

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

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Declared competing interests of authors: Jill Maben reports that she was a member of an advisory group from 2006 to 2009, advising on the development of the Point of Care project at The King's Fund, and a member of the Point of Care Foundation (PoCF) Board 2013–14; she stepped down as board member at the start of the evaluation. Jeremy Dawson reports that he is a board member of the National Institute for Health Research Health Services and Delivery Research programme. Shilpa Ross and Laura Bennett report that they are currently employed by The King's Fund, and Catherine Foot reports that she was previously employed by The King's Fund. The PoCF, which supports the implementation of Schwartz Center Rounds® in the UK, was set up in 2013 by colleagues who were previously also employed by The King's Fund between 2007 and 2013.

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Scientific summary

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Background

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

Study aims

To examine how, in which contexts and for whom participation in Rounds affects staff well-being at work, increases social support for staff and improves relationships between staff and patients, including compassion. Specifically:

- to scope the literature and map UK Rounds providers, including the resource implications
- to evaluate whether or not attendance at Rounds has an impact on health-care staff's work engagement, and other outcomes
- to determine staff experiences associated with Rounds
- to establish contexts in which, and mechanisms whereby, Rounds influence staff well-being and social support
- to 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
- to 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 as follows.

Phase 1: scoping review and national mapping study

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

Providers in England that had adopted Rounds at the start of our evaluation (1 September 2014; $n = 77$) were invited to participate in an online survey and an 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 vs. 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 vs. late adopters). Qualitative data were analysed thematically using the Framework analysis method.

Phase 2: survey and organisational case studies

Thirteen providers in total were purposively sampled from phase 1 data. Ten sites took part in the survey, and nine sites were used for organisational case studies. Six sites participated in both.

Following a pilot study in two sites, a survey (at baseline and 8-month follow-up) of staff new to Rounds [attenders, $n = 256$; non-attenders (controls), $n = 233$] in 10 sites (acute/mental health/community trusts and hospices) was conducted to determine if Rounds have an impact on work engagement and well-being. New attenders were recruited at Rounds and non-attenders were recruited via an online survey to a random sample. The questionnaire included measures of work engagement, psychological well-being, 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 with non-attenders; a supplementary analysis examined the effects of attending different numbers of Rounds.

Organisational case studies were undertaken in nine sites (acute/mental health/community trusts and hospices: six were also survey sites) to understand (1) the mechanisms by which Rounds 'work' and result in outcomes and ripple effects regarding staff well-being and social support and outcomes for patients; and (2) 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 ($n = 177$). The data were managed using NVivo (QSR International, Warrington, UK) and analysed thematically to allow us to identify staff experiences and contextual variation. The data were also analysed concurrently, using realist evaluation, to allow us 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 or moderate quality (weak study designs including a lack of control groups). The 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 Healthcare to interview the programme architects and observe Rounds in Boston, MA, 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 with 11 alternative interventions, which share some of the same features of Rounds, and found that the evidence for these is scant and of low or moderate quality. Rounds offer unique features that none of the alternatives provides.

National mapping study

The response rate to the survey was 41 out of 76 providers (54%), and 48 interviews were conducted across 45 out of the 76 (59%) providers. Of the 115 providers running Rounds by 15 July 2015, over half ($n = 71$, 62%) were based in the south of England, with over one-quarter of all of the providers located in London ($n = 32$, 28%).

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

Explanations for adopting Rounds often referred to the need to focus on staff well-being. Using the diffusion of innovations theory, the use of Rounds in England has, we suggest, been shaped by innate attributes; favourable circumstances and cumulative effects and providers 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.

The implementation of Rounds 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 7 to 82 hours per month (a mean of 28 hours), with costs ranging from £380 to £4477.50 per month.

Phase 2: survey and organisational case studies

Survey

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

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 well-being as a result of attending Rounds. We found that psychological well-being scores [measured by the clinically validated 12-item General Health Questionnaire (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-12 scores of > 3) among regular attenders of Rounds dropping from 25% to 12%, compared with a reduction from 37% to 34% among 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 of (e.g. convenient location and freedom over schedule) and barriers to (e.g. conflict with other clinical priorities or no one to cover work) attendance 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 that the experience felt safe.

Facilitators were often important Rounds champions, motivating others to be involved and helping to bring Rounds to their organisation. Initially, facilitators experienced Rounds facilitation as a great responsibility; confidence increased with experience. Many aspects of parallel-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 finding enough 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 Rounds by sourcing stories and panellists, debriefing, evaluating and promoting Rounds.

Context

There were multiple, interconnected contextual layers that had an impact on 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: (1) individual capabilities and characteristics of key actors (e.g. facilitators); (2) interpersonal relationships, such as behind-the-scenes support given by the core team and steering group; (3) the organisational setting [such as organisational characteristics, time spent running Rounds, audience (e.g. size, composition and diversity) and Rounds characteristics (e.g. such as theme or case based)]; and (4) the intrastructural setting (such as demands on staff in health-care organisations and the 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 panellists
2. preparing these stories
3. telling these stories in the Round
4. post-Round after-effects.

Over time, stage 4 of one Round or series of Rounds has an impact on 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

Realist evaluation focuses on identifying causal mechanisms that explain how an intervention such as Rounds works, and for whom and under what conditions it works, 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 (i.e. CMO) configuration.

We identified nine cross-cutting themes represented as CMO configurations, namely (1) trust, emotional safety and containment; (2) group interaction (identified as two important prerequisites) for creating (3) a countercultural space in which staff could (4) tell stories; (5) self-disclosing their experiences to peers; (6) revealing and role modelling their vulnerability; (7) providing an important context for patient, carer and staff behaviours; (8) shining a spotlight on hidden organisational stories and roles; and (9) providing an opportunity for reflection and resonance. The findings suggest that 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 health care. 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 forum for staff 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 for 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 at/contributing to Rounds is associated with improved well-being. 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 with other interventions. Organisation-level interventions for staff well-being are scarce, and Rounds uniquely straddle both individual and organisational levels.

Providing high-quality health care 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 well-being. Reported outcomes included increased empathy and compassion for patients and colleagues and positive changes in practice.

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