# Supplementary material 3: Evidence base (in healthcare professionals) for alternative interventions to Schwartz Rounds

**Adapted from Taylor et al (2018)[1]**

| **Intervention** | **Healthcare settings** | **Number/type of papers included** | **Intervention fidelity between studies** | **Key Findings to:<br>Self/ Others/ Organisation** | **Overall strength of the evidence base*** |
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| **Action Learning Sets** | Pre-registration nurses education; nurse practitioner and social work training; primary care (e.g. online networks for GPs); acute and mental health services; palliative and continuing care; care homes and prisons. | 14 papers:<br>- 6 quantitative<br>- 4 qualitative<br>- 4 mixed methods | Most hybrid interventions where ALS only one component. Group sizes between 4-8 members. Evaluation period 3months to a year, and 2- 6 sessions. | **Self**<br>*Empowerment:* foster greater psychological empowerment; sense of self-efficacy, self-esteem and confidence<br>*Awareness:* offer opportunity to explore self<br><br>**Others**<br>*Colleagues:* improved understanding and knowledge of colleagues; offers opportunity to share experiences and give/receive peer support<br><br>**Organisation**<br>*Workforce*: opportunities for mentoring and advice; satisfaction with the intervention being accessible and inclusive; possible limitations include having conflicting commitments and lack of group cohesiveness | Quantitative: Low due to lack of validated measures, and small sample sizes that were underpowered.<br><br>Qualitative: Moderate to high quality: some well-designed studies but others lacked detail on analytical strategy, limited transparency of findings (e.g. deviant cases not discussed, quotes not fitting themes and/or author interpretation)<br><br>Low for mixed method reporting based on GRAMMS criteria |

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| **After Action Reviews (AAR)** | Acute settings | 2 papers:<br><br>- 2 quantitative | Variability evident: 2 year evaluation of post-fall huddles vs. cross-sectional evaluation of one-off training in AAR | **Self**<br><br>*Empowerment:* improved confidence in dealing with difficult situations<br><br>**Others**<br><br>*Patients:* improved communication and listening skills<br><br>**Organisation**<br><br>*Practice:* reduced task and coordination errors; increased uptake of post-fall huddles; positive impact on patient care | Quantitative: Low to moderate – mostly non-experimental designs with convenience samples and non-validated (study-specific) outcome measures; poor survey response. |

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| **Balint groups** | Primary care, medical schools, acute settings | 26 papers:<br>- 12 quantitative<br>- 6 qualitative<br>- 8 mixed methods | Principles applied consistently but some variations or hybrid-models (e.g. Balint-inspired roundtable groups) | **Self**<br>*Awareness:* raised personal awareness in doctors; helped medical students build a professional identity as doctors<br>*Resilience:* reduced stress; helped doctors and students resolve challenging situations in practice<br>*Job satisfaction*: improved job satisfaction in doctors<br><br>**Others**<br>*Patients:* foster positive attitudes towards 'difficult' patients; improve students' ability to relate with patients; improve patient-centredness<br>*Colleagues:* promote teamwork<br><br>**Organisation**<br>*Practice:* reduced unnecessary prescriptions; increased uptake of psychosocial support; higher patient satisfaction | Quantitative: Low – mostly observational studies that lack randomisation, use non-validated measurement tools, and inadequately control confounding variables.<br><br>Qualitative: Moderate – mostly reflective case studies, with loose adherence to qualitative designs and limited description of approaches to rigour.<br><br>Low for mixed method reporting based on GRAMMS criteria |

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| **Caregiver Support Program** | Mental health /learning disability homes | 3 papers:<br><br>- 3 quantitative (all the same study) | No variability – has only been used and evaluated in one study. | **Self**<br><br>*Empowerment:* measured ability to cope with common work problems and ability to influence decision making (non-significant improvement);<br><br>*Wellbeing:* psychological wellbeing (non-significant improvement)<br><br>**Others**<br><br>*Colleagues:* greater supervisor support, less undermining, greater praise and feedback<br><br>**Organisation**<br><br>*Workforce:* No change in outcomes for managers (only direct-care staff); "train the trainers" element (to translate intervention to workplace) did not work | Quantitative: Moderate to low – the main limitations concern the sample (low response rates to surveys), method of analysis (did not use all the data, could have included people responding at only one time point) and measures (use of measures that were not well validated) |

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| **Clinical and Restorative Supervision** | Nursing education leadership, and nursing generally (including mental health, paediatrics, addiction, elderly and dementia care, oncology, hospice nursing), and in emergency departments. | 64 papers:<br><br>9 Secondary studies (literature reviews)<br>55 Primary studies:<br>- 22 quantitative<br><br>27 qualitative<br>- 6 mixed methods | Wide variability in every aspect.<br>Duration ranged from 1 mth to 5 yrs (median 12 mths).<br>Session length ranged from 1- 3hrs (median 1.5hrs), and frequency from weekly to monthly.<br>Most were group supervision, ranging from 2 to 12 supervisees.<br>Treatment fidelity was rarely referred to. | **Self**<br><br>*Awareness*: improved knowledge and insights, professional awareness and development<br><br>*Empowerment:* improved communication skills, job resources, professional efficacy and capacity for reflection<br><br>*Wellbeing*: reduced psychological distress; improved vitality; reduced stress; reduced burnout (lower emotional exhaustion and depersonalisation); improved sense of security, belonging and encouragement<br><br>*Resilience:* improved rational coping<br><br>*Job stress/satisfaction*: reduced job stress; improved job satisfaction<br><br>**Others**<br><br>Patients: better knowledge of patients' suffering and how to take responsibility; improved individualised documentation in patient notes;<br><br>Colleagues: foster solidarity, sharing and reflecting | Quantitative: Mostly Low/Moderate. Most are cross-sectional studies, with a few pre-post (mostly without control groups) and short-term follow-up. Only a few RCTs have been conducted and these are moderate-high quality. Inadequate sample sizes and unvalidated/ unreliable measures in most (mostly self-report of supervisor/supervisee rather than impact on patient/care).<br><br>Qualitative: Low/Moderate. Majority lack conceptual/theoretical bases; have inappropriate sampling and lack of transparency in methods/analysis.<br><br>Low for mixed method reporting based on GRAMMS criteria |

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| | | | | ***Organisation***<br>*Practice:* Reduced positive and total symptoms (in patients with psychosis) reported by student nurses<br>*Workforce:* staff retention<br><br>Continuity and quality of supervision are key moderators of outcomes. | |
| **Resilience Training** | Medical students, intensive care unit nurses, general medicine, emergency service personnel. | 6 papers:<br><br>- 6 quantitative (reporting on five studies) | Two studies (three papers) evaluated resilience training alone. The remainder combined resilience training with other interventions. Interventions varied from 10-12 weeks of regular training, to 40min one-off. | **Self**<br><br>*Wellbeing:* reduced depression, PTSD, stress and anxiety<br><br>*Resilience:* improved cognitive appraisal, control of stress; decreased negative emotion and expression inhibition | Quantitative: Moderate – mostly pilot studies to determine the feasibility, acceptability or prove the concept of the intervention. Limitations included only comparing within groups (despite having control group), ambiguous details regarding sampling and/or lacking control group. |

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| **Critical**<br><br>**Incidence Stress Debriefing** | Nurses in acute hospitals and care home workers. | 2 papers:<br><br>-2 quantitative | Fairly consistent approach to CISD following the Mitchell model (1983). Details of the content of the intervention lacking. Consistency in approach between group facilitators questionable. | **Self**<br><br>*Wellbeing:* no significant impact on stress reduction, but significantly lower PTSD scores; feeling part of a group and realising they were not alone<br><br>**Others**<br><br>*Colleagues:* opportunity for sharing experiences, and learning from others<br><br>**Organisation**<br><br>*Workforce:* potentially negative impacts included increased intrusive thoughts | Quantitative: Moderate – weaknesses or limited reporting of group allocation, sampling approach, consideration of confounding variables, and psychometric values of instruments used. |

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| **Peer-supported storytelling** | Paediatric nurses who had experienced grief | 1 paper:<br>- mixed methods | Only one study consisted of 3 self-selected dyads (6 nurses). Each dyad met biweekly for 2 months for brief informal storytelling sessions (each member taking a turn telling a story and listening at each session, mean length 17mins). | **Self**<br>*Wellbeing:* positive impact on grief<br>*Resilience:* positive impact on meaning-making, making sense of, and identifying benefit in, their experiences<br>**Others**<br>*Colleagues:* opportunity to receive and provide support during sessions<br>**Organisation**<br>*Workforce:* significant positive correlation between number of 'special' patient deaths during career and impact of sessions on grief | Quantitative: Low due to small (n=6), self-selected sample and no comparison group<br>Qualitative: Moderate due to descriptive approach to analysis, lacking in theoretical saturation<br>Low for mixed method reporting based on GRAMMS criteria |

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| **Reflective Practice Groups** | Clinical psychology, psychotherapy, nursing, medicine, midwifery and radiology. | 8 papers:<br><br>-3 quantitative<br><br>-3 qualitative<br><br>-2 mixed methods | All described as facilitated groups that explore practice related issues. Can last between 45-90 minutes; held weekly, fortnightly or monthly; group sizes varied from six to 20 attendees, with one or two facilitators. | **Self**<br><br>*Awareness:* improved self-awareness and clinical insight<br><br>*Empowerment:* increased confidence and capacity for reflection; better understanding of psychological ideas<br><br>*Wellbeing:* increased ability to cope with stress<br><br>**Others**<br><br>*Colleagues:* opportunity for peer support, sharing experience and learning; improved communication skills<br><br>*Patients:* positive impact on empathy<br><br>**Organisation**<br><br>*Practice:* perceived improvements in the quality of care provided | Quantitative: Low – mostly weakened by the absence of probability sampling, lack of validated tools, missing baseline measurements and inadequate control for confounding variables.<br><br>Qualitative: Low – mostly weakened by absence of an overall design and inadequate attention to data saturation, sampling and researcher reflexivity.<br><br>Low for mixed method reporting based on GRAMMS criteria |

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| **Psychosocial intervention training** | Mental health settings in the UK | 3 papers:<br><br>-3 quantitative | Consistent programme; delivered weekly over 4-5 months. Variable duration between 4 to 8 months. | **Self**<br><br>*Wellbeing:* improved burnout (emotional exhaustion, depersonalisation and personal achievement)<br><br>*Empowerment:* improved knowledge of, and attitude towards, mental illness and psychosocial approaches | Quantitative: Moderate –all 3 studies were quasi-experimental, utilising non-probability sampling, but lacking a power calculation and not clearly accounting for confounding variables. |

[1] Adapted from Taylor C, Xyrichis A, Leamy MC, Reynolds E, Maben J. Can Schwartz Centre Rounds support healthcare staff with emotional challenges at work, and how do they compare with other interventions aimed at providing similar support? A systematic review and scoping reviews. *BMJ Open* 2018;**8**:e024254. This is an open access article distributed in accordance with the Creative Commons Attribution 4.0 Unported (CC BY 4.0) license, which permits others to copy, redistribute, remix, transform and build upon this work for any purpose, provided the original work is properly cited, a link to the licence is given, and indication of whether changes were made.
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