Supporting staff to deliver compassionate care using Schwartz Center Rounds – a UK pilot

Staff who feel supported deliver better care. The King’s Fund report on how a US system, which encourages sharing of experiences, is being piloted in the UK.

INTRODUCTION
At The King’s Fund’s Point of Care programme, we aim to transform patients’ experiences of care in hospital and enable staff to deliver the same high quality care they would want for themselves and their relatives.

The key to this, as we have argued previously in Nursing Times (Cornwell, 2009), based on evidence from, among others, the Department of Health’s 2009 NHS Health and Wellbeing Review, may be to focus on improving staff experiences. Where staff feel supported in their jobs and perceive that their organisation cares about their health and wellbeing, they may in turn be better able to deliver compassionate care to patients.

How can trusts signal to staff that they aim to provide them with a supportive working environment? Last year, we suggested that providing staff with forums in which to have caring conversations with each other about experiences of care delivery could be an important step in trusts’ strategies towards improving staff health and wellbeing (Cornwell, 2009).

Below we explore the methodology and potential impact of one such forum, the Schwartz Center Rounds® (referred to as “Schwartz Rounds” or just “Rounds” from now on), now being piloted in the UK.

WHAT ARE SCHWARTZ CENTER ROUNDS?
Launched by the Kenneth B Schwartz Center in Boston, Massachusetts, in 1997, Schwartz Rounds provide a monthly or bimonthly one hour forum for staff from all hospital disciplines to come together to discuss the difficult emotional and social issues in caring for patients.

Healthcare attorney Kenneth B Schwartz founded the centre shortly before his death in 1995, spurred on by his experiences of care during treatment for terminal lung cancer. He founded it in acknowledgement of the profound importance of the relationship, the “human connection”, between healthcare professionals and patients, with the mission of strengthening that connection (Schwartz, 1995).

Schwartz Rounds are the centre’s widest reaching programme and are now held at over 180 sites in the US, most of them hospitals. They are also held in a small number of nursing homes, community health centres and outpatient practices.

In 2009, the Schwartz Center entered into an agreement with The King’s Fund for The Point of Care programme to test and implement Schwartz Rounds in the UK. It has been agreed that the Rounds will be implemented according to the same criteria as in the US: that it is essential they be given high profile support by the trust board; that they be led by a senior clinician; and that a multidisciplinary committee takes responsibility for organising them.

HOW THE ROUNDS WORK
Open to staff from all levels and disciplines, the Rounds aim to explore the human and emotional aspects of the experience of delivering care and the challenges that staff face. They are just not listening to me. How sharing experiences promotes compassion.

One such forum for these conversations is the multidisciplinary Schwartz Center Rounds®, now being piloted in two UK trusts with the support of the Boston based Kenneth B Schwartz Center and The King’s Fund’s Point of Care programme. Here we describe the history of the Rounds, explore what makes their format unique and so powerful and report initial observations from the UK pilots.

AUTHORS Jocelyn Cornwell, PhD, is director; Joanna Goodrich, MA, is senior researcher/programme manager; both at The Point of Care programme, The King’s Fund.


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face from day to day. With help from a trained facilitator, discussion focuses on a particular case and is introduced in a 10-15 minute presentation by a panel of staff who were involved in the patient’s care: often a doctor, a nurse and one other – a social worker or healthcare assistant, for example. Discussion begins with a brief summary of the patient’s case history, and panelists take turns describing their involvement in the case – and, in particular, how it made them feel and what emotional and social challenges it may have raised for them.

The dialogue then opens up – participants ask questions, share experiences and reflect on the challenges of delivering care both in this and analogous situations. Throughout, patient names are disguised in order to protect their confidentiality. Participants are asked not to continue discussing the specific case outside the actual Rounds, although it is fine to discuss the general issues raised.

The Rounds are designed to gain a foothold in the life of the hospital as a safe and confidential environment where staff can have caring conversations with each other. Participants, who by the very nature of their training are often inclined to propose solutions and suggestions for how the panel could have done things differently, are encouraged to try not to problem solve; instead, the purpose is to share ideas, thoughts and feelings. For example, in a case where a dying patient’s family blocked their transfer to a hospice, staff would be encouraged to think not about how they could have negotiated with the family differently but about how they responded to this news and how it made them feel to be involved in the patient’s care.

In American Schwartz Rounds, topics of discussion have varied widely, from emotionally challenging cases, such as caring for a seriously ill child or dealing with a patient’s hypervigilant and even bullying family members, to those a little lighter in nature, such as how to use humour appropriately in healing and practice.

Rounds in the US have used the forum to share thank you letters from patients and families to staff. Spouses and partners of staff talk about the experience of having family who work in hospital, that is, how that affects their lives at home. Box 1 shows some additional topics that have been explored in past Rounds and Box 2 provides an overview of one of the recent UK Rounds discussions.

**Box 2. Overview of a Rounds Case and Themes Discussed**

**Case summary**
The elderly care doctor on the stroke unit and one of the stroke nurses assigned to the patient’s care presented the following case history:

A 62 year old woman collapsed at home one evening, showing weakness on her right side. By the time the ambulance arrived, she was unresponsive, had difficulty breathing and had to be intubated. A head scan showed a large bleed, which was spreading through her ventricles. She was a fit person, with chronic obstructive pulmonary disease but no history of cardiovascular problems, stroke or high blood pressure. After a few days in hospital, she began to open her eyes, but showed no signs of meaningful communication. She was transferred to the stroke unit, where the team treated her for comfort rather than for recovery. Because of the extent of the stroke damage, the team decided against feeding and gave her only fluids.

The patient’s partner was especially distressed over her condition and was finding it difficult to accept she was not going to improve and would not be fed. He came to see her every day of the eight weeks she was in hospital, weeping openly at her bedside and repeatedly asking staff whether she was improving. He also made repeated requests that her feeding be reinstated. Staff felt unable to comfort him or to convince him of the inevitability of her death. He kept saying he loved her and wanted her to live, and, despite no signs that she would or could improve, his response never transitioned into one of acceptance – that is, that he loved her and was willing to let her go. Her niece, meanwhile, who understood that improvement in the patient’s condition was unlikely, acknowledged that her aunt would not have wanted her life prolonged in this state but was unable to convince the partner of the same.

Staff began to doubt their chosen path of care and, because the partner was so hopeful, those who spent the most time with the patient – particularly healthcare assistants and junior qualified nurses – began reporting any minor signs of responsiveness that could signal hope for recovery.

The partner’s demands were difficult to respond to, especially because some members of staff also had conflicting feelings about the decision not to feed.

The patient died in hospital eight weeks after being admitted.

**Issues discussed:**
- The emotional burden that distressed family members may place on staff;
- Difficulty of communicating to family the ethics of treating for comfort versus for recovery;
- Disagreement between staff on the best course of action;
- Perceptions of food as essential to care and life;
- Conflict between the patient’s and family’s end of life care wishes;
- Confronting assumptions about one’s own mortality (because of the patient’s age and relative good health);
- Feelings of culpability in a patient’s death;
- Balancing the demands on staff time of patients and their families;
- How to debrief as a team or seek closure following a patient’s death or at the conclusion of a challenging case.

**Why we support Schwartz Rounds**

Why is The King’s Fund’s Point of Care programme supporting implementation of the Rounds in the UK?

There is mounting evidence to support the assertion (DH, 2009) that staff who feel their organisations are supportive working environments, and their health and wellbeing are considered important, are better able to deliver high quality, compassionate care.

One practical step that trusts can take to help staff to feel supported is to provide them with an opportunity for caring conversations. These conversations allow them to take time out from their often fast paced, high pressure workdays to reflect on their experiences of caring for patients. This enables staff to gain insight into the non-clinical aspects of nursing.

While there is more than one way to encourage staff to have these caring conversations, we have chosen to collaborate with the Schwartz Center because of the particular strengths of the Rounds format. Rounds are unique in providing a forum for staff from all levels and areas of the hospital to come together to reflect on a case and how that particular experience of delivering care can be generalised to other settings. There is great value to this recognition of shared experiences.

Furthermore, their methodology has been well tested and is highly regarded. In evaluations of US sites, staff who have
attended Schwartz Rounds have reported the following:

- Their ability to provide compassionate care has improved;
- Teamwork has improved as a result of their “better appreciation for the roles and contributions of their colleagues” from different disciplines;
- Changes have occurred in practices or policies within their departments or hospitals as a result of specific Rounds discussions (Goodman Research Group, 2008).

Staff who have participated in Rounds report that they feel better supported in caring for patients, and their levels of stress and isolation have been shown to decline.

Moreover, it was found that the more Rounds staff attended, the greater was the positive impact on them (Goodman Research Group, 2008). A separate study of regular Rounds attendees concluded that compassionate caregiving requires “a lifetime of continuous support” (Sanghavi, 2006). The very act of attending Rounds regularly focuses staff attention on the need for compassion.

As part of the piloting phase in the UK, The Point of Care is evaluating staff perceptions of Rounds before they are launched at their hospital and will re-evaluate these perceptions after they have been running for 9-12 months.

We are interested to see whether surveys will reveal that UK staff also report better teamwork and improved ability to deliver compassionate care and feel more supported in the workplace following their involvement in Rounds.

In addition, qualitative interviews are being conducted at the sites with Rounds organisers, senior clinicians and board members to explore what they hope to achieve or change through them. In a year’s time, we will go back to them to find out whether their hopes have been realised and collect their thoughts on how Rounds might be developed in other hospitals.

A challenge for the future will be to design an evaluation to investigate the impact of Schwartz Rounds on patient care.

**SCHWARTZ ROUNDS IN THE UK**

With ongoing support from The Point of Care and guidance from the Schwartz Center, pilot Rounds were launched in autumn 2009 at the Royal Free Hampstead Trust in London and Gloucestershire Hospitals Foundation Trust.

Despite differences in the cultural and healthcare landscapes of hospitals in the US and UK, the Rounds format has adapted well to health service settings and seems poised to have a similar impact. Initial feedback has been overwhelmingly positive, as the staff comments in Box 3 demonstrate.

Already staff from a wide variety of backgrounds have attended Rounds: while nurses and doctors have been particularly well represented, Rounds have also attracted a strong turnout among allied health professionals, chaplains, administrators and HCAs.

**Other observations**

Observers at the initial Rounds have also commented about how powerful it is to hear senior level clinicians and managers express their fears and concerns, the challenges they face and the reservations they sometimes feel when prescribing a particular course of action. Rounds provide the forum for staff to realise that they all at times struggle to make decisions and may in these situations be susceptible to self-doubt – and that these feelings do not necessarily disappear after years of experience or entry into management.

The dialogue towards awareness works in reverse as well: we have observed frontline staff feel emboldened to comment on the power dynamics within the hospital, for example, to give voice to their frustration at being left to deal with the fallout from a doctor’s or manager’s decision for a patient’s care.

**CONCLUSION**

Although it may be too soon to predict the Schwartz Rounds long term impact in the UK, we have noted that, even in these early days, they have provided the setting for a great depth and richness of discussion, offering staff the opportunity to express the kinds of thoughts and emotions that in another context might seem unsayable. This alone has made them worthwhile.

Going forward, we would expect that Schwartz Rounds will have the potential to help shape the hospital’s culture, to support staff and encourage them to feel that the organisation values their health and wellbeing. Thus far, all signs are promising that the success of the Rounds in the US can be replicated here.

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