled to provide maximum variation (such as size of institution, established and new Rounds and early and late adopters).

We undertook observations of Rounds (n=42), panel preparation (n=29) and steering group meetings (n=28) and interviews with clinical leads, facilitators, panellists, and members of steering groups, audiences, organisation Boards and non-attenders (n=177). Data were managed using NVivo, and analysed thematically to identify staff experiences and contextual variation. Data were also analysed concurrently, using realist evaluation, to identify causal explanations for how Rounds work (Context-Mechanism-Outcome (CMO) configurations) which were tested in subsequent interviews and focus groups (n=2) with Rounds mentors and key Point of Care Foundation (PoCF) stakeholders.

Results

Phase 1: Scoping review and national mapping study

- **Scoping review**

The overall evidence base for Rounds is limited. We developed a composite definition to aid comparison with alternative interventions from 41 documents containing a definition of Rounds. Ten (eight studies) were empirical evaluations. All were of low/moderate quality (weak study designs including lack of control groups). Findings showed the value of Rounds to attenders, with a self-reported positive impact on individuals, their relationships with colleagues and patients, and wider cultural changes.

We proposed key mechanisms by which Rounds may work including reflection, group work, disclosure and safe environment, and reviewed the theories regarding each of these to help determine how they could help explain how Rounds "work".

Two researchers visited the Schwartz Center for Compassionate Care® to interview the programme architects and observe Rounds in Boston, USA. From this we identified seven guiding principles underlying Rounds, which contributed to the development of the initial programme theory of how Rounds work.

We compared Rounds to 11 alternative interventions, which share some of the same features of Rounds, and found the evidence for these is scant and low/moderate quality. Rounds offer unique features that none of the alternatives provide.

- **National mapping study**

The response rate to the survey was 41/76 (54%) and 48 interviews were conducted across 45/76 (59%) providers. Of the 115 providers running Rounds by 15.7.2015, over half (n=71, 62%) were based in the south of England, with over a quarter of all in London (n=32, 28%).

Most providers were NHS Trusts (n=86, 75%), with 22% (n=25) hospices, a prison, a university medical school, a private hospital and an ambulance Trust. Nearly half of all acute Trusts in England adopted Rounds by July 2015 (68/155, 44%) compared to 26% of mental health/learning disability Trusts (15/57), 18% of community Trusts (3/17), and 13% (25/197) hospices.

Explanations for adopting Rounds often referred to the need to focus on staff wellbeing. Using the Diffusion of Innovations theory, we suggest that Rounds provided many favourable conditions for adoption and cited the Francis Report, the dissemination activities of the PoCF and the availability of funding from recognised national charities as influences on adoption of Rounds.

Implementation increased rapidly from 2013 to 2015 and slowed during 2016. There was variability in how Rounds were implemented and challenges to implementation and

sustainability included attendance (particularly widening accessibility to ward staff, those with less autonomy), and the workload and resources required for planning and running Rounds. Costs (both staff and non-staff) were widely variable between and within types of providers: time spent by administrators, facilitators and clinical leads (combined) ranged from seven to 82 hours a month (mean 28hrs) with costs from £380 to £4477.50/month.

Phase 2: Survey and organisational case studies

- **Survey**

Including respondents from our pilot study, there were 1140/3815 (30%) responses at baseline and 500/1140 (44%) at follow up; 233 (47%) were at Bands 5-7. Of the 500 responses at both time points, 51 were regular attenders; 205 irregular attenders and 233 non-attenders (11 could not be categorised); 140/256 (regular/irregular attenders) had attended at least two Rounds; 77 had attended at least three, and 40 at least four Rounds.

The primary hypothesis - that work engagement would be positively associated with attendance at Rounds - was not supported. However, there is good evidence to suggest that there could be a significant reduction in poor psychological wellbeing as a result of attending Rounds. We found that psychological wellbeing scores (measured by the clinically validated GHQ-12) reduced significantly more in regular Rounds attenders (13% decrease compared with 3% in non-attenders, $p<0.05$), with the incidence of 'caseness' (GHQ scores >3) amongst regular attenders of Rounds dropping from 25% to 12%, compared with a reduction from 37% to 34% amongst non-attenders. There were no significant effects for the other secondary outcomes.

Case studies:

Staff experiences: Participants described Rounds as interesting, engaging and a source of support, and valued the opportunity to reflect and process work challenges. Many appreciated the opportunity to learn more about their colleagues, understand their perspectives and motivations and engage in multidisciplinary interaction. This led to feelings of greater understanding, empathy and tolerance towards colleagues and patients. A few described feelings of negativity associated with Rounds, including questioning the purpose

of unearthing feelings of sadness, anger and frustration. Enablers (e.g. convenient location and freedom over schedule) and barriers to attendance (e.g. conflict with other clinical priorities or no one to cover work) were identified.

Panellists were motivated to present for a variety of reasons including: contributing to professional development, seeking closure on a difficult situation, increasing visibility and helping others learn from their experiences. Panel preparation was important in shaping the stories and in preparing panellists for the Round itself, and helping panellists feel 'safe' to tell their story. Most panellists spoke positively about the experience, with the facilitator's role important in providing support and ensuring the experience felt safe.

Facilitators were often important Rounds champions, motivating others to be involved and helping bring Rounds to their organisation. Initially facilitators experienced Rounds facilitation as a great responsibility; confidence increased with experience. Many aspects of facilitation paralleled group facilitation in general, differences included the need to move beyond factual clinical details about a patient and encourage emotional disclosure, with staff telling stories about *their experiences* of care provision. Reasons given for becoming a Rounds facilitator included alignment with a person's professional values; activation of positive feelings; professional development; and expansion of one's professional network. Challenges included having adequate time to undertake the role as they would wish, and pressure to make Rounds a success, often with minimal resources.

Clinical leads were important to champion Rounds, particularly with doctors; their involvement varied between sites. Most Board member interviewees spoke positively of Rounds. Sufficient administrative support and an active steering group were key to supporting and sustaining Rounds, but this varied between sites. Steering groups supported by sourcing stories and panellists, debriefing and evaluating and promoting Rounds.

Context: There were multiple, inter-connected contextual layers which impact upon and explain variation in Rounds implementation. In realist evaluation terminology, these contextual factors operated together to 'fire' or 'switch on' underlying 'mechanisms of action'. Four layers of context were explored (i) individual capabilities and characteristics of key

actors (e.g. facilitators); (ii) interpersonal relationships, such as behind the scenes support given by core team and steering group; (iii) the organisational setting (such as organisational characteristics; time running Rounds; audience e.g. size, composition, diversity and Rounds characteristics e.g. such as theme or case based); and (iv) the intra-structural setting (such as demands on staff in healthcare organisations and policy context for Rounds). There was a cumulative impact of different stages of Rounds on the next, and we identified four-stages of Rounds:

1. sourcing stories and panelists
2. preparing these stories
3. telling these stories in the Round and
4. post-round after-effects.

Over time, stage four of one Round/series of Rounds, impacts upon the early stages of the next Round/Rounds. When comparing new and more established sites we saw the importance of this cumulative impact, for example through what we termed 'audience Schwartz savviness' (really understanding the purpose of Rounds/knowing how to contribute appropriately), as well as audience trust and confidence, and facilitator confidence.

We examined fidelity to the Schwartz Rounds model, identifying which components were 'core' and which were 'adaptable'. Core components include leadership, facilitation, group setting and the availability of food. Adaptable components include number of panellists, scale, regularity and the type of Round.

Realist evaluation: focuses on identifying causal mechanisms that explain how an intervention such as Rounds works, for whom and under what conditions with the aim of understanding the complex relationship between these mechanisms and the effect that context has on their operationalisation and outcome. This is summed up as a Context + Mechanism = Outcome (CMO) configuration.

We identified nine cross-cutting themes represented as CMO configurations, namely: trust, emotional safety and containment; group interaction (identified as two important pre-

requisites) for creating a counter-cultural space in which staff could tell stories; self-disclosing their experiences to peers; revealing and role-modelling their vulnerability; providing important context for patient, carer and staff behaviours; shining a spotlight on hidden organisational stories and roles; and providing an opportunity for reflection and resonance. Findings suggest Rounds impact develops over time and has a cumulative effect resulting in ripple effects and outcomes. Rounds offer an opportunity for organisations to have a community conversation and for staff to speak honestly and openly about their experiences of delivering healthcare. Reported outcomes include greater insights into the behaviour of colleagues and patients and carers; increased empathy and compassion for colleagues and patients; support for staff; reduced isolation; improved teamwork and communication; and reported changes in practice.

Discussion

Rounds offer an open staff forum to reflect on the emotional impact of providing patient care that no other alternatives provide. There was variability in how Rounds were implemented, and challenges included attendance (particularly ward staff, those with less autonomy), and the workload and resources required. Interviewees described Rounds as interesting, engaging and a source of support. This led to greater understanding, empathy and tolerance towards colleagues and patients. A few questioned the purpose of unearthing feelings of sadness, and frustration. Administrative support and an active steering group were key to sustaining Rounds

Mixed methods and integrated findings facilitated understanding of how Rounds work, with similarities and differences from qualitative and quantitative approaches. Both provided evidence that attendance/contributing to Rounds is associated with improved wellbeing. Behaviour changes towards patients and colleagues and changes in hospital culture were reported. Such outcomes included increased empathy, compassion, peer support, reflection, work engagement and communication with patients. Some ripple effects such as changes in protocols and conversations were also reported. Mixed methods provided richer insights and

a more comprehensive evaluation of Rounds contributing new knowledge to the evidence base.

Conclusions

This is the first realist-informed, mixed methods, large-scale evaluation of Rounds in the UK. Rounds have been shown to offer unique support compared to other interventions. Organisational level interventions for staff wellbeing are scarce, and Rounds uniquely straddle both individual and organisational levels.

Providing high quality healthcare has an emotional impact on staff, which often goes unnoticed. Rounds offer a safe, reflective space for staff to share stories with their peers about their work and its impact on them. Attendance is associated with a statistically significant improvement in staff psychological wellbeing. Reported outcomes included increased empathy and compassion for patients and colleagues and positive changes in practice.