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Can staff be supported to deliver compassionate care through implementing Schwartz Rounds in community and mental health services?

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Key words

Schwartz Rounds, compassion, mental health, staff support, culture

Abstract

Schwartz Rounds are evidence-based interdisciplinary discussions where healthcare staff can share experiences of the emotional and social aspects of care, to support improvements in patient care. Developed in acute services, they are now being implemented in various settings including UK community and mental health services where their implementation has not been researched. Realist evaluation was used to analyze three community and mental health case studies of Round implementation, involving Round observations (n=5), staff interviews (n=22), and post-Round evaluation sheets (n=206). Where Schwartz Rounds were successfully implemented and facilitated, the discussions enabled emotional resonance across interdisciplinary colleagues about caring experiences, enabling the recognition of a common humanity. Participants appreciated attending Rounds and saw they improved communications, trust and openness with colleagues and enabled more compassionate care with patients. The wide geographical dispersal of staff and work pressures were challenges in attending Rounds, and strong leadership is needed to support their implementation.

Key words

Schwartz Rounds, compassion, mental health, staff support, culture

Introduction

Concerns about compassion in healthcare are global (Lown, Rosen, & Marttila 2011; Mannion, 2014; Youngson, 2012). Compassion in care is an important element of health service quality, where patient experiences alongside clinical effectiveness and safety form the definition of quality within the National Health Service (NHS) (National Quality Board, 2013). In the UK since the Francis Inquiry (Francis, 2013) into failings of care at Mid Staffordshire NHS Trust, there has been a new emphasis on compassionate care, staff support and organizational culture. In the NHS, specifically within nursing, midwifery and care staff, the model of the six C's has been developed to encourage "Compassion in Practice" through a focus on care, compassion, competence, communication, courage, and commitment (NHS England, 2014).

Reports by Keogh (2013) and Berwick (2013) emphasize the need to engage and value staff, offering more support and an open, transparent culture. Good staff support and management are central to a positive and engaging culture, and directly related to patient experience and quality of care (Dixon-Woods et al., 2014). In health organizations where staff feel valued, engaged, respected and supported, it is understood that this will support more effective and compassionate care (Department of Health [DH], 2015). Organizational research on compassion illustrates how organizational contexts can shape thoughts, emotions and behaviors through their cultures (Rynes, Bartunek, Dutton, & Margolis, 2012). Health policy has recognized the importance of organizational culture and context in understanding how care and compassion can be supported, developing a "barometer" to measure cultures of care (Rafferty, Philippou, Fitzpatrick, & Ball, 2015). Leadership (NHS England, 2014a; West, Eckert, Steward, & Pasmore, 2014) is also key in facilitating compassionate care, with health services leaders

having a clear role in facilitating care cultures (Rafferty et al., 2015) through their abilities to reward particular practices and allocate resources, shaping organizational structures, systems and values (West et al., 2014).

Compassion can be understood as being open to others suffering, being moved by it and acting or feeling committed to relieve it (Strauss et al., 2016). It may also involve the toleration of difficult feelings that arise in seeing suffering and recognizing human commonalities (Strauss et al., 2016): “compassion is deeply rooted in the heart of what it means to be human” (Spandler & Stickley, 2011, p. 557). Compassion and care involve the recognition of others and a shared humanity (de Zulueta, 2013), and can be context-dependent and relational processes (Spandler & Stickley, 2011; Tronto, 1993). Care and compassion have distinct characteristics that limit how far they can be organized through rationalization, however health organizational systems that manage quality of care often use rational measures (Allen, 2015; Farr & Cressey, 2015). Instead of a focus on measures or procedures, the facilitation of compassion may be centered on “people, relationships and generating collective narratives” (Greenhalgh, 2013, p.481). Practices that enable people to connect with each other, their own humanity and core purpose may support greater compassion (NHS England, 2014a). Reflecting together may support learning and the processing of emotions (NHS England, 2014a); to maintain compassion, it is necessary to be skilled in reflection (Baverstock & Finlay, 2016). Yet healthcare cultures may downgrade reflective practice, in contrast to dominant scientific thinking and evidence-based practice which are given higher status (Mantzoukas & Jasper, 2004). More research is needed on what facilitates and inhibits compassion within the organizational contexts where individuals are embedded; how might organizations and processes promote compassionate care (Crawford, Gilbert, Gilbert, Gale, & Harvey, 2013)?

Schwartz Rounds are interdisciplinary reflective groups that encourage staff to share their own experiences and vulnerabilities, to support each other and enhance connections between patients and caregivers (Penson, Schapira, Mack, Stanzler, & Lynch, 2010). Developed by ‘The Schwartz Center for Compassionate Care’, they have been implemented across the US, Canada and the UK. In the UK with initial support from the Department of Health, Schwartz Rounds are supported by The Point of Care Foundation (POCF) under license from the US based Schwartz Center and are now running in over 150 organizations. Staff from all backgrounds (clinical and non-clinical) and from across the organization can attend Schwartz Rounds, offering them a regular time to discuss the social and emotional aspects of their work. The Rounds standard procedure starts with a mixed staff panel discussing a patient or a work related theme, to which all participants can then respond. Rounds use an evidence based model with trained facilitators moderating the group discussion. A steering group oversees the development and process of running Rounds. Originally Schwartz Rounds have been based largely in acute settings, with teams generally working from one or two geographical locations. Here impacts of Rounds include:

Staff reported feelings of empathy and compassion toward patients (Goodrich, 2012; Lown & Manning, 2010);

Improved teamwork (Goodrich, 2012; Lown & Manning, 2010) and insight into others (Chadwick, Muncer, Hannon, Goodrich, & Cornwell, 2016);

Staff feeling more supported and less isolated (Chadwick et al., 2016; Goodrich, 2012; Lown & Manning, 2010; Pepper, Jaggar, Mason, Finney, & Dusmet, 2012);

Building shared values of care and openness within the work environment (Goodrich, 2012) with a recognition of “common emotional ground” (Chadwick et al., 2016, p.6).

Reported impacts in hospices and palliative care are similar to those in acute settings (Moore & Phillips, 2009) providing a new space for interprofessional and organizational wide support (Reed, Cullen, Gannon, Knight, & Todd, 2015).

Schwartz Rounds are one of a number of different types of group support for healthcare practitioners. Schwartz Rounds open with short presentations from a multi-professional panel telling stories about one particular patient, or following a unifying theme, e.g. ‘the patient I’ll never forget’. Whilst preparing the Round the facilitators help the presenters not simply to tell a factual story, but to focus on their own emotions in relation to the event they are narrating. In the Round audience participants are invited to share reflections, but are not there to problem solve or provide advice. These aspects make them different to Balint groups or clinical supervisory groups. Balint groups are based on psychoanalytic principles; a clinician presents a challenging doctor patient relationship to a small group of eight to ten people; then questions, advice and emotional responses to this scenario are shared by the clinical group (Salinsky, 2009; R uth, 2009). Balint groups are only open to clinical staff and cover one case; in contrast Schwartz Rounds are open to all staff including non-clinicians and may focus on themes made up of a number of stories or different perspectives on one particular case. Balint groups focus on the psychodynamics and transference and counter-transference issues of one doctor-patient relationship; whereas the intention in Schwartz Rounds is to create emotional resonance with the stories shared. In this way Schwartz Rounds techniques link with key aspects of compassion such as emotional resonance alongside connection with the universality of human frailties (Strauss et al., 2016). Clinical supervision is carried out in a number of ways using different models; key aspects including normative (instructive), formative (reflective) and restorative elements (Buus & Gonge, 2009). Group supervision usually occurs with a specific staff group, is

provided by colleagues or a supervisor and aims to problem solve and improve practice (Francke & Graaff, 2012). In contrast, Schwartz Rounds aim to share and discuss issues across diverse staff groups arising from different clinical experiences; and their role is to support understanding of experiences from a social and emotional point of view but not to problem solve, provide advice or focus on technical aspects of care.

This article contributes to studying how different organizational contexts may affect the implementation of interventions designed to support compassionate care (Mannion, 2014). Schwartz Rounds are now being widely implemented in a new range of service contexts such as mental health services, community services and more recently primary care and education environments. Schwartz Rounds have not yet been studied within mental health and community services and less research has been conducted on the implementation process of Rounds and the contextual enablers and constraints within organizations. It has been highlighted that mental health services “need to embed a culture of compassionate, collaborative care” (Bee, Price, Baker, & Lovell, 2015, p.111); attention is needed to foster compassion within mental health services (Spandler and Stickley, 2011; Morse, Salyers, Rollins, Monroe-De Vita, & Pfahler, 2012). Interventions to support compassion within community services also need further study, existing interventions often being more individualized (Cocker & Joss, 2016) than relational or interdisciplinary. Using realist evaluation this article contributes to the debates by studying: staff experiences of Schwartz Rounds in mental health and community settings and the mechanisms within them that may support compassionate care; the enablers and obstacles to implementing Rounds; and the perceived effects of Rounds within community services and mental health services.

Methods

This research investigated the implementation of Schwartz Rounds, asking “How can Schwartz Rounds be implemented and support staff in community services and mental health services?” Realist evaluation (Pawson & Tilley, 1997) was used to ask “what works for whom in what circumstances” (Pawson, 2013, p. 15). It explored: the model and mechanisms of Rounds within community services and mental health services; practical and logistical issues of implementing Rounds within these different service and organizational contexts; and the perceived effects of Rounds at a personal and organizational level. The research was approved by the University of Bath, Department of Social and Policy Sciences ethical review process. The research recruited NHS staff members only, by virtue of their professional role, therefore being GafREC (Governance Arrangements for Research Ethics Committees) exempt, which was confirmed with the Health Research Authority (HRA). Research governance approval and permissions were obtained from the three case studies using the HRA Integrated Research Application System (project ID: 158237). Data collection began after approvals for the study were received in October 2014, and was completed at the end of April 2015. Interviews, observations and evaluation sheets were used within three case studies that represented a range of mental health and community services Trusts involved in implementing Schwartz Rounds. Case A was a large Foundation Trust, delivering mental health, community and specialist services to adults and children. Case A ran their first Round in October 2014 and continued monthly Rounds from this point. Case B was a large and complex community Foundation Trust covering a wide, rural geographical area, delivering services through doctors, community nurses, physiotherapists, dietitians and other healthcare professionals. Case B ran their first Round in February 2014 but withdrew from running Rounds in January 2015. Case C was a Foundation Trust that provided

mental health services. It had a mixed rural and urban geography. Case C ran their first Round in May 2014 and continued to run Rounds, branching out to different geographical areas.

Connections with Schwartz Round coordinators were enabled through the POCF. These connections enabled Trust permissions to be applied for and received, and Round observations and interviews to be organized. Observations of Rounds provided data on how Rounds were being run, the process of implementation, facilitation, participation and the concerns that were discussed within Rounds. Round attendees were informed about the research and the potential presence of an observer prior to their attendance at Rounds, through an emailed information sheet, sent by Round organizers. Then as Round attendees arrived before the Round started, the researcher introduced herself and provided paper information sheets, enabling people to ask questions about the research and give written consent to be observed (85 participants consented to being observed within 5 Schwartz Rounds). This was also an opportunity for attendees to give the researcher their email address, if they were happy to be contacted to arrange an interview about their attendance at Rounds. In addition to this face to face interview recruitment, further invitations to participate in interviews were emailed out by Round coordinators to lists of people who had previously participated in Schwartz Rounds. Five observations of Schwartz Rounds, lasting one hour each, were conducted through the research, three at Trust A and two at Trust C. No observations were possible at Trust B as they stopped running Rounds. These focused on understanding how Rounds were being structured and facilitated, and what stories, meanings, practices and beliefs were being shared and how. A structured observation template was used to take notes on facilitation styles and techniques, discussion themes, how staff participated and the interests and concerns that were discussed. These notes were written up straight after the observation had taken place. Purposive sampling was used to invite Rounds coordinators and

attendees to be interviewed. Coordinators included facilitators, clinical leads and steering group members to explore how Schwartz Rounds were being implemented. Panel presenters and attendees of Rounds were interviewed to understand participants' motivations for attending, their perceptions of and experiences at Schwartz Rounds and perceived effects. Topic guides were developed from a previous evaluation of Schwartz Rounds (Goodrich, 2012), with further detailed questions on implementation processes and experiences of attending Rounds. Twenty-two interviews were conducted mostly over the phone, and with consent were audio-recorded and transcribed. Interviews lasted between 13-54 minutes, dependent upon people's involvement with Rounds, with an average of 30 minutes. All those who took up the invitation to participate were interviewed, within the time period of the research. Few new themes arose in the last interviews conducted. A summary of interviews and observations is provided in Table 1 and 2. Where figures are in brackets steering group members also spoke of their experiences in attending Rounds. In order to ensure anonymity and confidentiality of interview participants, only gender has been given to label quotes, without case site or profession due to the specificity of people's Schwartz Round roles. Most clinicians spoken to worked in areas such as therapies, psychiatry, clinical psychology, mental health or learning disabilities, although not all had these mental health or psychological professional backgrounds.

Table 1. Interviewees and observations (by Farr, a social science researcher)

Trust	Number of interviewees	Number of observations
A	11	3
B	4	Rounds stopped

C	7	2
Total	22	5

Table 2. Characteristics of interviewees

Schwartz Round role	Total interviewees	Gender and job role	Total interviewees
Steering group/ co-ordination role	4	Male	3
Facilitator/ Clinical Lead role	7	Female	19
Panellists	4	-----	-----
Attendees	7 (2)	Clinical role	15
		Senior manager role	6
Total number of interviewees	22	Non-clinical role	1

Data were analyzed through the use of framework analysis (Ritchie & Lewis, 2003) starting with initial thematic code titles, and then populating them with data driven sub-codes. This thematic framework enabled a charting of the data synthesis to develop the main findings, and track different context mechanism outcome configurations (Pawson, 2013). In addition to this primary data collection, Trusts running Schwartz Rounds are asked to distribute, collate and return to the POCF standard evaluation sheets. These gather information on who is attending Rounds, how people found out about Rounds, and their perspectives on the discussions held. Table 3 provides a summary of the Rounds organized, attendees and forms collected at the three cases.

Table 3. Round attendees and evaluation sheets

CASE	Number of Rounds organized since first implemented	Total number of attendees at Rounds since first implemented	Response rate of evaluation sheets
A	6	121	93% (112)
B	8	63	0% (no forms used)
C	8	113	83% (94)
Total	22	297	69% (206)

Evaluation sheets were used as secondary data to analyze attendance, types of participants

attending Rounds and the perspectives of people attending Rounds (see supplementary data).

These enabled triangulation with qualitative interviews, to understand key perceptions of Rounds from a wider group of participants, alongside some characteristics of participants attending Rounds.

Results

The model and mechanisms of Rounds

The themes that were discussed at Rounds included: death and dying; the emotions raised when working with patients; managing unwell patients in the community and role expansion within that; the complex needs of patients with challenging behavior; how patients may split teams; being caught between the patient and their family; the interface between the personal and professional; and attending hearings and inquiries. During observations emotionally powerful discussions within Rounds focused upon the impact of connecting and working with patients, and what this meant in relation to staff's professional and personal lives. Discussions focused on how staff connected with and managed their own vulnerabilities and emotions, whilst working

with the suffering and distress of others. How could professionals connect with people who were experiencing pain and suffering in a way that did not then lead to burnout, or a stepping outside of professional boundaries, were issues that were explored within Rounds. It was reflected in Round observations that staff often worked with patients at some of their most personal and vulnerable times in their lives and through this:

If you connect deeply with patients, it causes a lot of feelings within self and others. It's about recognizing those feelings and recognizing that work and personal balance. (Male interviewee)

Managing to work as an active, reflective and caring professional, managing professional and clinical boundaries and integrity, and not getting caught up within patient and family dynamics were reflected upon. A focus on human connections with patients and families, rather than clinical or system interventions, made the Rounds engaging on a personal level. Where they overly focused on specifics within a clinical case, this could lessen engagement with Round discussions, especially for non-clinical staff:

There was a lot of stopping and starting, to try and clarify some of the jargon and the terminology ... My understanding of it was that the case study that was presented was supposed to act as a springboard to everybody chipping in and talking about experiences that they had had, that they had found difficult. But it became, the whole thing was just focused around that one case. (Female interviewee)

Interestingly this quote, and an observed Round enables a comparison between the Schwartz Rounds model and Balint groups. One observed Round focused in detail on the intricacies and psychodynamics of clinical relationships with a particular patient and in this regard was more

aligned to the Balint model than a traditional Schwartz Round. Within Rounds implementation, different professionals training and perspectives may have an impact upon how they are facilitated. In contrast, observing other Rounds where conversations were focused on themes relating to the emotions arising from interactions with different patients, supported a stronger emotional resonance and connection with the universality of human frailties (Strauss et al., 2016), including within the lead author as observer. The Schwartz Round approach where facilitation draws out common themes based on emotional and relational concerns about care rather than clinical or case specific issues, can better enable different participants, including non-clinicians to connect their own experiences to the dialogues. This could facilitate personal reflection on practice, where participants could “share” and “learn” (Female interviewee):

Next time when I’m doing something similar I have that discussion to draw on and what I’ve learnt from that Round. (Female interviewee)

It helps to develop your empathy and compassion in certain situations, because you’re seeing it from those different perspectives. (Female interviewee)

Alongside discussions about how people connected to patients’ difficulties and worked to relieve these, people also spoke about how to manage the considerable organizational complexities that they faced. These issues included many different pressures within health services such as how to manage:

The impact of the social and relational needs of patients that are beyond the capacity of health services, but yet affects patients’ health.

Anger and aggression in patients toward healthcare staff. How to ensure one’s own emotional safety within service provision.

The different pressures within health services, such as complaints, additional work pressures, reduced beds, service reorganization and patients perceptions of this, consistency of care and patients' expectations of the service.

Emotions arising where actions did and did not lead to the relief of patients' suffering.

The issues and concerns that people brought to the Rounds were based on:

... very human emotional issues that perhaps we don't voice that often, or voice in individual supervision, but what has been interesting is that being voiced in a wider public forum and everybody being able to relate to it. (Female interviewee)

The reflective nature of the discussions supported self-awareness:

In day to day life we do forget that reflection is a valuable part of our occupation. Because without reflection we can't learn and we can't examine how we could do things better. So I think that it is an excellent forum to just pull in our reins of our busy lives and have time to reflect and examine future practice. (Female interviewee)

The way in which Schwartz Rounds were facilitated was important to create a safe space where people could "dare to share" (Female interviewee), where "vulnerabilities are exposed" (Female interviewee) and "people feel able to speak quite openly about difficult things in a very contained way" (Female interviewee). The interdisciplinary nature of the reflective discussions was particularly appreciated: "so many people brought in so many different experiences I think and that made it much more valuable" (Female interviewee).

Context

There was variation in the extent to which different staff groups felt comfortable and familiar with these reflective discussions on the emotional and social aspects of care. It was considered in all three cases by interviewees that some professionals may consider Rounds as “fluffy” (Female interviewee):

I think that people felt maybe, oh, it’s touchy-feely, what’s the point, it doesn’t tick any sort of target box. (Female interviewee)

These perceptions of the value of a “touchy-feely exploration of your feelings” (Male interviewee) could vary across staff disciplines. In mental health and psychological services, reflective practice was considered part of professional practice:

What I have found is that it [Schwartz Rounds] is working absolutely well. No problems at all. Because myself and my colleagues, we are challenged with very difficult situations, difficult patients and the rest. So it was quite moving, people sharing that, so I don’t think that it is that much different really. (Male interviewee)

Where professional cultures were less rooted in talking about emotional and social aspects of care, it was considered that it could be harder to engage people. Within community services that involved a diverse range of professionals it could be more challenging to find common concerns across different specialties such as community dentistry, sexual health and community nursing:

It’s that commitment, is it relevant to me, is it my area? So I think it is selling it to people, that it’s relevant to them, even if it’s not specifically in their patch.
(Female interviewee)

Contextual factors that reduced openness and trust within the Rounds included organizational restructuring, and a feeling of needing to be “politically correct” (Female interviewee). One interviewee reflected on the suitability of more senior managers as facilitators, considering whether their presence as a facilitator may make people less likely to open up. Exposing emotional vulnerabilities in front of more senior staff may be challenging. Leaders and managers at all levels had an important role in promoting Rounds. Senior managers needed to endorse them and provide necessary resources. Team leaders had a role in enabling different staff to attend, supporting workload management.

Middle managers get a really hard deal, they’re not always obstructive in a deliberate way but I think they have so many competing pressures, that this looks like something they can ignore because it appears more fluffy as opposed to target driven. (Female interviewee)

There were several obstacles that could compound to make implementation more difficult in Trusts that operated over large geographical areas. The enablers and obstacles that affected the implementation of Rounds are outlined in Table 4.

Table 4: Enablers and obstacles to implementing Rounds

Enablers to implementing Rounds	Obstacles to implementing Rounds
A core group of dedicated staff who were committed to implementing Rounds and were able to share the workload associated with implementing Rounds	Two or three staff implementing Rounds with less wider organizational support and backing “It is on top of the day job.” (Female interviewee)

Managers at different levels providing support and enabling both their set-up and encouraging attendance	Managers at different levels not seeing the potential benefits of Round implementation or attendance
<p>Team managers enabling attendance</p> <p>“I do think it is something down to team managers to support staff to enable them, in exactly the same way as they would for any other mandatory training or professional supervision as well.” (Female interviewee)</p>	<p>Too many work pressures to attend/organize</p> <p>“It ended up being a bit of an oxymoron really. The Trust is saying we support you in this, we want you to be part of this. But then with work constraints I didn’t actually manage to attend the others.” (Female interviewee)</p>
<p>Organizational or professional cultures that value reflective practice and staff support</p> <p>“I think as psychologists we are more used to talking about those things than some other staff.” (Female interviewee)</p>	<p>Organizational or professional cultures that do not have a tradition of reflective practice</p> <p>“They might come and think, oh well maybe this isn’t for me because that’s not my personality or my style.” (Male interviewee)</p>
<p>Publicity that enabled staff to appreciate the potential benefits of attending</p> <p>“Within my team we have had a few people go now and come back and talked about having had a positive experience of it and then that has led to other people going.” (Female interviewee)</p>	<p>Difficulties in publicising what a Schwartz Round is</p> <p>“I think the word Schwartz Round doesn’t mean very much to people.... I don’t think that it’s that familiar to people that word, that terminology....” (Female interviewee)</p>
<p>Rounds located geographically in an area where staff could access them within 30 minutes travel time</p> <p>Participants travelled up to a maximum of 28 miles to get to a Round, the longest travel time was about 45 minutes one way, with 30 minutes being quite common.</p>	<p>Facilitating Schwartz Rounds over a wide geographical area</p> <p>“In journey times, 2 hours potentially, more or less, from one side of [the area] to the other.... Trying to get staff to a location for the Schwartz Round and it be accessible to everybody has been hugely challenging.” (Female interviewee)</p>

Organizational advocacy of the importance of staff support and compassionate care

“As with everything, organizational buy-in, absolutely critical. Consider the culture of the organization that you’re implementing it in.... It can’t be the panacea to all cultural problems. It needs to be part of a whole cultural programme of change within an organization.” (Female interviewee)

Wider organizational pressures such as financial stability or service reorganization

“We are going through a massive restructuring which has meant a lot of people have been reapplying for their own jobs... The whole culture has been very anxious, very suspicious, very untrusting.... I can imagine people might be a bit reluctant to speak up if they are not sure who the other people in the room are ... they might be the ones sitting on an interview panel when they reapply for their jobs.” (Female interviewee)

Rounds are seen as part of the vision and values of an organization

“The Schwartz Round also marks the organization’s approval or acknowledgement of the importance of emotional aspects of all of us as human beings and also emotional involvement in everything we do.... The Schwartz Round organization says to itself, ‘we think that the emotional side is very important, we know that it is very difficult sometimes, and we really want to support you in some way’.” (Male interviewee)

Rounds assessed through contribution to targets rather than understood as part of organizational vision and values.

“What certain members of the Board were asking for, numbers, facts and figures around what is the output of this, what is the outcome, what can we save, what can we achieve on the back of running Schwartz Rounds? For example, ‘Can you give me figures of reductions in staff sickness?’” (Female interviewee)

Geography was the main factor which impacted on attendance due to greater travel distances, awareness of the Rounds and networking to embed them. People’s reflections on the reasons for non-attendance included the lack of staff time to attend, fears of exposing potential vulnerabilities in front of colleagues and not being clear on what they would get out of attendance. The dynamic between being very busy and negotiating a series of complex demands whilst at the same time being able to carve out a space in the working day to attend Rounds was a dilemma that was often faced:

Staff have to make decisions and it is often things like their clinical supervision or their Schwartz Round or their protected time that they will always give up because that is the nature of the job that they actually do. Always sacrifice what their needs are for other people. (Female interviewee)

Rounds in community and mental health organizations tended to be smaller than those held in acute Trusts. Based on POCF data from the last two years (June 2013-June 2015) average attendance at a Round in an acute trust was 28, at a hospice 24 and a non-acute trust 19. In line with these figures the average attendance at Rounds organized within case study sites was 14 (including Case B figures where no one attended some Rounds organized). However the quantity of participants should not be conflated with the quality of Rounds, some staff comments on evaluation forms suggested that in larger groups it may be more difficult to contribute and interact. This research suggests a number of reasons for lower numbers including geographic difficulties in attending Rounds, workload and cover issues. In case B, a community trust, an accumulation of various obstacles to implementing Rounds led to costs becoming prohibitive. The other two cases A and C were continuing to further embed Rounds, Trusts were beginning to think about how to include Rounds as part of continuing professional development, building in mandatory time for staff support and including Rounds within organizational incentives, such as through Commissioning for Quality and Innovation targets (CQUINs) (NHS England, 2015).

Perceived effects

The perceived effects of attending Rounds were explored, to understand if benefits reported in acute settings (Goodrich, 2012; Lown & Manning, 2010) also occurred in community and mental health Trusts. Staff interviewees perceived positive impacts in all three cases. Impacts on

professional work with patients included being more patient aware, improving communications with patients, and being more mindful of the emotional impact of work, alongside being more empathetic and compassionate:

Just going back to your clinical practice. The thought of actually being much more patient aware and patient focused and thinking from the patients' perspective rather than from the health professional's perspective. I think it helps broaden your mind, your thinking around good patient care. (Female interviewee)

Where difficult feelings arose when working with patients, people spoke of how they could more easily manage these. 82% of evaluation form respondents agreed that they had gained knowledge that would help them in caring for patients; 94% agreed they had gained insight into how others think and feel in caring for patients (supplementary data). More generally there was a feeling of being looked after which helps "you look after the people you work with" (Female interviewee). In relation to the effects of Schwartz Rounds on relationships with staff, people spoke of a sense of increased trust with colleagues, relating to other colleagues "on a more human level" (Female interviewee) alongside being "braver, talking about some of the really difficult things" (Female interviewee):

I think it is very healthy to be exposed to other networks, other disciplines, other people and go, oh they have the same kind of stresses as we do... there's a humanizing, it helps with the much bigger dynamics of the splitting or the scapegoating, and brings us back to a much more real place where we can think about the quality of our relationships and our interactions ... between the individual, the team and the organization. (Female interviewee)

91% of evaluation form respondents agreed that the Round they attended would help them work better with colleagues (supplementary data). Recognizing shared experiences was important in developing trust, stronger relationships and connections between “the different levels of people, senior nurses, management, doctors” (Female interviewee).

Actually seeing senior people being quite open about the impact of people whom they have worked with in the past is actually incredibly valuable. Because you recognize that you have a shared value base, which in a busy context, isn't part of general conversation. (Female interviewee)

In two case organizations (A and B) there were examples where Rounds prompted and promoted other mechanisms of staff support. Where Rounds were continuing to be embedded it was considered that cultural change within organizations would take time. One Trust Board seemed to be signed up to Schwartz Rounds in relation to a broader set of work on compassion. In the other, evidence of how Rounds contributed to key performance indicators was asked for, which made promoting the value of Schwartz Rounds more challenging.

Discussion

Where Schwartz Rounds were successfully implemented and facilitated, the discussions can be likened to processes of compassion (de Zulueta, 2013; Strauss et al., 2016), where there is a recognition of and an open receptive space to narratives of distress or difficulty in self or others, with a view to understanding our shared humanity. The strengths within Schwartz Rounds are that by having a broad range of presenters with discussion focusing on the emotional aspects of their work, this moves conversations away from specific psychodynamics within cases or clinical

issues to broader connections in relation to our human commonalities, the essence of compassion. However supporting three to four presenters takes time and energy, especially when bringing them together across wide geographical areas so this can also make Schwartz Rounds more difficult to organize. In the Round observations in this study, there were always two or three panelists. This worked well where the panelists' contributions incorporated diverse stories, but on occasion where one patient case was substantially focused upon, the discussions were more reminiscent of a Balint group, a case panel or clinical supervision. Within Schwartz Rounds listening to other staff's experiences of working with patients could enable professionals to connect with each other's and patients' experiences, processing emotions (NHS England, 2014a; Strauss et al., 2016) alongside being "regrounded in the true values of my job"; "reminding me personally why I am here" (Evaluation form comments). This could then support staff in managing uncomfortable feelings when working with patients and seeing things from others' perspectives. Holding Schwartz Rounds can be perceived as an organizational acknowledgement and affirmation of "the importance of emotional aspects of all of us as human beings and also emotional involvement in everything we do" (Male interviewee). This could be an important cultural marker, to embed practices and values that support compassion within the organization (DH, 2015; West et al., 2014), following the advocacy of developing "compassionate spaces" (Spandler and Stickler, 2011, p.563).

Where staff saw the discussions of relational and emotional aspects of healthcare as a valid and important aspect of their practice, Rounds were highly valued. Where Schwartz Rounds may have been seen as "fluffy", or their value not appreciated there was less engagement with them. These findings align with literature that illustrates how organizational cultures influence what emotions are displayed within the workplace (Mastracci, Guy, & Newman,

2015). Because organizational contexts can shape people's emotions and behaviors, through their cultural values and norms (Rynes et al., 2012), an iterative relationship between organizational culture and staff support can be identified. In mental health contexts, reflective practice and discussion of the emotional and social aspects of care were more embedded into some professional cultures. Schwartz Rounds could add to other mechanisms of support such as clinical supervision, focusing more on the emotional and relational aspects of care within a collective, interprofessional setting. This could provide peer support, wider interdisciplinary understandings, a "shared value base" (Female interviewee), and stronger connections between the different parts of the organization, effects also noted in the study of Schwartz Rounds within hospice settings (Reed et al., 2015) and acute Trusts (Chadwick et al., 2016; Goodrich, 2012). However where there was less cultural tradition of reflective practice, combined with a wide geographical spread of diverse staff groups, this appeared to make Schwartz Rounds more difficult to embed. The geographical obstacle was being addressed in some Trusts through taking some Round techniques into a team approach, or setting up a series of smaller groups. Other obstacles that Round coordinators and facilitators may need to further reflect on, are the implications of how hierarchies, power relations and other organizational dynamics such as restructuring, may affect the process and dynamics of Round discussions.

Leaders have a clear role in facilitating and ensuring a culture of care and compassion (NHS England, 2014a), making decisions that support staff engagement (West et al., 2014). In relation to the implementation of Rounds this applies to all levels of leaders, as both senior and immediate manager support was needed for Rounds to be embedded and attended by a variety of staff. Some senior leaders supported Schwartz Rounds as part of the vision and values of their organization, whilst others were more reticent requiring evidence of value in relation to targets

such as reductions in staff sickness. This provided coordinators with a challenge as to how to account for the value of Rounds within wider organizational policies based on numbers and measurement. The logics of rational measurement and scientific thinking contrast with the intangible, relational and tacit dimensions of care (Farr & Cressey, 2015; Mantzoukas & Jasper, 2004) that were discussed in Rounds. Current health policies based on rational measurement, may undervalue the relational aspects of care because they are harder to measure. There is a tension between the ongoing rationalization of care and developing compassionate care cultures (Allen, 2015).

This article illustrates how interventions that support staff in delivering compassionate care may be implemented and discusses effectiveness in different contexts (Mannion, 2014), highlighting the enablers and obstacles that can occur in implementing Schwartz Rounds in community services and mental health services. It illustrates the iterative relationships between local organizational and professional cultures when implementing forms of staff support and reflective practice. There were limitations to this study. Further case studies in community services and mental health services would have enabled an understanding of the extent to which these issues are faced by a wider number of organizations. However the results do reflect existing research findings on Schwartz Rounds (Chadwick et al., 2016; Goodrich, 2012; Lown & Manning, 2010; Pepper et al., 2012) and POCF discussions with other community and mental health Trusts. The research only looked at the perceived effects of Rounds from the perspectives of participants. Maben, Taylor, Dawson, Foot, and Shulldham (2014) are conducting research into the implementation and effects of Schwartz Rounds over a wider range of organizations, to identify the mechanisms of Rounds that influence staff wellbeing. Such research aims to uncover to what extent participation in Schwartz Rounds affects staff wellbeing, relationships between

staff and patients, and the delivery of compassionate care. Other questions to be answered include potential gender differences in attending and the experiences of Rounds. Participants who stated their gender in the cases gives a proportion of 84% women to 16% men (see supplementary data). In comparison the NHS workforce is made up of 77% women and 23% men (NHS Employers, 2016). Another area that would benefit from further analysis is the impact of different group sizes on the experiences of Rounds. Within the case organizations studied, Round attendance numbers were lower than within acute Trusts, but staff commented that in larger groups it may be more difficult to contribute and interact. Further development of Schwartz Round models to suit different service contexts that can be used by smaller teams and demand less preparation may be beneficial. The provision of bounded time for reflection, whilst minimizing the time and resources that organizations have to expend to organize this, would be valued. Further research also needs to be conducted into whether Schwartz Rounds and other types of support such as Balint groups and group supervision have any effects on compassionate care and care outcomes as perceived by patients (Francke & Graaff, 2012), although linking Round interventions to changes in staff behaviors to perceived impacts felt by patients is methodologically challenging. Theoretically, linking sociological models of reflexivity (e.g. Archer, 2003) with different models of reflective practice may provide theoretical insights into the mechanisms within these group reflective practices.

Conclusion

Overall this research has found that Schwartz Round implementation had the potential to be successful in these community and mental health settings and provide new spaces for staff to share the emotional impact of their work, and were perceived to have had a positive impact on

working with patients, colleagues and the wider culture of an organization. This research has three key messages in relation to the implementation of Schwartz Rounds. First, where Schwartz Rounds were successfully implemented and facilitated, they could mirror processes of compassion, where there is a recognition of and an open receptive space to narratives of distress or difficulty in self or others (de Zulueta, 2013; Strauss et al., 2016). The discussions enabled emotional resonance across interdisciplinary colleagues about caring experiences, recognizing and understanding our common humanity, the essence of compassion. Second, these findings show that although there are challenges in implementation staff appreciate the unique opportunity that Schwartz Rounds provide for shared reflection. Staff spoke of strong benefits of attending Rounds, and participants clearly valued attending them. Third, strong leadership is a crucial factor in the success of staff support initiatives such as Schwartz Rounds, to ensure that such approaches are valued through the organization and that staff are given time and support to facilitate and attend them. Organizationally Schwartz Rounds can be seen to be part of demonstrating a more open, supportive culture where staff are valued. These research findings have fed into POCF work to develop further support and guidance for organizations implementing Rounds in a wider range of non-acute settings. Practical implications are that for successful implementation of Schwartz Rounds, organizational management need to provide financial and staff resources so that Schwartz Round implementers are supported and that staff from across the organization are enabled to attend. In organizations where staff are more dispersed, costs of staff travel and time spent attending Rounds will be higher and organizational arrangements may be more cumbersome. Where Schwartz Rounds were seen as contributing to a culture of care and compassion, they were an accepted and valued part of an organization. However if Rounds are valued only through their potential contribution to targets, this can create

difficulties in evidencing such impact. In order to facilitate compassionate care cultures, the dominant organizational logics of rationalization and financialization within healthcare need to be tempered with a wider accounting of the relational, the compassionate and the tacit aspects of care.

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Rhiannon Barker works for the Point of Care Foundation (POCF) responsible for supporting the implementation of Schwartz Rounds across the UK.

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Contributors

Michelle Farr led the overall study, led and undertook all research interviews, observations and analysis (ensuring research independence – see conflicting interests above) at the University of Bath. Michelle Farr wrote the analysis section and co-wrote all other manuscript sections of this article at CLAHRC West. Rhiannon Barker contributed to overall study design, co-wrote the literature review, discussion and conclusion and gave final approval of the manuscript.

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