



Final Report of the Evaluation of the Introduction of Schwartz Rounds in Ireland

Full Report | May 2019



Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin



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National Quality Improvement Team

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Conflict of interest statement:

The authors of the report certify that they have no affiliations with or involvement in any organisation or entity with any financial interest in this report.

Abbreviations

AHP	...	Allied health professional
CF	...	Compassion Fatigue
HCA	...	Health Care Assistant
HSE	...	Health Service Executive
ICU	...	Intensive care unit
IQR	...	Inter-quartile range
M	...	Mean
N	...	Number
NHS	...	National Health Service, United Kingdom
PICU	...	Paediatric intensive care unit
ProQOL	...	Professional Quality of Life Scale
SD	...	Standard deviation

Glossary

Glossary of terms

Clinical governance	...	<p>The system of authority through which health care teams are accountable for the safety, quality and satisfaction of persons in the care they deliver.</p> <p>https://www.nmbi.ie/Standards-Guidance/Glossary (Nursing and Midwifery Board of Ireland, 2018)</p>
Compassionate health care	...	<p>‘The sensitivity shown in order to understand another person’s suffering, combined with a willingness to help and to promote the well-being of that person, in order to find a solution to their situation. This should be a duty in healthcare professionals’ daily work’ (Perez-Bret et 2016, p. 605)</p> <p>Ref: Perez-Bret E, Altisent R, Rocafort J. Definition of compassion in healthcare: a systematic literature review. <i>International journal of palliative nursing</i>. 2016 Dec 2; 22(12):599-606.</p>
Coping	...	<p>Coping may be defined as the ‘constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person’ (Lazarus & Folkman 1984, p. 141).</p> <p>Lazarus, R. S., & Folkman, S. (1984). <i>Stress, appraisal, and coping</i>. New York: Springer.</p>
Critical incident	...	<p>The Health Service Executive use the following World Health Organisation definition of ‘critical incident’</p> <p>‘An event out of the range of normal experience – one which is sudden and unexpected, makes you lose control, involves the perception of a threat to life and can include elements of physical or emotional loss.’ (WHO, 2006)</p> <p>World Health Organisation (2006) <i>Stress Management in Emergency Deployment</i></p>

		https://www.who.int/hac/techguidance/training/predeployment
Empathy	...	<p>Empathy is an emotional response (affective), dependent upon the interaction between trait capacities and state influences. Empathic processes are automatically elicited but are also shaped by top-down control processes. The resulting emotion is similar to one's perception (directly experienced or imagined) and understanding (cognitive empathy) of the stimulus emotion, with recognition that the source of the emotion is not one's own." (Cuff <i>et al.</i> 2016, p.144)</p> <p>Cuff BM, Brown SJ, Taylor L, Howat DJ. Empathy: a review of the concept. <i>Emotion Review.</i> 2016 Apr; 8(2):144-53.</p>
Implementation Science	...	<p>Implementation Science is defined as a 'scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice and, hence, to improve the quality and effectiveness of health services and care' (Eccles & Mittman 2006, p.1).</p> <p>Eccles MP, Mittman BS. Welcome to implementation science. <i>Implementation Science</i> 2006;1:1 https://doi.org/10.1186/1748-5908-1-1</p>
Francis Report	...	<p>The report that arose from a public inquiry in the United Kingdom, The Mid Staffordshire NHS Foundation Trust Public Inquiry. The inquiry was established to 'examine the commissioning, supervisory and regulatory organisations in relation to their monitoring role at Mid Staffordshire NHS Foundation Trust between January 2005 and March 2009 [and to] consider why the serious problems at the Trust were not identified and acted on sooner, and will identify important lessons to be learnt for the future of patient care' (Francis 2013, p.10).</p> <p>Francis R. Report of the Mid Staffordshire NHS Foundation Trust public inquiry: executive summary. The Stationery Office; 2013 Feb 6</p>

Panellist	...	Panellists are people who present their stories during a Schwartz Round. Attendees are people who attend Schwartz Rounds.
Point of Care Foundation (PoCF)	...	An independent charity with a mission to humanise healthcare, developed from the Point of Care programme at The King's Fund (2007-2013). https://www.pointofcarefoundation.org.uk/about-us/
Proof of Concept	...	The proof of concept for Schwartz Rounds has been used to demonstrate the feasibility of Rounds in the Irish healthcare context and to verify that Rounds can support staff in line with evidence from the UK and US.
Psychosocial	...	Psychological, i.e. (cognition/thought/mental processing and emotion), and social elements, and the interaction between them.

Glossary of statistical terms

Bootstrapping	...	<p>An inferential statistical procedure involving random resampling with replacement from the sample many times using within-sample variability to generate empirical estimations of the sample's distribution. Bootstrapping may be used to generate confidence intervals (Lavrakas, 2008).</p> <p>Lavrakas, P. J. <i>Encyclopedia of survey research methods</i> Thousand Oaks, CA: SAGE Publications Ltd doi: 10.4135/9781412963947. 2008</p>
Confidence interval	...	<p>Gives an estimated range of values which is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data</p> <p>http://www.stat.yale.edu/Courses/1997-98/101/confint.htm</p>
Correlation	...	<p>In statistics, the correlation coefficient r measures the strength and direction of a linear relationship between two variables on a scatterplot. The value of r is always between +1 and -1. +1 is a perfectly positive relationship and -1 is a perfectly negative relationship</p> <p>https://www.statisticssolutions.com/statistical-analyses-effect-size/</p>
Pearson correlation coefficient	...	<p>In statistics, the Pearson correlation coefficient (Pearson's r), is a measure of the linear relationship between two variables X and Y.</p> <p>https://www.statisticssolutions.com/statistical-analyses-effect-size/</p>
Effect size	...	<p>A statistical concept that measures the strength of the relationship between two variables on a numeric scale</p> <p>https://www.statisticssolutions.com/statistical-analyses-effect-size/</p>

Inter-quartile range	...	The interquartile range (IQR) is a measure of variability, based on dividing a data set into quartiles.
Normal distribution	...	A normal distribution has a bell-shaped density curve described by its mean and standard deviation. The density curve is symmetrical and centered at the mean http://www.stat.yale.edu/Courses/1997-98/101/normal.htm
p (or p -value)	...	The P value, or calculated probability, is the probability of finding the observed results when the null hypothesis of a study question is true. https://www.statsdirect.com/help/basics/p_values.htm
Significance (statistical)	...	Significance testing refers to the use of statistical techniques that are used to determine whether the sample drawn from a population is actually from the population or if by the chance factor. https://www.statisticssolutions.com/directory-of-statistical-analyses-significance/
Standard deviation or SD	...	A standard deviation is a number that indicates how far a set of numbers lie apart. https://www.spss-tutorials.com/standard-deviation/

Chapter One: Executive Summary

1.1 Introduction

This project was commissioned by the Quality Improvement Division, Health Service Executive, to evaluate the introduction of Schwartz Rounds in two healthcare organisations in Ireland. The overall aim of the evaluation was to establish whether Schwartz Rounds are fit for purpose in the Irish Health Service. The evaluation was conducted in the two test of concept sites. Site 1 offers palliative in-patient and community care, and has approximately 66 staff. Site 2 offers acute and critical care services, and regional services for a wide range of specialities, and employs approximately 3,546 staff.

1.2 Context and Background

Schwartz Rounds are an intervention intended to develop compassionate and supportive cultures for staff working in health care settings, and in doing so, promote improvement in health care outcomes for patients and service users. Schwartz Rounds are a multidisciplinary forum designed for all staff to come together, once a month, to discuss and reflect on the non-clinical aspects of caring for patients and families through sharing of emotional and social challenges associated with their work.¹

Schwartz Rounds are comprised of highly structured one-hour, case/theme-based, interactive discussions. A trained clinical lead and facilitator facilitate a discussion, which typically begins with an introduction from the clinical lead, followed by each panellist verbally sharing their experiences under a previously agreed theme or case. The panel includes members drawn from clinical and non-clinical staff and discussions introduce multiple perspectives on selected themes. Schwartz Round participants and panelists join a facilitated group discussion, which follows a prescribed format and does not seek solutions, but instead encourages sharing of experiences and acknowledging feelings.

A 'Test of Concept' was undertaken between November 2015 and March 2017 by the Health Service Executive, Quality Improvement Division working in collaboration with the Point of Care Foundation (PoCF), to demonstrate the feasibility and practical potential of Schwartz Rounds in the Irish health care context². Both organisations committed to delivering 10 Schwartz Rounds within the proof of concept phase.

In November 2017, following an open tender process, the Quality Improvement Division (QID) of the Health Service Executive (HSE) commissioned a team from the School of Nursing and Midwifery, The University of Dublin, Trinity College to undertake an independent evaluation of the initial introduction of Schwartz Rounds in Ireland.

1.3 Aim and Objectives

The aims/key questions of this evaluation were to establish:

1. Whether Schwartz Rounds are suitable for introduction, practically and culturally, in the Irish health system;
2. The experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads;
3. The perceived and/or actual outcomes for the service/hospital;
4. Key learnings to inform HSE decision-making on rolling out the initiative further

The research objectives are outlined below:

1. At organisational level:
 - a. To identify the drivers for introducing Schwartz Rounds
 - b. To establish the anticipated gains for the organisation in initiating Schwartz Rounds
 - c. To establish evidence of impact thus far
 - d. To identify the unanticipated impacts of introducing Schwartz Rounds to the organisation
 - e. To identify, if any, the challenges in the planning and implementation process
 - f. To uncover how potential challenges were addressed within the organisation
 - g. To identify key learning achieved that might influence Schwartz Rounds delivery locally and in other organisations in the Irish context
2. At individual level:
 - a. To explore how individuals, describe their experiences of Schwartz Rounds
 - b. To identify the anticipated and unanticipated impact of participating in/attending Schwartz Rounds
 - c. To identify the drivers and barriers to engaging in Schwartz Rounds, whether as a member of the audience, panel or steering group, or as a facilitator

1.4 Methodology and Design Evaluation Framework

A mixed methods approach was used. The quantitative component of the evaluation comprised anonymous Schwartz Round evaluation forms and ProQOL questionnaires. The qualitative component comprised focus groups, individual interviews and anonymous comment cards. The evaluation was underpinned by RE-AIM, a well-established evaluation framework in health care to address the reach, effectiveness, adoption, implementation and maintenance (sustainability) of initiatives. The findings were considered in the context of the implementation science literature for quality implementation.

1.4.1 Sampling

All staff from the two test of concept sites, staff from the Health Services Executive Quality Office and a Schwartz Rounds facilitator from the Point of Care Foundation were invited to participate in this evaluation. Participants and non-participants of Schwartz Rounds were eligible for inclusion.

1.4.2 Data collection

Quantitative Arm

Professional Quality of Life Scales (ProQOL) Version 5 and anonymous Schwartz Rounds evaluations were collected from Sites 1 and 2 prior to the conduct of this evaluation. These were analysed together with comment card data.

Qualitative Arm

A total of 31 individuals took part in the qualitative aspect of this evaluation. This comprised of 26 staff from Sites 1 and 2 who participated in individual face-to-face and telephone interviews, or one of two focus group interviews. Individual interviews were also conducted with staff from HSE (n = 4) and one interview was conducted with a key person in the test of concept phase for both sites (PoCF facilitator) who was external to the sites and HSE.

1.4.3 Data Analysis

Qualitative data were analysed using a directed Content Analysis Framework followed by application of the RE-AIM evaluation framework.

1.4.4 Ethical Issues

Ethical approval was granted by School of Nursing and Midwifery Research Ethics Committee, Trinity College Dublin and Site 2 Research and Ethics Board. Access was granted by both sites.

1.4.5 Validity, Reliability and Rigour

Data analysis were conducted independently by two researchers using Statistical Package for the Social Sciences (SPSS) Version 24 for quantitative data and NVivo Pro 12 for qualitative data. Data from the ProQOL scales were entered, cleaned and analysed by one researcher (either MC or RLV) who independently checked each other's coding and analyses for accuracy. To ensure consistency in the approach to data collection and analysis of the qualitative data, qualitative focus group and individual interviews were conducted across the two sites by VB and MC. The same study researchers worked independently in extracting coding categories from the findings of published data on Schwartz Rounds. Areas of disagreement were adjudicated upon by RLV. VB and MC independently analysed the data using the agreed approach to the directed content analysis. One interview was randomly selected to test for consistency between the two researchers in coding. Interrater reliability was determined using Cohen's Kappa³, a test that measures the degree of agreement and consistency of coding between codes. A score of above 0.6 is considered substantial agreement and a score of 0.8 or higher is considered a high level of agreement⁴. The interrater reliability for the coded anonymised interview, S104 generated separately by MC and VB was independently tested and resulted in a Kappa score of 0.75, indicating a substantial level of agreement.

1.5 Findings and Results

Findings indicate that the ethos of Schwartz Rounds is compatible with the Health Service Executive's (HSE) strategic drive for quality and safe health care. Schwartz Rounds offer a forum for staff to share experiences in a potentially safe and structured medium, irrespective of their role or status within the organisation. This creates a culture of shared communication, trust, collegiality and teamwork. While specific challenges were evident for test of concept sites, positive aspects of Schwartz Rounds were reported by staff who participate in and embrace the concept. Findings are presented herewith under each of the key questions guiding the evaluation.

1.5.1 Findings in Response to Key Question 1

Participants gave mixed responses in relation to their experiences of Schwartz Rounds. For those who invest and engage in Schwartz Rounds, the impact is generally positive. Others were less positive and some early champions of the initiative were less enthusiastic as Schwartz Rounds moved into the second year. Unless carefully monitored and tailored to the changing needs of staff and/or the organisation, early enthusiasm for Schwartz Rounds can be replaced by feelings of pressure to participate and of being burdened by the process.

For successful national implementation of Schwartz Rounds, there is a need to adapt the implementation process to the unique and specific requirements and culture of stakeholder settings.

Overall, the findings reflect positive adoption at the organisational leadership level in the test of concept sites, however, this does not appear to have fully extended to the individual staff level. While some strongly support Schwartz Rounds and perceive them to be beneficial, this is not the view of others. Negative feedback related to Schwartz Rounds appears to be attributed mostly to practical considerations, such as frequency of Schwartz Rounds, numbers of staff in the organisation and perceived pressure to participate.

Findings of this evaluation indicate that the structures recommended by Point of Care need to be resourced to enable sharing information and knowledge about Schwartz Rounds. The findings also reflect, however, that it is essential that those driving the initiative respect the voluntary nature of participation, listen to and act promptly upon staff feedback regarding the operationalisation of Schwartz Rounds, as failure to do so is counterproductive.

1.5.2 Findings in Response to Key Question 2

Staff had high expectations of Schwartz Rounds and considered Rounds as a means through which compassionate care and staff well-being could be achieved. They were also viewed as a medium for creating and sustaining a collective sense of culture and shared responsibility for improving patient care.

Responses reflect that participants find Schwartz Rounds to be of benefit in terms of relevance to their daily work, working better with colleagues and gaining insight into how others care for patients. Areas consistently highlighted by respondents included gaining greater insight into self and others, the breaking down of barriers and levelling of hierarchical structure. This ultimately improved staff interaction and teamwork, and for some respondents, Schwartz Rounds has impacted positively on their own practice.

On the whole, participants reported that Schwartz Rounds in the test of concept sites were facilitated with skill and professionalism and that group discussions were helpful. In Site 2, the physical environment for Schwartz Rounds requires a larger room to accommodate participant numbers, in addition to measures to improve the general audibility of panellists and participants.

There are challenges specifically for management and leaders to maintain support and interest in Schwartz Rounds by adapting to the changing needs of the organisation and having measures in place to enable the release of staff from ward duties to attend. Efforts were made by Site 1 to adjust the frequency and location of Schwartz Rounds. In this instance, 'fit' at the individual level had changed over time, however, adaptations occurred at a later time point. Prompt and responsive change to the process may have sustained the interest and support of early champions of the initiative.

Findings of the evaluation indicate that for long-term sustainability, ongoing resources and supports must be in place. The motivation, drive and willingness of key stakeholders to give of their time and effort, voluntarily in some cases, was instrumental to successful organisational adoption and implementation of Schwartz Rounds. The findings indicate, however, that this is not sustainable, and additional resources, for example, the appointment of an administrator to co-ordinate and operationalise Schwartz Rounds to support and embed the process for long-term sustainability is required.

The immediate benefits from the experience evidenced in the anonymous Schwartz Round evaluations are supported by many responses in the qualitative component of the evaluation.

Schwartz Round participants reported gaining an appreciation of and increased connection with others across the organisation. Interview data suggest that the breaking down of barriers, the creation of a safe space for staff to share their experiences, the recognition of the roles played by others, and how people contributed in various ways to the journey of the patient and family, generated a sense of community and team spirit.

The findings indicate that Schwartz Rounds is one way of bringing two vital components characteristic of teamwork to an organisation, 1. Shared purpose and 2. Effective communication.

Participants of this evaluation indicated that insight into their colleagues' experiences enabled them to empathise with others in the organisation. This, along with the reported recognition of the role of others and shared connectedness can impact on interpersonal relationships and ameliorate some of the stress experienced in attending to the emotional needs of patients.

The sharing of stories was also found to be helpful, for junior staff particularly, as it was felt that this helped them to normalise their feelings of inadequacy with the knowledge that there were others, who, even after years of practice, continue to find the emotional aspects of caring challenging. This offered a reminder also of the availability and willingness of colleagues to offer support when needed.

Schwartz Round participants reported feeling supported in the emotional aspects of care provision and also reported improved interpersonal relationships.

This study has demonstrated that Schwartz Rounds are a positively evaluated initiative valued by the majority of staff who have attended or participated as panellist, facilitator, clinical lead and/or steering committee member.

1.5.3 Findings in Response to Key Question 3

The findings of this evaluation indicate that Schwartz Rounds has the capacity to bring members of the organisation together. Successful reach and adoption are affected by contextual factors related to organisation size and numbers of staff. This is an important issue in terms of reach and access to information, particularly relevant to Site 2.

Although research participants had difficulty extracting explicit outcomes at organisational level or tangible workplace culture change, responses reflecting the experiences and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads are mostly positive.

1.5.4 Findings in Response to Key Question 4

Qualitative interview data suggests that contextual factors in relation to stability of the organisation should be considered prior to introducing Schwartz Rounds. The impact of staff rotation and organisational change on the introduction of a new initiative has implications for the capacity of sites to support the attendance of target groups.

There is a need for additional support for organisations during times of challenge. The establishment of the core training team from the outset was highlighted as a key enabling factor. The need for ongoing education, support and expert help in maintaining Schwartz Rounds was stressed. This was particularly with regard to keeping Schwartz Rounds themes relevant and meaningful for participants and to achieve that, participants called for mechanisms to address organisation-wide issues that emerged from Schwartz Rounds discussions, while respecting the confidential nature of Schwartz Rounds.

There is a need for careful communication among organisational structures and processes to support the establishment of Schwartz Rounds and to secure on-going ownership by staff and management. This requires prompt responsiveness to staff needs from the very beginning.

The size of the site was found to be important for sustaining commitment. The bigger site had a larger pool of staff to draw upon. This contributed towards sustaining commitment and keeping Schwartz Rounds relevant; however, there are challenges to managing large numbers of participants.

Site 1 participants felt that the size of the organisation negatively impacted on their experiences due to perceived pressure to participate. Merging organisations for Schwartz Rounds presents practical issues, not least the prospect of travel commitments for staff.

Staffing levels posed challenges for management in terms of releasing staff and maintaining interest in Schwartz Rounds. A core team of individuals driving Schwartz Rounds, resulted in an over-reliance on key members. For long-term sustainability there is a need for more ownership to be taken by the steering group and the organisation in general.

1.6 Discussion of the Findings and Results

Findings suggest that the test of concept sites were under a process of adoption and embeddedness of Schwartz Rounds at the time of our evaluation. It was evident that, in both test of concept sites, the process had moved from the initial 'honeymoon' phase, characterised by staff enthusiasm and support for the initiative, to the reality of what is involved in the practical implementation and commitment required, to sustain Schwartz Rounds in the long-term.

The experiences of those who participated in the Schwartz Rounds as panellist, participant, steering group committee member, or combination of these roles, reflect those consistently reported in published research studies on Schwartz Rounds.

This study has demonstrated that Schwartz Rounds are a positively evaluated initiative valued by the majority of staff who have attended or participated as panellist, facilitator, clinical lead and/or steering committee member. The unique structure and processes of Schwartz Rounds allows for the inclusion of staff of all grades and disciplines. Our findings indicate that Schwartz Rounds enables a levelling effect by offering a forum to share experiences where staff at all levels are willing to be open and vulnerable with others. Areas consistently highlighted by respondents included gaining greater insight into self and others, the breaking down of barriers and levelling of hierarchical structure. This ultimately improved staff

interaction and teamwork, and for some respondents, Schwartz Rounds impacted positively on participants' own practice.

Study participants reported that attending Schwartz Rounds dismantled barriers, offered a forum for a greater sense of community, insight into self and others' emotional and support needs and consequently, promoted reflection on self and practice. They also reported that attending Schwartz Rounds enabled them to acknowledge a shared purpose with clinical and non-clinical staff across the organisation. This is important to ensure that members of the organisation feel a sense of belonging and can identify their position in the organisation and that their individual contribution is recognised.

The sense of community, connectedness, respect for others and the awareness of emotional and support needs of self and others reported in this study, has the potential to contribute to the management of workplace burnout⁵. Organisational strategies, such as local initiatives to promote community, connectedness and meaning have been shown to be effective in managing workplace burnout⁶.

The concept of unity in goal setting is significant, as characteristic of effective teams is the notion of shared ownership and clear purpose. Interview data suggest that the breaking down of barriers, the creation of a safe space for staff to share their experiences, and the recognition of the roles played by others and how people contributed in various ways to the journey of the patient and family, generated a sense of community and team spirit. These views are consistent with those expressed in the literature where the capacity for Schwartz Rounds to bring members of the organisation together is reported^{7, 8, 9}.

There are challenges to keeping themes relevant and engaging and while addressing difficult topics can be taxing, they may also lead to fruitful discussion⁹. Creating confidential space to articulate concerns may reveal organisation-wide issues; however, Schwartz Rounds are not designed to 'problem solve', but to focus on feelings and 'social challenges' (p.118) associated with work¹¹. It is important, therefore, that staff are fully aware of the scope and purpose of Schwartz Rounds and are supported by leaders and managers to seek practical solutions to organisational issues.

These findings provide valuable insights into strategies that will facilitate the introduction of Schwartz across the Irish health care system and increase the quality of evidence from future evaluations.

The findings, however, are not in keeping with the literature reporting culture change associated with Schwartz Rounds^{10,11,12,13}. This is not unusual and most likely due to the early

stage of the implementation phase relative to the time required to effect change. Further research is required to capture and measure the impact of Schwartz Rounds on organisational culture over time.

1.7 Conclusion

The introduction of Schwartz Rounds to the Irish context represents a significant contribution in the staff engagement work of the HSE in both its reach across different care contexts, and across clinical, support and administrative staff. The two test of concept sites were of sufficient differences in size and contexts as to provide valuable information on the practical experiences of implementing Schwartz Rounds in the HSE. The findings were largely positive, though a number of challenges were reported. Impact at individual level, including those involved in the roll-out, facilitation, and steering committee and those who attended found the experience largely positive. Schwartz Rounds render issues discussable that may not have been previously, and present a means to articulate deep-rooted questions or concerns within the organisation. Key learnings suggest that staff need to be fully aware of the purpose and scope of Schwartz Rounds as a confidential space, as distinct from a problem solving forum. The confidential nature of Rounds means that emotions and challenges associated with social aspects of work that are shared, should not be discussed in that same way in settings outside of Rounds; however, other fora and support should be available to enable staff to address organisational issues.

1.8 Key Learnings Arising from the Findings of this Evaluation

1.8.1 Insights for Policy and National Supports

Key Learning 1

Use the findings of this evaluation to highlight how staff in the Irish context have reported benefiting from participation in Schwartz Rounds.

Key Learning 2

Organisations adopting Schwartz Rounds need ongoing and objective monitoring of facilitation of Schwartz Rounds, in accordance with the changing needs of the staff and the organisation. This should be followed up, where possible, by a mechanism to action practical adaptations in response to organisational needs.

Key Learning 3

Seek expert help to establish support structures for facilitators and steering committees to introduce and manage discussion around challenging and complex topics.

*1.8.2 Insights for Organisations Introducing Schwartz Rounds***Key Learning 4**

The structures recommended by Point of Care need to be resourced to enable sharing information and knowledge about Schwartz Rounds.

Key Learning 5

Information about Schwartz Rounds, aims and process should be in an accessible format. Where possible, host communication tools (e.g., screen display) containing Schwartz Rounds related information in strategic locations; for example, staff canteen, changing rooms, and staff coffee areas.

Key Learning 6

Dedicate a specific part of the local organisation's website to Schwartz Rounds, with staff sharing their experiences of participating in Schwartz Rounds. Where feasible and appropriate, use written word, video and audio of staff from across the organisation sharing their experiences of attending Schwartz Rounds. Organisation could also advertise in advance upcoming Schwartz Rounds and all future planned rounds for that year.

Key Learning 7

Schwartz Rounds participation should be embedded as part of the role of staff working in health care settings, but communication should clarify that participation is voluntary. Time should be allocated for participation in a minimum number of Schwartz Rounds each year, where possible. The voluntary nature of participation should be respected at all times. For successful adoption of Rounds at the individual level, consider flexible ways to acknowledge attendance.

Key Learning 8

Consider co-ordinating Schwartz Rounds within an established timetable of staff events to support practical planning for attendance, for example, scheduling team meetings and Schwartz Rounds on the same day, particularly in the event where staff need to travel to the host site.

Key Learning 9

Appoint an administrator on a rotational post basis to co-ordinate and operationalise Schwartz Rounds to support and embed the process with a view to long-term sustainability and learning.

Key Learning 10

Communicate a clear definition of the steering group role, and have well defined Terms of Reference (quorum, membership, rotation).

Key Learning 11

Provide recognition for the importance of the work of steering group members by ensuring that time is allocated for committee work.

Key Learning 12

Organisations need to analyse the core values, attitudes and behaviours that define the organisation, with the support of management and leadership, to grasp the extent to which the intervention fits.

Key Learning 13

For medium to longer-term sustainability consider the possible gain from merging two smaller sites of similar ethos and interests. Take into account travel and accessibility as possible deterrents from participation.

Key Learning 14

Consider practical ways to facilitate staff attendance at rounds. Strategies such as ward/unit pop-up rounds where members of the interdisciplinary team and support staff for that ward/unit are invited to attend may be helpful. This may fit well with an extended staff handover during the afternoon shift, but would need to be off-set against the pressures that holding rounds outside normal lunch times would pose for other disciplines. Some clinically-based disciplines would also experience additional pressures from moving the Rounds outside lunch times, for example, medicine and allied healthcare professionals.

1.8.3 Insights for Schwartz Rounds Evaluation

Key Learning 15

Provide evidence to determine the true contribution of Schwartz Rounds towards addressing the needs of health care workers in support of their delivery of compassionate care. This may be achieved by evaluation, using instruments that are specific and sensitive to the purpose of Schwartz Rounds. Instruments used in previous studies can be considered and tested for appropriateness for use in the Irish context.

Key Learning 16

The body of evidence to support the impact of Schwartz Rounds can be strengthened by using research designs that minimise bias.

Key Learning 17

Conduct an independent longitudinal evaluation of Schwartz Rounds in Ireland incorporating methods to include a specific focus on identifying organisational culture change.

Key Learning 18

Future evaluations of Schwartz Rounds in the Irish setting need to incorporate pilot studies to test the potential sensitivity of the instruments selected for measuring impact.

Key Learning 19

Schwartz Rounds render issues discussable that may not have been previously, and present a means to articulate deep-rooted issues or concerns within the organisation. Taking issues outside of Schwartz Rounds, however, is not consistent with the confidential and non-problem solving ethos of the Schwartz Rounds model. There is a need to ensure that staff are fully aware of the purpose and scope of Schwartz Rounds.

Key Learning 20

Staff need a safe space, outside of Schwartz Rounds, to discuss organisational issues that need action. Therefore, other fora to address organisation-wide issues, which are of concern to staff, need to be explored.

1.9 References for Chapter one: Executive Summary

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2 Chapter Two: Introduction

2.1 Introduction

Schwartz Rounds are an intervention intended to develop compassionate and supportive cultures for staff working in health care settings, and in doing so, promote improvement in health care outcomes for patients and service users. Schwartz Rounds are a multidisciplinary forum designed for all staff to come together, once a month, to discuss and reflect on the non-clinical aspects of caring for patients and families and the emotional and social challenges associated with their work.¹

Schwartz Rounds are comprised of highly structured one-hour, case/theme-based, interactive discussions. The trained clinical lead and facilitator facilitate a discussion, which typically begins with an introduction from the clinical lead, followed by each panellist verbally sharing their experiences under a previously agreed theme or case. The panel includes members drawn from clinical and non-clinical staff and discussions introduce multiple perspectives on selected social and psychological topics. Staff members and panelists participate in the facilitated group discussion, which follows a prescribed format that does not seek solutions, but instead encourages sharing of experiences and acknowledging feelings.

Akin to other methods adopted internationally in support of staff well-being and patient care, for example, Balint rounds² and debriefing^{3, 4}, Schwartz Rounds have been evaluated in their countries of adoption, primarily in the United Kingdom and United States of America. A detailed review of the literature on Schwartz Rounds is offered in Chapter Four.

2.2 Background

In 2015, Schwartz Rounds were introduced in Ireland to two contrasting and diverse health care organisations that held a range of services:

1. One palliative (inpatient and community) care setting with approximately 66 staff, referred to as Site 1 throughout this report.
2. One acute and critical care service teaching hospital with regional services for a wide range of specialities, with approximately 3,546 staff, referred to as Site 2 throughout this report.

A 'Test of Concept' was undertaken between November 2015 and March 2017 by Health Service Executive, Quality Improvement Division working in collaboration with the Point of Care Foundation to demonstrate the feasibility and practical potential of Schwartz Rounds in the Irish health care context⁵. Both sites committed to delivering 10 Schwartz Rounds within the proof of concept phase.

In November 2017, following an open tender process, the Quality Improvement Division (QID) of the Health Service Executive (HSE) commissioned a team from the School of Nursing and Midwifery, The University of Dublin, Trinity College to undertake an independent evaluation of the initial introduction of Schwartz Rounds in Ireland.

The aims of this evaluation were to establish:

1. Whether Schwartz Rounds are suitable for introduction, practically and culturally, in the Irish health system;
2. The experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads;
3. The perceived and/or actual outcomes for the service/hospital;
4. Key learnings to inform HSE decision-making on rolling out the initiative further.

The results and findings of this evaluation are detailed in the report presented herewith.

2.3 References for Chapter Two

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3 Chapter 3, Schwartz Rounds: The Journey to Date in Ireland

3.1 Introduction

In this chapter, we present the journey leading to the introduction of Schwartz Rounds in Ireland, as described by HSE staff members with responsibility for improving staff engagement. Staff engagement is one of six drivers underpinning the HSE QID framework for improving quality in the health service¹. Schwartz Rounds is one of several interventions explored by the HSE QID to support a positive culture of staff engagement across health care settings in Ireland.

The introduction of Schwartz Rounds supported several organisational goals, including the *Health Service Executive Corporate Plan for 2015*² and the *National Standards for Safer Better Healthcare*³. The findings of the Keogh Review⁴ in the UK, which emphasised the impact of positive staff engagement on patient outcomes, and the Francis Report⁵, which highlighted the importance of improving teamwork within health organisations, urged the government and other leaders to work towards a culture that supports dedicated staff, listens to patients and embraces transparency. The results of the 2014 HSE National Staff Survey⁶ (HSE 2014), suggested that staff did not feel valued, or that the employers were unconcerned about their personal wellbeing. One interviewee reported that in 2015, €181 million was spent on absenteeism in the health services in Ireland. Some of the drivers for an intervention also included the need to (1) address the negative emotional impact of critical incidents on staff working in health services, (2) promote a sense of community following critical incidents resulting in high profile media attention, and (3) acknowledge responsibility for staff support and care from those in leadership positions.

These concerns are not specific to the Irish context. In the UK, for example, the *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis Report)*⁵ highlighted the association between staff wellbeing and the quality of care delivery. Nevertheless, there are important Irish contextual challenges. Significant cuts in health budgets since the recession, loss of staff across the health service and overall reduced staffing have placed particular strain on staff morale.

According to HSE participants, a review of various approaches to leading, fostering and engendering authentic staff engagement, pointed to Schwartz Rounds as a potentially powerful forum for organisational and cultural improvement and staff engagement. Initial

findings from the roll-out of Schwartz Rounds in the NHS lent support for prompting staff engagement and improving compassionate care. Schwartz Rounds were viewed as an approach that bypassed the perceived hierarchical system of the health care setting, a system that was believed to impact negatively on teamwork and safety. Evidence from staff engagement presentations highlighted a link between engagement and organisational performance, patient mortality and patient safety.

3.2 Drivers for Choosing Schwartz Rounds

A number of factors influenced the decision to introduce Schwartz Rounds in HSE clinical sites in Ireland. These included the reported uptake of Schwartz Rounds in the UK involving 100 Trusts, access to a structured and branded ‘tried and tested’ methodology, and a white paper publication about creating joy and meaning at work from the Institute of Health Care Improvement in Boston ⁷. Finding joy and meaning in the workplace was viewed as a desirable aim for health care workers.

The feedback emerging from the UK on the Schwartz Rounds ‘brand’ was very positive and was supported by a website, videos and supporting testimonials. There was also an appetite for an intervention in clinical practice settings in Ireland. Staff from two health care settings, which were eventually chosen as the sites for Proof of Concept of Schwartz Rounds, had come forward and indicated enthusiasm and a desire to engage with Schwartz Rounds.

It is worth noting that Schwartz Rounds were one element of HSE efforts targeting staff engagement, support and wellbeing. Ballint Rounds, for example, are also supported by the HSE; but serve a different, if complementary role in the HSE’s overall staff support programme. The expectations from Schwartz Rounds, as expressed by the HSE staff members are summarised below.

3.3 Expectations of Schwartz Rounds

Reports from HSE QID staff leading staff engagement indicate the following expectations of the introduction of Schwartz Rounds in health care institutions in Ireland:

- Improving staff wellbeing, which may also have a long-term effect on absenteeism
- Recognising that health care work is emotionally charged, and the importance of caring for staff
- Creating a sense of collective culture, collective responsibility and reciprocal

responsibility for change

- Creating a culture to optimise quality improvement initiatives
- Creating a space for all staff to meet, and create a forum for problems to be shared, heard and understood, but not solved; it was envisaged that with good leadership, organisational issues identified in the Rounds would be addressed in a separate forum as appropriate.
- Creating teams with greater diversity, recognising and respecting the contribution of all team members
- Creating joy

3.4 Funding and introduction process

A Proof of Concept was conducted to determine if Schwartz Rounds offer a culturally and socially appropriate intervention for the Irish context. The Point of Care Foundation, UK, was established to support the roll-out of Schwartz Rounds across the UK. The Point of Care Foundation is the licenced holder for Schwartz Rounds and received some funding from the UK Department of Health from 2013-2015 to support the introduction of Schwartz Rounds more widely in the UK. This was in response to the Francis Report⁵. The Foundation was contracted by the Staff Engagement Team in the HSE QID to provide training and support for the Proof of Concept phase.

Following procurement, organisations participating in Schwartz Rounds began a Service Level Agreement of two years with Point of Care Foundation. This involved identifying a clinical lead and a minimum of two facilitators, with proposed protected time for the clinical lead and facilitator roles, a Schwartz Rounds administrator and steering group. The organisations were required to enable these personnel to commit to co-ordinating and facilitating monthly Schwartz Rounds and provide the funding necessary to offer lunch, or breakfast for staff attending Schwartz Rounds. The people identified as clinical leads and facilitators were required to have expertise in facilitation. Two days training was provided by Point of Care on how to use the Schwartz Round model.

A number of the national directors within the acute services, mental health and community care, who were responsible for the delivery of services were contacted with an open invitation for expressions of interest to participate in the Proof of Concept. The HSE agreed to fund the licence, the training and support and coordinate the Proof of Concept. The National Directors

from two sites where staff had previously indicated interest made contact and the sites were selected for the Proof of Concept, one from community care and one from the acute care services. Schwartz Rounds were introduced in these two named sites in 2015. A Report spanning the full length of the Proof of Concept for Schwartz Rounds at both sites from November 2015 – March 2017 was completed in 2017⁸.

The purpose of this evaluation study is to establish:

1. Whether Schwartz Rounds are suitable for introduction, practically and culturally, in the Irish health system;
2. The experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads;
3. The perceived and/or actual outcomes for the service/hospital;
4. Key learnings to inform HSE decision-making on rolling out the initiative further.

3.5 References for Chapter Three

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4 Chapter 4 Literature Review

4.1 Introduction

This chapter presents the findings of a review of literature evaluating Schwartz Rounds. A systematic search of published literature was undertaken across a range of databases and a number of grey literature sources were also searched (Appendix 1). The findings are synthesised in the following sections and are presented under the following themes: overall evaluation of Schwartz Rounds, psychosocial aspects of health care provision, interpersonal understanding, relationships and teamwork, personal impact of Schwartz Rounds, influence of Schwartz Rounds on policy and practice, and implementation of Schwartz Rounds.

4.2 Search Results

The literature search uncovered 12 original research and evaluation reports on Schwartz Rounds ¹⁻¹². From the grey literature search, we identified a pre-publication peer-reviewed summary of an evaluation research project¹³, one original research report¹⁴ linked to a published evaluation report¹, three discussion papers ^{15,16,17}, and one conference abstract¹⁸. We also identified one article, which reported on an adaptation of the Schwartz Rounds process in a health care setting ¹⁹. Two additional research studies were sourced during a follow up search in July 2018 ^{20, 21}.

Most studies used methodological approaches incorporating qualitative and quantitative data²⁻⁸. A small number of studies used either solely quantitative approaches^{9,11} or qualitative methods¹⁰, mixed methods ^{2, 4, 6, 13} and multi-methods ^{20, 21}. The included research papers were quality appraised using the Crowe Critical Appraisal Tool ³¹. This appraisal tool was chosen as it allowed for research designs to be appraised on their own merits according to 8 categories (Appendix 2). Each category has a score of 0 - 5. The total score ranging from 0 – 39 along with the corresponding percentage rating for each study is reported in Appendix 3. Scores ranged from 13 (33%) ¹² to 39 (98%) ²⁰.

Schwartz Rounds have been evaluated in a range of single and multi-site settings, including one hospital in the US¹⁰, one NHS trust⁴, two hospices in the UK^{2,13}, and an integrated university teaching NHS trust, with acute and community services in North East England³ and other specialist areas such as mental health ⁵ and paediatric rehabilitation^{20, 21}. In some instances, single site evaluations were undertaken with health care professional students, for example, students at UK medical schools⁸ and interdisciplinary graduate students⁷.

Evaluation of Schwartz Rounds facilitated in two or more settings include two NHS hospitals in the UK providing acute care¹; 16 hospitals from across the USA⁹; three community and mental health services in the UK⁵; 20 paediatric intensive care units¹¹, a paediatric rehabilitation unit^{20,21}, 113 public health care organisations and hospices, one medical school, one private hospital, one prison⁶ and a mixture of sites (acute, mental health, hospice)¹³ from across the UK. Articles reporting original research, numbers of participants and size of organisations, in addition to detail about Schwartz Round initiatives are summarised in Table 1 (Appendix 3). As expected, most of the studies were based in the US and UK.

4.3 Overall Evaluations of Schwartz Rounds

Analysis of standard evaluation forms used in acute^{3,14}, hospice², and medical educational^{7,8} settings, reveal that the experience of participating in Schwartz Rounds is rated highly, with no notable differences between professions³. Of interest, however, evaluation of the introduction of Schwartz Rounds in a UK hospice, using surveys and focus groups, identified that Schwartz Round non-attenders believed that exposure to perceived experiences of clinicians or patients was not a necessary requirement for the provision of good health care².

In their analysis of the availability, practice, and helpfulness of resilience-promoting resources in 20 paediatric intensive care units in the US (PICUs), a survey by Lee *et al.*¹¹ identified challenges in information dissemination regarding the introduction of Schwartz despite the initiative being organisational. Of 1066 PICU staff members, just 24% (n=256) of staff and 20% (n=5) of management reported awareness of the conduct of Schwartz Rounds in their organisations¹¹. Of those who reported awareness of Schwartz Rounds, just 33% (n=84) of staff and 75% (n=4) of management reported occasional or frequent use of Schwartz Rounds. Of those who reported that they attended Schwartz Rounds, 61% (n= 51) of staff and 50% (n= 2) of management rated the resource, by using a Likert Scale, as moderately or very helpful. Lee *et al.*¹¹ defined accessing Schwartz Rounds as ‘occasional or frequent use’ (p. 424) of Schwartz Rounds among those who were aware of the availability of Schwartz Rounds in their institution. Access was significantly higher among physicians and advanced practice professionals (72%) than among nurses (25%, $p < .001$)¹¹

In the research, when 17 resilience-promoting resources^{1*} were rank ordered, Schwartz Rounds were one of the two most perceived impactful but underused resources.¹¹ Although

^{1*}Resilience-promoting resources measured included: ‘one-on-one discussions with colleagues’; ‘informal/social mechanisms with colleagues out of hospital’; ‘taking a break from stressful patients’; ‘staff notification of the death

generally well received^{3,7,8} and potentially underused¹¹, Schwartz Rounds are not acceptable to everyone².

4.4 Psychosocial Aspects of Health Care Provision

A number of research studies evaluating the impact of Schwartz Rounds examined psychosocial^{2*} aspects of health care provision^{1,5,9}. Findings indicate that Schwartz Rounds contribute positively to psychosocial aspects of health care, including awareness of the significance of empathy and compassion^{1,5,9}. Research by Farr and Barker⁵ reports enhanced awareness amongst staff of the emotional impact of health care⁵. This result needs to be interpreted with caution however, as Schwartz Rounds were discontinued in one of the three organisations due to cost and poor attendance, and the impact of this on the findings is unclear. The results of a prospective investigation involving nurses, physicians, social workers, clergy and 'others', demonstrated that higher frequency of attendance at a multidisciplinary Schwartz Round was associated with better insight into psychosocial aspects of care, and increased focus on the effects of illness on patients' lives and on families⁹. Staff reported feeling that they provided more compassionate health care following attendance at Schwartz Rounds¹, and higher frequency of attendance was associated with increased beliefs in the importance of empathy and compassion in patient care⁹.

Higher frequency of attendance was also found to be associated with better patient interaction scores⁹, while in research interviews, staff in community and mental health services also reported their perceptions of improved patient communication⁵. The dose effect was also emphasised in a qualitative strand of a study that received an overall high quality rating in this review²⁰. Attending more than one Round was found to have greater frequency of reporting personal and professional impact²⁰. Qualitative findings reporting the influence of Schwartz Rounds on psychosocial aspects of care are promising and may be transferable to similar contexts.

of your patient'; 'being sent home/relieved of duties after a patient's death'; 'palliative care program involvement with staff'; 'structured social mechanisms out of hospital'; 'Schwartz Center rounds'; 'acute debriefings after stressful events or deaths'; 'social work involvement with staff'; 'chaplain/spiritual care available for staff'; 'facilitation of attendance at funeral of your patient'; 'education regarding self-care, self-assessment, coping'; 'institutional memorial service'; 'autopsy results available to staff'; 'other human resource offerings'; 'employee assistance program'; 'ethics committee involvement with staff'¹¹(p. 426).

^{2*} None of the included studies defined the term 'Psychosocial'. The term Psychosocial support has been described as the culturally sensitive provision of psychological, social and spiritual care²²

4.5 Interpersonal Understanding, Relationships, and Teamwork

Several studies report that involvement in Schwartz Rounds influences participants' understanding of others, teamwork and team building, and creates a sense of shared purpose^{1-3,5,9,11}.

Researchers in one such study in a large acute general hospital in the UK, analysed 795 completed evaluation forms based on 18 Rounds, yielding 158 free text comments³. Qualitative analysis found that 89 comments reported increased understanding of the perspective of other staff, awareness of emotional response within others (in this case the Schwartz Round speakers), and recognition of staff needs for emotional support. Another UK based multi-method study with staff in mental health and community settings⁵, had a response rate of 69% (n=206) from Schwartz Round evaluations. Results revealed that 94% (n=194) of respondents reported greater insight into how others think and feel while providing health care, and 91% (n=187) reported that Schwartz Rounds would improve working relations with colleagues. These results are supported by the findings of 22 interviews, where participants reported that Schwartz Rounds enabled them to recognise that shared experiences are essential to developing trust and better relationships between colleagues.

Qualitative data obtained from inter-professional focus groups at a UK hospice² indicated that Schwartz Round attendees' experiences resonated with panellists' experiences and promoted connection to a shared purpose. Schwartz Rounds also had a positive influence on inter-professional relationships, promoting the idea of a shared experience, which led to greater sense of shared purpose, the perception of being part of a team, and validation of one's personal experiences. Interviews with attendees from two Schwartz Round pilot sites¹ indicate that participation facilitated improved relationships with colleagues and within teams, advancing respect, empathy, and understanding between staff, and was especially valued by those with less professional experience. The opportunity to hear and share in the stories of colleagues considered more experienced and sharing self-doubts or mistakes was particularly powerful. Appreciation for how others felt about their work was also cited as a contributor to increased potential for multidisciplinary working¹. Similarly, findings were reported from a Canadian study where respondents were found to value the communal sharing of emotions and experiences, the modelling of behaviours of vulnerability and building bridges within the hospital²⁰. Study participants reported renewed passion for work, improvements in inter-professional practice, attitudes and behaviours and how Schwartz Rounds impacted on their thinking about practice issues²⁰. They also reported improved relationship with colleagues through greater perspective taking and increased level of approaching behaviours²⁰.

An evaluation conducted in the US between 2006-2007⁹ found that Schwartz Rounds impacted positively on teams and teamwork. Teamwork was measured by the researchers⁹ as having the following components: appreciation of colleagues' contributions, communication, cooperation, openness to sharing care-related thoughts and concerns with colleagues, willingness to offer support, and feeling a sense of belonging to the care team. Results from retrospective respondents indicated that Schwartz Rounds had much improved participants' team involvement, appreciation of colleagues' roles and contributions, and had improved communication about psychosocial and clinical issues. While controlling for pre-Schwartz Round differences in the prospective group, increased Schwartz Round attendance was associated with higher overall teamwork scores and included positive associations with interpersonal communication and appreciation of colleagues' roles and contributions. A more recent study conducted in Canada in a paediatric setting support the belief that attendance at Schwartz Rounds has a positive impact²¹. When compared to non-attendees, attenders at Rounds were found to have significantly greater communication with co-workers after each Round ($p < 0.001$) and more personal conversations with supervisors after Round 2 and Round 4 ($p < 0.05$)²¹. Attending rounds was also found to increase attendees' perspective taking capacity²¹. These findings are consistent with those previously reported from semi-structured interviews with 44 participants (Schwartz Round leaders, facilitators and hospital administrators), which supported the quantitative findings⁹. Interviewees reported that Schwartz Rounds helped participants get to know each other and enabled them to empathise with colleagues by hearing about their perspectives and experiences and by gaining a deeper understanding of their personal and professional challenges. Interview data supported improved inter-professional teamwork and communication, as well as development of a sense of 'the big picture' (p. 1078) of patient care and respondents' place therein. The more Schwartz Rounds the participants attended, the greater the impact⁹.

There is evidence from one US study that Schwartz Rounds may be particularly useful in settings where teamwork is limited or underappreciated¹¹. Similarly, findings of a UK survey of staff across 20 paediatric intensive care units (PICUs) indicated that PICUs with lower levels of teamwork rated Schwartz Rounds significantly more impactful^{3*} than staff in PICUs with higher teamwork scores (72% versus 50%, $p < .05$)¹¹. Despite this, the utilisation of Schwartz Rounds as a resource was not significantly different between the two sites. Likewise, no significant differences were found in the utilisation or impact ratings of Schwartz Rounds

^{3*} Impact of resources was self-reported by staff in a questionnaire. Questionnaire items were not published.

between research participants whose resilience scores were moderately high or better and those whose resilience scores were moderate or lower.

4.6 Personal Impact of Schwartz Rounds: Self-understanding, Stress, and Coping

The research outlined below reported that Schwartz Rounds promote self-understanding, contribute to reduced levels of stress, and help attendees to cope with the social and emotional aspects of health care.

Assessment of impact on increased self-reflection is difficult to establish and findings across reports are mixed. Qualitative analysis of 158 free text comments, drawn from 795 completed evaluations of 18 rounds, found that 68 comments evidenced insight with a focus on the self³. Aspects of insight included, a new understanding of oneself based upon emotional responses to Schwartz Round content, resonance with and reflection upon own experiences, and insight-based future intentions, including the desire for future Schwartz Round attendance or potential change in future practice. George *et al.* assessed changes in self-reflection following attendance at one Schwartz Round with 55 respondents⁴. Although the researchers narratively reported actual increases in self-reflection, this conflicted with the data presented in the paper, which indicated no statistically significant difference. It may be the case that attendance at one Schwartz Round is insufficient to identify an increase in self-reflection. The findings from interviews reported in a study carried out in community and mental health settings⁵ do, however, suggest that the process of reflection in Schwartz Rounds promotes self-awareness.

Two quantitative studies using survey research designs, with various instruments, reported on outcomes relating to stress^{4, 9}. Statistically significant decreases in perceived stress was reported by a group retrospectively assessing frequency of feelings of stress prior to attendance at any Schwartz Round in six sites, where Schwartz Rounds had been in progress for a minimum of three years⁹. In contrast; however, the prospective group in the same study, where 10 new sites had held a minimum of seven Schwartz Rounds; reported a non-significant reduction in feelings of stress. Precisely how perceived stress was measured in this case is unclear; the authors used items 'excerpted and modified'⁹ (p. 1074) from the Cohen *et al* (1983) Perceived Stress Scale²³. Attendees of Schwartz Rounds have also expressed in interviews that they felt less stressed working with patients¹. Reduced stress was also reported in a qualitative study within a Canadian paediatric rehabilitation setting exploring the

impact of Schwartz Rounds on clinical and nonclinical hospital workers management of their work experiences²⁰.

A model has been suggested, based on data for a sequential case study evaluation⁴, outlining how Schwartz Rounds might reverse the process of workplace stress. The model suggests that feeling stressed leads to an inward focus, which reduces compassion and empathy for others. Attending Schwartz Rounds and hearing other's stories/ experiences can bring about reappraisal of one's own assumptions and this lessens threat and anxiety, which in turn breaks the cycle that can lead to withdrawal from patients and restores connection with colleagues. This model has yet to be tested.

Only one study reported on the concept of coping as an outcome of Schwartz Rounds⁹. Lown and Manning's research involving 256 retrospective respondents⁹ reported significant increases in research participants' ability to cope with work-related psychosocial demands ($p<.05$) and with work-related emotional difficulties ($p<.01$) following the introduction of Schwartz Rounds. While there were no statistically significant changes for their prospective group of 222 respondents, the group reported feeling more supported and less isolated following Schwartz Round attendance. Positive outcomes were also reported by interview respondents in Farr and Barker's study⁵ in community and mental health settings. Attendees reported an increased ability of attendees to manage difficult feelings arising from working with patients⁵.

During the conduct of this review, the evaluation team were awaiting the publication of a large-scale evaluation of Schwartz Rounds in the UK health care system by Maben and colleagues^{6,13,26–30}. One outcome of that study is a publication by Robert *et al.*⁶, which is acknowledged in this review. With the exception of a 'first look' draft summary paper¹³, at the time of conducting this literature review further peer reviewed publications had yet to emerge from this programme of research. Reported findings on Maben and colleagues study²⁵ indicated that "attending SCR reduces psychological distress and increases compassion" (p.11). The final report published in November 2018³⁰ confirmed the primary hypothesis that work engagement is positively associated with attending Schwartz Rounds was not supported. It is notable that Roberts *et al.*⁶ reported that organisations adopting Schwartz Rounds had significantly higher levels of staff engagement than non-adopting organisations. Results from a realist informed mixed methods evaluation of Schwartz Rounds across ten sites in the UK by Maben *et al.*³⁰, suggested that attending rounds could reduce poor psychological wellbeing scores. An important finding from the study³⁰, which used a clinically well-validated measure of psychological wellbeing (GHQ-12), was a statistically significant improvement in well-being

scores of attenders, when compared to a group of Schwartz Rounds non-attenders. The non-randomised sample comprised 51 regular attenders, 205 irregular attenders and 233 non-attenders. In the Schwartz Round attender group, poor psychological wellbeing scores reduced by 13%, and in the non-attenders group, poor psychological wellbeing scores reduced by 3% ($p = < 0.05$).

Furthermore, the authors state that for regular attenders, psychological wellbeing scores reduced from 25% to 12%, compared with a reduction from 37% to 34% among non-attenders; thus, demonstrating an overall improvement in wellbeing. Although these findings suggest a 50% reduction in poor psychological well-being scores for regular attenders, when compared to non-attenders, the findings need to be interpreted with caution due to risk of bias associated with a non-randomised comparative group and imbalances at baseline. The regular attender group were more senior and from medical professions. In an effort to minimise the impact of imbalances at baseline, adjustments were made during the analysis of the data. In addition, a sample size of 500 with the same staff responding at both time-points adds to the strength of the findings³⁰.

In the qualitative component of the study, Maben *et al.*³⁰ reported that respondents felt unable to judge the potential impact of Schwartz Round participation on staff well-being or delivery of patient care. Despite this, participants reported that Rounds were interesting, engaging, offered a source of support and space to reflect and process the challenges they faced at work. The opportunity to learn more about their colleagues, patient situations and engagement with multidisciplinary colleagues, created greater understanding, empathy and tolerance towards colleagues, and patients and their families. However, some respondents reported being unprepared for the sadness, anger and frustration that they experienced or witnessed in Rounds. Maben *et al.*³⁰ contend that when implemented in accordance with their philosophy, Schwartz Rounds offer a medium for staff to feel safe when vulnerable, to reduce anxiety and to process emotions and experiences. Rounds also improve coping skills and empathy, which overall, contributes to greater compassion^{13, 30}.

In summary, evidence suggests value in Schwartz Rounds for promoting staff wellbeing and self-understanding, reducing levels of perceived work related stress, and supports attendees to cope with the social and emotional aspects of health care provision.

4.7 Influence on Policy and Practice

Three studies reported on organisational culture change associated with the introduction of Schwartz Rounds^{1,9,10}. The studies varied in size and health care setting (single and multi-sites), using a combination of pre/post Schwartz Rounds surveys, qualitative interviews and focus groups. Interviewees from the two pilot settings in a study assessing the transferability of Schwartz Rounds from the US to a UK setting and its potential impact in the UK, found that Schwartz Rounds may have contributed to making the hospital working environment less hierarchical¹. In recognition of similarity of challenges across roles and disciplines, professionals felt enabled to meet and have discussions with all colleagues as equals. Schwartz Rounds were reported as attributable to improving the experiences of staff and patients by providing support, in contrast to the philosophy of a reward/punishment management system¹. Schwartz Rounds were viewed as helpful by creating a sense of shared vision at an organisational level, while the act of implementing Schwartz Rounds was identified as being positive, symbolically. The presence of senior and more experienced staff at Schwartz Rounds was important in creating a sense of valuing of the process. Research participants considered it too soon after one year to assess whether Schwartz Rounds had influenced practice or organisational policy¹.

Changes in institutional practices and policies were, however, noted by 51% (n=131) of 256 retrospective respondents and 40% (n=89) of 222 prospective respondents in an evaluation of Schwartz Rounds in the US⁹. Additional interview data identified an otherwise unobtainable opportunity for dialogue with concomitant potential to change institutional culture⁹. Another US study¹⁰ using focus groups and telephone interviews also reported a positive culture change, with feelings of increased support, lower levels of hierarchy and appreciation of the importance of the contribution of all staff¹⁰.

4.8 Implementation of Schwartz Rounds

The process of implementing Schwartz Rounds is reported in research by Robert *et al.*⁶ The researchers describe a sharp increase in the adoption of Schwartz Rounds in the UK in late 2013 and 2014, ostensibly as a result of the publication of the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Report)*²⁴. Robert *et al.* incorporated secondary data analysis to examine the relationship between adopters and non-adopters of Schwartz Rounds in 116 public health care organisations in England by early 2015⁶. The researchers identified that although there were no significant differences in national accreditation ratings or overall patient experience scores, adopting organisations had significantly higher levels of

staff engagement (incorporating advocacy, motivation, and involvement) than non-adopting organisations in both 2013 and 2015⁶. To examine reasons why Schwartz Rounds were adopted by organisations, the researchers interviewed 45 Schwartz Round clinical leads and facilitators. Findings revealed that the primary reason for the adoption of Schwartz Rounds was to improve staff well-being.

In Farr and Barker's⁵ study involving three community and mental health settings, a requirement in one setting to link Schwartz Rounds to key performance indicators reportedly made promotion of Rounds more difficult⁵. The researchers did not detail these difficulties; however, one Trust, though it was not reported whether it was the same one, discontinued Schwartz Rounds after one year, due to prohibitive costs for the organisation. Various suggestions have been made in the literature about how to modify or improve Schwartz Rounds programmes operationally in local contexts. There are suggestions that interaction is more difficult in larger groups^{5,8}. The authors of a publication²⁵ documenting their reflections of implementing Schwartz Rounds in the year of 2015-2016, in a UK paediatric setting, reported that running the Rounds within an established timetable of Grand Rounds, which were traditionally supported by medical staff was helpful, from a practical perspective. Advertising through word of mouth, discussions regarding the value of Schwartz Rounds and dissemination of information, offered mechanisms to reach and include additional staff members.

4.9 Limitations

The extant literature is mainly limited, due to a lack of clarity as to whether all participants responded to the evaluations, whether responses were from repeated attendees, as repeat responses may skew evaluation results, and the relationship between attendance rate and evaluation. From a methodological perspective, this risk is compounded by the assumption that those who are favourably inclined toward Schwartz Rounds may attend more frequently, and may provide positive ratings more frequently, which can skew results in one direction^{2,3,7,13}. There is potential for the evaluations of a group of dedicated attendees, for whom Schwartz Rounds are useful or beneficial, to conceal limited or absence of value of Schwartz Rounds to less frequent attendees, or non-attendees.

Another limitation is that research on Schwartz Rounds is predominantly descriptive^{1,3}, or exploratory in design.⁴ This is likely to reflect the nature of the intervention; attendance is voluntary and there are cultural differences across organisations, even those of similar size

and purpose. The significant challenges in demonstrating real impact on aspects such as culture and individual practices should be acknowledged. To increase confidence in the findings and to enable generalisability of results, studies need to use research designs that minimise bias, and adopt probability sampling techniques, powered sample sizes, and validated instruments that are pilot tested for appropriateness to measure outcomes of Schwartz Rounds and to examine variables that influence outcomes and the effectiveness of Rounds.

In general, the literature appears to centre on self-reported evaluations of Schwartz Rounds using either the standard Point of Care Schwartz Round evaluation forms or other unspecified evaluation forms either alone, or along with interview and/observational methods^{2,3,7,8, 12, 13}. Where additional surveys were conducted, ^{4, 6, 9} the validity and reliability of the instruments used were not reported in detail. One study reported on the validity of a resilience instrument used based on previously conducted studies¹¹ and one provided validity and reliability results specific to the study³⁰. Despite some positive findings, there have been few reports on the actual impact of Schwartz Rounds upon health care practice, teamwork, stress, or coping, with the exception of new findings from a large scale realist evaluation of Schwartz Rounds conducted by Maben *et al*¹³.

In the absence of estimates of effect size, actual effects of Schwartz Rounds on personal, team, and cultural outcomes cannot be quantified. The manner in which quantitative approaches to evaluating Schwartz Rounds have been conducted means that there is high potential for scientific bias, potentially including for example, confirmation bias (e.g. false identification of evidence of Schwartz Round effects) and socially desirable responses (including acquiescence). It is unclear whether efforts were made to control for such biases in the majority of studies. Despite this, the inclusion of qualitative approaches to evaluating the Schwartz Rounds indicate that attendees and others participating and organising Rounds consistently report positive benefit. In this review the findings from some of the qualitative studies need to be interpreted with caution, because detail relating to qualitative data analysis is not reported⁹, or limited to including staff with a specific role in Schwartz Rounds, for example, organisers, panellists or facilitators¹.

At the time of conducting this study, other than the proof of concept conducted by Point of Care, Schwartz Rounds have not been independently evaluated in Ireland. There may be differences in culture, subtle or otherwise, between the Irish context and those previously studied.

4.10 Conclusion

The findings from this review indicate that evaluations of Schwartz Rounds are generally positive and there were no reports of any potentially negative effects. Evidence points to potential benefits for the psychosocial aspects of health care, and for interpersonal understanding, relationships, and teamwork. There is also emerging evidence that Schwartz Rounds promote self-understanding, reduced stress, and overall better 'coping' systems. Although earlier findings in the review were based on studies of low quality, approaches to evaluation have developed with researchers striving to follow best practices, such as quasi-experimental designs,²¹ and mixed methods³⁰, valid and reliable measures, and reporting on qualitative studies with evidence of rigour²⁰. Many of the findings from these high quality reports support the earlier literature, thus strengthening the evidence in support of the benefits of Schwartz Rounds for health care organisations and health care staff.

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5 Chapter Five Evaluation Design and Methods

5.1 Introduction

In this Chapter we present the evaluation design, methods, recruitment strategies, data collection and analysis, and ethical considerations.

5.2 Aim

The aim/key questions of this evaluation as formulated by the funder, the HSE QID, was to establish:

1. Whether Schwartz Rounds are suitable for introduction, practically and culturally, in the Irish health system;
2. The experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads;
3. The perceived and/or actual outcomes for the service/hospital;
4. Key learnings to inform HSE decision-making on rolling out the initiative further.

From the above, we developed the following questions to reflect impact at various organisational levels and to drive our evaluation, namely:

1. Organisational level:
 - a. What were the drivers for introducing Schwartz Rounds?
 - b. What were the anticipated gains for the organisation?
 - c. What is the evidence so far of impact?
 - d. What were the unanticipated impacts?
 - e. What, if any, challenges arose in the planning and implementation process?
 - f. How were potential challenges addressed within the organisation?
 - g. What key learning has been achieved that might influence Schwartz Rounds delivery locally and other organisations in the Irish context?
2. Individual level:
 - h. How do individuals describe their experiences of Schwartz Rounds?
 - i. What were the anticipated and unanticipated impacts of participating?

- j. What were the drivers and barriers to engaging in Schwartz Rounds whether as a member of the audience, panel or steering group, or as a facilitator?

5.3 Evaluation framework

This evaluation was underpinned by RE-AIM¹ (Appendix 4), a well-established evaluation framework in health care to address the reach, effectiveness, adoption, implementation and maintenance (sustainability) of initiatives. The findings were considered in the context of the implementation science literature for quality implementation.

5.4 Eligibility criteria

All key stakeholders involved in the Test of Concept phase of Schwartz Rounds in Ireland were eligible for invitation to participate. This included individuals who were employed by the organisations at the time of the Schwartz Rounds roll-out. Key informants (from each site) including clinical leads, facilitators, steering group, panellists, participants, staff who did not attend, and senior managers and administrators who had responsibility for supporting the introduction and implementation of Schwartz Rounds, including those who facilitated staff attendance at the rounds were invited to participate. Staff from the HSE QID and Human Resource (n=4) involved in implementing Schwartz Rounds and a facilitator from the Point of Care Foundation (n=1) were interviewed individually.

5.5 Ethical approval

Ethical approval was granted by School of Nursing and Midwifery Research Ethics Committee, Trinity College Dublin and Site 2 Research and Ethics Board.

5.6 Access and recruitment methods

Access was granted from both sites. Letters of invitation and information packs were distributed to clinical leads, facilitators, steering group, panellists, and senior administrators and managers. In consultation with steering groups from each site, recruitment strategies included a leaflet advertising the evaluation, comment cards

(Appendix 5) and poster display (Appendix 6). Posters stated the purpose of the evaluation and schedule for focus group sessions and an option to contact the research team for an individual interview. These were exhibited in key staff areas in Sites 1 and 2, and research stands were placed strategically in each site to advertise the research. Members of the evaluation team conducted site visits and attended Schwartz Rounds to promote the research and were available to respond to staff queries as required. In addition, e-mail shots were sent out to all staff notifying them of the evaluation and inviting them to participate, with a link to the participant information pack, Schwartz evaluation website (<http://www.nursing-midwifery.tcd.ie/research/schwartz-rounds-evaluation/>) and contact email and phone contact for the research team. Potential research participants contacted the research team to express interest, and to receive further information about the research. Posters were developed further in response to feedback from the Schwartz Rounds steering group to ensure that potential research participants were aware that they were invited to engage in a research interview, despite whether they had/had not completed comments cards.

5.7 Ethical Dimensions

Ethical principles were integrated throughout the research evaluation and underpinned by National and International Codes of good practice in research.

5.7.1. Informed Consent

Following review of the Participant Information Leaflet (PIL) (Appendices 7a and 7b), and immediately prior to data collection, the researcher conducting the interviews (focus group and individual face-to-face) co-signed the consent form (Appendix 8) with the participants. Copies of the signed consent form were made available to all participants. Participants were self-selecting and had access to study information via the Schwartz evaluation website, poster display and information packs which were distributed in key areas and research stands and were available to download from the website.

In the case of a telephone interview, the participants emailed a scanned signed consent form and the PIL was re-visited prior to commencing the research interview.

5.7.2. Anonymity and Confidentiality

Members of the focus groups were known to each other. Prior to commencement of the focus group, the moderator, a member of the research team, opened a

discussion on ground rules and the importance of confidentiality. Participants were requested not to reveal the identities of other participants and were asked not to refer to others by name during the interview.

All identifying markers including names and wards were removed during analysis. Focus group participants were referred to by number e.g. FG1A; FG1B and so on. For individual interviews, participants were allocated a code. All other identifying features for example, the ward or unit were coded. The engagement of the test of concept sites (n=2) in the initial roll-out of Schwartz Rounds has been well publicised through HSE publications and therefore, the identity of the two organisations is already in the public domain. For the purpose of this report however, the test of concept sites are referred to as Site 1 and Site 2.

The quantitative data collected for this evaluation were mainly completed and collected prior to the commencement of this evaluation study, these were Professional Quality of Life Scales (ProQOL) V5 and anonymous Schwartz Rounds evaluations from Sites 1 and 2 (Appendix 9). Focus group and individual interviews were recorded, transcribed and uploaded directly into data management and analysis software NVivo Pro 12. In reporting direct quotations, participants were referred to by their assigned code. The recordings and NVivo were stored in password protected computers in the School of Nursing and Midwifery, Trinity College Dublin. Hard copy records of signed consent forms were stored in a locked cabinet in a secure office.

5.8 Data Collection Methods

The evaluation applied a mixed methods design (Figure 1).

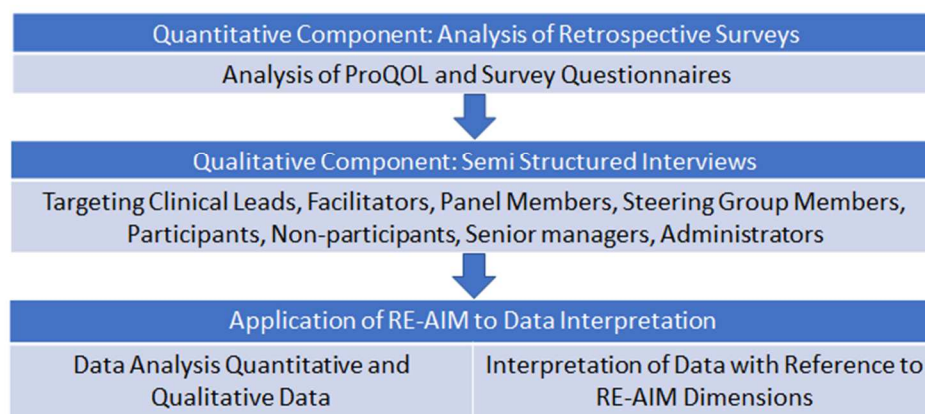


Figure 1: Overview of Mixed Methods Design

5.8.1. Data Collection – Quantitative Arm

Staff from QID, Sites 1 and 2, and the Point of Care Foundation considered a number of methods to evaluate the introduction of Schwartz Rounds in real time. It was noted that evaluation protocols, unique identifiers and lengthy questionnaires may be perceived as burdensome by staff and potentially affect participation. A decision was taken to maximise the perceived safety, confidentiality and experience of Schwartz Rounds participants by using ProQOL, which was recommended by the Point of Care Foundation facilitator, and identified by the teams as the approach that would work best in their organisations.

Point of Care Schwartz Rounds evaluation forms and ProQOL (Professional Quality of Life) Version 5 measures were collected by Steering Committee members during the initial Schwartz Rounds programme roll-out in Site 1 and Site 2. In Site 2, the second round of ProQOL was collected during the Schwartz Round on the 9 April 2018. The rationale to avoid participant follow-up between the two time points, as expressed by the HSE, was to maximise participation and experience while establishing Schwartz Rounds in the test of concept sites. Completed evaluation forms were forwarded to the researchers for data entry and analysis.

ProQOL (Version 5) is comprised of 30 items rated on a Likert scale of 1 to 5 (1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = very often). The ProQOL is divided into two subscales, 'compassion satisfaction' and 'compassion fatigue'. Compassion fatigue is further sub-divided into two parts, 'burnout' and 'secondary traumatic stress'. Each subscale has a summary score²

Compassion satisfaction refers to the pleasure one receives through working to help others, feeling positive about colleagues and the ability to work well; higher scores indicate greater satisfaction in the ability to be an effective caregiver. Burnout is an element of compassion fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively e.g., feelings that your efforts make no difference, or feelings can be associated with very high workload or a non-supportive work environment. Higher scores signal higher risks of burnout. Secondary traumatic stress is the second component of compassion fatigue, which may be primary or secondary. Primary exposure refers to direct exposure to traumatically stressful events e.g., field work in a war area. Secondary exposure refers to repeated exposure to other people's traumatic events e.g., that experienced by a therapist or emergency worker caring for a person following a primary traumatic event.

In Site 1, ProQOL was administered to all staff attending the first Schwartz Round in January 2016 and those attending Round 10. In Site 2, ProQOL was administered to all staff attending the first Schwartz Round and to all new attendees attending each subsequent Schwartz Round. For the purpose of this report, all ProQOL questionnaires administered to attendees the first time they attended a Round were included in the time-one data analysis (Site 1, n=33; Site 2, n=239). ProQOL administered to attendees at Round 10 in Site 1 (n=32) and at the Schwartz Round in April 2018 in Site 2 were analysed as time-two ProQOL data collection (n=31).

It is important to note that the ProQOL questionnaires were administered anonymously; it is therefore, not possible to determine with certainty that the ProQOL data collected at the second-time point are from the same individuals that attended Round one. This limits the potential benefits of Time 1 and Time 2 comparison.

Individual respondent's ProQOL findings were calculated when respondents completed 50% or more of the scale items. In addition, if more than 50% of items were missing from a subscale, the score for that subscale for an individual response was not calculated.

5.8.2 Data Collection – Qualitative Arm (two elements):

Individual face to face and telephone interviews were conducted by Margarita Corry (MC) and Vivienne Brady (VB) with staff members in Sites 1 and 2, with key members (n=4) of the HSE, charged with steering the initiation and implementation of Schwartz Rounds in Ireland, and a Schwartz Round facilitator from the Point of Care Foundation (n=1). Interviews began with a broad open question to elicit individual views and experiences of Schwartz Rounds. Subsequent questions included prompts to gain research participants perspectives in line with the RE-AIM dimensions and specific to their organisational role (Appendix 10). Eight individual face-to-face interviews and two focus group interviews (Group 1, n=5 and Group 2, n=2) were conducted with staff members in Site 1. Eleven individual interviews, were conducted with staff from Site 2. For those persons who did not wish to participate in focus group interviews, individual interviews were facilitated via face-to-face/telephone depending on availability and preference. All focus group and individual interviews were recorded digitally and selected interviews were transcribed.

Anonymous comment cards (Appendix 5) and collection boxes were placed at strategic points that were recommended by the Schwartz Rounds team. This ensured that staff members who were unable/did not wish to participate in an interview could contribute to the evaluation. Information requested on comment cards also assisted in eliciting the views of those who did not attend the Schwartz Rounds. Comment cards contained the questions:

1. *'Did you attend Schwartz Rounds?'*
2. *'What influenced your decision?'*
3. *'Any other comments?'*

5.8.3 Data Collection – Cost estimates

We estimated both direct and indirect costs associated with the Schwartz Rounds. Direct costs represent the value of all goods, services, and other resources consumed in an activity (and so would not exist if the activity was not undertaken). Indirect costs are additional resource considerations that cannot be directly attributed to an activity; depending on the context these can include proportions of associated overheads and/or reductions in productivity.

In this study, no-one associated with the Schwartz Rounds was reimbursed for their contribution and rooms were provided free of charge, so relevant direct costs are limited to the cost of providing food at each meeting. Indirect costs include all unpaid time contributed in the preparation, presentation, facilitation and attendance of the sessions, as well as a proportion of overheads associated with the use of a room. We estimated the cost of donated time using the professional affiliations reported in questionnaires, using the full cost of employment (including PRSI and pension contribution) at the mid-point of the relevant salary scale: (<https://www.hse.ie/eng/staff/benefitservices/pay>).

Food costs were reported direct to the research team by individual site contact persons.

The HSE Quality Improvement Division paid the PoCF for the training, mentoring and the licencing arrangement.

5.9 Data Analysis Methods

Data were analysed using a two-stage approach. In stage one, quantitative and qualitative data were entered into data management software and analysed as described below. The coding framework for a directed content analysis approach³ was developed from an extensive review of the literature on Schwartz Rounds. In stage two, the data analysed in stage one were evaluated through the lens of the RE-AIM framework to address the study objectives.

5.9.1. Stage 1

Quantitative data:

As requested by the funder, the summary data provided by the test of concept sites for the Point of Care Schwartz Round evaluation forms were used where possible. The responses to each of the eight questions on the evaluation form were summarised for each round and an overall summary for 10 Rounds in Site 1 and 6 Rounds in Site 2 was provided.

Data from the ProQOL questionnaires were managed using Statistical Package for the Social Sciences (SPSS) Version 24 for quantitative data. Following data entry, the data were reverse coded where appropriate in accordance with the ProQOL guidelines. A total score was computed for each scale. An overall average

response score for each of the ProQOL scales was computed for both sites individually.

Qualitative data:

VB and MC listened to recorded interviews independently while simultaneously reading transcribed interviews. Transcribed data were checked for anonymity and accuracy against the recordings. The transcripts were then entered into the qualitative data management software NVivo 12 Plus and analysed using directed content analysis³. Study participants were entered in NVivo 12 Plus in accordance to site, number of rounds attended, category of staff (clinical/non-clinical), role in organisation (e.g. nurse, doctor, physiotherapist) and role in Schwartz Rounds (e.g. panellist, participant, facilitator, committee member). The coding framework for the directed content analysis was developed from an extensive review of the literature on Schwartz Rounds. Concepts emerging from the literature were organised into codes and categories. Categories included reference to wellbeing, compassion, empathy, support and dialogue. These concepts were tabulated, reviewed independently by three team members and agreed. The coding applied in NVivo by MC were validated and agreed using additional manual direct content analysis by a second team member, VB. New concepts that emerged from the data as part of this evaluation were coded separately. The coded data were further categorised in accordance with the RE-AIM framework to elicit reach, effectiveness, adoption/embeddedness, implementation and maintenance/sustainability.

The open comments from the Point of Care evaluation forms were analysed using content analysis.

5.9.2 Stage 2

Following the analysis of the quantitative and qualitative data, the findings from both data sets were examined through the lens of RE-AIM and aligned to the aims of the study. This was conducted manually by two of the study authors working independently (VB and MC) and then together to finalise categorisation according to study aim.

5.10 Rigour

To ensure rigour, all processes adopted in the analysis of the data were conducted independently by two researchers. For the quantitative data from the ProQOL

instrument, data were entered, cleaned and analysed by one researcher (either MC or RLV) who independently checked each other's coding and analyses for accuracy. To ensure consistency in the approach to data collection and analysis of the qualitative data, qualitative focus group and individual interviews were conducted across the two sites by VB and MC. The same study researchers worked independently in extracting coding categories from the findings of published data on Schwartz Rounds. Areas of disagreement were adjudicated upon by Richard Lombard Vance (RLV). As outlined, VB and MC independently analysed the data using the agreed approach to the directed content analysis. One interview was randomly selected to test for consistency between the two researchers in coding. Interrater reliability was determined using Cohen's Kappa⁴, a test that measures the degree of agreement and consistency of coding between codes. A score of above 0.6 is considered substantial agreement and a score of 0.8 or higher is considered a high level of agreement⁵. The interrater reliability for the coded anonymised interview S104 generated separately by MC and VB was independently tested and resulted in a Kappa score of 0.75, indicating a substantial level of agreement. This is expected given that the approach used was directed content analysis and MC and VB generated the codes.

In Chapter Six, the findings are presented in accordance with the study objectives.

5.11 References for Chapter Five

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6 Chapter Six Results and Findings

6.1 Introduction

This chapter is presented in two sections. Section 1 contains the results from the ProQOL scales, anonymous staff feedback forms and comment cards. Section 2 contains the findings from interviews and anonymous feedback survey data presented under the four key evaluation questions, informed by the RE-AIM constructs.

6.2 Section 1 ProQOL Scales, anonymous staff feedback forms and comment cards results

Quantitative data were extracted from the Point of Care anonymous staff feedback forms and Professional Quality of Life ProQOL scores taken at the two sites involved in the test of concept phase. These data were collected prior to the commencement of this evaluation, with the exception of the second round of ProQOL data at Site 2, which was collected during the Schwartz Round in April 2018, as part of this evaluation.

Quantitative data were retrieved also from anonymous comments cards. Table 1 illustrates the number of comment cards collected according to Site and the proportion of respondents who stated that they had attended/had not attended a Schwartz Round.

Table 1: Number of comment cards collected in each site

Site	Number of Comment Cards Collected	Attended Round	Did not Attend Round
Site 1	18	17	1
Site 2	57	21	36
Total	75	38	37

6.2.1: Results from anonymous staff feedback forms

Quantitative data were gathered at each of the ten Schwartz Rounds via routine anonymous evaluation forms.

Table 2 illustrates the number of anonymous staff feedback forms as provided by the test of concept Sites 1 and 2

Table 2: Number of anonymous Point of Care Schwartz Rounds Evaluation feedback forms collected in each site

Site	Total attendance over all Rounds	Total number of forms returned over all Rounds
Site 1 10 Rounds	354	331 (94%)
Site 2 10 Rounds	864	581 (67%)
Total	1218	912 (75%)

Tables 3-10 illustrate separate and merged responses to the eight questions contained in the Schwartz Round Evaluation Forms.

In all cases, a large majority of attendees at both sites evaluated the Rounds positively:

- Over 94% at both sites agreed that stories presented were relevant to their daily work (Table 3)
- Over 85% at both sites agreed that they gained knowledge to support them in caring for patients (Table 4).
- Over 95% at both sites agreed that the Schwartz Rounds would help them to 'work better' with their colleagues (Table 5).
- Over 94% at both sites agreed that facilitated discussions were helpful (Table 6).

- Over 97% at both sites agreed that discussions were facilitated well (Table 7).
- Over 90% at both sites agreed that they gained insight that would help them to care for patients (Table 8).
- Over 95% at both sites had plans to continue attending (Table 9).
- Over 93% at both sites would recommend Schwartz Rounds to their colleagues (Table 10).

Table 3: The stories presented by the panel were relevant to my daily work' %

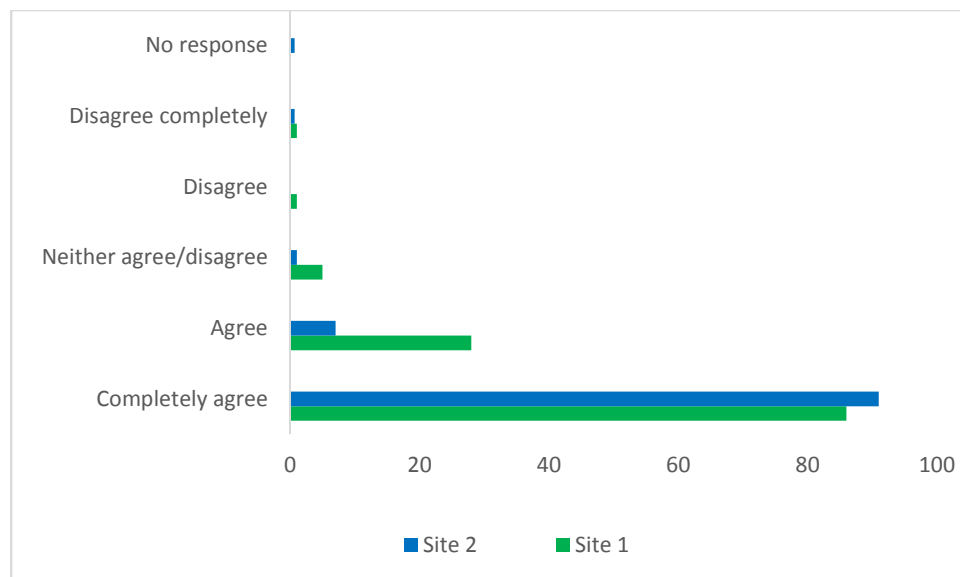


Table 4: 'I gained knowledge that will help me care for my patients' %

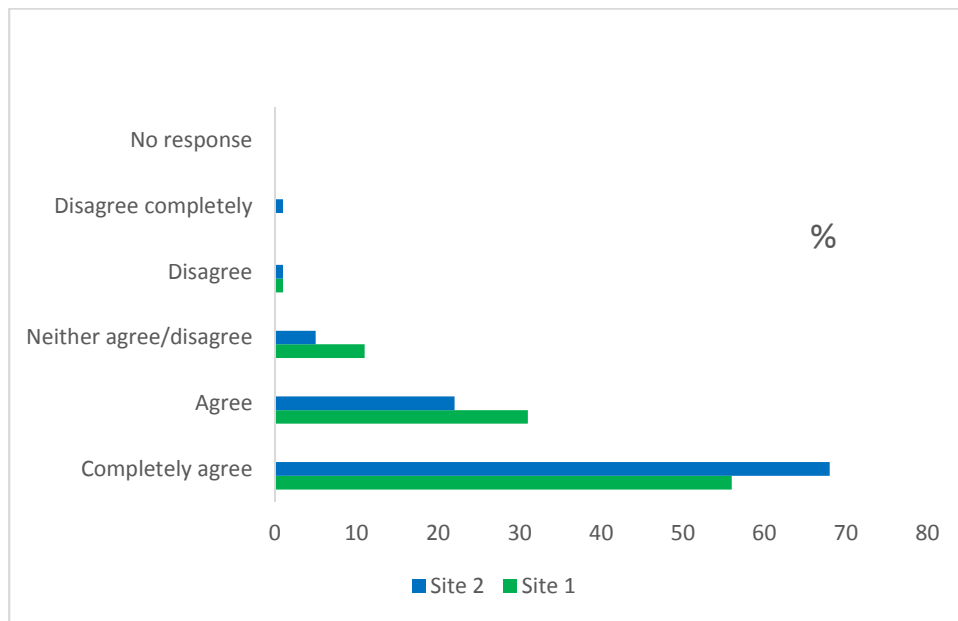


Table 5: 'Today's Round will help me to work better with my colleagues' %

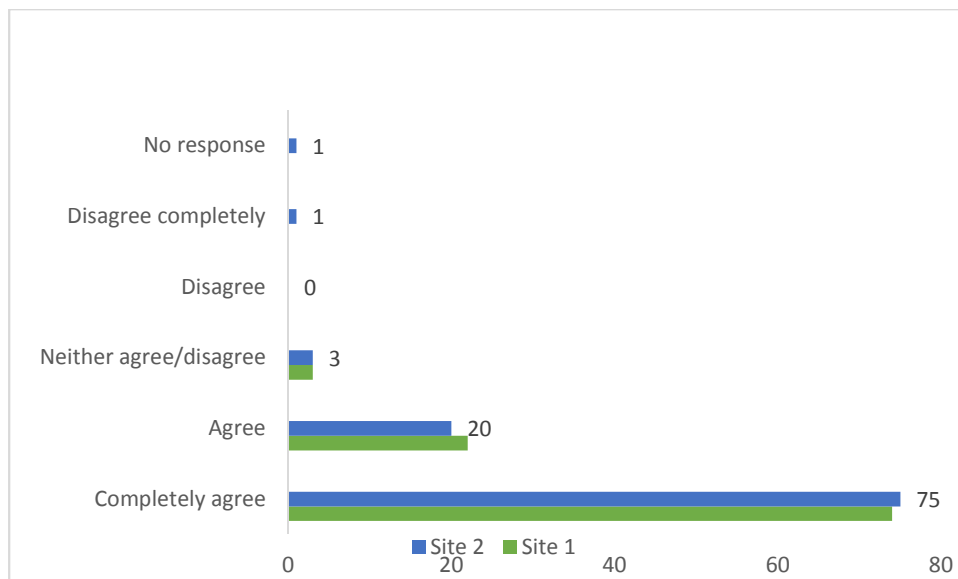


Table 6: 'The group discussion was helpful to me' %

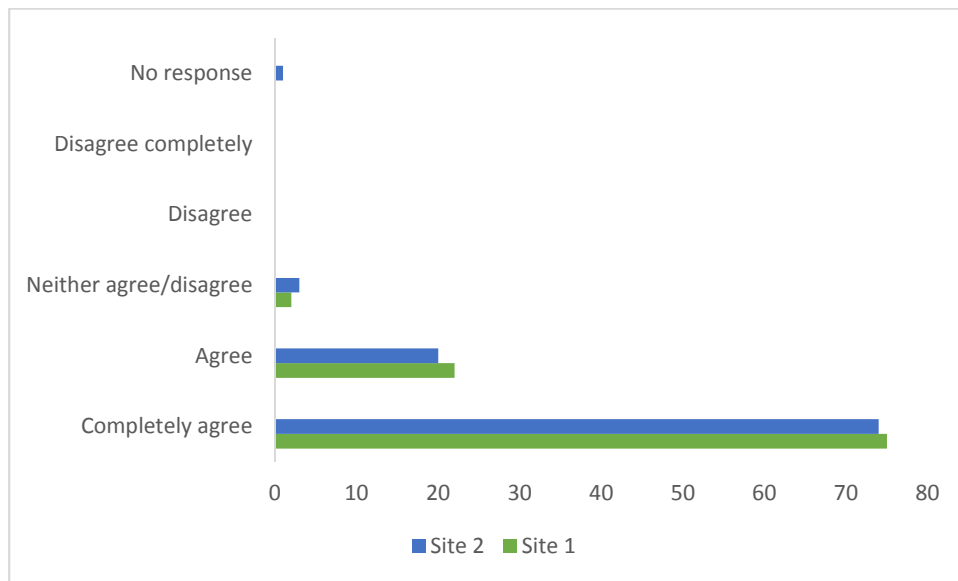


Table 7: 'The group discussion was well facilitated' %

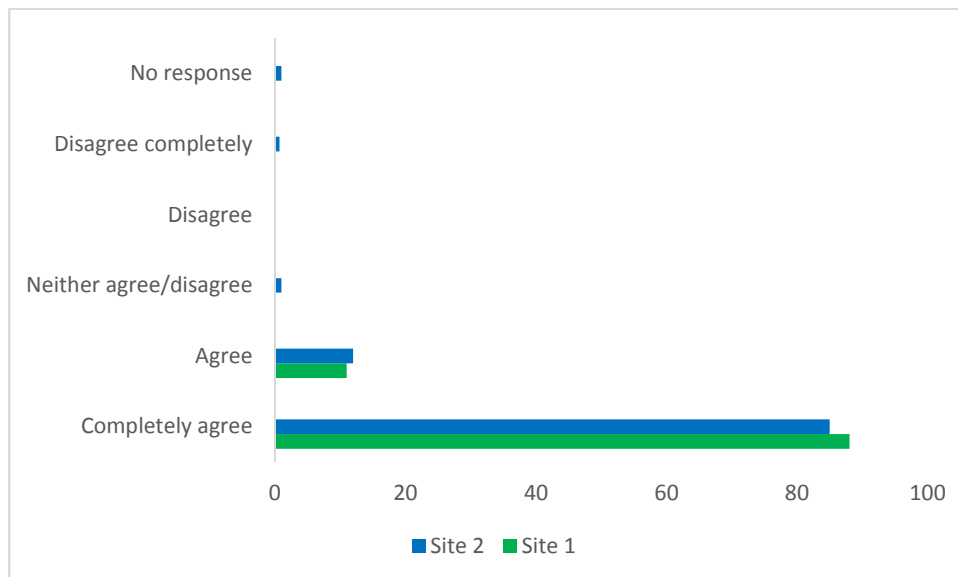


Table 8: 'I have gained insight into how others care for patients' %

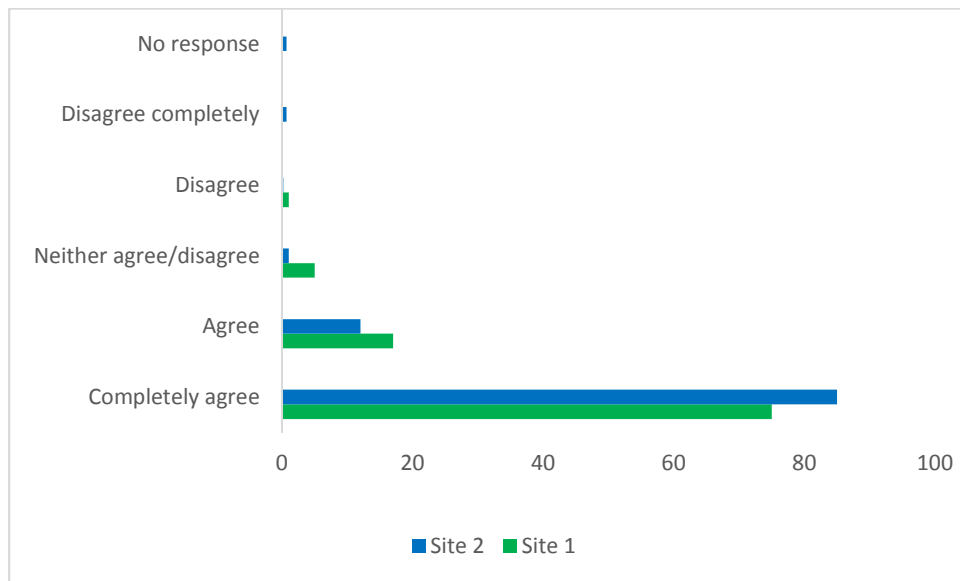


Table 9: 'I plan to attend Schwartz Center Rounds again' %

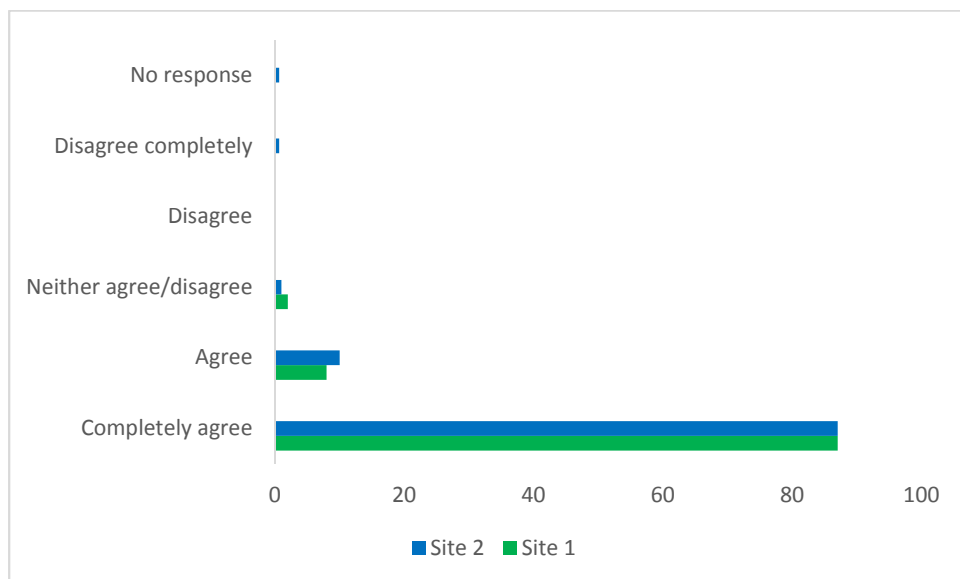
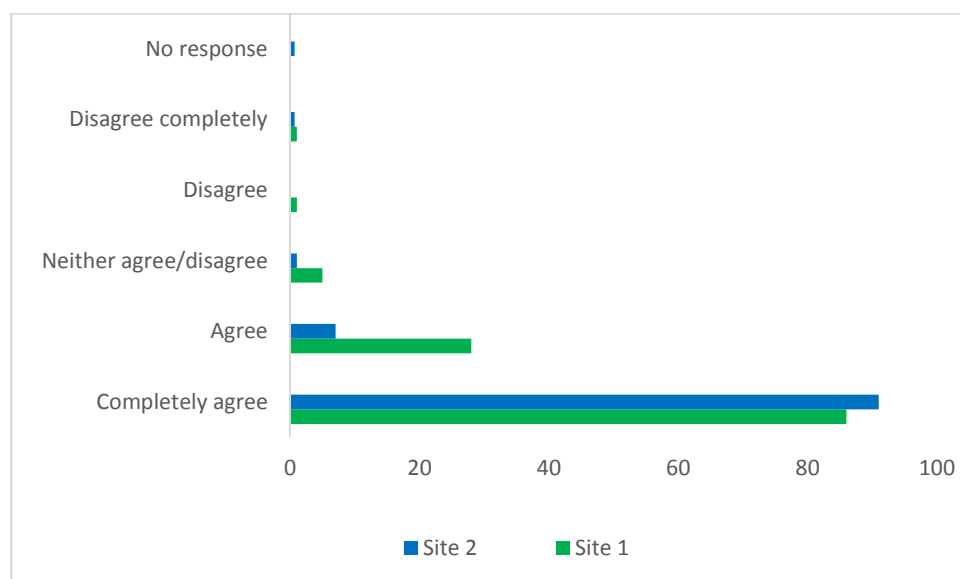


Table 10: 'I would recommend Schwartz Center Rounds to colleagues' %



Open Comments from Schwarz Rounds Evaluation Forms

Open comments sections on Schwartz Round evaluation forms included benefits of attending Schwartz Rounds, the environment where Schwartz Rounds were held and practical issues, for example, opportunities for attendance, and organisation and facilitation of Schwartz Rounds were highlighted in open comments.

In Site 1, twenty-eight comments focused on the benefits of attending the Schwartz Rounds, these included, for example, increased awareness and appreciation of the work of colleagues, awareness of how others manage and counteract feelings of isolation and the usefulness of stories shared to promote self-care.

In Site 1, one positive comment reflected the feedback and warmth of the audience. Three negative comments related to the environment, harsh lighting, intimidation felt by sitting in front of an audience, and practices that were perceived as distracting, such as the use of mobile phones and eating during Schwartz Rounds.

Ten comments reflected positive feedback about Schwarz Rounds' facilitation, 7 comments related to the openness and honesty of discussions held, 14 stated that the relevant Round was interesting and/or enjoyable and 12 remarked on the 'powerful', 'genuine and authentic' and 'making sense of chaos' nature of discussions also.

There were occasional comments reflecting the challenging nature of sharing personal experiences, but that Rounds afforded time for reflection. Four participants commented on challenges to attending, one indicated time pressures, two indicated that patient care was impacted or may be impacted if busy and two participants requested that Rounds be held on alternative days or times to facilitate patient care.

Nineteen comments reflecting dissatisfaction with the environment emerged from Site 2, for example, the room was too small to accommodate those wishing to attend, the air-conditioning was noisy and there was difficulty in hearing speakers. There were requests for larger rooms and the use of microphones.

Thirty-seven comments reported positive benefits to attending Schwartz Rounds, for example, appreciation for the supportive nature of Rounds, awareness of the need to step back to think and to make time for others, and gaining insight into others' experiences

Other positive comments related to the openness and honesty of panellists (n=5 comments), facilitation of individual Schwartz Rounds (n=4) and organisation of Schwartz Rounds (n=3). One comment related to staff on the wards having difficulty attending in the middle of the day and one asked that community colleagues be included.

6.2.2: ProQOL Results

There were 33 respondents from Site 1 at the first data collection time-point and 32 at the second time point of ProQOL administration.

Almost one fifth (19%) of Schwartz Rounds participants for Site 2 did not complete the ProQOL Scale. ProQOL forms were administered to each attendee at their first Schwartz Round in Site 2. This resulted in a total number of 239 respondents across 12 Rounds (as per Site data). Due to a number of previously collected ProQOL questionnaires with missing information (Table 11), specific subscales could not be calculated for some participants. There was a total of 31 respondents at the second time-point ProQOL administration in Site 2.

The results for ProQOL at Points One and Two of data collection are presented in Tables 11 and 12. As the questionnaires are not linked to individual participants at each time point, a direct comparison cannot be made.

It is notable that scores indicate that the majority of participants had average or high compassion satisfaction at Point One data collection (Table 11) and this was stable

for Site 1 at Point Two data collection (Table 12); however, in Site 2, almost one third (32%) had low compassion satisfaction scores at Point Two data collection.

All participants had low or average burnout at Point One data collection (Table 11) across the two sites, and at Point Two data collection (Table 12), 6 participants (19.4%) in Site 2 reported high burnout.

All participants had low or average Secondary Traumatic Stress scores at Point One data collection (Table 11) across the two sites; however, at Point Two data collection (Table 12), 10 participants (32.3%) in Site 2 reported high Secondary Traumatic Stress, this was regardless of number of Rounds attended.

Across the two sites at Point One data collection (Table 11), there were 4 people with low Compassion Satisfaction in Site 2, and no-one with high Burnout or Secondary Traumatic Stress scores. At Point Two data collection (Table 12), there was one person in Site 1 with low compassion satisfaction (n=1, 3.33%) and a higher number in Site 2 (n=10, 33%). In Site 2, there were 6 (19.4%) with high burnout and one third (n=10, 32%) with high Secondary Traumatic Stress.

Table 11: Results for ProQOL at Point One of Data Collection

Point One Data Collection					
Subscale	Site	Low n (%)	Average n (%)	High n (%)	Missing n (%)
Compassion Satisfaction	Site 1 (n=33)	0	22 (66.7)	11 (33.3)	-
	Site 2 (n=239)	4 (1.7)	96 (40.2)	95 (39.7)	44 (18.4)
Burnout	Site 1 (n=33)	16 (48.5)	17 (51.5)	0	-
	Site 2 (n=239)	124 (51.9)	70 (29.3)	0	45 (18.8)
Secondary Traumatic Stress	Site 1 (n=33)	19 (57.6)	14 (42.4)	0	-
	Site 2 (n=239)	130 (54.4)	65 (27.2)	0	44 (18.4)

Note: Compassion Satisfaction Higher Scores indicate greater satisfaction in the ability to be an effective caregiver

Table 12: The Results for ProQOL at Point Two of Data Collection

Point Two Data Collection					
Subscale	Site	Low n (%)	Average n (%)	High n (%)	Missing n (%)
Compassion Satisfaction	Site 1 (n=32)	1 (3.33)	14 (46.67)	15 (50.0)	-
	Site 2 (n=31)	10 (32.3)	14 (45.2)	6 (19.4)	1 (3.2)
Burnout	Site 1 (n=32)	23 (74.19)	8 (25.81)	0	-
	Site 2 (n=31)	11 (35.5)	13 (41.9)	6 (19.4)	1 (3.2)
Secondary Traumatic Stress	Site 1 (n=32)	25 (78.13)	7 (21.88)	0	-
	Site 2 (n=31)	7 (22.6)	11 (35.5)	10 (32.3)	3 (9.7)

Note: Compassion Satisfaction Higher Scores indicate greater satisfaction in the ability to be an effective caregiver

6.2.3 Association between attendance and ProQOL scores

Self-reported frequency of attendance at Schwartz Rounds was available for 23 participants at Site 2 at Point Two data collection time point.

To determine the potential impact of Schwartz Rounds attendance on ProQOL scores, Pearson correlations were calculated with $\alpha=.05$ and two-tailed significance. Bootstrapping* techniques were used to generate estimates of 95% confidence intervals (CI) for the Pearson correlation values.

Correlation analyses are summarised in Table 13. Neither the correlations between attendance and compassion satisfaction, nor attendance and burnout were statistically significant. In site 2, there was, however, a statistically significant relationship between attendance and secondary traumatic stress, with higher frequency of attendance associated with lower secondary traumatic stress ($r = .428$, $p = .042$, 95%CI [-.680, -.070]). While this findings suggests that more frequent attendance at Schwartz Rounds may lower secondary traumatic stress, due to the small sample size and risk that those who completed the forms at the second time point were different staff members to those who completed them at the first time point, the finding must be interpreted with caution. Despite this, it is a finding that is worthy of robust testing in future evaluations of Schwartz Rounds in the Irish context.

Table 13: Summary of Correlation Analyses

Post-Final Round (Site 2) Relationship Between Schwartz Round Attendance and Compassion Satisfaction and Fatigue (ProQOL)					
ProQOL Subscale	N	Pearson r	p	95% CI	
				Lower	Upper
Compassion Satisfaction	23	-.050	.820	-.406	.411
Burnout	23	-.122	.580	-.454	.153
Secondary Traumatic Stress	23	-.428*	.041	-.680	-.070

Note. Bootstrapped confidence intervals are based on 999 samples

* Correlation is significant at the 0.05 level (2-tailed).

6.3 Section 2: Interview and anonymous feedback from data

In this section, the findings are presented under the four key evaluation questions, informed by the RE-AIM constructs. The four evaluation questions are:

1. Whether Schwartz Rounds are suitable for introduction, practically and culturally, in the Irish health system (addressed through the uptake and embeddedness (reach and adoption), and implementation and maintenance dimensions);
2. The experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads (addressed through effectiveness and implementation dimensions);
3. The perceived and/or actual outcomes for the service/hospital (addressed through effectiveness, implementation and maintenance dimensions);
4. Key learnings to inform HSE decision-making on rolling out the initiative further (addressed through all dimensions).

6.3.1 Participants: Qualitative Data

Qualitative research allows researchers to explore the meanings that people attribute to everyday phenomena, while acknowledging that meanings are particular to the individual, cannot be generalised and are coloured by contexts. Analysis and understanding of a concept is aided by recognition of patterns in participants' speech or text (data), which may be clustered into categories or themes. The themes are reported with the background and situation in narrative form, to contextualise the person's account and are usually accompanied by rich quotation, expressive language and the use of personal voice. In qualitative research, the researcher looks for commonalities and outliers (observation points that are distinct to others) to explore the concept or phenomenon in full. Data are in the form of words and are not generally reduced to numbers; with the exception of where a content analysis framework is used and there is a focus on the frequency of terms or words seen. The use of an analytical framework, the reporting of rich quotation and personal voice makes this aspect of the research process more explicit and guards against the researcher imposing their own meanings on the data. A total of

26 staff took part in individual face-to-face and telephone interviews, or one of two focus group interviews from Site 1 and Site 2. Individual interviews were also conducted with staff from HSE (Table 14). An additional interview was conducted with a key person in the test of concept phase for both sites (PoCF facilitator) who was external to the sites and to the HSE.

Table 14: Number of individual and focus group interviews and number of participants

Interviews	Face to Face/ Phone	Focus Group	Total number of participants
HSE	4	-	4
External	1	-	1
Site 1	4	2 (n=2, n=5)	11
Site 2	15	0	15
Total	24	2 (n=7)	31

Table 15 illustrates interview participants for Sites 1 and 2 according to role in Schwartz Rounds initiative and representation according to clinical/non-clinical role.

Table 15: Interview participants for Sites 1 and 2 according to role in Schwartz Rounds Initiative and according to clinical/ non-clinical role.

Role in Schwartz Rounds	Site 1	Site 2	Total
Clinical			
Clinical Lead	1	1	2
Participant - Facilitator*	1	0	1
Participant - Panellist **	6	4	10
Participant	2	4	8
Facilitator	0	1	1
Non-Clinical			
Participant	1	1	1
Participant - Panellist	-	4	4
Total	11	15	26

* Participant facilitator: an individual who reported being a participant and also a facilitator of Schwartz Rounds on various occasions. ** Participant - panellist: an individual who reported being a participant and also a panellist in Schwartz Rounds on various occasions.

6.3.2 What were the drivers to introducing Schwartz Rounds?

Analysis of data from interviews with HSE staff, clinical leads and facilitators illustrates the rationale for the introduction of Schwartz Rounds in test of concept sites, from their perspectives:

‘At the time, our own hospital was going through the fallout from a [patient] death. And we had a need for some way of coming together as a hospital community...I felt that this was something that we would really benefit from as a hospital community...we have very few opportunities to meet as a community...hospitals are almost like a family and we don’t have any opportunity to come together across all of the various different disciplines and professions that work here. Schwartz Rounds provided us with that opportunity. And I think we’re very lucky to have it...’ (S213)

The above quotation reflects apparent grass roots awareness of the difficulties facing staff and the perceived timeliness of the intervention of Schwartz Rounds. Individual interviews with members from HSE reveal coexisting mindfulness of the challenges and potential impact for front line health care staff offering patient care:

'It [Schwartz Rounds] started from a confluence of our awareness, some people in the system creating a demand for it and it fitted in with our set of priorities and I suppose, our values...we try and bring to the thing, which is about valuing staff and as being the door through which we really unlock better health care...personally, I believe, it [Schwartz Rounds] is quite different, because it is very specifically aimed at, I suppose, improving morale, teamwork, mutual respect, non-hierarchical respect, and respecting the process of care and the impact it can have on us as human beings, more so than anything else I've seen' (HSE03)

6.4 Key Question 1

Are Schwartz Rounds suitable for introduction, practically and culturally, in the Irish health system?

This question is addressed through reach, adoption, implementation and maintenance dimensions of RE-AIM. In this sense, 'reach' refers to the uptake including the absolute number, proportion, and representativeness of individuals willing to participate in an initiative ¹

Site 1 offers palliative inpatient and community care, and has approximately 66 staff (53 clinical and 13 non-clinical). Site 2 offers acute and critical care, and regional services for a wide range of specialities and has approximately 3,546 staff. Numbers of clinical and non-clinical staff attending each Schwartz Round during the test of concept phase are presented in Tables 16 and 17. Full break down by role, for those returning evaluation forms, is presented in Appendix 11. In Site 1, clinical staff approximate attendance, as measured by return of evaluation forms, ranged from 27-47% of total clinical staff across the 10 Schwartz Rounds. This represented an attendance ranging from 25-100% medical staff, 7-50% nursing staff and 27-81% allied health carer staff. Non-clinical staff attendance ranged from 17 - 43%. This represented attendance ranging from 25-100% for administration staff and 9-55% for other support staff of which, nursing assistants' attendance ranged 13-25%. On occasion, subgroups of non-clinical support staff were in attendance as there was only one member of staff in the role e.g., Chaplain (attended 9 rounds),

porter (attended 7 rounds), security (attended 4 rounds) and fundraiser (attended 4 rounds). In Site 1, 23 participants across the 10 Rounds in the test of concept phase did not submit evaluation forms.

In Site 2, clinical staff attendance ranged from 1-3% across the 10 rounds and this reflected an attendance range of 0.85 - 2.48% for nursing, 0.16 - 1.48% for medical staff and 1.0 - 7.45% for allied health staff. Non-clinical staff attendance ranged from 0.44 - 1.54%. This represented management attendance ranging from 0.59 - 2.78% and support staff 0.2 – 1.71%. Most support staff did not report attending Rounds. The only support staff that reported attendance at the rounds were the HCAs where 1 attended on 4 occasions. In Site 2, support staff such as porters, chaplain, security and domestic staff did not report attendance, although it is possible that they and other staff attended and categorised their affiliation as 'other'. In Site 2, 283 participants across the 10 Rounds in the test of concept phase did not submit evaluation forms.

Table 16: n (%) clinical and non-clinical staff attending each round in Site 1

Clinical/non-clinical roles	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Round 7	Round 8	Round 9	Round 10
Clinical staff Consultants and NCHDs (n = 4), Nurse/midwife (n = 30), Allied health care professionals (n = 11) Total number in the organisation (n = 45)	18 (40)	20 (44)	11 (24)	23 (51)	19 (42)	22 (49)	21 (47)	22 (49)	19 (42)	9 (20)
Non-clinical staff** Non-clinical (Board members (n = 11); Support staff (n = 19), managers** Total number in the organisation (n = 30)	5 (17)	10 (33)	7(23)	11 (37)	12 (40)	13 (43)	8 (27)	11 (37)	12 (40)	11 (37)
*Total number of clinical and non-clinical staff in the organisation (n = 75)	23 (31)	30 (40)	18 (24)	34 (45)	31 (41)	35 (47)	29 (39)	33 (44)	31 (41)	20 (27)

Other	5	5	3	3	5	2	4	2	3	2
Total attendance at the Round	38	38	27	39	36	39	39	40	31	27
Total number of evaluation forms not returned	9	4	1	3	0	0	4	2	0	0

*Breakdown of staff numbers as received from Site Management.

**Managers are only included if they specified discipline/profession.

***Volunteers have not been included here as they were not involved at the time of test of concept.

Table 17: n (%) clinical and non-clinical staff attending each round in Site 2

Clinical/non-clinical roles	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Round 7	Round 8	Round 9	Round 10
Clinical staff <i>Consultants and NCHDs (n=608), Nurse/midwife (n=1,409), Allied health care professionals (n=496)</i> Total number in the organisation 2,513	45 (2)	63 (3)	62 (3)	23 (1)	44 (1.75)	50 (2)	24 (1)	40 (1.59)	50 (2)	47 (2)
Non-clinical staff Non- clinical (Management/Admin (n=502); Support staff (n=409) Total number in the organisation 911	14 (1.54)	8 (0.87)	4 (0.44)	4 (0.44)	7 (0.77)	7 (0.77)	4 (0.44)	5 (0.55)	10 (1.09)	7 (0.77)
*Total number in the organisations 3424	59 (1.72)	72 (2.1)	66 (1.92)	27 (0.78)	51 (1.48)	57 (1.66)	28 (0.82)	45 (1.31)	60 (1.75)	54 (1.58)

Other	9	25	8	2	5	6	5	6	9	0
Total attendance at the Round	102	108	102	50	84	104	43	83	95	93
Total number of evaluation forms returned	62	83	74	29	63	63	33	49	68	57

*Breakdown of staff numbers as received from Site.

6.4.1 Why Schwartz Rounds?

One appealing characteristic of Schwartz Rounds is the inclusivity and relevance to all members of the organisation and the capacity of Schwartz Rounds to bring members of the organisation together.

'The attraction with Schwartz was, you know, the Chair of the Board, CEO, pharmacist, doctor, nurse, catering staff, ground staff, security staff, finance, that anybody who is involved has an opportunity to participate...to work in a system where we do and we see horrible things and that has to have, and we know it has an impact on people' (HSE02)

This emphasis and importance on securing a non-hierarchical setting for staff is evident from the perspective of frontline health care providers in the organisations, who discussed the 'levelling' effect of Schwartz Rounds also:

'I think in Ireland there's this adopted structure of a hierarchy of jobs, you know, the consultant, the ADON, you know that kind of tier level, but I think it's broken down that, especially in [Site 1]. That we're all on a level playing field when it comes to giving support and care to all the patients that we look after...the biggest thing I think it's broke down that hierarchy of professions and given everyone the same voice, it makes everyone acutely aware of the other person.' (S107)

The statement below suggests that Schwartz Rounds participation appears to enable staff members to feel a sense of belonging and a part of the mission of the organisation:

'What it's done is, it's kind of given a status to staff that weren't used to having a status, always been in the background. Not knowing what they've done, you know what they do, what keeps them awake at night...when I say status, I'm thinking of this globally...there's a huge amount of work being done by different people right across the organisation and they don't get an opportunity to express themselves. And this gives them an opportunity to express themselves and get that kudos or given that opportunity to the wider audience and that improves the morale within an organisation, regardless of who it is.' (S209)

6.4.2 Factors influencing attendance/non-attendance across groups

Rationale for non-attendance is captured somewhat by comment card responses. While Site 1 participants appeared fully cognisant of the initiative, of the 57 comment cards completed in Site 2, 20 respondents stated that they had never heard of Schwartz Rounds. In relation to the Reach aspect of RE-AIM, which refers to the uptake including the absolute number, proportion, and representativeness of individuals willing to participate in an initiative, three respondents from one department suggested that their lack of awareness of Schwartz Rounds was likely to be because they did not have access to internal email. One respondent stated their understanding was that Schwartz Rounds did not apply to their service.

Anonymous responses from Site 2 comment cards indicate issues with reach and representation from some staff groups and this is reflected by the comment below:

'It does not reach out to some disciplines due to their structure/timing-mainly nursing/portering/HCAs/and clerks are excluded. None of these disciplines get over 1 hour for lunch or can be released 1-2pm. I contributed to a mini Schwartz round during a nursing study day where there were less panellists to accommodate the shorter lunch break and the nurses were engaged and relished the experience. We need to reach out to all frontline staff, Schwartz Rounds I attended had lots of senior administration/management there, pharmacy, physiotherapists, CPCs, specialist nurses, CNMs but very few junior doctors and staff nurses' (Comment card response Site 2).

Data covering impetus to attend first time and drivers and barriers influencing attendance, revealed that reasons for attending Schwartz Rounds are varied. The impetus to attend first time is driven by curiosity, word of mouth, and general motivation to support a staff initiative in the workplace. Positive feedback from colleagues involved in Schwartz Rounds also influences desire and motivation to participate. Interview data suggests that personal bias prohibited Schwartz Rounds attendance, in addition to other factors:

'Some people are more open to receiving information...there's a natural bias there towards the people that want to be there, as opposed to the people that don't want to be there...' (S212)

Attendance is also affected by the role of the staff member, the nature of the work and associated responsibilities. Two of the main challenges associated with

attendance are ensuring adequate patient care and services at ward level and ensuring that everyone has a fair opportunity to attend Schwartz Rounds:

'I think Schwartz might be hitting a wall at the moment in terms of that and I know the attendance has dropped off, not a lot, but a little bit...I think the challenge now is just to sustain the rounds...to have high levels of sponsors I think, is really important and it would be really good to see more consultants coming too...it seems difficult, it's a real challenge for staff and nurses to get off the ward to attend Schwartz and I think they would really benefit from attending the rounds' (S210).

The transferability of the Schwartz Rounds' structures and processes to the Irish setting is influenced by practical considerations and specific contexts relevant to the two sites, such as challenges for management and leaders to release staff to participate in Schwartz Rounds. Capacity of test-of-concept sites to support attendance of target groups is hindered in Site 2 because of the potentially large volume of attendees. This was the case, particularly when Schwartz Rounds were introduced initially:

'I understand a lecture theatre would create a didactic setting; however, Schwartz Rounds are very important, and people will not continue to come if they are turned away due to a lack of seating' (Open comments anonymous staff feedback form, Site 2)

'There's a very good level of attendance. And they're always chock a block and oversubscribed. There's been multiple sessions where they've had to turn people away, because the room was just too full...' (S212)

Environmental issues were also highlighted in comment card responses:

'I no longer attend these rounds, oversubscribed with admin, venue too small' (Comment Card, Site 2)

Similarly, albeit for the opposite reason, capacity of test of concept sites to support attendance of target groups is hindered in Site 1 because of the potentially small volume of attendees:

'I think if you were in an acute hospital with a staff of six hundred, you know, you'd have a pool of staff, but with the same sixty here and we're going every month and it was just coming around too soon. The environment I felt was safe, you could say

what was on your mind, but the theme sometimes wasn't related to anything that we, I felt I'd anything to say about.' (FG2B)

In both sites, the sustainability of the intervention relied heavily on the motivation and commitment of the steering committee.

'We're probably up to about, I don't know eighteen or nineteen Rounds at this stage. And I'd say one, maximum two, have been offered to us, you know by a person, or by a team, but mostly that we've had to come up with the idea and sort of you know shape it and make it happen. So, that's a concern' (S213).

The above comment reflects a desire for increased ownership and involvement in the operationalisation of Schwartz Rounds by staff generally and less reliance on the efforts of the core group to maintain the initiative.

Motivation was evidenced by sacrifices of individual staff members and for some, motivation and desire to be involved appeared to outweigh practical obstacles to participation in Schwartz Rounds. An example of this is the practical support of Schwartz Rounds in Site 1 by one steering committee member in a voluntary capacity.

'And my agreement with my line manager, was that I would do the Schwartz on my own time...' (S103)

Again, in Site 2:

'This is really done through volunteering' (S213)

In Site 2, the motivation for involvement in planning and coordinating Schwartz Rounds was the view that involvement in operationalising the initiative may be the sole opportunity to attend and potentially benefit from Schwartz Rounds:

'I can do it (participate in Schwartz Rounds) because I'm involved in organising the whole thing, it is different, it's a job...' (S205)

In contrast, communication of structures and processes to support establishment of Schwartz Rounds and on-going buy-in from target groups and management is hindered by the perceived pressure to participate in Schwartz Rounds in Site 1.

'I do think there's a little bit of pressure now too, it's Schwartz day, so there's this flurry around the place, you know, for speakers – I don't know anyone who's volunteered per se, it's always they've been asked, and I do feel now that it's getting

to be a little bit pressurised, when I hear it's Schwartz day I go, you know, it doesn't fill me with glee, it's, you know – the same people are speaking, we just don't have that turnover of staff' (FG2B)

The capacity of the test-of-concept sites to support training, roles and time commitments of Schwartz Rounds' key personnel is reflected in comments that illustrate the need for additional trained employees.

'I think we need to appoint somebody as a facilitator, you know. That it's written into their job description...I think it's dedicated time with you know, ideally a facilitator and an administrator freed up. You know, for part of their week, or month, or whatever it is to do this work, that I think, would send a really strong message, you know' (S213)

The importance of representation from as many professions (clinical and non-clinical) as possible involved in participation and operationalisation of Schwartz Rounds from a steering committee point of view is stressed; this is particularly in relation to succession planning:

'We feel very strongly that the various parties should be represented here [on steering committee]' (S102)

Similarly, in Site 2,

'I think the steering group probably you know, is not as well defined in terms of its role and its contribution...I'd say that's our weakest link, you know. And it's not a reflection on those who sit on the steering group. It's more that we haven't, people haven't got on with it, to ensure it happens, rather than you know, waiting for the steering group to come up with ideas... I think we, as a core group, probably need to step back a little bit. And if it falls flat then so be it...we probably need to be brave enough at some point to do that' (S213)

The findings indicate that the core group, those initially involved in the introduction of Schwartz Rounds, view it as important that the steering committee members and staff in the organisation begin to take more ownership of ongoing development of Schwartz Rounds.

6.4.3 Non-attendance – Schwartz is not for me

Interview data suggest that Schwartz Rounds do not appeal to everyone. The notion that Schwartz Round attendance is not attractive to all is reflected in comments from

the following attendees, one from each site:

'I asked him to come along; his comment afterwards was quite interesting. He said, 'I could see that loads of people saw value in the Round and I'm trying to figure out why I didn't, and he hasn't come back. So, it's clearly not for everybody and I think we have to respect that. It's definitely not for everybody, but I don't think we ever intended it to be for everybody...' (S213)

'I think there are people who have come and didn't like it. I think we've encouraged people to give it a try, and if it's not for you, it's not for you. And I don't think it is for everyone, I think it's something that's personal - it's a sense of team, but also to be able to share the types of stories that are being shared. And for people that's just not their thing or sometimes it can feel too raw.' (S102)

The following quotation reflects the need to ensure that information about Schwartz Rounds and expectations are clear when establishing Schwartz Rounds within the organisation:

'I have to say I was really disappointed with what I had heard and what it was. I didn't find that it was of any support or of any benefit to me in my working day or in my career here...I was open to believe that it would be of benefit and that it might be a nice forum for offloading and for gaining from other's experiences and that type of thing. But for me it wasn't...I just felt it was a waste of time when I could have been seeing patients...which, I don't think is ok' (S105)

The notion of 'selling the concept' is acknowledged in Site 1; this was particularly the case in the initial stages of introduction of Schwartz Rounds

'As we've come through the journey the challenges have been different. So initially, it was I suppose selling the concept, so that was a challenge. You'd like people to experience it and to make a decision for themselves. So, the challenges around getting people to attend and try it, it's not for everybody, so people can make a decision, after they've been there. So, there's always people who are very quick to comment on something that they haven't experienced.' (S101)

6.4.4 The Spread Effect – new attendees at each meeting

Representation of groups within the target audience for each Schwartz Round and trends in representation over the course of the Schwartz Rounds, is reflected by

adoption, which is defined as the absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program ¹.

Quantitative data via routine anonymous evaluation forms collected at each Schwartz Round, indicated that in Site 1, the total number of attendees over 10 Rounds was 354, with an excellent return of 94% (n=331) of evaluation forms.

At Round 10, 175 persons (53%) stated they had attended 1-5 Rounds, with an additional 71 (21%) having attended more than five Rounds. For 76 participants (23%), Schwartz Round 10 was their first Round.

The total number of attendees over 10 Rounds in Site 2 was 864, with 67% (n=581) of evaluation forms returned. At Round 10, 213 participants (37%) were first time attendees with 90 (15%) having attended up to five Schwartz Rounds. For 213 participants (37%), Schwartz Round 10 was their first Round.

It is possible that repeat attendee numbers may be counted more than once.

Qualitative data from Site 2 suggest that there is a balance of new and returning staff to Schwartz Rounds:

'You know, we still have people attending their first Round, every Round we've had a minority of people who are new to the forum...I'm pleased that people are coming back, but I'm also pleased that people are coming to their first Round, you know, in the third year of Schwartz. So, I don't know how to describe that impact, or how to describe that effect. But it's, I do think it is happening' (S213)

The comment from another participant in Site 2 suggests perhaps the impact of word of mouth:

'I have seen a lot of the same people that I would've seen at previous ones. There's a far higher return rate than there is new person rate, but there are still consistently new people coming.' (S212)

There is less representation from certain groups, this may be due to the nature of their work, or responsibilities for care:

'I don't go every time simply because on the ward we have to release staff, we don't get extra staff to cover us...so, I probably go to maybe every second or third one, depending...so, to be aware of everyone, we try to give everyone a kind of a fair chance of going and get the benefit of it.' (S107)

Non-attendance may be due to a lack of interest, or for reasons unknown:

'I mentioned that I see my role as championing Rounds, within the medical, within the doctors you know, medical consultants and so on. The buy in from that group has been poor...the attendance from within the consultant rank, in the audience has been very poor, that's a disappointment to me.' (S213)

The role of the volunteer is of chief importance in Site 1, and while volunteers played a supportive role in Schwartz Rounds attendance, they were not invited to participate in the test of concept phase of Schwartz Rounds. The reasons for this are outlined in the narrative below:

'People can have concerns around the confidentiality side of it...and because their role is in the volunteering, it's slightly different to somebody who is in a work capacity...and I suppose, some of the feedback from staff was that they may not have been as comfortable speaking. I think it was the right thing to do at that time, yeah, but they had supported us...so we would have had volunteers come in and man the reception desk, so our receptionist could attend...we have to maintain our patient services. So, not everybody is going to get to go' (S101)

6.4.5 Embedding Schwartz (Adoption)

One indicator of the success of an initiative may be the degree to which the initiative is embedded within the organisation².

According to one HSE staff member, engagement in Schwartz Rounds should be integral to professional growth and development:

Evidence of emerging embeddedness was apparent across Sites 1 and 2, as participants referred to keeping up the momentum, the potential for expanding Schwartz Rounds, in terms of setting, and reference to 'site maturity' are reflected in comments that follow from interview participants from Site 1:

'The third thing we're looking at doing now is moving towards complex cases, or complex issues...we feel we need to start moving in the direction of giving better space to more troubling things' (S103)

'I think the team is kind of hoping to train up another couple of people, so that we have other people there that are able to run it and it would be something that I think [name of organisation] were really pushing that we keep it going, you know, and make sure that its kept because it just seems to give a very good voice for everyone' (S107)

Similarly, in Site 2:

'You know we've only had, probably, we're probably up to about, I don't know eighteen or nineteen Rounds at this stage...one, maximum two have been offered to us, you know by a person, or by a team. But mostly that we've had to come up with the idea and sort of you know shape it and make it happen...we have a very strong kind of core team, who have led out on Rounds, but we haven't been as good at getting our steering group to. And it may be that you know, because the core team's so strong, the steering group don't have to perform, as it were. But that's something we talk about quite a bit. You know trying to get our steering group more invigorating and more kind of engaged...I think people associate Rounds with me and with [name] and with a small number of people. And that to me is a negative rather than a positive thing. I'd rather they wouldn't associate it with me. You know I'd prefer to be able to step back from it and not have it dependent on us, you know the small core group of us here...' (S213)

6.4.6 Challenges to Embedding Schwartz Rounds in the Organisation

Challenges to embedding Schwartz Rounds were experienced by both test of concept sites, but impacted in ways unique to each organisation, most specifically in relation to organisation size and numbers of staff. Challenges included, barriers to participation, the need for resources to support attendance, the need for flexibility in relation to timing, frequency and location (most specifically in the smaller site) and greater understanding of where Schwartz Rounds fitted within the organisation and organisational culture.

Despite the commitment of the 'core team', interview narratives suggest that Schwartz Rounds are not embedded to the point where staff participation is prioritised.

'Some people suggested there should be extra staff allocated on the day of Schwartz, so each ward could release at least one person for that period of time and for there to be an understanding that it is for people, rather than being expected to attend, you know, and I think nurses are very poor at asking on their own behalf for things. If it was a mandatory training session, they would be sent to it much quicker than the fact that it is to support each other. Therefore, if you are busy, it is the one thing in the day you are going to draw aside' (S203)

'I suppose the environment and the culture that we're trying to build, what we want is that Schwartz Rounds actually becomes part and parcel of my working day...it's recognised as just as important as maintaining my CPD on a particular area' (HSE01)

In Site 1, one participant indicated that Schwartz Rounds may be of relevance and support to staff who are new to an organisation,

'...because I'm not here that long, I found it a really good learning experience to be able to relate to my colleagues more. I found that really good' (FG1B)

There was a suggestion that Schwartz Rounds were not needed in Site 1, because of a pre-existing culture of inclusivity, coupled with the smaller size of the organisation. Reports of pressure to send people from departments to participate in Schwartz Rounds and pressure on staff to act as panellists, indicated that for some, Schwartz Rounds was becoming an additional burden, as distinct from a support.

'I'll help them out, but I think you reach a point too where you say well, actually, I'm after doing enough and I'm uncomfortable to do it and I don't like to be put in a position where you're kind of pushed in to doing it...I do think the year was long enough and people to give up their time and, you know, create that energy to support it and to help it and to will it on, I do think the unit here is too small, I don't think we have enough people and I don't think we have a new, enough new people coming in, like fresh blood coming in...to sustain it long term' (FG2A)

Extending the invitation to attend to staff who were visiting the hospital community was viewed as compromising the inclusive nature of Schwartz Rounds:

'They're not part of [Site 1], they're only passing through, they're visitors, we'll never see them again and yet, you know, they're front row, and I just felt we were filling seats, I chose to sit where I sat, but that's not the point, I just felt sometimes when I looked around and saw people that I didn't know, that I'd never see again, that we were filling seats' (FG2B)

6.4.7 Do we need Schwartz Rounds?

A potential challenge to embedding and subsequently measuring the effectiveness of Schwartz Rounds is the perception that Schwartz Rounds were not needed.

'It's to do with the well-known fact in any kind of research, that the sicker people are entering an intervention the more likely they are to be better following an intervention. So, if they're on the clinical spectrum they're more likely to get well. Whereas, when you move up into the wellness spectrum where people are well psychologically entering an intervention. And this would always have been a high functioning unit broadly speaking. People like working here and that kind of thing. Then it's very hard to get substantial measured gains' (SI03).

In Site 2, there were other challenges to embedding Schwartz Rounds as an initiative.

'If we're going to really bed them in as, you know as a regular part of the working week, or the working month, then I think there will be need for additional support. An awful lot of where we are now is down to good will and people volunteering their time and you know, taking on roles in addition to their day job and work. I think we need to appoint somebody as a facilitator...written into their job description...we have some very good people, you know, who if they were enabled.' (S213)

6.4.8 Personnel

The following comment is also an indicator that resources (personnel) to sustain Schwartz appears to be an issue for the larger site, Site 2:

'I'd say our team is a bit all over the place compared to the first year...now sometimes, people being pulled in different directions, everything is being done late, last minute...its about regrouping. Two years is long time to be involved in something, so maybe it's the extra work and sometimes you need something to reenergise yourself.... more people on the steering group, or more info or help from our steering group, you know...' (S205)

'I think we need to appoint somebody as a facilitator, you know. That it's written into their job description...I think it's dedicated time with you know, ideally a facilitator and an administrator freed up. You know, for part of their week, or month, or whatever it is. You know, to do this work that I think would send a really strong message you know' (S213)

6.4.9 Other resources

Efforts to embed Schwartz Rounds within the organisation require flexibility, motivation, creativity, capacity and drive:

'And then the next year we increased it to every 2 months, and I think that might have been less helpful around the momentum, but it was around going through our small base of people very quickly. So, we've shortened it down to every 6 weeks now. So, we're probably getting to be a little bit more flexible as to how we run it.' (S101)

On a wider scale, there is room to expand in terms of understanding where Schwartz Rounds as an initiative or intervention fits with the organisation and its culture:

'I think you know, to go to the next stage of what this can deliver. I think we need a better understanding of you know, what makes an organisation work or not work and we don't have that, in my opinion yet...' (S213)

Similarly, in Site 1,

'I do think when it was on, it was presented to us that it was for a year, so there was a start, a middle and an end, it's now gone in to its second year, so I don't think we have the staff to sustain it... the same people are speaking, we just don't have that turnover of staff...I don't think we have the interest long term' (FG2A)

The initial burst of enthusiasm for Schwartz Rounds and challenges in sustaining this for Site 1 is evidenced by the narrative from the facilitator from the Point of Care

Foundation charged with supporting staff in the roll out of Schwartz Rounds in the test of concept sites:

'The early adopters are going to be your passionate people...potentially they're honeymoon people, but what you want to do is engage them so they stay for a longer period...there's the potential for a bit of a lull...I think [Site 1] had a little bit of it too that the resource it required to run rounds is potentially exhausting for the people who are doing it.' (M1)

There is a need for additional support for organisations during times of challenge, or lapse:

'I think it does require, potentially some ongoing support actually from either the Point of Care or another kind of supportive mechanism. In terms of helping organisations to be creative, when those lull periods happen...there have been examples in the UK, where organisations have started rounds at the wrong time. They may not have realised it was the wrong time, but where you know, there hasn't either been enough organisational support, or enough resource for the rounds to be delivered, or you know the logistics haven't been well placed. And there have been very, very few, I think one or two organisations where they've stopped Rounds for a while and then restarted them, with kind of renewed confidence and a little bit of space and time to gather and collect, if that makes sense' (M1)

The size of the organisation and numbers of staff in Site 1 presents a challenge to remain faithful to various elements of the Schwartz Rounds protocol

'I would see the kind of medium to long term challenges would be that, because it is a small site and there's so many, that there is just an amount of people you know that might be willing to take part, you know. I think with the bigger site and more people you'd get more variety probably, you know.' (S108)

6.4.10 Perceived support for staff to attend Schwartz Rounds

For the test of concept Sites, it appears that the initiative is supported in terms of local management and organisational leadership:

'It is very much supported by our line manager, she would be an active attendee as well. So, that's definitely a help in terms of attendance...' (S107)

I'm completely supported to do what I need to do, whatever it is that needs to be

done with Schwartz (my manager) supports me a hundred percent...I mean I've a very supportive line manager and a CEO and they've all been extremely supportive of what it is I'm doing.' (S211)

There is emphasis on making the initiative work and freeing staff to attend:

'So, the trial of the different times now, we're going to see how that goes, just to see can we free up and in fairness to the organisation, as a whole, where they can, they do try and give us someone just to free us up for that hour and a half. So that we can kind of send as many as possible to it, to get the benefit of it...' (S107)

The quotation below suggests that efforts to embed Schwartz Rounds are ongoing:

'It's the day before and it's the reminder from Management that it's on and 'I hope you can send as many of your staff as possible' and possibly get that on the day of Schwartz Rounds as well, so that's pressure, that I just feel for a voluntary session, and this is supposed to be about us, the staff, and how it supports us – to go in to a room feeling that pressurised to start with for a year, every month, it takes the joy out of it.' (FG2B)

6.4.11 Perceived awareness and evidence of reference to Schwartz Rounds across the organisations

Both sites have made concerted efforts to advertise, promote, market and engage staff in Schwartz Rounds. Spreading the message was more challenging in the larger of the two organisations (Site 2), as some staff had limited, or no access to staff email. These challenges are offset by additional advertising and marketing strategies in Site 2:

'Posters, email, an information stand the day before around lunch that always brings a crowd. We put ourselves in the newsletters, the [Regional] newsletter that goes out ever two to 3 months, we have done an article for that, word of mouth, picked our facilitators carefully...' (S205)

'It is very well advertised and promoted, within the organisation. And you'd see notices up around the hospital as well, in the general notice board areas...going into we'll say like, the staff canteen; anywhere where there's a lot of through traffic...in

fairness, it is very well advertised. And in my opinion, it couldn't, if it was any more advertised, it'd nearly be a nuisance trying to keep them deleted' (S212)

Yet, despite the intensity of advertising and marketing in Site 2, there are members of the organisation who remain unaware of Schwartz Rounds, as evidenced by the comment card responses.

As part of the implementation process, Schwartz Rounds were advertised widely and positioned strategically within the test of concept sites' event schedules.

'We have been engaged as a committee, a steering group and we had a board day in the restaurant for people to kind of come along and talk about Schwartz. Different members of the steering group took their time, we set the dates, set out the general email' (S104)

In Site 2, Schwartz Rounds is a standing item on meeting agendas

'It is on the agenda, not for an everyday meeting, I know, say the one [name] does once a month, the report for our executive council, an update would be on that. Tomorrow, there's a patient fair in the hospital, its going to be on the main foyer, a Schwartz Round stand...' (S205)

6.4.12 Operationalising Schwartz Rounds– remaining faithful to the process:

Transferability of the Schwartz Rounds' structures and processes to the Irish context has manifested in efforts to support and educate key personnel, and acknowledge the various roles and responsibilities associated with Schwartz Rounds and the inherent time commitments:

'We've developed a network...for the people who are, very important people who make the glue of it – the administrative support in each site for the Rounds, so that's the person who books the rooms, who does the notices, who arranges the catering, who organises the sign-in, who organises all the evaluation forms and collects all the evaluation forms, who inputs all the evaluation information on to a spreadsheet that gets sent to Point of Care, so it's a very important role, and we have developed a network for those and a training day for them, and that's another new contribution that they didn't do in the UK' (HSE02)

The importance of investing in mentorship is clear.

‘...the mentorship piece was absolutely essential...’ (HSE02)

Adherence to the philosophy of Schwartz Rounds as a medium of support for staff, as distinct from a mechanism for problem solving, is a necessary feature in the implementation of Schwartz Rounds.

‘And I think that then leads to that kind of level playing field that experience, you know and that’s had, I think a very interesting, it’s very well run and I suppose we’ve had a couple of times where someone doesn’t realise the meaning of what we’re doing, you know it’s their first time to go and they kind of might start to go on it to see how will we fix this. But it’s interesting how the clinical lead and the leads kind of pull it back around and bring it back to well actually what did you feel? How did you experience it? And I think that way that its run and I suppose that’s how it’s taught. But they’re very good at leading and bringing the person and saying ok that’s not what we’re doing, keeping it all very, do you know like, not that you’ve done something wrong, but just getting them back to actually, this is not what this is about, it’s about more your experience and more your feelings’ (S107).

‘The Schwartz model itself, initially it appears deceptively simple, but it’s not, you know, and it’s really focused on the psychological safety and trust and good psychological principles and very active facilitation and really sticking to it’s not a problem solving forum - and it can descend in to that if it’s not carefully facilitated and a lot of doctors who attend Schwartz Rounds would be used to attending Grand Rounds and they want to solve the problem here and now and you need very skilled people who can kind of steer you and guide you out of that hole, and we have had experiences of getting in to that hole – stories, the stories have a real purpose...focus on emotions and feelings and building resilience’ (HSE02)

Research participants refer to the formula or fixed nature of Schwartz Rounds that contribute to its successes.

‘It’s a very fixed methodology, which is good in one way...[Schwartz Rounds] is about valuing staff as being the door through which we unlock better health care, I think’ (HSE03)

6.4.13 Conclusion

The transferability of the Schwartz Rounds' structures and processes to the Irish setting, is clearly influenced by practical considerations and specific contexts relevant to the two test of concept sites. The results and findings confirm that while Schwartz Rounds may be desirable, the organisational culture, size and baseline of staff wellbeing are key considerations prior to introducing Schwartz Rounds nationally. Staff in test of concept sites had mixed views about Schwartz Rounds. Staff, particularly those engaged in the organisation and planning of the Schwartz Rounds were enthusiastic and willing to contribute to the process emotionally and practically and for some, on a voluntary basis. There is evidence that organisation managers and leaders actively support and encourage Schwartz Rounds participation, which lends support to cultural suitability. In relation to practical suitability, some key considerations include the capacity of smaller organisations to maintain interest and avoid staff feeling pressured to participate.

6.5 Key Question 2

What is the experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads?

Questions surrounding the experience of and personal impact on panellists, attendees, administrators, facilitators and clinical leads participating in Schwartz Rounds was addressed through the effectiveness and implementation dimensions of the RE-AIM evaluation framework. Effectiveness may be described as the impact of an intervention on outcomes, including potential negative effects, quality of life, and economic outcomes ¹ (p. e38). It is important to acknowledge the limitations of our findings on effectiveness and implementation dimensions, because findings reflect feedback from participants in the short term only. To establish embeddedness and effectiveness, more time is needed with a much longer lead in period.

6.5.1 Experience of Attending Schwartz Rounds

Content analysis of qualitative data from individual interviews and focus groups indicate that participants' experiences were individual and varied, according to role and site. For some, attending Schwartz Rounds is worthwhile, and opportunities to attend should be more wide spread, others reported discomfort participating in Schwartz Rounds.

"I think that is really important. I would like to see it reach out to wider areas say like you know more management, admin, HR, that kind of thing. I don't think it should just be about patient care either. I personally had negative experiences dealing with HR and I think something like Schwartz Rounds and staff engagement help people identify we are dealing with people. I think that's lost in the health system quite a bit, whether it be your own colleague or patient. I think Schwartz Rounds would have the potential to reach out to some of these people, I think it is really beneficial" (S207)

For one participant, being present was enough to benefit:

'I never felt like I wanted to speak. I liked being there, I would get a lot out of just listening to other people, I wouldn't be a talker in front of people, but being there and hearing other people talk was enough for me, it suited me, I think I got the most out of Schwartz by just listening to other people's stories, you are there silent yourself, but you know, you are there thinking, yea that happens to everybody.' (S205)

In contrast to the quotation above, silence was uncomfortable for others; the narrative below from a Site 1 respondent, reflects felt pressure to contribute to the Schwartz Rounds discussion:

'Nine times out of ten I'd be sitting in the audience and, there wasn't one Schwartz Round actually that I didn't speak at all...somebody has to speak up because it is, I think, I think the part with the silence, I think it's dreadful, dreadful is the word that was used, and very uncomfortable for people... I don't think it's nice to put people in that situation...I don't think it's nice, I don't think it's a comfortable situation and I don't think it's a nice situation to put people in to.' (FG2B)

6.5.2 Experience as a panellist

Staff who shared their experiences as panellists reported a rich experience and described the role and skill of facilitators as central to supporting Schwartz Rounds participation:

'If we didn't have it here, I wouldn't have that richer experience. And so therefore, I think it enables me to do my job better and to be, I suppose better support really of the wider team here, you know. Because we're non-clinical, we don't meet as part of the wider team, do you know what I mean?' (S108)

'I was a panellist fairly early on and I think that's what really sealed my commitment to Schwartz because it was a very positive experience...and I was quite open and quite vulnerable, but it felt safe to do that and I got really good feedback about it as well. You know, people were very respectful, people said I know it's confidential I'm not going into the specific details, but it was really good to hear what you had. Well done.' (S210)

There is an awareness of the need for adequate support and preparation for the panellist role. Facilitation is an important aspect of safety in sharing experiences:

'I suppose if the Schwartz committee were not careful about a panellist and didn't vet them or think about them and make sure that they were thinking of saying or doing something inappropriate or exposing themselves unnecessarily...it is reasonable to imagine that somebody is maybe a little naive and the management outfit, perhaps for the meeting, was maybe not as attentive or careful, that you could put someone in a vulnerable position' (S208)

6.5.3 Pressure to participate in Schwartz Rounds and pressure to be a panellist

Despite the perceived benefits of panel participation, there were reports of perceived pressure to participate in Schwartz Rounds and to be a panellist. This is reflected in the quotation below from a Site 1 respondent:

'I found too in the early stages I was putting pressure on my own staff to go up and they didn't want to go, and the staff that work directly with me would say no, I'm not going...not going to Schwartz, no, not going to Schwartz, didn't want to go to Schwartz...you know, are you telling me to go, and I said well no, it's optional, but it's not optional, you're after asking me four times, so is it optional or is it not optional...it's optional with pressure...I think it's every month, because the month

just is not long enough between them. Again, it's the same group, the same, it's just the same, the sameness, the group is the same as – the pressure to go is becoming now, taking the joy out of it for me' (FG2A)

Five respondents referred directly to perceived pressure to attend (4 from Site 1 and 1 from Site 2), with four of the five referring to experiencing pressure to participate as a panellist; however, one respondent from Site 2 referred to pressure being self-imposed:

'That's [the prospect of being a panellist] nearly is the only thing that makes me think about not going, even though I go anyway. I kind of feel a little bit guilty that I'm not contributing back, but I'm just, that's the way I have to be at the moment. So, you know, if I started to feel too much pressure, if too many people asked me to present. I'd be like, oh God, well then I can't go anymore' (S206)

Repeated invitations for potential panellists were reported from Site 1 participants; this was attributed to numbers of staff.

'I spoke because they had nobody else, and when I was asked, I said I prefer not to, but if you're really stuck come back to me, and they did come back to me and I think I did it out of whoever's organising it being so needy to have somebody that they're my work colleagues as well, that I'd say well, I'll help them out, but I think you reach a point too where you say well, actually, I'm after doing enough and I'm uncomfortable to do it and I don't like to be put in a position where you're kind of pushed in to doing it...I said please don't come back to me again...' (FG2A)

'I've been approached three times and I said to the person that approached me, two people approached me, that I felt it was voluntary from the onset and that we shouldn't need to be put under pressure to be there, or to present at it...and I really feel, for me there was huge pressure that I didn't need. So, I found it of no benefit and no support' (S105).

The possibility of feeling pressure to participate in Schwartz Rounds was acknowledged in Site 2 also; however, the opportunity to be a panellist appears to present less often, with no-one participating on the panel more than once in Site 2:

'There's usually a bit of arm twisting involved in getting people to you know, participate on the panel...I think most people find it daunting and if they had, I think if they had the opportunity, they would probably step back from it. So, there is a bit

of arm twisting involved...it takes a certain type of person, I think to be brave enough to put themselves out there...we haven't had anybody on a panel twice. And if people are not ready, or willing, you know, or able to do it. Then we don't, we don't put pressure on them' (S213)

6.5.4 The Impact of Schwartz Rounds Participation

Research participants reported impact based on their observations of how they perceived *others* had gained from the experience, and also how they had gained personally from participating in Schwartz Rounds.

'There's that broader sense of connection to that organisation and to the work that health care staff do, no matter what level, no matter what grade. But that idea that we're all connected by virtue of the fact that we're doing our best for the people that we meet. And that sometimes we don't get it right and sometimes we do. And that sometimes no matter how hard we want to get it right, it's not possible to have a nice neat happy ending. And being ok and at ease with that. But knowing that you're not alone in it is, there is that, that comes across, that connectivity piece comes across very strongly for me' (HSE03)

This sense of connection is underpinned by comments from Schwartz Rounds participants reflecting personal gains. The following narratives reflect the perception that Schwartz Rounds has increased staff relations, team work, and sense of insight to others and 'connection' in both Sites:

'It's one thing having a chat to someone at work, but to go into the details of why it's so tough, whereas Schwartz is the place, or even connections through Schwartz, that supporting colleagues...' (S102)

'I just felt there was a connection with the panellist who was talking and not just the person I knew on the panel, but the others as well and when I finished you had to do that little questionnaire thing again and I was actually quite surprised by how moved I had been by the round' (S103)

'What Schwartz does is it allows people to connect with other people's experiences, I think that's the real value of Schwartz it's about connection and I think what surprised me about Schwartz was its not just about caring for patients it's about caring for staff and caring for each other.' (S210)

'They [panellists] may not even know because of course, when they're up there, they're presenting...they're probably not too aware of who's in the audience or not...I feel a better connection maybe with them...just better connection maybe with other staff members' (S206)

Research participants referred to increased self-awareness, and opportunities for reflection and for learning:

'But then when you stand back, and Schwartz allows that time to reflect back on a situation. And when it's a different situation to your own. You're thinking right, well how would I have dealt with that? Would I have been able to do it any differently, not necessarily better or worse? But could it have been approached differently? And to achieve the desired outcome. So, it has just given me that kind of self-awareness, to stand back and think for a second...I've enjoyed it, I've enjoyed the sessions...when you sat down and actually, put it down in black and white on a sheet of paper in front of you. That's when thoughts become reality...I suppose I did a lot more thinking about it. That was very helpful to me' (S212)

'I've learned how to deal in certain situations, as well from just listening to people's experiences' (FG1D)

Participants referred to positive impacts on relationships between co-workers and patients and this was attributed directly to Schwartz Rounds participation.

'The unexpected gain I suppose is, feeling part of a team that is outside of my own core work team, so I've joined the Schwartz committee now the steering group, and you know, over time I feel like OK I'm forming relationships with these people who I normally wouldn't interact with...I can stop and have a conversation, a chat with them...it might only be a couple of words, but it can boost your day, or help me to feel better during my day' (S210)

'You find that you can talk to anybody on the [hospital] team and because of that, within the room I think everybody, it's the one opportunity that everybody can kind of open up to each other...you know that what they said is confidential, but you know that you can rely on somebody at any time with any issues you'd have.' (FG1A)

General gains attributed to Schwartz Round attendance was increased awareness of colleagues' experiences.

'What I liked about it was getting the insight on your colleagues into their experiences and getting the insight in where they're coming from, their backgrounds, their experiences and maybe to understand them better and, you know, you can relate more to them' (FG1E)

There was an increased awareness of the emotional costs of patient care for colleagues:

'I think in doing it, it's made me more aware of everyone around me...I'm very aware of my own staff, so the nurses, the carers on the ward, where I found it, not easy to forget, but they run into the background a little bit, the catering staff, the kitchen staff, you know the cleaners. And you kind of forget that they're as involved in the person as we are...I suppose it's that thing that Schwartz is about more emotional experience than the physical or fixing stuff. So, it made me very aware of how they feel...I never realised how effected they were by that person' (S107)

Qualitative interview data suggest that Schwartz Round participants have an increased sense of wellbeing for the most part, as evidenced by the narratives below; however, for one research participant, personal and professional wellbeing is contingent upon other initiatives promoting wellbeing in the workplace, and Schwartz Rounds are just one aspect of this.

'Yes, I think if it is part of an overall hospital consciousness, everything from the dignity and respect and anti-bullying policies right through to Schwartz is bringing a more positive contribution to tone down the panic and pandemonium sometimes in an acute health care institution...just bringing [people] together and making them conscious of each other and to have respect and sympathy for each other' (S208)

For others,

'It motivates me. If I'm feeling, because morale in our department is not hugely good at the moment...and you know, you sort of feel like you're ground down a bit, or worn down, or just not wanting, that it doesn't feel that there's a huge team involved anymore. And you just, you go, and you come out and you feel better. And you go, oh yea, ready to go and it's just like having your batteries recharged...I come out feeling better about myself, about my work' (S206)

Of a total of 23 people interviewed, almost one fifth (n=4) of respondents referred to the 'cathartic' nature of Schwartz on separate occasions and this appears to be firmly linked to panellist participation:

'I definitely found my participation as a panellist on that occasion quite, now you know, probably like cathartic, but it definitely helped to clear the air a little bit and you know, yea, that was personally beneficial to me [the act of verbalising the experience] the positive messages I got from the audience that day' (S213)

The word 'release' was also used:

'Personally, I think it lets you release, do you know? Feelings and experience you've had, which then impact you, like even in your personal home life. That you can kind of just park that and say that happened in work. I got the support I needed for it and you can kind of let go of that part...so, it gives you that kind of emotional support that you need in work and then, as I said, you can park it in work, come home and have your own life then obviously, with your own experience that's going on then. And you're not bringing extra baggage' (S107)

'Maybe a little more resilient in how you handle things, you remember, you know what, everyone is having a bad day, whereas prior to SCRs you look at all these people who seem to have it all together and you think everything is too much for you, you are very self-centred and it makes you go actually I am ok' (S205)

The statement below is infused with the sense of release:

'I never realised how upset I was until I opened my mouth that day' (S103).

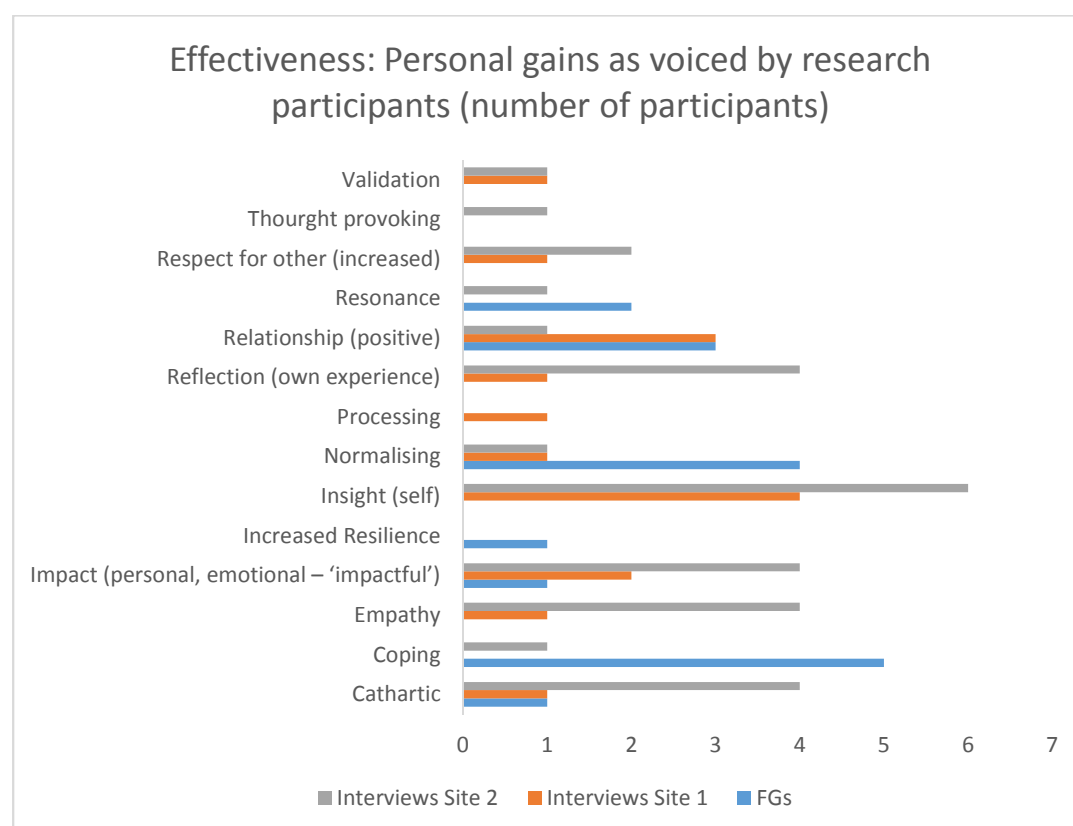
These are largely positive comments with the exception of two respondents who stated the following, in response to question about personal gain resulting from Schwartz Rounds participation:

'I don't think I gained much myself, because I think I am who I am' (FG2A)

'Not hugely, I have to be perfectly honest' (FG2B)

Table 18 reflects the personal gains, as voiced by research participants in Site 1 and 2 and Focus Group (Site 1). These include feeling self-validation and insight.

Table 18: *Personal gains as voiced by research participants in Site 1 and 2 and Focus Group Site 1*



Study participants reported observed benefits for others; these included that Schwartz Rounds gives people voice, more support, greater empathy from colleagues, help staff to cope, and for some, others noted that being a panellist was cathartic.

6.5.5 Safety

Confidentiality was viewed as essential to the success of Schwartz Rounds.

'We're bound by confidentiality. So, you kind of can't divulge stuff that's gone on. Where that's a safe environment, its confidential, whatever is said in the room doesn't go back out. We talk about the experience, but you wouldn't go out and talk about a particular person, or this person said this' (S107)

Confidentiality was acknowledged as potentially challenging in Site 2, given the numbers of participants; however, success in this regard was linked with fidelity to

the Schwartz Rounds process.

'Confidentiality is not broken, it's amazing, people talk in general terms, but confidentiality is not broken, it's amazing to get 100 people in a room and get them to agree confidentiality maintained and it actually happens...and there was a confidentiality agreement form to be signed at the door and also how do you feel in yourself and how do you feel today going in' (S203)

The concept of safe space extends to safety in facilitation also, and the importance of competence and training in facilitation skills:

'I was very carefully prepared for it...what she was very carefully doing was surfacing the emotions within my story that she knew would be impactful for the audience, so she was helping me to craft the story to get that response from the audience...now she met me afterwards, she checked in, she made sure that I was okay... that's part of the debrief with the steering group, you know your audience and you know the people and that's a big job of the clinical lead and the facilitators because they're standing up, they can see the audience, they can see if there's distress, you know, and they can seek that out and follow that up and they know the audience to be able to do that...that's why the training, you know, that whole piece around the psychological safety is ingrained in the whole model of Schwartz Rounds (Q02)

6.5.6 Conclusion

Qualitative data analysis indicates that participants' experiences were individual and varied. For some, attending Schwartz Rounds is worthwhile, and opportunities to attend should be more wide spread. The impact of SR participation and the reported benefits of panel participation are presented. Panellist participation was associated with catharsis and release and positive feedback from others. Overall, participants reported greater insight and awareness into the self, colleagues and an increase sense of connection with each other and the organisation. A small number of respondents from one site reported a level of discomfort in participating in Schwartz Rounds and that they felt pressurised to attend. Confidentiality is an important aspect of safety in Schwartz Rounds participation, as is the concept of a safe space to share; this is promoted largely by adherence to the Schwartz Rounds structure and the skill of the facilitator.

6.6 Key Question 3

What are the perceived and/or actual outcomes for the service/hospital?

The perceived and actual outcomes were viewed through the effectiveness, implementation and maintenance dimensions of RE-AIM. Qualitative data reflect opportunities in Schwartz Rounds engagement for person-centeredness across the organisation.

The quote below suggests a move towards challenging discussions in Schwartz Rounds that are not generally aired elsewhere. This is viewed as a positive step forward and an indicator of maturation of Schwartz Rounds within the organisation:

'You know the negativity that is part of our health service, you know can, Schwartz Rounds, to me it provides a way for people to almost fight back against that negativity...we had a Round yesterday with members of the hospital management team involved. And you know, very powerful, it was a very kind of a negative Round, because it was dwelling on a lot of frustrations that have come into our work...we had the hospital manager...we had at least three or four of the senior management team in the room and then two on the panel. So, I feel we're kind of tapping into, you know, discussions and conversations that don't normally get aired...but for us to be able to air those, in the way that we did yesterday. I feel we're entering another phase of Schwartz...it's through those more difficult conversations that Rounds can really make a contribution...I think we have set things up, you know in a way that can facilitate you know, more difficult conversations. And yesterday was probably the start of it...now, (going in to Year 3 of SR) we need to probably tackle some of the more you know, difficult organisational issues' (S213)

Schwartz Rounds offer a forum for raising issues of emotional concern, but are not a forum for problem solving. In this evaluation; however, qualitative data reflect the call for follow-up support or mechanisms to resolve or progress discussion about issues that are first highlighted in Schwartz Round discussions, and which may also be of significance for practice.

'...so, my only improvement suggestion is that I think there needs to be some sort of avenue for pushing that kind of, when you make that insight, you have that more

awareness, you have those ideas...I think it would be good to have something more structured in place to bring those benefits to the hospital' (S207)

The impact of Schwartz Rounds on outcomes, including potential negative effects, quality of life, and economic considerations was viewed through the effectiveness dimension of RE-AIM. The personal and professional gains had been examined through Question 2 and the interviews suggest that Schwartz participants have an increased sense of wellbeing for the most part, with the exception of two respondents who were focus group participants in Site 1 and who expressed little personal gain.

6.6.1 Measuring Outcome

Research participants suggest that measuring the outcomes of Schwartz Rounds is challenging:

'I think because it's relevant at a basic human level. I think it would be very hard to have particular KPIs around it, because it's helping people to do the basics properly, as opposed to achieve particular outcomes' (S212)

Measuring outcomes, in this instance, may be viewed through the lens of perceived relevance of Schwartz Rounds to roles and effectiveness of staff and patient care:

'The other thing is that even though some of the stories might, well some of the themes might in and of themselves be emotive, there's still a lot of positive impact of that, even though at the time it might be a bit upsetting, you know it's always about how it is dealt with, do you know what I mean? How it's resolved, how it's dealt with, how that person continued you know, so that kind of output. And again, I know that can't be measured, but that's really important. And I think that really helps a team you know because you could have a younger nurse here, or a younger whatever, social worker or whatever, it might be that might not have experienced that yet, or might be struggling with something like that, you know' (S108)

Overall, research participants reported perceptions of a generally positive impact of Schwartz Rounds engagement on the less tangible aspects of wellbeing, communication and relationships with others, including co-workers and patients:

'I think it has helped communication. It helped the ability to listen...I probably have improved at just being able to sit and listen and let the story happen. And out of the

story you'll get the answers to what you might have wanted. So, sometimes and I find that with the patients and the families, is just when you bring them into the clinic room to see them. Is just let them tell their story, not to start with questions. Just let them tell their story and then you can ask the particular questions to get the finer detail of what you need. But it's their story to tell, it's not my interrogation to have with them...' (S212)

According to qualitative interview data, Schwartz Rounds encourages an openness to feedback from others and awareness of the importance of creating a balance between listening and assertion:

'So, [I'm] able to hold their voice and accept that somebody else might feel differently. And that's, to me, that's so important that we free up communication. You don't have to agree with me, and I can accept we feel differently about things... I'm probably a bit clearer and a bit more assertive in the way I now talk to people...' (S103)

For two participants in Site 2, engagement in Schwartz Rounds has impacted significantly on patient interaction and improved relationships, which again, highlights the impact and potential benefits of Schwartz Rounds:

'I think Schwartz has helped me to realise that it's just as important to stop if I see somebody, like a patient or a visitor who looks a bit confused, to stop and ask them if I can help them, it might take 30 seconds, but that's well worth it, it's time well spent. It kind of helps reorient or point somebody in the right direction yeah, so it [Schwartz Rounds] has made me slow down a little bit and realise that it's the interactions with people that are important and similarly, with other staff, if I see somebody's struggling or having a tough time, I stop, 'are you alright?', and it's not even to try fix them, it's just to stop and put a hand on their shoulder and say 'Are you doing ok? Do you want to talk?' And similarly, with patients you know, when I'm on the wards doing my work, you know, I have some patient contact, but not a lot of direct patient contact. But again, I think it's just hurry, I find myself saying to patients now a lot more than I used to do, you know, 'How are you doing? How are you feeling? Best of luck, I hope everything goes well for you'. You know, take a few seconds to just say those few words, I think does make a difference in patients experience of the health care system in the hospital' (S210)

'Through the Schwartz Rounds maybe, as well as other things that I've been doing. Maybe learn to slow down a bit, particularly slow down. But at the patient's bedside, whatever about moving quickly in between them...I think it's kind of got into my mind-set that need to slow down with patients. Or to maybe spend that little bit of extra time with them. That it makes a big difference...because I can tend to be a bit all business' (S206)

6.6.2 Unanticipated Gains:

Fourteen respondents from a total of 31 (across both sites and HSE staff) referred to increased insight into others' (co-workers and patients) journey. Both anticipated and unanticipated gains from engaging in Schwartz Rounds were described:

'I see Schwartz as an opportunity for me to develop personally and professionally to get to know people, and to be honest with you, I suppose the relationships that I have built up through Schwartz have helped me do my [job] because I suppose that's allowed me to, it's opened a few more doors for me, got to know other people and I suppose it's through those relationships that I've been able to not only progress with Schwartz, but also to progress my other role too' (S211)

'I think by having Schwartz it's given people an opportunity to express their emotions whereas they probably wouldn't have broken down an emotion barrier before in the ordinary setting, just a working day, so it's given them a forum to actually do that and I think, I think in that way it's kind of helped people as well, deal with their emotions as well and to feel supported from the staff, knowing that they've actually gone through this experience' (FG1 B)

6.6.3 Maintenance

Maintenance is the extent to which a program or policy becomes institutionalised or part of the routine organizational practices and policies. Maintenance also has referents at the individual level. At the individual level, it is defined as the long-term effects of a programme on outcomes (six or more months) after the most recent intervention contact¹.

Challenges arose in sustaining the initial excitement, interest and welcome for Schwartz Rounds in Site 1:

'There was an enormous high, you know, it was phenomenal the impact that it had early, and you can get carried away on that' (S101)

Smaller staff numbers and variety of participants is perceived as a challenge to sustaining interest and engagement.

'I would see the kind of medium to long term challenges would be that, because it is a small site and there's so many, that there is just an amount of people you know, that might be willing to take part. I think with the bigger site and more people you'd get more variety probably.' (S108)

Efforts were made to offset this challenge by adjusting the frequency and location of Schwartz Rounds:

'If we keep doing Schwartz at lunch time, well you are not going to get your nursing staff. So again, they've done some pop-up rounds here on wards, and that type of thing...so Schwartz was happening very structured at lunch time on a certain day at a certain time. It was all scheduling and I suppose, we realised that people weren't getting to it. So, subsequent to that, Schwartz is now breakfast Schwartz meetings, there was a pop-up on the ward so, that's happened this year. So, there's been some changes to how, to the timings, not the structure obviously, but the timings, to try and I suppose, maximise the participation' (S104)

The narrative below stresses the importance of ensuring that such decisions are in keeping with the Schwartz Rounds' philosophy:

'I think if any decision is taken in the initial early stages of running Schwartz, or implementing them later on, or sustaining them that isn't considered and isn't bespoke to the context of the organisation, then it can be risky and it can potentially go against a Schwartz philosophy, but I think any decision that's taken with consideration and with consultation, is easily the right decision. So the organisations have spent time thinking about you know, we really value rounds. But we know we can't sustain them every month. So we will go to every second month' (M1)

The need to foster creativity across both Sites 1 and 2 is a potential issue to sustain interest and engagement of participants outside of the core or steering group.

'It starts on time, it finishes on time. So, it's accessible to people in that regard. The only, in my own opinion, the only potential stumbling block is, one keeping it fresh

and keeping it relevant. So that it doesn't become repetitive. And the other then, the other side of that same coin is to keep having different topics and it's difficult to come up with new topics every time, or a new theme for the discussion, but creativity I think is the answer to that particular barrier. As opposed to it being a limiting factor on its life span within the organisation.' (S212)

'I think it's about making sure that the themes are engaging enough, that people want to come along to it...I'm sure people from this site could attend the ones in [name of place] and vice versa, you know do you open it up to the volunteers here on site as well, to make it that little bit more interesting, do you know what I mean' (S108)

For three respondents in Site 1, Schwartz Rounds had run its course, as evidenced by the statement below:

'I really think it was a great idea and it rolled out very well and, you know, there was a lot of work and a lot of effort put in to it and I was a hundred and ten percent behind it for the year, but for me I think the year was enough to do...I feel I was led to believe that it was for a year. It was a system that was going to come in, now maybe I'm wrong, maybe I took them up wrong, but I think that was the general concession, that it was for a year and a year long, and I just feel a year was long enough to do it, do it, avail of it, you know, let the staff feel whatever they feel about it and talk and move on.' (FG2A)

6.6.4 Conclusion:

Qualitative data reflect opportunities in Schwartz Rounds engagement for person-centeredness across the organisation. There is a move towards challenging discussions in Schwartz Rounds that are not generally aired elsewhere. This is viewed as a positive step forward and an indicator of maturation of Schwartz Rounds within the organisation where views are discussed and highlighted. While Schwartz Rounds is not a forum for problem solving, it offers a space for conversations about issues that may be positive, or may be troubling and of concern. Participants suggest that measuring outcomes is challenging; however, one key outcome that is evident from qualitative data is the impact on staff mentorship, enhanced wellbeing, communication and relationships with others. This extends to patients, as well as co-workers. Efforts to maintain interest and engagement in Schwartz Rounds require creativity and attention of steering groups to participant feedback related to

meaning and relevance of Schwartz Rounds at the individual and organisational levels.

6.7 Key Question 4

What are the key learnings to inform HSE decision-making on rolling out the initiative further?

In this section, key learnings, including contextual factors are presented with a view to supporting decision making on rolling out the Schwartz Rounds initiative further and begins with the results relevant to financial outlay.

6.7.1 Costing exercise

Estimated costs per round are given in Table 19. Total costs are €5,840 (€68 per head) for Site 2 and €1,699 (€75 per head) for Site 1.

Direct costs (the provision of refreshments at each meeting) account for 9% and 8% respectively. The remainder of costs are indirect – preparation and attendance calculated according to staff salaries.

Per capita costs are higher for Site 1 (€75) than Site 2 (€55), reflecting that even though time committed to preparation in Site 2 by administrators, facilitators and speakers was greater, this cost was spread over a higher number of attendees.

The HSE Quality Improvement Division paid the PoCF for the training, mentoring and the licencing arrangement. The costs of the test of concepts cannot be released as they are commercially sensitive to The Point of Care Foundation.

Table 19 Estimated cost per round (€)

	Site 1	Site 2
Direct costs		
<i>Food</i>	€120*	€518
Indirect costs		
<i>Preparation</i>		
>>Administrators	€100*	€300
>>Leads	€137*	€548
>>Facilitators	€115*	€460
>>Speakers	€225*	€300
<i>Attendance</i>	€1002	€3,714
Total	€1,699	€5,480
% of total in direct costs	8%	9%
Total per person attending	€75	€68

Note: estimated costs do not include an indicative cost for a room as no figure has been provided.

6.7.2 Contextual factors impacting upon the stability of Schwartz

Rounds in the organisation

Qualitative interview data suggests that contextual factors in relation to stability of the organisation should be considered prior to introducing Schwartz Rounds. The impact of staff rotation and organisational change on the introduction of a new initiative has implications for the capacity of sites to support the attendance of target groups, and this was evident, particularly in Site 1:

'But here's our problem, just as we brought Schwartz in, we had a huge change of staff. So, we lost some senior nurses off the ward. And the ward, it's very important for us that the ward is stable...my perception is that we probably lost about six to ten very senior people, which is a lot for us, a lot...I'd say the first six to twelve months we had quite a shift in staff. So that always destabilises... because it hit a very volatile patch in the organisation anyway... overall, there was an organisational change of management and a local change of management.' (S103)

The importance of establishing the core team composed of clinical leads and facilitators who have experience in facilitation, irrespective of their background and role in the organisation, is highlighted as a key learning factor also.

'The first challenge really is that the small group that's set out to use it...so that little team needs to learn how to communicate with each other. And I would never take

that for granted, if you know what I mean. That takes time to build. That's why it's really helpful to do the training together and to come to conference days because they're days where you get a chance to spend time together' (S103)

There are recommendations for safe, skilled and appropriate facilitation:

'I think that's really important. I would be slow ever to let anybody facilitate a large group of staff, who did not have some background in facilitation...I think groups inherently can go crazy. I think you know, I think groups collective, the collective mind can drift off in funny spaces. I think groups are very volatile, they're very uncertain. You're not quite sure what are going to come up. So, you need to be very steady in yourself. And I think the only way really to get steady in yourself, is to know what you're doing...I find Schwartz theoretically light on the facilitation side, now not on the other stuff, but on the facilitation side...and I don't think that a HR background in and of itself, is necessarily robust enough to facilitate, unless that person has already done facilitation.' (S103)

'I think there are [risks], and I think there are organisations that unless, it's well policed, during the session, and that the ground rules are very definitive, there is the risk that it could become a finger pointing exercise, within it and you know a blaming forum...the bigger [the organisation], to be honest, the more likely risk is to happen, if it's not very well facilitated...the potential for it to become a blazing row is there' (S212).

Key learnings include appreciation for careful communication among structures and processes to support the establishment of Schwartz Rounds and to secure on-going ownership by staff and management. This requires prompt responsiveness to staff needs from the very beginning:

'I think go a little bit more slowly at the beginning. We lost a very key staff member out of Schwartz...I think if we'd gone a little bit more slowly in retrospect, maybe we'd have been able to keep her in...you need a certain amount of energy to propel it out, so, it's hard to be passionate and measured at the same time, do you know what I mean? It's a hard thing to do. But I think if we had just gone a tad more slowly, we might've held her on board.' (S103)

Prompt responses relate to feedback also:

'I think even when we were holding the Rounds, just to be mindful of you know, any negative feedback you get...just to watch the spot because you really, going forward, need those key people on board...I just think we're a very small unit. So, we're not a good example of that in the sense that I think the three of us would've taken on that role of, you know kind of talking about it, informally. Encouraging people to come. I do appreciate though in a large hospital setting, it would be really important to have champions you know...it's tricky to talk positively about something that's only beginning, do you see what I mean? And trying to gain traction on it. And you're trying to be encouraging and yet trying to let people have their democratic right to not come.' (S103)

6.7.3 Sustaining Schwartz

There are challenges to managing large numbers of participants. Uptake was complicated also by the involvement of a smaller health care site that is part of the overall group and Schwartz Rounds participation was open to staff from each organisation. While there were a small number of Rounds in the smaller organisation, the following quotations reflect challenges to this:

'Well, we have two sites in Site two and we were very keen, early on, to make sure that we delivered Rounds on both sites [of Site 2]. And that has been a challenge and we have not delivered a Round in XX, for probably twelve months now. We plan to do a Round in XX over the summer. But it is difficult to maintain two sites, you know. They're part of the same organisation, but they're kind of separate, I think we probably took on a bit too much with the two sites' (S213)

This notion is re-enforced by the comment below that Schwartz Rounds need to be accessible in terms of travel and time:

'I wouldn't get the bus over to XX for it because I wouldn't have the time for that' (S206)

'The main challenges are the practical logistics of actually delivering it on the ground, having continuity of, commitment to it and continuity of leadership within it, facilitation, continuity of facilitation, so you're always preparing, if somebody has to step down from, you know, three people or four people run it, you're preparing somebody else to come in already so you maintain momentum – sustainability I would think, and I'd say starting off Schwartz Rounds would be relatively easy in

most places – now I say relatively easy, it's actually not easy, it's not like, because it is, it's a whole methodology that you have kind of get your head round, but generally speaking we find with improvement initiatives, and I think this would be true of this as well, it's easier to initiate it than to sustain it...particularly in a system where people get chopped and changed in the job all the time, people leave, the turnover of staff, people are stressed out and they're picky and, and management focused on the next big thing' (HSE03)

6.7.4 Needing additional expertise and understanding organisational culture.

The narrative below from a Site 2 participant reflects the view that a solid understanding of organisational culture is needed to progress Schwartz Rounds initiative to the next level where complex themes may be introduced as themes for discussion. This participant does not feel as though Site 2 has achieved that level of understanding.

'I think you know, to go to the next stage of what this can deliver, I think we need a better understanding of what makes an organisation work or not work...and we don't have that in my opinion yet. But we, you know, we're hoping to get [Name] over in the summer and have some sessions with her around you know, mentoring and maybe exploring, taking things to the next level. And you know, if we don't achieve that, I think we still have done something worthwhile. But to answer your question, I think you know they have held Rounds in the [name of place], on topics that we would not be able to hold a Round on... so they had a Round on their involvement with Ebola...I would liken that to our, you know [incident] and we've not yet been able to go there, in terms of holding a Round on that care' (S213)

A person key to driving the introduction of Schwartz Rounds in Site 2 highlighted the need to have someone in the organisation that can have matters of concern to staff heard through Schwartz Rounds:

'I think that's the next phase for us. And I think we need to get an occupational psychologist, or if not...somebody skilled up in those kinds of you know, recognising that. [Name] describes in her book how that when before Schwartz came to the [organisation] she would be referred a staff member by a manager, but then she realised that the problem was really the manager, not the staff member and Rounds enabled her and enabled the organisation to, not to fix that, because they're not

about fixing things, but just to you know, to recognise that you know...she was able to go up stream of the problem' (S213).

The narrative below is from a HSE staff member who shares their experience of Rounds and personal gain that was unexpected:

'I learned some things professionally...somebody was talking about, you know, a conversation being a bit existential or why we're here kind of thing, but it was, one of the things I took away was if you're nice to your own staff and you develop them as people and as professionals, and you've no impact whatsoever on the health service other than that, which hopefully wouldn't be the case, but if you only did that, that wouldn't be a bad thing to do' (HSE03)

Maintaining interest was viewed as important to keeping momentum in Site 1:

'I think once a month ongoing is too short of a period in between and I think the topics, eventually you run out of topics or things for people to say and I just find that when you come the same people are talking all the time, you know, it's the same few' (FG2A).

6.7.5 Conclusion

In this section we presented findings on the contextual factors impacting upon the stability of Schwartz Rounds in the organisations, challenges with sustaining Schwartz Rounds and its fit with organisational culture. A solid understanding of organisational culture is needed to progress Schwartz Rounds to the next level where complex themes may be introduced for discussion. This may require the support of additional expertise.

6.8 Overall Conclusion

In this Chapter, we presented the results from ProQOL measures and anonymous Schwartz Rounds evaluation forms and comment cards collected from Sites 1 and 2, and findings of analysis of qualitative interviews. Findings and participant quotations appear to be mainly positive though clearly, there are practical challenges for the sites, which vary depending on the size of the organisation. There are clear personal gains for participants and for co-workers and patients, these were anticipated and unanticipated. Schwartz Rounds were intended to develop compassionate and supportive cultures for staff working in health care settings, and

in doing so, promote improvement in health care outcomes for patients and service users. The findings of this evaluation suggest that these original Schwartz Rounds' aims were met. The results and findings will be discussed in Chapter Seven.

6.9 References for Chapter Six

1. Gaglio B, Shoup JA, Glasgow RE. The RE-AIM framework: a systematic review of use over time. *American journal of public health*. 2013 Jun; 103(6):e38-46.
2. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of innovations in service organizations: systematic review and recommendations. *The Milbank Quarterly*. 2004 Dec;82(4):581-629

7 Chapter Seven: Discussion

7.1 Introduction

This discussion chapter is structured around the four key evaluation objectives and grounded in the context of recent themes from Implementation Science literature, with respect to critical considerations for quality implementation.

Findings indicate that the ethos of Schwartz Rounds is compatible with the Health Service Executive's (HSE) strategic drive for quality and safe health care. Schwartz Rounds offer a forum for staff to share experiences in a potentially safe and structured medium, irrespective of their role or status within the organisation. This creates a culture of shared communication, trust, collegiality and teamwork.

Findings indicate that for those who invest and engage in Schwartz Rounds, the impact is generally positive. Despite this, unless carefully monitored and tailored to the changing needs of staff and/or the organisation, early enthusiasm for Schwartz Rounds can be replaced by feelings of pressure to participate and of being burdened by the process. For successful national implementation of Schwartz Rounds, there is a need to adapt the reach, adoption, implementation and evaluation process to the unique and specific requirements and culture of stakeholder settings. To accomplish this, adopting organisations need resources and independent, objective support and assistance during the adoption and embedding phases of implementation. The key learnings emerging from this evaluation offer some guidance for how this may be achieved and are set out at the end of the discussion chapter for ease of reference.

7.2 Key Question 1

Are Schwartz Rounds suitable for introduction, practically and culturally, in the Irish health system?

The test of concept sites were under a process of adoption and embeddedness at the time of our evaluation. It was evident that, in both test of concept sites, the process had moved from the initial 'honeymoon' phase, characterised by staff enthusiasm and support for the initiative, to an awareness of the commitment required to sustain Schwartz Rounds in the long-term.

The findings reflect positive adoption at the organisational leadership level in the test of concept sites, however, this does not appear to have fully extended to the individual staff level. In a review focusing on how innovations can be spread and sustained, Greenhalgh *et al.*¹ reported that health service organisations embrace innovations according to levels of ease of adoption and implementation. Factors that promote adoption and implementation include: 1.the compatibility of the innovation with the adopters' values, norms and perceived needs, 2.the complexity of the innovation, and the opportunity to trial the innovation, 3.the observable benefit, 4.the relevance and value of the task to the users' performances, and 5.knowledge transferability for its use from one context to another¹.

In the initial introduction of Schwartz Rounds in Ireland, the benefits were apparent from the literature and lead individuals from the two test of concept sites had the opportunity to experience Schwartz Rounds in the UK and this assisted in the initial adoption and implementation of Schwartz Rounds. The motivation, drive and desire to sustain Schwartz Rounds from an organisational leadership and management perspective was evident. At the individual level, however, adoption has been less successful, and while some staff support Schwartz Rounds and perceive Schwartz Rounds to be beneficial, this is not reflected in the views of others, most specifically in Site 1. This was attributed mainly to practical considerations, such as frequency of Schwartz Rounds and relatively smaller numbers of staff.

In Site 1, initial introduction of Schwartz Rounds was supported generally; however, as time progressed, Schwartz Rounds were viewed by some as burdensome. According to Greenhalgh *et al.*¹, an innovation is more likely to be assimilated to an organisation, if the meaning and significance attached to it by individual adopters is similar to that of top managers and key stakeholders. Over time, however, meaning can change and in the test of concept sites, the meaning held by some individual adopters strayed from that of key stakeholders within the organisation, and this negatively impacted on the assimilation process. In Site 1, there was an understanding for some participants that Schwartz Rounds would be in operation for one year, as distinct from two. Levasseur² suggests that active participation of persons affected by a change initiative is the most important element of adoption, and receptiveness to change is 'inversely proportional' to the degree to which a person is involved². Success of the initiative depends on continuing communication and involvement of those directly engaged.

In Site 2, pressure to attend was of less concern due to the availability of a larger pool of potential participants and panellists; however, promoting awareness of Schwartz Rounds to large numbers of staff was essentially problematic. Greenhalgh *et al.*¹ propose that impediments to assimilation may be addressed by adapting and refining the innovation in

question to the needs of individual adaptors. Disseminating news of Schwartz Rounds in Site 2 could be addressed by having an information system that enables individual adopters continuing access to information¹. Ensuring the spread of Schwartz Rounds information and awareness falls within the remit of the steering group; however, when these recommended structures are challenged, sharing information and knowledge about Schwartz Rounds may be facilitated by a knowledge broker³. According to Long *et al*³, the knowledge broker keeps separate groups in a network informed and prevents fragmentation of information. In relation to Schwartz Rounds, findings of this evaluation, specific to Site 2, support the need for a named individual to broker the flow of information between organisational members.

Positive aspects of Schwartz Rounds, such as greater insight into others' roles and experiences, and enhanced communication, are reported by persons who participate in and embrace the concept. Findings, however, also reflect, that it is essential that those driving the initiative respect the voluntary nature of participation, listen, and act promptly upon staff feedback, as failure to do so, is counterproductive.

The suggestion that Schwartz is 'not for everyone' has been acknowledged by participants of this evaluation and supported by the work of Maben *et al*⁴. In this evaluation, individuals' perceptions of the benefits of Schwartz Rounds changed over time, with some persons more engaged than others. In Site 1, this may have been avoided by an earlier review of the needs at individual level and by adapting the process, in tandem with the ethos and philosophy of Schwartz Rounds. The importance of fit between the innovation and local context as essential for success in implementing innovations in practice is highlighted by McCormack *et al*.⁵ There are challenges specifically for management and leaders to maintain support and interest in Schwartz Rounds by adapting to the changing needs of the organisation and having measures in place to enable the release of staff from ward duties to attend. One possible solution suggested by Hughes *et al*⁵ might be to co-ordinate Schwartz Rounds within an established timetable of meetings or staff events, which may help participants in practical planning for attendance.

According to Meyers *et al*⁶, success in sustaining an initiative, requires that organisations have an ongoing tracking process and be flexible in their approach, while still meeting the standards necessary to achieve the desired outcomes. Efforts were made by Site 1 to adjust the frequency and location of Schwartz Rounds to support attendance. In this instance, 'fit' at the individual level had changed over time, however, adaptations occurred at a later time point. Prompt and responsive change to the process may have sustained the interest and support of early champions of the initiative.

Findings of the evaluation of Schwartz Rounds in test of concept sites suggest the need for ongoing resources and supports. The results of analysis by Rycroft-Malone *et al.*⁷ of factors that influence the implementation of evidence into practice indicate that resource issues are complex and varied, and need to be addressed in the early stages of the planning process. The motivation, drive and willingness of key stakeholders to give of their time and effort, voluntarily in some cases, was instrumental to successful organisational adoption and implementation of Schwartz Rounds. The findings indicate, however, that this is not sustainable. Additional resources, for example, the appointment of an administrator to co-ordinate and operationalise Schwartz Rounds to support and embed the process for long-term sustainability is required. This post should be rotational to ensure that there is a shared body of expertise when a staff member is unavailable.

Overall, findings indicate that Schwartz Rounds are suitable for introduction, practically and culturally in the Irish health system; however, successful adoption and implementation requires ongoing monitoring to respond and adapt the process to individual and organisational levels.

7.3 Key Question 2

What is the experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads?

Quantitative results following each Round are similar to those reported in the international literature. Each Schwartz Round evaluation demonstrated consistently high positive responses, and anonymous staff feedback form responses reflect that participants find Schwartz Rounds to be of benefit in terms of relevance to their daily work, working better with colleagues and gaining insight into how others care for patients. Although there was no statistically significant correlation between attendance and compassion satisfaction or burnout, the statistically significant relationship between more frequent attendance and lower secondary traumatic stress is of interest and warrants detailed investigation in future studies. The mechanism by which Schwartz Rounds might reduce secondary traumatic stress also warrants further investigation.

Participants of this evaluation reported that, on the whole, Schwartz Rounds were facilitated with skill and professionalism and that group discussions were helpful; participants indicated their intent to return to later Schwartz Rounds and stated that they would recommend

Schwartz Rounds to colleagues. The immediate benefit from the experience evidenced in the anonymous Schwartz Round evaluations are supported by many responses in the qualitative component of the evaluation.

Findings indicate that Schwartz Rounds can provide the vehicle through which many of the expectations of both staff and those driving the introduction of Schwartz Rounds can be realised in the Irish Health Care context. Staff had high expectations of Schwartz Rounds and considered it as a means through which compassionate care and staff well-being could be achieved. They were also viewed as a medium for creating and sustaining a collective sense of culture and responsibility for improving patient care. This was reflected through shared awareness and appreciation that everyone in the organisation is involved in contributing to promoting best outcomes for patients and families and, through good leadership, can bring about culture change. The experiences of those who participated in the Schwartz Rounds as panellist, participant, steering group committee member, or combination of these roles, reflect those consistently reported in published research studies on Schwartz Rounds.

Positive outcomes reported in the literature include gaining insight into others^{8,9,10,11,12,13,14}, a positive impact on teamwork^{10,12,13,14,15}, and on the self^{8,11,12,16,17}. Impact at the personal level included reflection on self and on own practice^{18, 19, 20}, manifestations of positive changes in practice^{8,11,12,13,14,20} and enhanced communication^{8,10,12,21}.

Evaluation findings signal the potential for Schwartz Rounds to support delivery of quality health care in the Irish context. Patient safety is a key indicator of quality in health care and many of the findings from this study are pre-requisites for quality; for example, insight into the role and contribution of others, team work and compassion.

A number of high profile incidents in the Irish Health sector has highlighted that poor communication across the interdisciplinary team and lack of compassion in health care were key contributors to adverse patient care outcomes, and in some instances, patient mortality. Improved communication and appropriate involvement of the multidisciplinary team were key recommendations in the report into the death of Savita Halappanavar²². Similarly, poor communication and lack of compassionate care were central to many other high profile instances of unacceptable standards of care, including the care of people in residential settings, such as Aras Attracta²³ and Leas Cross²⁴

Effective communication and an interdisciplinary approach to care is important for quality of care across all sectors of the health care setting²⁵. The results of a Cochrane Systematic Review, which included 17 trials focusing on the effectiveness of early supported discharge services, indicate that coordinated multidisciplinary team input can reduce long-term

dependency and the length of hospital stay, at least for a selected group of patients affected by stroke²⁶. Further research suggests that teamwork enhances the quality of patient care, but requires a commitment of individuals to engage in shared learning and dialogue²⁷. A review by Manser²⁸ suggests that teamwork is an important aspect of prevention of adverse events.

As part of this evaluation, staff reported that attending Schwartz Rounds enabled them to acknowledge a shared purpose with clinical and non-clinical staff across the organisation. Effective teams demonstrate high levels of mutual respect where there is an openness to the talents of others and a belief that working in a team is the best way to integrate the contributions of all members²⁹.

Schwartz Round participants reported gaining an appreciation of others and increased connection with others across the organisation. The concept of unity in goal setting is significant, as characteristic of effective teams is the notion of shared ownership and clear purpose²⁹. Interview data suggest that the breaking down of barriers, the creation of a safe space for staff to share their experiences, and the recognition of the roles played by others and how people contributed in various ways to the journey of the patient and family generated a sense of community and team spirit. These views are consistent with those expressed in the literature where the capacity for Schwartz Rounds to bring members of the organisation together is reported^{4, 14, 19}.

According to Mickan and Rodger²⁹, team success is fostered by a culture that incorporates shared experiences of success, and communication across the organisation is an essential part of the process²⁹. To achieve a substantial improvement in the quality of health care services, team-work skills should be part of healthcare education²⁷. Schwartz Rounds is one approach to achieve this³⁰; the unique structure and processes of Schwartz Rounds allows for the inclusion of staff across the organisation, of all grades and disciplines including clinical and non-clinical staff.

The findings from this evaluation study indicate that Schwartz Rounds is one way of bringing two vital components characteristic of teamwork to an organisation, 1. Shared purpose and 2. Effective communication. According to Gallie *et al*³¹, teamwork breaks down organisational hierarchy and associated conflict³⁰. Hierarchical systems obstruct the flow of communication, have a negative impact on patient care^{32, 33}, and lead to burnout and dissatisfaction among nurses³³. Our findings indicate that Schwartz Rounds enable a levelling effect by offering a forum to share experiences where staff at all levels are willing to be open and vulnerable with other staff across the organisation. This is important to ensure that members of the

organisation feel a sense of belonging, can identify their position in the organisation, and that their individual contribution is recognised.

The sense of community, connectedness, respect for others and the awareness of emotional and support needs of self and others reported in this study, has the potential to contribute to the management of workplace burnout. Health sector workers internationally are at risk of burnout with research evidence clearly demonstrating the extent of the problem in physicians³⁴, nurses³⁵ and midwives³⁶ and all healthcare workers³⁷. Burnout is linked to staff attrition, but intention to leave employment is ameliorated by collegial interdisciplinary relationships³⁸. In addition, moderate to high burnout is associated with poor patient safety outcomes and medical errors³⁹. Risk to patient safety was also identified in a meta-analysis, where a negative association between burnout in health care providers and the quality of care and patient safety was identified⁴⁰. Risk to patient safety should be addressed through the introduction of effective burnout interventions for healthcare providers⁴⁰ of which Schwartz Rounds may support. Organisational strategies, such as local initiatives to promote community, connectedness and meaning have been shown to be effective in managing workplace burnout⁴¹. The findings of this evaluation provide support for the view that Schwartz Rounds can contribute to reducing burnout in the Irish healthcare setting.

Study participants reported that attending Schwartz Rounds dismantled barriers, offered a forum for a greater sense of community, insight into self and others' emotional and support needs and consequently, promoted reflection on self and practice. Self-awareness and reflection are also essential for the management of conflict within teams.⁴² Almost *et al*⁴² conducted a literature review drawing on forty-four papers, which identified poor communication as one of the antecedents that influences interpersonal conflict and purported that self-awareness and self-reflection are key to addressing conflict within teams. Trust was identified as an essential ingredient for team cohesiveness and incorporating teambuilding strategies for improving communication and building trust⁴².

Participants of this evaluation reported that Schwartz Rounds increased awareness of the wider hospital team and the role that everyone plays in the patient's journey. In addition, the reported impact on communication has potential for enhancing patient outcomes. Patient communication with physicians and nurses is important for patient satisfaction, with nurse communication having a significant impact and having the most influence on patient experience⁴³.

Respect and trust are key features of successful inter-professional nurse-doctor relationships⁴⁴. Factors that contribute to workplace stress for nursing staff are interpersonal relationships^{45,46,47,48} and caring for the emotional needs of patients⁴⁹. Participants of this

evaluation indicated that insight into their colleagues' experiences enabled them to empathise with others in the organisation. According to our evaluation findings, this, along with reported recognition of the role of others and shared connectedness can impact on interpersonal relationships and ameliorate some of the stress experienced in attending to the emotional needs of patients. The sharing of stories was also found to be helpful, for junior staff particularly, as this helped to normalise their feelings of inadequacy with the knowledge that there were others, who, even after years of practice, continue to find the emotional aspects of caring challenging. This offered a reminder also of the availability and willingness of colleagues to offer support when needed.

Findings indicate that those who participated in Schwartz Rounds reported support for the emotional aspects of care provision and improved interpersonal relationships, two of the identified causes of workplace stress for nurses. Nurse engagement is critical to patient experience, clinical quality and patient outcomes. Nurse engagement with the organisation and profession reduces compassion fatigue, burnout and turnover, while improving teamwork, the patient experience, and organizational outcomes across multiple clinical, operational, cultural, and behavioural measures⁵⁰. In a study evaluating job satisfaction in advanced nurse practitioners in the Irish health care system, O' Keefe *et al*⁵¹ concluded that enhancing inter-professional collegial relationships and improving managerial recognition of the role within nursing, are key areas to be targeted to promote job satisfaction in Advanced Nurse Practitioners. Similarly, the results of a survey of 10,702 employees from 16 facilities indicate that high levels of healthcare employee engagement positively impact on patient safety and care as well as quality of care and services provided⁵².

This study has demonstrated that Schwartz Rounds are a positively evaluated initiative valued by the majority of staff who have attended or participated as panellist, facilitator, clinical lead and/or steering committee member. Areas consistently highlighted by respondents included gaining greater insight into self and others, the breaking down of barriers and levelling of hierarchical structure. This ultimately improved staff interaction and teamwork, and for some respondents, Schwartz Rounds impacted positively on their own practice.

These findings provide valuable insights into strategies that will facilitate the introduction of Schwartz across the Irish health care system and increase the quality of evidence from future evaluations.

7.4 Key Question 3

What are the perceived and/or actual outcomes for the service/hospital?

The findings of this evaluation indicate that Schwartz Rounds has the capacity to bring members of the organisation together. Successful reach and adoption are affected by contextual factors related to organisation size and numbers of staff. This is an important issue in terms of reach and access to information, particularly relevant to Site 2.

The findings suggest that research participants had difficulty in extracting explicit outcomes at organisational level. Individuals described tacit changes, which reflect the positive personal impact of Schwartz Rounds, which may impact upon long term organisational culture change, however, no tangible workplace culture change was reported. Workplace culture refers to 'shared basic assumptions, norms, and values and repeated behaviours of particular groups into which new members are socialised, to the extent that culture becomes 'the way things are done around here' ⁵³ (p 107). Our findings are not in keeping with the literature reporting culture change associated with Schwartz Rounds ^{17, 11, 12}. This is not unusual and most likely due to the early stage of the implementation phase relative to the time required to effect change. Curran *et al* ⁵⁴ (p. 2) suggest that the time lag between 'research discovery and routine uptake' in practice is influenced by a myriad of factors, which will be described in the following section, under Key Question Four. Further research is required to capture and measure the impact of Schwartz Rounds on organisational culture over time.

7.5 Key Question 4

What are the key learnings to inform HSE decision-making on rolling out the initiative further?

Findings indicate a need for additional support for organisations during times of challenge. Participants stressed the need for ongoing education, support and expert help in maintaining Schwartz Rounds. This is particularly with regard to relevance of Schwartz Rounds themes discussed, and areas of concern within the organisation highlighted by participants. Schwartz Rounds did not address all of the needs and expectations of participants, as staff believed that the learning from deep-rooted issues or concerns articulated in Schwartz Rounds, should be taken upstream and addressed by leaders within the organisation. Taking issues outside of Schwartz Rounds; however, is not consistent with the ethos of the Schwartz Rounds model. There is a need to ensure that staff are fully aware of the purpose and scope of Schwartz Rounds and that other fora to address organisation-wide issues, which are of concern to staff, be explored. There are challenges also, with keeping themes relevant and engaging. While addressing difficult topics can be challenging, they may also lead to fruitful discussion¹⁷.

Findings suggest that the core team driving Schwartz Rounds in Site 2 had considered introducing more contentious themes for reflection. This was considered to be, *'the next phase for us'*, with a view to progressing general interest and relevance of Schwartz Rounds to staff. Research findings by Deploitti¹⁷ suggest that introduction of more emotive and challenging scenarios increases participation and impact of Schwartz Rounds by participants who expressed a preference for the introduction of more controversial topics. This also increased personal impact and employee performance¹⁷.

Our findings suggest that a bigger site with more potential participants contributes towards sustaining interest and keeping Schwartz Rounds relevant. Site 1 participants felt that the size of the organisation negatively impacted on their experiences due to perceived pressure to participate. On the other hand, merging organisations for Schwartz Rounds presents practical issues, not least the prospect of travel commitments for staff. One possible solution might be building Schwartz Rounds into a larger initiative within the organisation that would explore how the individual piece could be developed into learning for the organisation as a

whole. This would mean looking at how the learning from individual experiences that are presented during Schwartz Rounds, while respecting the confidential nature of Rounds, could be discussed in terms of learning for the team and from there, for the organisation. A question that might be asked of leadership in the organisation might be, *'how do we go from the 'I' to the 'we' within the organisation in terms of relevance and implications?* The ultimate target for expanding discussion in this way might be to encourage participation in and engagement with organisation strategy and mission⁵⁵.

Staffing levels posed challenges for management in terms of releasing staff and maintaining interest in Schwartz Rounds. To ensure that all staff have opportunity to attend a number of Schwartz Rounds throughout the year, extra staff may be needed on the day of Schwartz Rounds. An hour is a long time in the middle of the day, particularly for ward work and having additional personnel on duty may enable ward managers to extend lunch breaks for attendance. Linking the timing of Schwartz Rounds to activities that require staff to come together may also facilitate attendance for some disciplines. Reflections of implementing Schwartz Rounds in 2015-2016 in a UK paediatric setting reported that running the Rounds within an established timetable of Grand Rounds, which were traditionally supported by medical staff, was helpful from a practical perspective⁵⁶.

The appointment of an administrative post, while useful to operationalise the Schwartz Rounds, should be embraced with caution against diminishing a sense of shared ownership and responsibility for Schwartz Rounds. The findings indicated that in Site 2, a core team of individuals were driving Schwartz Rounds and that there was a need for more ownership to be taken by the steering group and the organisation in general. This resulted in an over-reliance on key members, which is unsustainable. Adoption and sustainability long term is enhanced by direct involvement and perceived ownership of an initiative; therefore, issues of concern for sustaining Schwartz Rounds in the organisation include the need to address the 'spread effect', and to promote ownership among staff and all members of the steering group. In that way, the steering group can be more involved in strategic planning for succession, securing resources and support to progress the initiative.

7.6 COST

The direct costs of the programme are negligible – the cost of providing lunch during Schwartz Rounds are less than €6 per head – and as such the Rounds would have to achieve very small productivity gains to justify the investment. Additional direct costs include payment (non-disclosed) to the Point of Care Foundation for training, mentoring and licencing arrangement.

Indirect costs are much more significant, over 90% of relevant costs in both cases. These costs are easy to discount for managers and organisations considering implementing the Schwartz Rounds, since they do not have to be met out of traditional budgets. However, they represent the sacrifice of attendees' time and as such are an important factor for consideration. In attending Schwartz Rounds, participants are implicitly deciding that the benefits (to themselves, to patients, to the hospital) merit the sacrifice of a scarce resource (their lunch break) that could be used in other ways. If the benefits of attending fall, attendees will choose to spend their lunchbreaks elsewhere. Total costs therefore, represent a more appropriate estimate of the overall benefits that the Schwartz Rounds must achieve to be sustainable in the long term.

7.7 Potential Strengths and Limitations of this Evaluation

This evaluation study has strengths and limitations. In terms of strength, the evaluation was conducted independently and the authors of this report have no vested interest in the continuation or discontinuation of Schwartz Rounds. All raw data sources were made available to the authors for confirmation of summarised data provided by the two sites, if required. Best practice in the conduct of data collection and analysis were adopted and these are outlined in the methodology chapter, Chapter 5. In addition, the use of multi-modes of data collection afforded all staff an opportunity to participate in this evaluation. The use of focus groups and interviews afforded all staff (both Schwartz Round participants and non-participants) choice as to how they wished to participate. Those who did not wish to be interviewed had opportunity to participate in the evaluation through the use of anonymous comment cards.

Despite this, the findings must be interpreted within the limitations of the study. First, we were seeking to interview approximately 60 people between Sites 1 and 2, either through focus group or individual interviews. Just under half of our target number was achieved. Although this is a relatively small sample, it was sufficient to answer the key evaluation questions and the sample size is in keeping with the principles of qualitative research, the aim of which is not to generalise. It is, however, important to highlight that over one third (38%) of interviewees were members of the steering committees and therefore, champions of Schwartz Rounds. This may have led to bias towards positive findings and, despite the modest numbers of staff who participated in the qualitative aspect of the evaluation, those interviewed welcomed this evaluation. The voices of those who felt strongly about aspects of Schwartz Rounds that differed from possible champions of Rounds are presented and balance the discussion. In addition, the use of multi-methods of evaluation provided an opportunity to deepen insight into

aspects of Schwarz Rounds that are unique to the Irish culture and important to address for medium and long-term successful implementation of Rounds nationally.

The findings from the ProQOL questionnaires are limited as they were administered at two different Rounds and it is unknown if the participants were the same at both administration time-points. The ProQOL evaluation at the second time-point was conducted at the end of the 10 Rounds in Site 1 and prior to the start of this evaluation. The ProQOL evaluation at the second time-point in Site 2 was conducted towards the end of the data collection phase of this evaluation (April 2018). Any differences between the time-points is likely to be due to differences between the samples and differences between the sites, due to the nature of the organisations and the data collection time-points. Repeated measurement of outcomes in identical samples and settings would reduce the sources of variation and measurement error, allowing for conclusions to be drawn more definitively on the relationship of Schwartz Rounds to outcomes.

In addition, the ProQOL is used to measure work related difficulties and satisfaction in the broader sense. Work related wellbeing is complex and multifactorial⁵⁷ and quality of life measures may not be sensitive to the changes experienced by staff as a result of attending Schwartz Rounds, as personal life challenges may negatively or positively skew the results. Measures of compassion and well-being need to be explored for sensitivity and pilot testing in advance of large scale evaluation and can help determine potential instrument sensitivity. The anonymous staff feedback form approach to evaluation of Schwartz Rounds, where those responding were likely to be repeat attenders, also impacted on the outcomes and may have led to the consistently high positive evaluation outcomes; those who repeatedly attended were likely to be those who were benefitting from the experience or enjoyed the social aspect of the Schwartz Rounds. The potential limitation of self-report questionnaires, combined with motivation to attend was also identified by Mabel *et al.*⁴ Schwartz Rounds attendance may be an indication of level of engagement with the organisation, consideration of the wider issues and how they might be dealt with.⁴ Another point to note is that the effects of Schwartz Rounds were likely to be more pronounced immediately following the Rounds and the longer term impact was not captured.

These limitations can be addressed in future evaluations by following Schwartz Rounds participants and non-participants over a defined period of time and ensuring protocols are developed to address recruitment challenges. In addition to pilot testing and ensuring instrument sensitivity, methods to capture the potential impact on patient experience and care need to be considered. Measuring impact at the organisational level is challenging, however,

the literature¹² indicates that although the length of time needed for organisational change is difficult to determine, the impact of continued Schwartz Rounds attendance over a long period cannot be out ruled. Likewise, George¹⁹ argues that eradicating stigma associated with emotional responses should help improve organisational culture. Longitudinal evaluations can take cognisance of such factors and how they may affect impact by mapping attendance at Schwartz Rounds and the airing of challenging topics to possible individual and organisational impact.

7.8 Overall conclusion

The introduction of Schwartz Rounds to the Irish context represents a significant addition to the staff engagement work of the HSE in both its reach across different care contexts, but also across clinical, support and administrative staff. The two test of concept sites that were represented in this evaluation were of sufficient differences in size and contexts as to provide valuable information on the practical experiences of implementing Schwartz Rounds in the HSE. Using a mixed methods approach we employed a well-recognised evaluation framework (RE-AIM) to address reach (spread and uptake), effectiveness, adoption (embeddedness), implementation process, and maintenance (sustainability). The findings were largely positive, though a number of challenges were also reported. These included impact at individual level for participants, including those were involved in the roll-out, facilitation, and steering committee levels and those who attended and who did not attend.

Participants found the experience largely positive. These were not dissimilar to those found in recent Schwartz Rounds evaluations including the recently published UK findings from a large-scale longitudinal evaluation report⁴. Of note, evaluation participants reported on the topics that were presented as being relevant, insightful and well-facilitated. Participation in Schwartz Rounds afforded participants with insights that inform their care delivery and collaboration with colleagues. The inclusivity of all members of the organisation and the capacity of Schwartz Rounds to bring members of the organisation together was viewed by participants as being particularly valuable. However, attendance was affected by staff availability and as one would expect, there was no specific scheduled time that suited everyone. Attendance was also negatively affected by the size of the pool of potential participants with one of the sites being much smaller in size and number of staff. Particular challenges that were noted included shifting ownership of sourcing topics from leaders to other members of the steering groups and sustaining buy in across participants and attendees. Key Learnings include giving consideration to strategies for maintaining the current structures and focus, while also exploring how the learning from issues discussed may be brought to other

fora to support organisational responsiveness, while respecting confidential nature of Schwartz Rounds.

Key Learnings arising from the findings of this evaluation are presented under three headings:

1. Insights for Policy and National Supports,
2. Insights for Organisations Introducing Schwartz Rounds
3. Insights for Schwartz Rounds Evaluation

Insights for Policy and National Supports

Key Learning 1

Use the findings of this evaluation to highlight how staff in the Irish context have reported benefiting from participation in Schwartz Rounds.

Key Learning 2

Organisations adopting Schwartz Rounds need ongoing and objective monitoring of facilitation of Schwartz Rounds, in accordance with the changing needs of the staff and the organisation. This should be followed up, where possible, by a mechanism to action practical adaptations in response to organisational needs.

Key Learning 3

Seek expert help to establish support structures for facilitators and steering committees to introduce and manage discussion around challenging and complex topics.

Insights for Organisations Introducing Schwartz Rounds

Key Learning 4

The structures recommended by Point of Care need to be resourced to enable sharing information and knowledge about Schwartz Rounds.

Key Learning 5

Information about Schwartz Rounds, aims and process should be in an accessible format. Where possible, host communication tools (e.g., screen display) containing Schwartz Rounds related information in strategic locations; for example, staff canteen, changing rooms, and staff coffee areas.

Key Learning 6

Dedicate a specific part of the local organisation's website to Schwartz Rounds, with staff sharing their experiences of participating in Schwartz Rounds. Where feasible and appropriate, use written word, video and audio of staff from across the organisation sharing their experiences of attending Schwartz Rounds. Organisation could also advertise in advance upcoming Schwartz Rounds and all future planned rounds for that year.

Key Learning 7

Schwartz Rounds participation should be embedded as part of the role of staff working in health care settings, but communication should clarify that participation is voluntary. Time should be allocated for participation in a minimum number of Schwartz Rounds each year, where possible. The voluntary nature of participation should be respected at all times. For successful adoption of Rounds at the individual level, consider flexible ways to acknowledge attendance.

Key Learning 8

Consider co-ordinating Schwartz Rounds within an established timetable of staff events to support practical planning for attendance, for example, scheduling team meetings and Schwartz Rounds on the same day, particularly in the event where staff need to travel to the host site.

Key Learning 9

Appoint an administrator on a rotational post basis to co-ordinate and operationalise Schwartz Rounds to support and embed the process with a view to long-term sustainability and learning.

Key Learning 10

Communicate a clear definition of the steering group role, and have well defined Terms of Reference (quorum, membership, rotation).

Key Learning 11

Provide recognition for the importance of the work of steering group members by ensuring that time is allocated for committee work.

Key Learning 12

Organisations need to analyse the core values, attitudes and behaviours that define the organisation, with the support of management and leadership, to grasp the extent to which the intervention fits.

Key Learning 13

For medium to longer-term sustainability consider the possible gain from merging two smaller sites of similar ethos and interests. Take into account travel and accessibility as possible deterrents from participation.

Key Learning 14

Consider practical ways to facilitate staff attendance at rounds. Strategies such as ward/unit pop-up rounds where members of the interdisciplinary team and support staff for that ward/unit are invited to attend may be helpful. This may fit well with an extended staff handover during the afternoon shift, but would need to be off-set against the pressures that holding rounds outside normal lunch times would pose for other disciplines. Some clinically-based disciplines would also experience additional pressures from moving the Rounds outside lunch times, for example, medicine and allied healthcare professionals.

Insights for Schwartz Rounds Evaluation

Key Learning 15

Provide evidence to determine the true contribution of Schwartz Rounds towards addressing the needs of health care workers in support of their delivery of compassionate care. This may be achieved by evaluation, using instruments that are specific and sensitive to the purpose of Schwartz Rounds. Instruments used in previous studies can be considered and tested for appropriateness for use in the Irish context.

Key Learning 16

The body of evidence to support the impact of Schwartz Rounds can be strengthened by using research designs that minimise bias.

Key Learning 17

Conduct an independent longitudinal evaluation of Schwartz Rounds in Ireland incorporating methods to include a specific focus on identifying organisational culture change.

Key Learning 18

Future evaluations of Schwartz Rounds in the Irish setting need to incorporate pilot studies to test the potential sensitivity of the instruments selected for measuring impact.

Key Learning 19

Schwartz Rounds render issues discussable that may not have been previously, and present a means to articulate deep-rooted issues or concerns within the organisation. Taking issues outside of Schwartz Rounds, however, is not consistent with the confidential and non-problem solving ethos of the Schwartz Rounds model. There is a need to ensure that staff are fully aware of the purpose and scope of Schwartz Rounds.

Key Learning 20

Staff need a safe space, outside of Schwartz Rounds, to discuss organisational issues that need action. Therefore, other fora to address organisation-wide issues, which are of concern to staff, need to be explored.

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APPENDICES

Appendix 1

Search Protocol/Method

A review using a systematic approach was undertaken of evaluations of Schwartz Center Rounds (SCR). A search for published academic literature was applied in a range of databases in order to capture as much of this literature as possible. Databases were searched using permutations of the name of Schwartz Center Rounds in titles, abstracts, and keywords or medical subject headings. Sample search criteria for the MEDLINE database are presented below:

“Schwartz Center Rounds” OR “Schwartz Rounds” OR “Schwartz Centre Rounds” OR “Schwartz clinical rounds” OR “Schwartz medical rounds” OR “Schwartz hospital rounds” OR “Schwartz center” OR “Schwartz Centre” OR “Schwartz hospital”

Registries of research protocols and clinical trials were searched to retrieve as much ongoing work in the area as possible. This was accompanied by a search for grey literature was undertaken on websites of relevant organizations and general research networks to capture reports or evaluations not published in the academic literature. The databases are presented below:

- Published Academic Literature
 - MEDLINE
 - PsycINFO/PsycARTICLES
 - CINAHL
 - Scopus
 - Embase
 - Emerald
 - Cochrane Database of Systematic Reviews
 - EconLit
 - Web of Science
- Protocols and Trial Registries
 - PROSPERO Systematic Review Protocol registry
 - Cochrane Central Register of Controlled Trials (CENTRAL)
 - World Health Organization (WHO) International Clinical Trials Registry Platform (ICTRP)
 - ClinicalTrials.gov
- Grey Literature (e.g. reports)
 - Point of Care Foundation website
 - Schwartz Center website
 - Google Scholar
 - Research Gate
 - Academia.edu

Appendix 2: Crowe Critical Appraisal Tool

Crowe Critical Appraisal Tool (CCAT) Form (v1.4)

Reference

Reviewer

This form must be used in conjunction with the CCAT User Guide (v1.4); otherwise validity and reliability may be severely compromised.

Citation	
	Year

Research design (add if not listed)

<input type="checkbox"/> Not research	Article Editorial Report Opinion Guideline Pamphlet ...
<input type="checkbox"/> Historical	...
<input type="checkbox"/> Qualitative	Narrative Phenomenology Ethnography Grounded theory Narrative case study ...
<input type="checkbox"/> Descriptive, Exploratory, Observational	A. Cross-sectional Longitudinal Retrospective Prospective Correlational Predictive ... B. Cohort Case-control Survey Developmental Normative Case study ...
<input type="checkbox"/> Experimental	<input type="checkbox"/> True experiment Pre-test/post-test control group Solomon four-group Post-test only control group Randomised two-factor Placebo controlled trial ...
	<input type="checkbox"/> Quasi-experiment Post-test only Non-equivalent control group Counter balanced (cross-over) Multiple time series Separate sample pre-test post-test [no Control] [Control] ...
	<input type="checkbox"/> Single system One-shot experimental (case study) Simple time series One group pre-test/post-test Interactive Multiple baseline Within subjects (Equivalent time, repeated measures, multiple treatment) ...
<input type="checkbox"/> Mixed Methods	Action research Sequential Concurrent Transformative ...
<input type="checkbox"/> Synthesis	Systematic review Critical review Thematic synthesis Meta-ethnography Narrative synthesis ...
<input type="checkbox"/> Other	...

Variables and analysis

Intervention(s), Treatment(s), Exposure(s)	Outcome(s), Output(s), Predictor(s), Measure(s)	Data analysis method(s)

Sampling

Total size	Group 1	Group 2	Group 3	Group 4	Control
Population, sample, setting					

Data collection (add if not listed)

Audit/Review	a) Primary Secondary ... b) Authoritative Partisan Antagonist ... c) Literature Systematic ...	Interview	a) Formal Informal ... b) Structured Semi-structured Unstructured ... c) One-on-one Group Multiple Self-administered ...
	Observation		a) Participant Non-participant ... b) Structured Semi-structured Unstructured ... c) Covert Candid ...

Scores

Preliminaries	Design	Data Collection	Results	Total [/40]
Introduction	Sampling	Ethical Matters	Discussion	Total [%]

General notes

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Appraise research on the merits of the research design used, not against other research designs.

Category Item	Item descriptors [<input type="checkbox"/> Present; <input type="checkbox"/> Absent; <input type="checkbox"/> Not applicable]	Description [Important information for each item]	Score [0-5]
1. Preliminaries			
Title	1. Includes study aims <input type="checkbox"/> and design <input type="checkbox"/>		
Abstract (short text)	1. Key information <input type="checkbox"/> 2. Balanced <input type="checkbox"/> and informative <input type="checkbox"/>		
Text (short text)	1. Sufficient detail others could reproduce <input type="checkbox"/> 2. Clear/concise writing <input type="checkbox"/> ; table(s) <input type="checkbox"/> ; diagram(s) <input type="checkbox"/> ; figure(s) <input type="checkbox"/>		
			Preliminaries [/5]
2. Introduction			
Background	1. Summary of current knowledge <input type="checkbox"/> 2. Specific problem(s) addressed <input type="checkbox"/> and reason(s) for addressing <input type="checkbox"/>		
Objective	1. Primary objective(s), hypothesis(es), or aim(s) <input type="checkbox"/> 2. Secondary question(s) <input type="checkbox"/>		
Is it worth continuing?			Introduction [/5]
3. Design			
Research design	1. Research design(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Suitability of research design(s) <input type="checkbox"/>		
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Precise details of the intervention(s)/treatment(s)/exposure(s) <input type="checkbox"/> for each group <input type="checkbox"/> 3. Intervention(s)/treatment(s)/exposure(s) valid <input type="checkbox"/> and reliable <input type="checkbox"/>		
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) <input type="checkbox"/> 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid <input type="checkbox"/> and reliable <input type="checkbox"/>		
Bias, etc	1. Potential bias <input type="checkbox"/> ; confounding variables <input type="checkbox"/> ; effect modifiers <input type="checkbox"/> ; interactions <input type="checkbox"/> 2. Sequence generation <input type="checkbox"/> ; group allocation <input type="checkbox"/> ; group balance <input type="checkbox"/> ; and by whom <input type="checkbox"/> 3. Equivalent treatment of participants/cases/groups <input type="checkbox"/>		
Is it worth continuing?			Design [/5]
4. Sampling			
Sampling method	1. Sampling method(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Suitability of sampling method <input type="checkbox"/>		
Sample size	1. Sample size <input type="checkbox"/> ; how chosen <input type="checkbox"/> ; and why <input type="checkbox"/> 2. Suitability of sample size <input type="checkbox"/>		
Sampling protocol	1. Target/actual/sample population(s): description <input type="checkbox"/> and suitability <input type="checkbox"/> 2. Participants/cases/groups: inclusion <input type="checkbox"/> and exclusion <input type="checkbox"/> criteria 3. Recruitment of participants/cases/groups <input type="checkbox"/>		
Is it worth continuing?			Sampling [/5]
5. Data collection			
Collection method	1. Collection method(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Suitability of collection method(s) <input type="checkbox"/>		
Collection protocol	1. Include date(s) <input type="checkbox"/> ; location(s) <input type="checkbox"/> ; setting(s) <input type="checkbox"/> ; personnel <input type="checkbox"/> ; materials <input type="checkbox"/> ; processes <input type="checkbox"/> 2. Method(s) to ensure/enhance quality of measurement/instrumentation <input type="checkbox"/> 3. Manage non-participation <input type="checkbox"/> ; withdrawal <input type="checkbox"/> ; incomplete/lost data <input type="checkbox"/>		
Is it worth continuing?			Data collection [/5]
6. Ethical matters			
Participant ethics	1. Informed consent <input type="checkbox"/> ; equity <input type="checkbox"/> 2. Privacy <input type="checkbox"/> ; confidentiality/anonymity <input type="checkbox"/>		
Researcher ethics	1. Ethical approval <input type="checkbox"/> ; funding <input type="checkbox"/> ; conflict(s) of interest <input type="checkbox"/> 2. Subjectivities <input type="checkbox"/> ; relationship(s) with participants/cases <input type="checkbox"/>		
Is it worth continuing?			Ethical matters [/5]
7. Results			
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen <input type="checkbox"/> and why <input type="checkbox"/> 3. Suitability of analysis/integration/interpretation method(s) <input type="checkbox"/>		
Essential analysis	1. Flow of participants/cases/groups through each stage of research <input type="checkbox"/> 2. Demographic and other characteristics of participants/cases/groups <input type="checkbox"/> 3. Analyse raw data <input type="checkbox"/> ; response rate <input type="checkbox"/> ; non-participation/withdrawal/incomplete/lost data <input type="checkbox"/>		
Outcome, Output, Predictor analysis	1. Summary of results <input type="checkbox"/> and precision <input type="checkbox"/> for each outcome/output/predictor/measure 2. Consideration of benefits/harms <input type="checkbox"/> ; unexpected results <input type="checkbox"/> ; problems/failures <input type="checkbox"/> 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) <input type="checkbox"/>		
			Results [/5]
8. Discussion			
Interpretation	1. Interpretation of results in the context of current evidence <input type="checkbox"/> and objectives <input type="checkbox"/> 2. Draw inferences consistent with the strength of the data <input type="checkbox"/> 3. Consideration of alternative explanations for observed results <input type="checkbox"/> 4. Account for bias <input type="checkbox"/> ; confounding/effect modifiers/interactions/imprecision <input type="checkbox"/>		
Generalisation	1. Consideration of overall practical usefulness of the study <input type="checkbox"/> 2. Description of generalisability (external validity) of the study <input type="checkbox"/>		
Concluding remarks	1. Highlight study's particular strengths <input type="checkbox"/> 2. Suggest steps that may improve future results (e.g. limitations) <input type="checkbox"/> 3. Suggest further studies <input type="checkbox"/>		
			Discussion [/5]
9. Total			
Total score	1. Add all scores for categories 1-8		
			Total [/40]

Appendix 3: Summary of research papers included in the literature review

Study	Design & Aim	Setting	Participants	Methods & Analysis	CCAT Quality Appraisal Total Score (%)
Studies Published in the Peer-Reviewed Academic Literature					
Adamson et al. 2018 ²⁰ Canada	Design: Qualitative descriptive Aim: To assess the perceived impact of Rounds in the health care context of paediatric rehabilitation, as well as a comparative analysis of how Rounds affected clinical versus nonclinical staff. Does effect on perceived outcomes was also investigated.	Paediatric rehabilitation hospital	29 hospital staff (15 clinicians, 14 non-clinicians).	Method: Semi-structured interviews. Analysis: Descriptive	39 (98)
Adamson et al. 2018 ²¹ Canada	Design: Online survey Aim: To assess the perceived impact of Rounds in the health care context of	Paediatric rehabilitation hospital	571 responses from clinical and non-clinical attendees.	Method: Online questionnaire. Original instrument measuring 4 domains of impact: ability of SCRs to address staff needs, communication with co-workers and supervisors, perspective taking capacity on other's experiences and perceived work stress	27 (68)

				Analysis: Thematic	
Chadwick <i>et al.</i> (2016) UK ³	<p>Design: Evaluation (quantitative and qualitative)</p> <p>Aim: To evaluate, quantitatively and qualitatively, Rounds held in an acute NHS trust.</p>	1x integrated university teaching NHS trust with acute and community services	<p>795 evaluations completed over 18 rounds in 3 years.</p> <p>Unique participant N = unreported. Anonymity of responses precluded determination of which participants were repeat attendees.</p> <p>Evaluations were completed by nurses (36%); doctors (18%); allied health professionals/other clinical (14%); administrative/managerial (9%) and other (social worker, chaplain, domestic, porter, volunteer; 20%).</p> <p>Additionally, qualitative comments (n = 158) were completed by nurses (39%), doctors (18%), allied health or other clinical (9.5%), administrative/managerial (15%) and other (16.5%)</p>	<p>Method: Standard Schwartz Center Rounds evaluation questionnaire after each round (quantitative Likert & qualitative free text)</p> <p>Analysis: A. Descriptive statistics, ANOVA, <i>t</i>-tests B. Thematic analysis (Braun & Clarke) of free text comments.</p>	24 (60)
Corless <i>et al.</i> (2009) USA ⁷	<p>Design: Evaluation</p> <p>Aim: To describe the development of Schwartz Center Educational Rounds and report on an evaluation of their</p>	1 x educational institution	Interdisciplinary group of graduate students. Programmes included "nursing, physical therapy, communication disorders, and clinical investigation". Faculty, who were	<p>Method: Evaluation questionnaire and free text comments</p> <p>Analysis: Frequencies</p>	19 (48)

	introduction and utility for students.		<p>facilitators, also completed evaluations.</p> <p>329 evaluations, from 7 Rounds, were completed by an unreported number of participants</p>		
<p>Deppoliti <i>et al.</i> (2015)¹⁰</p> <p>USA ¹⁰</p>	<p>Design: Qualitative descriptive study</p> <p>Aim: To examine the impact of Schwartz Center Rounds in the authors' own institution so as to</p> <ol style="list-style-type: none"> 1. Learn the reasons why people attend SCR and why some continue to attend Rounds 2. Understand what attendees gained from the experience 3. Learn what benefits have been derived from attendance 4. Determine whether any negative impacts have resulted from attendance. 	1 x hospital	<p>N = 30 participants</p> <p>Focus groups: n = 27 nurses, nurse managers, physicians, allied health professionals and pharmacists, management, administration, spiritual, patient relations, patient safety.</p> <p>Interviews: n = 3 physicians.</p>	<p>Method: Focus groups (4x) and telephone interviews (3x). Used the same interview guide for both focus groups and interviews.</p> <p>Analysis: Thematic analysis. Iterative process of analysis. Measures to enhance trustworthiness.</p>	35 (88)
<p>Farr & Barker (2017)</p> <p>UK ⁵</p>	<p>Design: Evaluation (Realist)</p> <p>Aim: To examine:</p>	3 x community and mental health services	<p>N = 27 participants.</p> <p>Participants included people involved in Schwartz Center</p>	<p>Method: Realist evaluation: A. Round observations x5. B. Staff interviews (n =</p>	28 (70)

	<p>1. Staff experiences of Schwartz Rounds in mental health and community settings</p> <p>2. The mechanisms within them that may support compassionate care,</p> <p>3. The enablers and obstacles to implementing Rounds</p> <p>4. The perceived effects of Rounds within community services and mental health services</p>	<p>During the course of the research, one site (a community trust) ceased running Schwartz Center Rounds after just under 12 months as various barriers made the implementation of Schwartz Center Rounds cost-prohibitive.</p>	<p>Rounds as steering group members, clinical leads, facilitators, panellists, and attendees.</p>	<p>22). C. Post-Round evaluation sheets (n = 206)</p> <p>Analysis: Framework analysis.</p>	
<p>George (2016)</p> <p>UK ⁴</p>	<p>Design: Sequential exploratory case study</p> <p>Aim: To examine whether Schwartz Rounds promoted staff well-being and reduced the stress inherent in their work.</p>	<p>1 x NHS Trust</p>	<p>N = 11 (for interviews, 9 nurses and 2 health care assistants)</p> <p>N = 55 (for questionnaire data)</p> <p>N = 187 (staff stress results for 2014)</p> <p>N = 122 (staff stress results 2015 for 6 month period)</p>	<p>Method: Mixed-methods approach to data collection using qualitative case study with secondary quantitative pre-post data collection (using a new measure 'The Organisational Response to Emotions Scale' developed from the interviews)</p> <p>Retrospective analysis of staff stress data from staff surveys for all clinical and non-clinical staff.</p>	<p>30.5 (78)</p>

				Analysis: Grounded theory analysis of interviews. Descriptive, repeated measures ANOVA, <i>t</i> -tests and correlational tests for the quantitative data.	
Gishen (2016) UK ⁸	Design: Cross-sectional evaluation and qualitative Aim: To examine the applicability of Schwartz Center Rounds to medical schools and determine if they could provide a reflective and supportive culture within an undergraduate setting.	1 x medical school	N = 384 participants Questionnaire: Year 5 medical students n = 258, and Year 6 medical students n = 126 Focus group: N=7 volunteer year 5 medical students	Method: A. Evaluative questionnaire based on the Point of Care Foundation feedback form (immediately after each Round). B. Additional free text comments C. Focus group; open questions, semi-structured approach. 10 days after the initial Round. Analysis: A. Descriptive statistics, chi-square with Fisher's exact test. B. & C. Thematic analysis, with methods to ensure the trustworthiness of the data.	32 (80)
Goodrich (2012) UK ¹	Design: Qualitative Additional design: Evaluation questionnaire and pre-post survey,	2 x NHS Hospitals providing acute care One central London hospital (1000 plus beds) and one in the	N = 28 participants Time 1 (start of pilot): n = 18. Attended ≥1 Round (n = 17), member of the organizing committee (n =	Method: A. Qualitative interviews (n=41). B. Quantitative evaluation data	25 (63)

	<p>presented in a grey literature report ¹⁴.</p> <p>Aim: To explore</p> <ol style="list-style-type: none"> 1. Whether Rounds 'translated' to the UK context, both in process and in ethos 2. The impact of Rounds on participants and their working relationships 3. Additional aim*: "assess whether Rounds have an impact on participants and on their individual conversations with colleagues and relationships with patients" (p. 118) ¹ 	west of England (480 beds).	<p>14), panellist (n = 2) or facilitator (n = 2).</p> <p>Time 2: n = 23. Members of organizing committees (n = 11), panellists (n = 4), facilitators (n = 4).</p> <p>Interviewed at both time 1 and time 2 = 13.</p> <p>No demographic information.</p>	<p>Analysis: Main publication: Framework method (qualitative interview data)</p> <p>Grey literature report: graphs, narrative</p>	
<p>Lee <i>et al.</i> (2015)</p> <p>USA ¹¹</p>	<p>Design: Cross-section, with two phases.</p> <p>Aim: To describe the landscape of resilience-promoting resource availability, use, and helpfulness in a large cohort of Paediatric Intensive Care Units (PICUs) so as to identify an intervention that could</p>	20x paediatric intensive care units (PICU) across 19 x institutions	<p>n = 25 Leadership surveys (nurse managers, medical directors and other disciplines)</p> <p>n = 1066 PICU staff (nurses (893), physicians (136), attending intensivists (99), critical care fellows (n=32) and 5 unspecified)</p>	<p>Method</p> <p>A 2-phase descriptive survey study</p> <p>The survey was constructed by using input for nurses and physicians from 18 different institutions.</p>	31 (78)

	be implemented and assessed for efficacy across multiple PICUs.			Analysis: Descriptive and inferential statistics, including correlation, <i>t</i> -tests, and Mann-Whitney U tests. Qualitative analyses were also reported but were beyond the scope of this review.	
Lown & Manning (2010) USA ⁹	<p>Design: Cohort study with a retrospective arm and a longitudinal prospective arm. Additional qualitative interviews with a subsample.</p> <p>Aim: Assess the impact of the Rounds on self-reported changes among attendees in their beliefs about patient care, their behaviours during health care interactions, their participation in teamwork, their sense of stress and personal support.</p> <p>Changes in institutional practices and policies that study participants attributed to the rounds were investigated.</p>	<p>16 hospital sites (6 for the retrospective arm and 10 for the prospective arm)</p> <p>Retrospective arm: <i>Survey:</i> 6 x organisations that had adopted Schwartz Center Rounds at least 3 years prior to research commencement (5 hospitals in the Northeast and 1 in the Midwest). E-mail request with Web link to electronic survey.</p> <p><i>Interviews:</i> 5 x of these organisations</p>	<p>Retrospective arm: <i>Survey:</i> N = 256 respondents. Experience: 43% with >20 years.</p> <p>Sex/gender: 78% female. Ethnicity: 90% white. Profession: 38% nurses, 21% physicians, 18% social workers, 6% clergy, 17% other.</p> <p><i>Interviews:</i> N = 44 participants. Roles: providers, Schwartz Center Round leaders and facilitators, and hospital administrators.</p> <p>Prospective arm: N = 222 respondents. Experience: 51% with >20 years. Ethnicity: 88% white.</p>	<p>Method: A. Surveys after 3+ years of Schwartz Center Round (retrospective arm). B. Pre-post at newly adoptive sites (prospective arm). C. Semi-structured interviews conducted with a subsample of n = 44 retrospective participants.</p> <p>Measures: Insight into psychosocial and emotion aspects of health care: The Patient Interaction Scale Teamwork: The Teamwork Scale. Support for providers/stress: The Perceived Stress Scale ¹⁸. The Patient Interaction Scale (which included</p>	28 (70)

		<p>Prospective arm: 10 organisations were contemporaneously adopting Schwartz Center Rounds (2 in the Midwest, 6 in the Northeast, 1 in the South and 1 West), with baseline measurement just prior to Schwartz Center Round introduction and with follow-up after at least seven Schwartz Center Rounds had been held</p>	<p>Sex/gender: 82% female. Profession: 51% nurses, 19% physicians, 5% social workers, 5% clergy, 20% other.</p>	<p>items adapted from the Jefferson Scale of Physician Empathy) and the Teamwork Scale comprised items organized into scales post-hoc. Items used 6-point Likert scales in general.</p> <p>Analysis: Surveys: descriptive and inferential statistics, including linear regression, one-way ANOVA, and <i>t</i>-tests. Interviews: Not reported.</p>	
<p>Maben et al. 2017^{13,30}</p>	<p>Design: Longitudinal evaluation mixed methods, underpinned by realist evaluation</p> <p>Research question: To what extent is participation in Rounds associated with enhanced staff wellbeing at work, social support for staff and improved relationships between staff and patients including compassion and empathy?</p> <p>Aim:</p>	<p>National study</p> <p>Longitudinal evaluation across 10 sites</p>	<p>Phase 1:</p> <p>Phase 2: Survey and organisational case studies</p> <p>Phase 2a) Survey in 10 sites (baseline/8 months) to 800 attenders and 2500 controls</p> <p>Phase 2b): Ethnographic field work in 9 sites: including observation and interviews with Rounds facilitators; presenter teams in Rounds and in practice;</p>	<p>Phase 1: Scoping review of the literature including comparison with alternative interventions; Rounds Provider Mapping & costs: profile of all UK Rounds provider organisations at 1 September 2014 and reasons for adoption (interviews with key Rounds champions).</p> <p>Phase 2: Survey and organisational case studies</p>	<p>38 (95)</p>

	<ol style="list-style-type: none"> 1. To investigate contexts in which/mechanisms whereby Rounds influence staff wellbeing at work and social support 2. To identify and evaluate any changes in relationships between staff who attend Rounds and their patients/colleagues 3. To identify/consider any wider changes in teams/the wider organisation in relation to the quality of patient care and staff experience and to suggest whether/how these may be linked 		<p>attenders, non-attenders and stakeholders.</p>	<p>Thirteen providers purposively sampled from Phase 1; ten sites for the survey, and nine for organisational case studies. Six sites participated in both.</p> <p>Phase 2a) Longitudinal survey in 10 sites (baseline/8 months) to 800 attenders and 2500 controls to measure changes in staff work wellbeing, social support and relationships with staff and patients.</p> <p>Phase 2b): Ethnographic field work in 9 sites: including observation and interviews with Rounds facilitators; presenter teams in Rounds and in practice; attenders, non-attenders and stakeholders. Synthesis of findings from Phases 1&2 to produce recommendations.</p> <p>Synthesis of findings from Phases 1&2 to produce recommendations</p>	
Mullick et al. (2013) ¹²	Design: Evaluation	1x hospice	Not stated, between 23 and 52 staff attended each	Method:	13 (33)

UK	Aim: None specified. The paper reports on the initial introduction of Schwartz Rounds in a hospice setting.		round (number of rounds attended not included) Evaluations: number returned not stated	Round evaluation questionnaires.	
Reed <i>et al.</i> (2015) UK ²	Design: Mixed methods Aim: To evaluate the impact of Schwartz Center Rounds on staff and on an organisation (after 12 rounds).	1x hospice	535 attendances across 12 rounds. Attendance per round: N = 44, range = 31 to 57. Evaluations: N = 398 evaluations completed. Unique participant N = unreported. Focus Groups: N = 33 focus group participants. This included 19 Schwartz attendees, 8 Schwartz presenters, and 6 Schwartz non-attendees. A range of professions were represented.	Method: A. Exit survey using a 5-point scale (topic relevance, knowledge gained, impact on individual, facilitation, working relationships). B. 4 inter-professional focus groups (tape recorded and transcribed verbatim) Analysis: Survey: Frequencies. Focus groups: Categorical indexing, sub-themes subsequently generated. Analysed by one researcher and reviewed by another.	15 (38)
Robert <i>et al.</i> (2017) UK ⁶	Design: Mixed methods Aim: To 1. Describe how many and what types of organisations were running Rounds in England (as at July 2015)	116 x settings in total: 113 x public health care organisations and hospices, 1 x medical school, 1 x private hospital, 1 x prison	N = 46 participants (interviews). Group 1 (n = 45) <i>Schwartz Rounds Roles:</i> clinical leads or facilitators from acute hospitals n = 28, hospices n = 10, mental health/community organisations n = 7. Group 2 (n = 1)	Method: A. Semi-structured telephone interviews: “ B. Secondary quantitative data from national surveys: i) rankings from a national accreditation body, ii) staff overall engagement score from a national staff engagement survey, and iii) an overall	31 (80)

	<p>2. Report when the organisations adopted Rounds;</p> <p>3. Compare the performance of adopting and non-adopting organisations on three selected measures.</p> <p>4. Explore how and why organisations had adopted Rounds by September 2014.</p>		CEO of the Point of care Foundation	<p>patient experience score from a national inpatient survey.</p> <p>Analysis: Interviews: Framework approach. “Themes were extracted deductively using the Diffusion of Innovations model” (p. 3).</p> <p>Secondary/quantitative: Categorization of time of adoption, according to the diffusion of innovations model. Secondary quantitative: rankings from a national accreditation body; ‘staff overall engagement score’ from a national staff experience survey, and; an ‘overall patient experience score’ from a national inpatient survey.</p>	
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Appendix 4: RE-AIM

RE-AIM Dimensions(1)	Application of dimensions specific to Schwartz Rounds evaluation	Sources of data for the evaluation of Schwartz Rounds
Reach: the absolute number, proportion, and representativeness of individuals who are willing to participate in a given initiative.	<ul style="list-style-type: none"> • The target audience in each of two pilot sites • The numbers attending in each meeting • Representation of groups within target audience for each meeting • Factors influencing attendance/non-attendance across groups • Spread effect – new attendees at each meeting 	<ul style="list-style-type: none"> • Attendance breakdown from each meeting • Interviews with people who attended and who chose not to attend (covering impetus to attend first time; drivers and restrainers influencing attendance)
Effectiveness: the impact of an intervention on outcomes, including potential negative effects, quality of life, and economic outcomes.	<ul style="list-style-type: none"> • Rationale for engaging in Schwartz Rounds from perspective of clinical leads, facilitators and CEO/Senior management within organisation and Schwartz Evaluation Steering Group 	<ul style="list-style-type: none"> • Analysis of raw data from ProQOL and survey questionnaires • Interviews with attendees, clinical leads, facilitators, panel members and steering group: <ul style="list-style-type: none"> ○ Perceived impact on wellbeing, communication and relationships with others, including co-workers and patients, and sense of support for person-centeredness across the organisation ○ Anticipated and unanticipated gains from engaging in Schwartz Rounds
Adoption is the	<ul style="list-style-type: none"> • Representation of groups within target audience for each meeting 	<ul style="list-style-type: none"> • From raw data: attendance breakdown from each meeting

<p>absolute number, proportion, and representativeness of settings and intervention agents who are willing to initiate a program.</p>	<ul style="list-style-type: none"> • Trends in representation of groups over the course of the meetings • Interest from other organisations in initiating Schwartz Rounds • Evidence of embeddedness of Schwartz Rounds in the organisation 	<ul style="list-style-type: none"> • Interviews with attendees, clinical leads, facilitators, panel members and steering group <ul style="list-style-type: none"> ○ Perceived support for staff to attend Schwartz Rounds ○ Perceived awareness of Schwartz Rounds across the organisation ○ Evidence of references to Schwartz Rounds across organisation (newsletters, reports, reminders and staff meetings) • Perceived drivers and restrainers that influence ability to attend Schwartz Rounds
<p>Implementation refers to the intervention agents' fidelity to the various elements of an intervention's protocol. This includes consistency of delivery as intended and the time and cost of the intervention.</p>	<ul style="list-style-type: none"> • Transferability of the Schwartz Rounds' structures and processes to the Irish context – specific contexts of the two sites • Capacity of pilot sites to support training, roles and time commitments of Schwartz Rounds' key personnel • Capacity of pilot sites to support attendance of target groups • Positioning of Schwartz Rounds meetings within organisations' schedules for key events (meetings and training programmes) • Communication structures and processes to support establishment of Schwartz Rounds and on-going buy-in from target groups and management 	<ul style="list-style-type: none"> • Attendance breakdown for Schwartz meetings • Interviews with senior managers from disciplines and support staff <ul style="list-style-type: none"> ○ Engagement with Schwartz Rounds ○ Experience of interest among staff ○ Capacity to support their attendance at Schwartz Rounds meeting ○ Perceived relevance of Schwartz Rounds to roles and effectiveness of staff • Interviews with clinical leads, facilitators, panel members and steering group <ul style="list-style-type: none"> ○ Experience of support for preparedness for Schwartz Rounds' roles including support for training and time commitments ○ Anticipated versus actual time commitments needed ○ Anticipated and unanticipated current and future challenges of roles • Interviews with attendees <ul style="list-style-type: none"> ○ Experience of support and ability to attend ○ Experience of capacity to apply personal/professional learning gained from attending Schwartz Rounds

<p>Maintenance: extent to which a program or policy becomes institutionalised or part of the routine organizational practices and policies. Maintenance also has referents at the individual level. At the individual level, it is defined as the long-term effects of a programme on outcomes (six or more months) after the most recent intervention contact.</p>	<ul style="list-style-type: none"> • Alignment of Schwartz Rounds experience with the organisations policies and quality agendas • Responsiveness of the two sites to anticipated and unanticipated learning to date from Schwartz Rounds • Evidence of actions to support preparation and roles of key personnel for Schwartz Rounds including succession planning • Evidence of feedback loops from the anticipated and unanticipated learning to date to inform organisations' policies and quality agendas, and planning and organisation of Schwartz Rounds • Budgetary capacity to ensure on-going commitment to Schwartz Rounds 	<ul style="list-style-type: none"> • Interviews with senior administrators and senior managers <ul style="list-style-type: none"> ○ Engagement with Schwartz Rounds ○ Experience of interest among staff ○ Capacity to support staff attendance at Schwartz Rounds meeting ○ Perceived relevance of Schwartz Rounds to roles and effectiveness of staff ○ Perceived relevance to organisational, discipline and service specific KPIs ○ Perceived challenges in supporting Schwartz Rounds in the short, medium and long term ○ Capacity to respond to anticipated and unanticipated challenges in supporting Schwartz Rounds in the short, medium and long term
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Alignment of RE-AIM to the Evaluation Steering Group's stated purpose:

1. Whether Schwartz Rounds are suitable for introduction, practically and culturally, in the Irish health system (addressed through the uptake and embeddedness (reach and adoption), and implementation and maintenance dimensions);
2. The experience and personal impact of participating in Schwartz Rounds for panellists, attendees, administrators, facilitators and clinical leads (addressed through effectiveness and implementation dimensions);

3. The perceived and/or actual outcomes for the service/hospital (addressed through effectiveness, implementation and maintenance dimensions);
4. Key learnings to inform HSE decision-making on rolling out the initiative further (addressed through all dimensions).

Appendix 5 Comment Cards



Did you attend Schwartz Rounds? _____

What influenced your decision?

Any other comments?

The form is set against the same colorful, wavy background as the title slide. It contains three white rectangular boxes with rounded corners and thin black borders. The first box is for a yes/no answer, the second is for a short answer, and the third is for a longer comment.

Appendix 6: Poster

Research to Evaluate Schwartz Rounds

Whether or not you completed a comment card,
all staff are now invited to participate in further
research:

Individual Interviews or Focus Groups

Interviews can take place over the phone and should
last no longer than 20 minutes.

To find out more:

www.nursing-midwifery.tcd.ie/research/schwartz-rounds-evaluation/

Text/phone: 087 9126286
Email: schwartzrounds@tcd.ie

Dr Vivienne Brady & Dr Margarita Corry,
Trinity College Dublin



Trinity College Dublin
Collegium sive Trinitatis, Buxi Aetha Claret
The University of Dublin

Appendix 7a Participant Information Leaflet (PIL) for focus group

Title of study: Evaluation of the initial introduction of Schwartz Rounds in Ireland

Introduction

Schwartz Rounds are monthly structured meetings for all staff that are designed to provide time to reflect on the emotional aspects of their work and the focus is on the human dimensions of care. Schwartz Rounds have been running in Site 1 and Site 2 since 2016. An independent evaluation of the Schwartz Rounds experience is now planned and the findings will inform the HSE's plans for extending this initiative to other healthcare environments. An evaluation team from Trinity College Dublin has been commissioned to undertake the evaluation of the introduction of Schwartz Rounds.

The purpose of the evaluation is to establish:

1. Whether Schwartz Rounds are suitable for introduction practically and culturally in the Irish health system
2. The Schwartz Rounds experience for those staff members who attended and participated in one or more meetings
3. The perceived and/or actual outcomes for the service/hospital
4. Key learnings about the planning, roll-out and promotion to help inform any extension of the Schwartz Rounds initiative to other healthcare environments.

Evaluation procedure

The evaluation team will hold a number of group interviews and individual interviews with staff to discuss their views on Schwartz Rounds. The participants in these interviews will include staff members who attended Schwartz Rounds meetings and staff who chose not to, or who were unable to attend. The group discussions will take place over a one month period on days and times that work best for the majority of participants and the hospital. Two members of the evaluation team will facilitate the discussion. The facilitators will first ask about people's experiences of the Schwartz Rounds. The discussion will be recorded on audio. The discussion will last between 40 minutes to one hour.

Criteria for participating in the discussions

The evaluation team is interested in hearing the views from all staff who were working in the hospital since the introduction of Schwartz Rounds, regardless of whether or not they attended meetings.

Benefits

There are no direct benefits to you from participating in this evaluation. However, you may benefit indirectly from being able to reflect on your Schwartz Rounds experience.

Risks

The potential risk to you as a participant is low, however there are some issues you should keep in mind. You may become upset during the discussion. If this happens, a member of the project group will offer to leave the room with you until you feel ready to continue, and if you choose you can leave the interview.

Exclusion from participation: You cannot participate in this study if any of the following are true:

You were not working in the hospital during the months that Schwartz Rounds were held in your hospital/hospice.

Confidentiality

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group.

Compensation

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary Participation

If you decide to volunteer to participate in this study, you may withdraw at any time during the group discussion. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study.

Stopping the study

You understand that the investigators may withdraw your participation in the study at any time without your consent.

Permission

This evaluation has received This evaluation has received ethical approval from the School of Nursing and Midwifery Research Ethics Committee and the respective ethics and access committees for Site 1 and Site 2.

Dissemination:

The findings of this evaluation will be presented nationally and internationally at research conferences. The research will be published in Full and Executive Summary reports and peer review journals.

Further information

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Geralyn Hynes who can be telephoned at 01 8964081 or emailed at hynesg2@tcd.ie. If the study team learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Appendix 7b: Participant information leaflet (PIL) for individual semi-structured interviews

Title of study: Evaluation of the initial introduction of Schwartz Rounds in Ireland

Introduction

Schwartz Rounds are monthly structured meetings for all staff that are designed to provide time to reflect on the emotional aspects of their work and the focus is on the human dimensions of care. Schwartz Rounds have been running in Site 1 and Site 2 since 2016. Evaluation of the Schwartz Rounds experience is now planned and the findings will inform the HSE's plans for extending this initiative to other healthcare environments. An evaluation team from Trinity College Dublin has been commissioned to undertake this evaluation of the introduction of Schwartz Rounds.

The purpose of the evaluation is to establish:

1. Whether Schwartz Rounds are suitable for introduction practically and culturally in the Irish health system
2. The Schwartz Rounds experience for those staff members who attended and participated in one or more meetings
3. The perceived and/or actual outcomes for the service/hospital
4. Key learnings including about the planning, roll-out and promotion to help inform any extension of the Schwartz Rounds initiative to other healthcare environments.

Evaluation procedure

The evaluation team will hold a number of group interviews and individual interviews with staff to discuss their views on Schwartz Rounds. The participants in these discussions and interviews will include staff members who attended Schwartz Rounds meetings and staff who chose not or were unable to attend. Individual interviews will take place over a one month period. Your interview will take place on a day and time that best works for you. The interview can be undertaken face to face; by telephone or over skype depending on what works best for your schedule. The interviewer will be a member of our evaluation team and will first ask you about your experience of Schwartz Rounds. If you have not participated in a Schwartz Rounds meeting, the interviewer will first ask you about factors that influenced

your decision not to participate. With your permission, the interview will be recorded on audio and will last approximately 40 minutes. A copy of the recording will be made available to you at your request.

Criteria for participating in the discussions

The evaluation team is interested in hearing the views from all staff who were working in the hospital since the introduction of Schwartz Rounds and regardless of whether or not they attended meetings. You cannot participate in this study if:

You were not working in the hospital during the months that Schwartz Rounds were held in your hospital/hospice.

Benefits

There are no direct benefits to you from participating in this evaluation. However, you may benefit indirectly from being able to reflect on your Schwartz Rounds experience.

Risks

The potential risk to you as a participant is low; however, there are some issues you should keep in mind. You may become upset during the discussion. If this happens, a member of the project group will offer to leave the room with you until you feel ready to continue, or you can leave the meeting.

Confidentiality

Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study group.

Compensation

This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary Participation

If you decide to volunteer to participate in this study, you may withdraw at any time during the group discussion. If you decide not to participate, or if you withdraw, you will not be penalised and will not give up any benefits that you had before entering the study.

Stopping the study

You understand that the investigators may withdraw your participation in the study at any time without your consent.

Permission

This evaluation has received ethical approval from the School of Nursing and Midwifery Research Ethics Committee and the respective ethics and access committees for Site 1 and Site 2.

Further information

You can get more information or answers to your questions about the study, your participation in the study, and your rights, from Geralyn Hynes who can be telephoned at 01 8964081 or emailed at hynesg2@tcd.ie. If the study team learns of important new information that might affect your desire to remain in the study, you will be informed at once.

Appendix 8 Consent Form

Project Title: Evaluation of the initial introduction of Schwartz Rounds in Ireland

Principal Investigators: Prof Geralyn Hynes¹; Dr Margarita Corry¹; Dr Vivienne Brady¹; Dr Peter May²

¹ School of Nursing and Midwifery, Trinity College Dublin

² School of Medicine, Trinity College Dublin

BACKGROUND

Schwartz Rounds are monthly structured meetings for all staff that are designed to provide time to reflect on the emotional aspects of their work and the focus is on the human dimensions of care. Schwartz Rounds have been running in Site 1 and Site 2 since 2016. Evaluation of the Schwartz Rounds experience is now planned and the findings will inform the HSE's plans for extending this initiative to other healthcare environments. An evaluation team from Trinity College Dublin has been commissioned to undertake this evaluation of the introduction of Schwartz Rounds in Ireland. The purpose of the evaluation is to establish:

1. Whether Schwartz Rounds are suitable for introduction practically and culturally in the Irish health system
2. The Schwartz Rounds experience for those staff members who attended and participated in one or more meetings
3. The perceived and/or actual outcomes for the service/hospital
4. Key learnings including contextual factors to help inform any extension of the Schwartz Rounds initiative to other healthcare environments.

Evaluation procedure

The evaluation team will hold a number of group discussions and individual interviews with staff to discuss their views on Schwartz Rounds. The participants in these discussions and interviews will include staff members who attended Schwartz Rounds meetings and staff who chose not or were unable to attend. The group discussions will take place over a one month period on days and times that work best for the majority of participants and the hospital. Two members of the evaluation team will facilitate the discussion. The facilitators will first ask about people's experiences of the Schwartz Rounds. The discussion will be recorded on audio. The discussion will last between 40 minutes to one hour. Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone

outside the study group. The interview recordings will not be used in any future unrelated research without first seeking your permission. Should you disclose unsafe or malpractice, the researcher will report this to the Director of Nursing in keeping the policies and procedures for disclosure in your organisation.

Dissemination:

The findings of this evaluation will be presented nationally and internationally at research conferences. The research will be published in Full and Executive Summary reports and peer review journals.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study up to the point of data analysis and I have received a copy of this agreement.

PARTICIPANT'S NAME:

.....
.....

CONTACT DETAILS:

.....
.....

PARTICIPANT'S SIGNATURE:

.....
.....

Date:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:..... Date:.....

Appendix 9: Professional Quality of Life Scale (ProQOL) V 5

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1.					
_____ 2.					
_____ 3.					
_____ 4.					
_____ 5.					
_____ 6.					
_____ 7.					
_____ 8.					
_____ 9.					
_____ 10.					
_____ 11.					
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_____ 26.					
_____ 27.					
_____ 28.					
_____ 29.					
_____ 30.					

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/www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix 10: Interview schedule with prompts to address RE-AIM dimensions

Opening Question

Please can you tell me about your experience of Schwartz Rounds?

Prompts (some targeting specific stakeholders such as managers as indicated):

- Impetus to attend first time; drivers and restrainers influencing attendance (addressing *reach* and *adoption*)
- Impact on wellbeing, communication and relationships with others, including co-workers and patients, and sense of support for person-centeredness across the organisation (addressing *effectiveness*)
- Anticipated and unanticipated gains from engaging in Schwartz Rounds (addressing *effectiveness*)
- Experience of support to participate in Schwartz Rounds (addressing *adoption*)
- References to Schwartz Rounds across the organisation in newsletters/reports/reminders/staff meetings (addressing *adoption*)
- Capacity to engage in (interviews with participants and panel members) support attendance at Schwartz Rounds (interviews with managers) (addressing *implementation*, *adoption* and *maintenance*)
- Support for preparedness for Schwartz Rounds' roles including support for training and time commitments (interviews with facilitators and panel members) (addressing *implementation*, *adoption* and *maintenance*)
- Experience of capacity to apply personal/professional learning gained from attending Schwartz Rounds (addressing *effectiveness*)
- Relevance of Schwartz Rounds to roles, discipline and service specific KPIs (addressing *effectiveness* and *maintenance*)
- Perceived challenges in supporting Schwartz Rounds in the short, medium and long term (interviews with managers) (addressing *adoption*)
- Capacity to respond to anticipated and unanticipated challenges in supporting Schwartz Rounds in the short, medium and long term (interviews with managers) (addressing *adoption*)

Dimensions are inter-related and though focus of prompt may be on one/two dimensions, all may be addressed in responses to any one prompt.

Appendix 11

Breakdown of representation of staff groups by role in Site 1 for each Schwartz Round.

Role in organisation (Total staff number in that role)	Staff role	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Round 7	Round 8	Round 9	Round 10
Medical (n=4)	Doctor	0	1	1	1	1	4	4	1	4	1
	Junior doctor	1	1	2	2	2	1	0	2	0	0
	GP	0	0	0	0	0	0	0	0	0	0
	Total n (%) of medical staff	1 (25)	2 (50)	3 (75)	3 (75)	3 (75)	5 (100)	4 (100)	3 (75)	4 (100)	1 (25)
Nursing (n=30)	Nurse/midwife	6	8	2	10	5	5	10	13	6	3
	Ward sister/manager	3	2	0	1	1	3	0	2	0	1
	Total n (%) of nursing staff	9 (30)	10 (33)	2 (6.6)	11 (36.6)	6 (20)	8 (26.6)	10 (33)	15 (50)	6 (20)	4 (13)
Health care assistants (n=8)	HCA	1	2	1	0	2	1	0	0	0	1
	Total n (%) of health care assistants	1 (12.5)	2 (25)	1 (12.5)	0	2 (25)	1 (12.5)	0	0	0	1 (12.5)

Allied & social health care-11	Dietician	0	0	0	0	0	0	0	0	0	0
	Physiotherapist	3	2	0	3	2	2	2	2	2	2
	Speech therapist	0	0	0	0	0	0	0	0	0	0
	Radiographer	0	0	0	0	0	0	0	0	0	0
	Psychologist	1	1	3	1	2	3	1	2	4	0
	Pharmacist	1	1	1	1	1	1	1	0	2	1
	Social worker	1	2	1	2	2	1	2	0	1	0
	Occupational therapist	1	0	0	2	1	1	1	0	0	0
	Total n (%) of allied health care staff in attendance	7 (63.6)	6 (54.5)	5(45.45)	9 (81.8)	8(72.2)	8 (72.2)	7 (63.6)	4 (36.36)	9 (81.8)	3(27.27)
Admin- 4	Admin and clerical	1	1	1	2	1	3	2	4	3	-
	Ward clerk	1	1	1	1	1	1	1	1	1	1
	Total n (%) of administration staff in attendance	2 (50)	2 (50)	2 (50)	3 (75)	2 (50)	4 (100)	3 (75)	5 (100)	4 (100)	1 (25)
Volunteers 65**	Volunteer	0	0	0	0	0	0	0	0	1	0
	Total n (%) volunteers in attendance	0	0	0	0	0	0	0	0	1 (1.5)	0

Manager*	Manager	2	5	4	3	4	4	2	2	5	6
	Total n (%) of managers in attendance	2	5	4	3	4	4	2	2	5	6
Board member (n=11, including Chief Executive Officer)	Board member	0	0	0	0	0	0	0	0	0	0
	Total n (%) of board members in attendance	0	0	0	0	0	0	0	0	0	0
Support staff (n=11: 1 chaplain, 1 porter, 1 security, 7 hotel services, 1 fundraising)	Chaplain	1	0	1	1	1	1	1	1	1	1
	Porter	0	1	0	1	1	1	1	1	0	1
	Security	0	1	0	1	1	1	0	0	0	0
	Domestic	0	0	0	2	3	2	1	1	0	1
	Fundraiser	0	1	0	0	0	0	0	1	1	1
	Total n (%) of support staff in attendance	1 (9)	3 (27.27)	1 (9)	5 (45.5)	6 (54.5)	5 (45.5)	3 (27.2)	4 (36.36)	2 (18)	4 (36.36)
Other (number by role not possible to calculate)	Other	5	5	3	3	5	2	4	2	3	2

*Some people may have indicated their discipline e.g., Nurse Managers, as distinct from 'manager', so these results are merged within discipline/profession. ** Volunteers were not involved in test of concept phase

Breakdown of representation of staff groups by role in Site 2 for each Schwartz Round.

Role in organisation (Total staff number in that role)	Staff role	Round 1	Round 2	Round 3	Round 4	Round 5	Round 6	Round 7	Round 8	Round 9	Round 10
Consultants and NCHDs (n = 608)	Doctor	3	4	5	2	4	5	1	4	5	7
	Junior doctor	0	5	0	1	4	?	0	0	0	0
	Total n (%) of medical staff attending	3 (0.49)	9 (1.48)	5 (0.82)	3 (0.49)	8 (1.31)	5 (0.82)	1 (0.16)	4 (0.65)	5 (0.82)	7 (1.15)
Nurse/midwife (n=1,409)	Nurse/midwife	19	34	15	13	11	13	9	13	16	13
	Ward sister/manger	4	1	5	2	2	1	3	1	0	0
	Total n (%) of nursing staff attending	23 (1.63)	35 (2.48)	20 (1.41)	15 (1.06)	13 (0.92)	14 (0.99)	12 (0.85)	14 (0.99)	16 (1.13)	13 (0.92)
Allied health care professionals (n=496)	Dietician	0	0	0	0	0	?	0	0	0	0
	Radiographer	0	1	0	1	0	2	0	0	3	0
	Psychologist	1	0	0	0	0	?	0	0	0	0
	Pharmacist	4	2	2	0	4	1	0	5	4	1

	Social worker	3	2	10	0	4	10	2	2	6	3
	Physio	9	14	15	3	7	13	9	11	13	18
	Speech therapist	0	0	1	0	3	?	0	0	0	0
	OT	2	1	9	1	5	5	0	4	3	5
	Total n (%) of allied health staff attending	19 (3.83)	20 (4.03)	37 (7.45)	5 (1)	23 (4.63)	31 (6.25)	11 (2.21)	22 (4.43)	29 (5.84)	27 (5.44)
Management/Admin (n=502)	Manager	10	4	1	1	2	4	0	3	0	0
	Board member	0	0	0	1	0	?	0	0	0	0
	Admin and clerical	4	3	3	2	4	3	3	2	9	7
	Total n (%) of management/admin staff attending	14 (2.78)	7 (1.39)	4 (0.79)	4 (0.79)	6 (1.19)	7 (1.39)	3 (0.59)	5 (0.99)	9 (1.79)	7 (1.39)
Support staff (n=409)	HCA	0	1	0	0	1	-	1	0	1	0
	Chaplain	0	0	0	0	0	0	0	0	0	0
	Ward Clerk	0	0	0	0	0	0	0	0	0	0
	Porter	0	0	0	0	0	-	0	0	0	0
	Security	0	0	0	0	0	-	0	0	0	0
	Domestic	0	0	0	0	0	-	0	0	0	0
	Fundraiser	0	0	0	0	0	-	0	0	0	0

	Total n (%) of support staff attending	0	1 (0.2)	0	0	1 (0.2)	0	1 (0.2)	0	1 (0.2)	0
Other (number by role not possible to calculate)	Other	9	15	8	2	5	6	5	6	9	0