



CREATE

Canterbury Research and Theses Environment

Canterbury Christ Church University's repository of research outputs

<http://create.canterbury.ac.uk>

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g. Gallagher, M. (2018) Schwartz rounds: a staff support intervention staff can engage with? D.Clin.Psychol. thesis, Canterbury Christ Church University.

Contact: create.library@canterbury.ac.uk



Marguerite Gallagher

Schwartz Rounds: a staff support intervention staff can engage with?

Section A: What is the theoretical and empirical basis of Schwartz Rounds as a staff support intervention?

Word Count: 8000 (213)

Section B: Factors influencing attendance and engagement with Schwartz Rounds: perspectives of attendees and non-attendees

Word Count: 7984 (215)

Total word count: 15992 (428)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2018

SALOMONS CENTRE FOR APPLIED PSYCHOLOGY
CANTERBURY CHRIST CHURCH UNIVERSITY

Letter to the examiners:

In line with the corrections required for a pass to be achieved, please see the amendments made as detailed below.

Section A

1. Add five key words to the abstract.

These were added to the abstract on page 10.

2. Use the information from within the critical appraisal stage to consider the quality of the studies within and throughout the results section more explicitly.

An attempt was made to highlight the quality of the studies throughout the results section and within the concluding paragraph. Specific changes can be found on several pages including pages 31, 33, 37, 38, 47.

3. Include a section considering the clinical implications from the review's findings.

A clinical implications section was added on page 46

Section B

4. Add five key words to the abstract.

Key words were added to the abstract on page 60

5. Include some contextual information around the sampling strategy, recruitment pool and consider how this may have contributed to making a decision that the sample had reached theoretical sufficiency.

This point was addressed in the sampling section of the methodology on page 67, and the theoretical sufficiency section on page 69-70.

6. Consider the limitations of the study in more depth, with particular attention being paid to the issue of theoretical sufficiency and sampling strategy

The limitations of the study were redressed, and further discussion was provided on page 87.

I hope these changes are satisfactory.

Yours sincerely

Marguerite Gallagher

CANTERBURY CHRIST CHURCH UNIVERSITY
Doctorate in Clinical Psychology (D.Clin.Psychol.)

Assessment Cover Sheet

Please read the following candidate's declaration, and tick the adjacent boxes to confirm that you have complied with each statement. Then complete the cover sheet below in full. Failing to do either will result in your assessment being delayed and/or returned to you for resubmission. Please raise any queries regarding this form with your manager well in advance of submission.

CANDIDATE'S DECLARATION

This is my own work except where I have acknowledged the work of others. I am aware that it is a breach of university regulations to copy the work of another without clear acknowledgement, and that attempting to do so will render me liable to disciplinary proceedings, both potentially through the University and my employer.

Tick to confirm

I confirm that, for Clinical Portfolios and Professional Practice Reports: Direct Work, where appropriate and feasible, client consent for the writing up of clinical work has been sought and obtained. If consent has not been sought and/or obtained I confirm that the reasons for this have been addressed in the body of the report.

Tick to confirm

I confirm that the word count cited below is exact, and within the limit allowed for this type of assessment. The count includes all free text as well as words and numbers contained in quotations and footnotes (though not the title page, contents page, abstract, tables, figures, reference list or appendices). I have presented the assessed work with line spacing, font size and page numbers as required in the relevant section of the assessment handbook.

Tick to confirm

I confirm that I have fully anonymised the context of this piece of work, such that no clients, personnel or services are identified. I am aware that should breaches of confidentiality be found, I may face both university and employer disciplinary procedures.

Tick to confirm

CCCU CANDIDATE NUMBER

CP 001897 15

WORK TO BE ASSESSED

(e.g. Clinical Portfolio Part 1, Child PPR, QIP)

Major Research Project

Tick if this is a resubmission of a Pass with Conditions

SUBMISSION DATE

28/08/18

FOR PPRs ONLY: YEAR OF TRAINEE
WHEN CLINICAL WORK WAS CARRIED OUT

WORD COUNT

15992 (428)

This cover sheet should be stapled to each copy of your work, in front of the title page.

Acknowledgements

I would first like to express my gratitude to the participants who willingly gave their time to contribute to this study and to my supervisors Sue Holttum and Melanie George for their guidance and support over the last 2+ years.

Huge thanks to my family for their constant support and calls and, not to pick favourites, but especially to Aimee!

Summary of the MRP Portfolio

This work considers the use of Schwartz Rounds, termed ‘rounds’ as a staff support intervention.

Section A is a review of the literature exploring the theoretical and empirical basis for rounds. It found a relative lack of research into rounds as is common with staff support interventions generally. The papers to date are not of high quality, however, there is consistency across papers in the findings related to the benefits of rounds. There is a need for further research to develop understanding of the process of rounds as well as staff’s motivation to use such an intervention.

Section B uses a grounded theory methodology to develop understanding of staff’s attendance and engagement with rounds. The theory developed suggests that due to the busy roles of staff, they must view rounds as beneficial to make the effort to attend. Staff experienced rounds as beneficial when they identified or connected with the stories told. Staff would not prioritise rounds if they viewed sharing vulnerability as risky or lacking a purpose. The theory suggests that the culture and supportiveness of staff’s environment may impact their ability to attend and engage with the emotional content of rounds.

Table of Contents

Summary of the MRP Portfolio.....	5
List of tables and figures	8
List of appendices.....	8
Abstract.....	11
Introduction.....	12
Staff Support in the NHS	12
Schwartz Rounds	15
Rationale	16
Aims.....	16
Methodology	17
Search Strategy	17
Selection Criteria	17
Figure 1: Outline of search strategy	18
Review	18
Table 1: Context and participant summary information	20
Table 2: List of papers and summary of study design, data analysis and markers of validity	23
Analysis.....	26
Review	27
Results – Theories	27
Results - quantitative evidence	32
Table 3: Summary of feedback responses.....	33
Qualitative results on perceived experience of rounds.....	37
“A safe space”.....	38
“A sense of ‘the big picture’”	39
Emotional Resonance.....	40
Being looked after	42
Impact on Care.....	43
Discussion	44
Appendices.....	55
Appendix A – Yalom’s Therapeutic Factors (2008)	55
Appendix B – Critical appraisal skills program: Qualitative checklist	58
Abstract.....	61
Staff well-being in the NHS	62
Table 1: NHS staff survey responses 2017*	63

Talking about difficulties	64
A problem shared	64
Method	65
Epistemological Stance	66
Participants	66
Table 2: Participant information	67
Procedure	67
Ethical considerations	67
Informed Consent	68
Sampling	68
Interviews	68
Data collection	69
Data analysis	69
Table 3: Stages of GTM coding.....	70
Theoretical Sufficiency	70
Quality Assurance	71
Figure 1: Diagram of theory explaining staff attendance	72
Results	73
Summary of the theory	73
Practicalities	74
The effort to go	75
Sharing stories	76
'If you are going to do something what are you gaining from it?'	77
Rounds as risky	78
Pandora's box	78
Lack of support	79
Perception shifts	79
Frame of mind	81
Lack of support in a 'warzone'	82
Limitations	88
Implications	89
Future research	90
Conclusions	90

List of tables and figures

Section A

Figure 1: Outline of search strategy.....	18
Table 1: Context and participant summary information.....	20
Table 2: List of papers and summary of study design, data analysis and markers of validity	23
Table 3: Summary of feedback responses	33

Section B

Table 1: NHS staff survey responses 2017*	63
Table 2: Participant information	67
Table 3: Stages of GTM coding.....	70
Figure 1: Diagram of theory explaining staff attendance	72

List of appendices

Section A

Appendix A – Yalom’s Therapeutic Factors (2008).....	55
Appendix B – Critical appraisal skills program: Qualitative checklist.....	58

Section B

Appendix A – Canterbury Christ Church University Ethics Approval	94
Appendix B – Health Research Authority Approval	95
Appendix C – Research and Development approval	96
Appendix D – Participant information sheet	97
Appendix E – Consent Agreement Form.....	101
Appendix F – Interview Schedule.....	102
Appendix G – List of sample codes.....	104
Appendix H - Coded transcript.....	110
Appendix I – Diagrams.....	152
Appendix K - Excerpt from bracketing interview	158
Appendix L - Reflective diary excerpts	163
Appendix M – Ethics Outcome Letter	165
Appendix N – Summary of research for participants and the ethics panel.....	166

Section A: What is the theoretical and empirical basis of Schwartz Rounds as a staff support intervention?

Marguerite Gallagher

April 2018

Salomons - Canterbury Christ Church University

Word count: 8000 (213)

A thesis submitted in partial fulfilment of
the requirements of Canterbury Christ
Church University for the degree of Doctor
of Clinical Psychology

Abstract

This paper reviews the literature on Schwartz Rounds, termed ‘rounds’, a staff support intervention currently run in over 100 NHS trusts. Rounds are a forum for staff to come together to reflect on the emotional impact of caring. The review aimed to synthesise and critically evaluate the theoretical underpinning and empirical support for rounds to date. Eleven studies met the criteria for inclusion. While the theoretical and methodological basis was relatively weak in many of the studies, the findings were consistent across them. Few studies gave a clear account of a proposed theoretical basis for rounds suggesting it is not clearly understood. A summary and critique of those described was included. This is an area warranting further research. Qualitative findings suggest staff benefit from the opportunity to reflect in a safe space, initiated by the sharing of stories which lead to emotional resonance between staff. Findings suggest rounds initiate a perspective shift which allows staff to connect with the values of their work and with their colleagues. Proposed benefits to care include improved team working. Further high-quality research is necessary to support, what appears to be, a useful resource for staff.

Key words: ‘Schwartz Rounds’, ‘Rounds’, ‘Staff support’, ‘Reflective practice’, ‘Compassion’

Introduction

Staff Support in the NHS

The provision of space for healthcare staff to reflect on their practice care is not a new phenomenon. A recent initiative, Schwartz Rounds, termed 'rounds' hereafter will be the focus of this review. Rounds are a multi-disciplinary forum for staff across all levels of an organisation to come together to discuss the emotional impact of their work (Goodrich, 2012).

The nature of healthcare means staff are repeatedly confronted by illness, disability, and death. Menzies-Lyth (1960) described the emotional complexity of the role of healthcare staff, specifically nurses, who must manage primitive anxieties not typically experienced in the conscious minds of adults. She identified several challenges including the often disgusting or frightening tasks staff must do, the mixed feelings and behaviour displayed by patients and their families and the management of feelings aroused by their own phantasies. Menzies-Lyth describes the need for the organisation to provide containment of the anxiety. Her extensive qualitative research suggested the healthcare organisation she studied inadvertently created secondary anxiety through the development of systems designed to help reduce anxiety. They seemed to support defences in unhelpful ways, by breaking up the nursing tasks, routinizing and reducing decision-making and ultimately distancing staff from patients. Some shifts in the way services work have evolved from Menzies-Lyth's study including the allocation of a primary nurse or care co-ordinator (Lawlor, 2009). However, due to medical and technological improvements and a push to reduce time in hospitals, the pace at which patients move through the system reduces the opportunity for therapeutic relationships to develop (Bridges et al., 2013). The role for the organisation to contain and support staff in the process of coming to understand and manage the anxiety inherent in the work is ongoing. Additionally, healthcare staff may benefit from support for an increasing number of reasons beyond the nature of the

work, including increasing pressures within roles, an emphasis on targets and productivity over the primary role of delivering care, and financial pressures caused by austerity (Lawlor, 2009).

Austerity measures in the UK since 2010 have led to expenditure reduction in social care which disproportionately impacts older people and people with disabilities (The Kings Fund, 2017). In addition, restrictions on spending in the health sector have undermined its capacity to meet demand associated with shortfalls in social care. Hiam, Dorling, Harrison and McKee, (2017) postulate that failure of the health and social care systems are linked to an increase in deaths by 30,000 in the UK in 2015; a significant proportion of these were over 65 years old. A meta-ethnographic study of primary research into the nurse-patient relationship reported that at times nurses refrained from doing things they knew would build a therapeutic relationship with patients when they were unable to deliver the standard of care they felt was appropriate or when they were unable to advocate for their patient's wishes (Bridges et al., 2013). This may suggest that, in addition to the anxiety described by Menzies-Lyth, nurses who are witnessing increasing demand and have less ability to meet the needs of patients because of this demand may also protect themselves from developing therapeutic relationships if they feel they cannot meet their expectations of care. Maben, Adams, Peccei, Murrells, and Robert, (2012) reported that poor relational care was associated with poorer patient experience.

The British Psychological Society's (BPS) paper on well-being and productivity in the workplace (2017) outlines sources of psychological distress and disengagement from work including uncertainty, job insecurity, lack of meaning within the job and lack of autonomy over one's role. They go on to discuss the theory of learned helplessness in relation to work. Learned helplessness occurs when an individual comes to learn that their actions have no impact on the outcome of negative situations, which leads them to believe that their efforts to effect change will not make any difference (Abramson, Seligman, & Teasdale, 1978). In the context of the

NHS which is influenced by broader political and public forces and subject to changes such as restructuring, funding cuts and top-down directives, this theory may be useful.

The Francis Report (2013) highlighted pervasive issues of poor care and disengagement of staff maintained by a culture of blame, fear, defensiveness and concealment. The organisational focus was on targets and finances rather than on care provision in the drive to gain Foundation Trust status. Staff were publicly condemned particularly by the media for demonstrating a lack of compassion (George, 2016). However, the report highlighted repeated ignoring of staff and patients' complaints about what was occurring within the Trust. Applying the theory of learned helplessness to this context may go some way towards explaining staff's apparent apathy and compliance with neglectful and abusive practices, as their attempts to address issues had little impact. The report went on to suggest many reforms primarily focused on the prioritisation of compassionate care. Following the initial justifiable response of outrage to the findings of the inquiry, it was recognised that staff well-being needed to be considered and this became incorporated in the NHS Constitution (Department of Health, (DOH) 2015). Funding was granted by the government to the Point of Care Foundation (POCF) to promote and support the implementation of rounds across UK Trusts for two years (Robert et al., 2017)

Hartley and Kennard (2009) outline several reasons why providing support to staff as a group can be helpful including amongst others; the promotion of communication between staff, the sharing of support and knowledge amongst colleagues, the exploration of a variety of feelings or responses to the work and the recognition and normalisation of vulnerability. Additionally, providing support in groups emphasises that much of the stress and challenges experienced are inherent in the work rather than an ineptitude of the individual, which individualised support may implicitly imply.

Schwartz Rounds

Rounds were developed in the USA by the Schwartz Center for Compassionate Healthcare. This not-for-profit organisation was set up by Kenneth Schwartz, following his experience of care over the course of a terminal illness. He identified that relational elements of care and staff's kindness had a vital impact on his experience (Schwartz, 1995). Rounds are a forum wherein staff discuss and reflect upon the emotional and social components of care provision. They last for one hour, beginning with a panel discussion based on a pre-determined topic, followed by audience contribution led by two trained facilitators. Lunch is provided beforehand. The original aims of rounds were to improve relationships and communication between staff and with patients and to enhance staff's sense of support (Lown & Manning, 2010).

Rounds were piloted in the UK in 2009 and now run in over 100 trusts. A study investigating the adoption of rounds in the UK suggests that qualities of rounds such as their perceived benefit relative to cost, their compatibility with the desired values of organisations and the ready-made design were key in their adoption, alongside favourable conditions, the latter including organisations becoming more aware of the need to support staff, and social processes such as formal promotion of rounds (Robert et al., 2017). The study found that uptake of rounds following the Francis report (Francis, 2013) and the government's response (DOH, 2013) greatly increased, even though rounds were only briefly referred to in both. Robert et al. (2017) acknowledge the limited evidence to support the effectiveness of rounds, which is common across staff well-being initiatives. They and others highlight the need to investigate interventions even when they may seem common sense to enable the complexities of their adoption within large organisations like the NHS to be drawn out and for the opportunity of unintended outcomes of such interventions to be observed (Ramsay & Fulop, 2016; Robert, et al., 2017). Robert et al.'s study found that organisations spearheading rounds

as an initiative to support staff had higher levels of patient and staff satisfaction than those which adopted rounds at a later stage or those not running rounds at all. Interviewees speaking about the adoption of rounds in these early-adopting organisations spoke about rounds matching their agenda to support staff. Later organisations gave additional reasons for adopting rounds including a need to be seen to be doing so and rounds implementation as helping tick a box for the organisation.

Rationale

Rounds are the focus of this review due to their relatively quick adoption by trusts across the UK even with a dearth in evidence to support their use (Robert et al. 2017). In some organisations, support for rounds implementation is dependent on evidence of outcomes e.g. reduction in staff sickness (Farr & Barker, 2017). While it would be difficult to demonstrate direct causation in the outcomes of rounds due to the complexity of systems and factors within the NHS, it is important that attempts are made to understand their theoretical underpinnings, to draw out any potential outcomes and for staff voices to be heard in respect of what rounds may or may not offer to them. A clear theoretical understanding of the structure of rounds may highlight ways of measuring their efficacy, support the maintenance of the essence of what is useful about rounds, and influence financial investment in them.

Aims

The aims of this review are to examine the literature and evidence relating to the use of rounds as a healthcare intervention to support staff, addressing the following questions:

- What are the proposed theoretical underpinnings of rounds as described in the research papers and scholarly texts?
- What is the evidence to support the use of rounds as a staff support intervention?
- What are staff's experiences of rounds?

Methodology

A literature review was carried out to examine the proposed theoretical underpinning of rounds and to synthesis the findings related to their efficacy and the experience of attendees. Findings were reviewed considering the methodological strengths and limitation of the papers.

Search Strategy

A search of Web of Science, PsycINFO, and ASSIA was carried out for papers relevant to the review. The reference lists or bibliographies of papers were also searched for relevant citations. The POCF and the Schwartz Center for Compassionate Health Care websites were checked for references to suitable papers or grey literature. The included papers were assessed for relevance and quality. The Critical Appraisal Skills Program (CASP) tools for qualitative and quantitative studies were used as a guide for assessing quality. A full description of the search and terms used is depicted in Figure 1.

Selection Criteria

Papers were included in the review if:

- They focused on the evaluation of rounds as an intervention for healthcare staff
- They were written in English

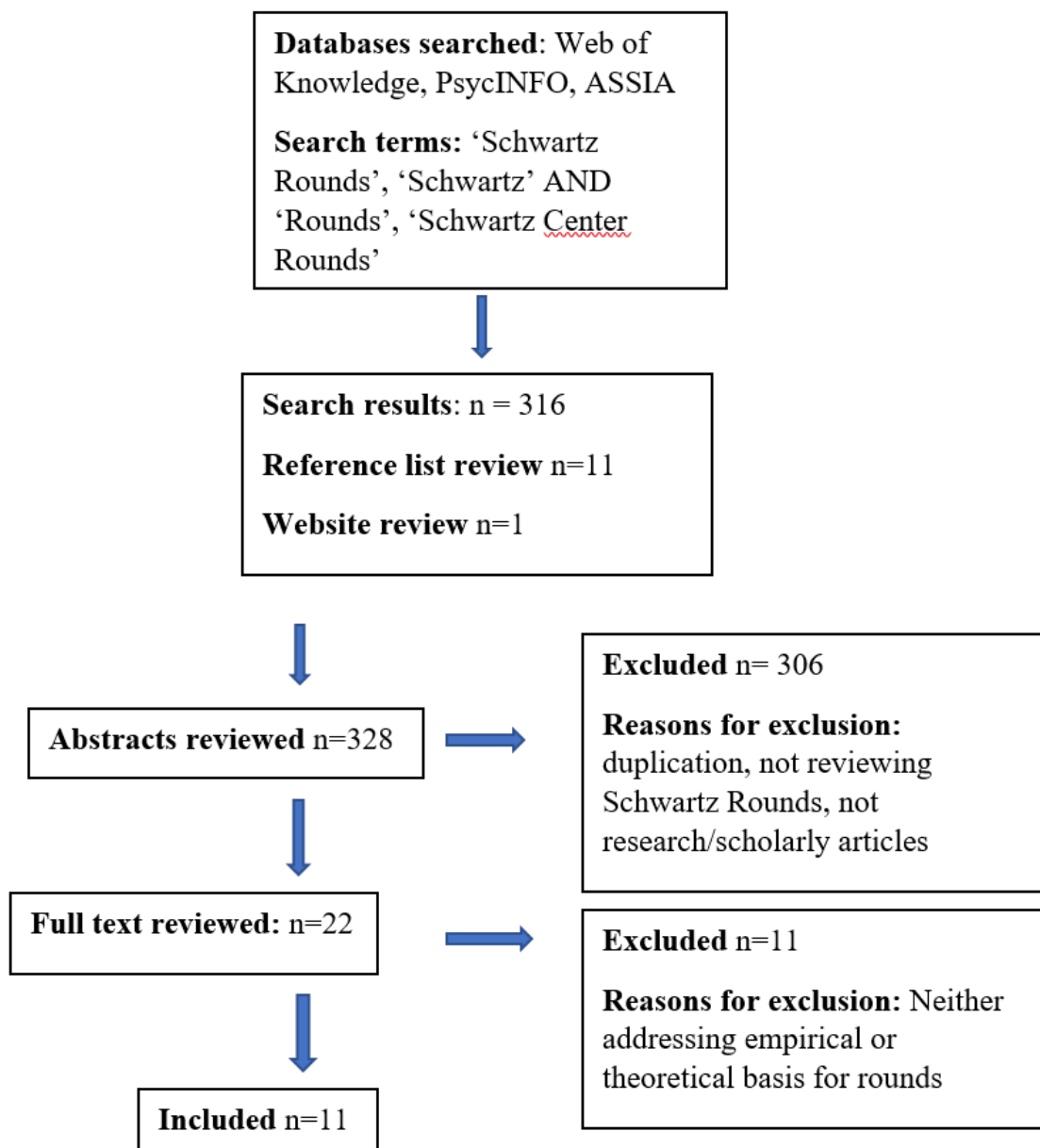


Figure 1: Outline of search strategy

The evidence from primary and secondary research into rounds was reviewed. Eleven articles were found for inclusion. There were many more articles written about rounds, however, these were largely opinion pieces and so are not incorporated in the review.

Review

Eleven articles reporting direct findings about the impact of rounds were found. Of these, nine were UK based studies and two were US studies. Three were clinical audits (one

stated this explicitly) which looked at data routinely collected at rounds. Two of the papers, Goodrich (2011) and Goodrich (2012) used the same data set. Seven of the studies used a mixed methods approach. A peer-reviewed ‘first-look draft’ of a large-scale study was included (Maben et al., 2017). Table 1 gives a summary of the papers’ contexts, their aims and the participants involved. Table 2 displays the papers, a brief description of their design, data collection and analysis and any measures taken to monitor quality of the research and validity of the findings.

Table 1: Context and participant summary information

	Context	Aims	Participant number	Demographics
Lown & Manning, 2010	American hospitals Retrospective sites - SR's running more than 3 years Prospective sites - rounds were being established (less than 1 year)	To investigate the impact of rounds on attendees self-reported changes in - their beliefs about care - their behaviour in interactions - their teamworking and their sense of stress and support To consider institutional changes observed by staff which they perceived to be linked to rounds	Retrospective respondents N=256 (62% response rate) Prospective respondents n=222 (56% retention across 2 time points)	43% > 20 years' experience 78% female 90% white 38% nurses 21% physicians 18% social workers 6% clergy 17% other 51% > 20 years' experience 82% female 88% white 51% nurses 19% physicians 5% social workers 5% clergy 20% other
Goodrich, 2011, 2012	2 sites piloting rounds in the UK Acute trusts running rounds for 1 year	To consider if rounds could translate from a US to a UK context To consider the impact of rounds on attendees and their working relationships	Feedback completed by 69% and 74% of attendees at the sites Pre-/post- SR implementation data had too few respondents to be valid though this was reported in the 2011 paper 41 interviews	Interviewees – n=28 (13 people were interviewed twice) Start 14 organising committee 2 Facilitators 2 Panellists End 11 4 4
Reed, Cullen, Gannon, Knight & Todd, 2015	Clinical audit of Rounds at a UK hospice	To evaluate the impact of rounds on staff and the organisation	74% of attendees completed feedback 33 participants in focus groups	Focus groups 19 attendees 8 presenters 6 non-attendees
Deppoliti et al., 2015	Study of rounds prompted by the planning group at a non-profit hospital in New York	To consider why staff attended rounds, why they chose to return To consider any positives or negatives experienced through attending	Focus group attendees N=27 Interview participants N=3	24 Rounds attendees 11 panellists (2-3 only attended as panellists) 3 attendees 2 panellists

				(Profession, years of service and experience of rounds was also provided)
Chadwick, Muncer, Hannon, Goodrich & Cornwell, 2016	Clinical audit in a UK Trust	Aims were not clearly stated	795 responses to the post-round feedback form (62% response rate based on mean attendance at rounds)	Attendees Trust workforce 36% Nurses 43% 18% Doctors 9% 14% AHP/Other clinical 10% 9% Managerial/admin 20% 20% Other 18%
Gishen et al., 2016	Pilot rounds run at a medical education centre for year 5 and year 6 medical students	To examine the applicability of rounds in a UK medical school To consider the transferability of the culture of support and reflection to the undergraduate setting	77% of year 5 students attended 96% participated 52% of year 6 students attended, (70%) participated Focus group N=7	Year 5 N=247 Year 6 N=126 N=7 year 5
George, 2016	Case study of one UK hospital running rounds within a Trust. The Trust was under 'special measures' The qualitative component of this study focused on the experience of stress rather than the experience of rounds.	To consider if rounds promoted the well-being of staff To consider if it reduced the inherent stress in their work To consider the impact of rounds on staff interconnectivity To consider the descriptions of feelings of stress before and after rounds	Interview participants N=11 ORES responders N= 55	Interviewees 10 female 1 male 10 white British 1 Asian Indian Age range 30-59 Mean time in post 19years 2 HCAs 9 nurses ORES responders 91.3% female 87.3% white 98% heterosexual 'well distributed' within age range of 20-59 years, 2 were 60-69 years
Farr & Barker, 2017	3 UK sites implementing rounds for community and mental health services	To consider staff's experience of rounds in a mental health setting To consider the mechanism underlying rounds which supports compassionate care To consider the barriers and enablers to implementation	Feedback responses Site A – n= 112 (93% response) Site B – n = 0 Feedback not collected Site C – n = 113 (83% response) Interviews n = 22	Interviewees 19 female 3 male 7 attendees 4 presenters 7 facilitators 4 Organisers

Hughes et al., 2018	UK children's hospital running rounds since 2014. Rounds are run monthly in a slot allocated for grand rounds	Aims were not provided	No information given	No information given
Maben et al. 2017	Participants from 10 sites were recruited for the survey component 9 sites were involved in observations and interview process (6 sites were involved in both. Sites included acute, community and mental health trusts and hospices	Clearly stated aims including: Evaluate the impact of attendance of rounds on staff engagement, and other outcomes Evaluate the mechanism by which rounds works and the context in which it works Explore staff's experience of rounds	Survey respondents at two time points n=500 Observations of Rounds n=42 Panel preparation n=29 Steering group meetings n=28 Interviews n=177 (breakdown not given) Focus groups n=2 (with rounds mentors and POCF stakeholders)	Survey 233 Band 5-7 staff 51 regular attendees 205 irregular attendees 233 non-attendees Interviewees clinical leads/facilitators panellists members of steering groups audiences organisation Boards non-attenders

Table 2: List of papers and summary of study design, data analysis and markers of validity

Author & year	Title	Study design - Data collection	Data analysis	Validity
1. Lown & Manning, 2010	The Schwartz Center Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centered Communication, Teamwork, and Provider Support	Mixed methods - Self-report surveys - Unstandardised Interviews	Regression analysis ANOVA and t-tests to compare group differences Unclear how qualitative data were analysed	Stakeholder checking of scale items Cronbach's alpha (0.88)
2. Goodrich, 2011	Evaluation of the UK pilots The Point of Care Are you seeing the person in the patient?	Mixed methods - Self-report surveys (as used in Lown and Manning) - unstandardised Post-rounds feedback forms* Interviews	Unclear how quantitative data were analysed Qualitative interviews were analysed using framework method and themes were generated	No information was provided about quality assurance measures employed in the study
3. Goodrich, 2012	Supporting hospital staff to provide compassionate care: Do Schwartz Center Rounds work in English hospitals?			
4. Reed, Cullen, Gannon, Knight, & Todd, 2015	Use of Schwartz Centre Rounds in a UK hospice: Findings from a longitudinal evaluation	Clinical audit - Post-rounds feedback forms* Focus groups	Descriptive statistics Categorical indexing to generate themes	Analysis reviewed by second researcher
5. Deppoliti, Côté-Arsenault, Myers, Barry, Randolph & Tanner, 2015	Evaluating Schwartz Center Rounds in an urban hospital center (sic)	Qualitative descriptive design - Focus groups Interviews	Thematic analysis of interviews and focus groups and 'field notes' collected during the process	Analysis conducted by a group of researchers from different backgrounds – unclear if this was done independently of others. A 'third-party reviewer' checked findings and quotes used.

6.	Chadwick, Muncer, Hannon, Goodrich, & Cornwell, 2016	Support for compassionate care: Quantitative and qualitative evaluation of Schwartz Center Rounds in an acute general hospital	Clinical audit Post-rounds feedback forms*	Thematic analysis of qualitative data Descriptive statistics of survey data ANOVA used to compare professional groups	Two coders and a third author checking
7.	Gishen, Whitman, Gill, Barker, & Walker, 2016	Schwartz Centre Rounds: a new initiative in the undergraduate curriculum—what do medical students think?	Design not specified (Mixed methods) - Post-rounds feedback forms* Focus groups	Chi-squared or Fishers' exact tests were used to compare two groups – year 5 and year 6 Percentage and mean data were calculated for Likert and dichotomous responses Qualitative data were analysed using thematic analysis	Two researchers independently developed themes (not stated if initial coding was completed independently) Third researcher reviewed coding and themes A focus group participant also reviewed themes
8.	George, 2016	Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: this is reversed by Schwartz Rounds	Interpretivist study – mixed methods ORES questionnaire – unstandardised Secondary data – staff survey Interviews	Grounded theory	Triangulation between interview data and ORES questionnaire. Details of ORES reliability and validity were not provided. A factor analysis was not carried out due to small numbers of participants. Staff survey data were not usable to answer the question intended due to the pooling of this data with wider Trust data.
9.	Farr & Barker, 2017	Can staff be supported to deliver compassionate care through implementing Schwartz Rounds in community and mental health services?	Realist evaluation Interviews Observations Post-rounds feedback forms*	Framework analysis Post-rounds surveys were used for triangulation of findings	Triangulation of primary data with secondary post-rounds feedback data
10.	Hughes, Duff, & Puntis, 2018	Using Schwartz Center Rounds to promote compassionate care in a children's hospital	Clinical audit (not stated) Post-rounds feedback forms*	Not stated	None stated

11. Maben et al. 2017	A realist informed mixed methods evaluation of Schwartz Center Rounds® in England. First look draft.	Mixed methods evaluation Surveys – GHQ – standardised measure Observations Interviews	Statistical analysis described comparison of 2 groups – unspecific Qualitative data were analysed thematically Context – mechanism – outcome (CMO) configurations were also used	CMO were tested through further sampling. Quantitative findings were in line with qualitative reports.
-----------------------	--	--	--	--

* Post-rounds feedback forms are those required to be completed by POCF at each Round. They are unstandardised and information about reliability and validity is not discussed in any paper or on the POCF website

Analysis

In relation to the first review question, theories to explain rounds mentioned or discussed within the introduction or discussion of the papers were outlined and critiqued.

For the second question, a meta-analysis of quantitative data could not be carried out due to poor reporting of results. A brief description of the findings and the methodological and reporting limitations are considered. The data from the post-round feedback forms reported in several papers were collated.

For question three, a thematic review following the methodology of Thomas and Harden, (2008), was used to elicit the main themes from the qualitative findings of the papers. The results sections of the papers were read and re-read and codes were developed to categorise each line. The codes were then drawn together based on similarities and themes were generated, which aimed to encapsulate the sentiment of the code groupings. When suitable, direct quotes from the papers were used to represent the themes. Quotes provided by the papers were used; keeping the synthesis connected to the studies' data.

Review

The review section is split into three parts. The first focuses on the theoretical basis for rounds. This includes theories proposed within the papers and the application of Yalom's theory relating to therapeutic processes in groups. The second section gives a summary of the quantitative findings of the papers and the third gives a thematic synthesis of the qualitative findings of the papers.

Results – Theories

The theoretical basis of rounds upon which eight of the eleven studies are based is scant or not discussed. A broader search of the literature including publications in journals and professional correspondence, which do not meet the definition of research, was conducted with the aim of capturing any relevant proposed theory, however this also proved somewhat lacking. The proposed theories are reviewed below.

Rounds as reversing a stress-induced narrowing of focus

George (2016) outlines a theoretical basis for rounds. She reviewed theories purporting to explain a lack of compassion including Menzies-Lyth's psychoanalytic theory (1960) and emotional labour theory (Hochschild, 1983). George highlights that Menzies-Lyth's theory has not had a significant impact on the issue of disconnection. Through her observations, George felt emotional labour theory did not explain the depth of change described by staff anecdotally in response to rounds. George goes on to preference theory relating to stress in understanding the issues of lack of compassion and disconnection within teams and between staff and patients upon which she builds a theory explaining how rounds work incorporating her experiences and observations of rounds.

George draws on findings from neurological studies of stress describing; increased selective attention in response to threat, egocentrism in relation to emotions underpinned by uncertainty and reduced empathy for strangers in situations of stress (Martin et al., 2015; Robinson et al., 2013; Todd, Forstmann, Burgmer, Brooks, & Galinsky, 2015). Drawing on the aforementioned strands, she suggests a narrowing of focus inward to one's own experience, driven by an evolutionary response for self-preservation in the face of stress (Arnsten, 2009 as cited in George 2016), reduces one's ability to empathise and connect with another. Going further, George draws on literature relating to cultural understanding of mental health difficulties (Gurung & Roethel-Wendorf, 2009) to suggest feelings of stress within western society can in themselves become stressors and compound difficulties as they are perceived as individual (dispositional) failings rather than 'normal' responses to challenging and demanding situations (situational). The narrowing of focus prevents disconfirmation of the idea that 'I am not coping as well as others'.

Rounds then provide an opportunity for staff to express the emotional and psychological impact of the work they do, beginning with a panel modelling this. George suggests that through rounds staff's 'cognitive distortions' (p.12) are challenged through hearing others' disclosures of difficulties. This allows a shift in perspective and a broadening of focus to incorporate the experience of others and provides an opportunity for attendees to re-connect with the shared experience of suffering. This is in line with Yalom's therapeutic factor of universality in group therapy, discussed further below (Yalom & Leszcz, 2008). George suggests this move from a dispositional to a situational understanding of stress may provide a sense of increased social support which impacts one's perceived resources for managing stress. George draws on Haslam and Reicher's (2006) paper on stress within groups in which they talk about the importance of a shared identity and social support in mediating the experience of stress. George theorises through her observations in rounds that as one's focus

shifts away from the self, improved connectivity with colleagues may enhance social support and ability to manage stress which may indirectly impact patient care as staff rely less on withdrawal as a means of coping.

George's theory gives a plausible explanation of how rounds may work, drawing on existing findings across fields. Weight could be added to the theory through clarification of how it was reached, including which parts were derived through George's observation of rounds and participant data.

Additional theories

Reed et al. (2015) likened rounds to a community of practice. While they do not expand on this idea, literature on communities of practice suggests that learning and development occur through social processes (Hoadley, 2012). This theory may be of use in understanding rounds wherein attendees 'practice' together the components of listening, empathising and being with the experience of others. Newer attendees may learn this from those who have been before. The panel models openness, sharing and vulnerability and the facilitator models a non-judgemental, empathic response, both of which other attendees can then practice. Learning may then be generalised to other places, such as work with patients, as practice develops. This theory is limited in its explanation of the emotional and cognitive changes described by individuals attending rounds, however.

Farr and Barker (2017) describe the cultural, organisational and leadership factors which might influence compassionate care. They refer to Strauss et al.'s (2016) definition of compassion drawn from a review of definitions and theories, describing compassion as encompassing emotional resonance and recognition and connection with common humanity. They suggest the process of rounds, specifically the opportunity to listen and reflect on multiple emotional experiences shared by panellists, enables emotional resonance and enhances

attendees' ability to connect to their humanness and that of their colleagues and patients. While Farr and Barker do not discuss the theoretical mechanisms that may underpin this, they cite Strauss et al., who describe theories of compassion including Buddhist philosophies and evolutionary theories proposed by Gilbert (2010) and others. Farr and Barker suggest, based on theories of the influence of organisational contexts on people's emotions, thoughts and beliefs (Rynes, Bartunek, Dutton, & Margolis, 2012), that organisations, cultures and leadership which value practices with a primary aim of allowing people to connect with their humanity and that of others may support greater compassion. They describe the holding of rounds as a 'cultural marker' indicative of the values the organisation is aiming to promote (p.1660).

Maben et al.'s (2017) longitudinal study included a review of the perceived components of rounds and a model proposing how they work. This is described in summary in their paper and in a short video describing the findings of the study. The model describes trust, emotional safety and containment and group interaction as pre-requisites of creating a safe space. They suggest this occurs through appropriate facilitation and over time a 'Schwartz savvy' audience - one which trusts rounds and knows how to respond to panellists and contributors. Maben et al. (2017) suggest that rounds have a cumulative effect in part due to the time it takes to fully trust and understand the aims of rounds. Other factors including the disclosing of stories and modelling of vulnerability are suggested to reduce hierarchy, which allows organisational stories to be heard, the perspectives of others to be considered and gives space for reflection and resonance to occur which could help staff make sense of their experience. The theoretical basis upon which the model was developed remains unclear and leaves questions, such as how hierarchies are reduced through the sharing of stories, unanswered. However, as this is a draft paper, this may be addressed more fully in the published account. Some components of this

model overlap with those described in previous studies such as the emphasis on the function of resonance in Farr and Barker's paper (2017).

Yalom's group therapeutic factors

The descriptions of rounds in the papers suggest that insight into one's own experience and that of others is facilitated in rounds through the witnessing and expression of vulnerability and emotion. It is hypothesized that this leads to an increased awareness of one's own emotions and an increased ability to recognise and empathise with the experience of others (Deppoliti et al. 2015). While specific theories of how this happens are not elaborated upon in much of the writing, existing psychological knowledge of groups may be of use in understanding the processes at play.

Rounds are not promoted as therapy groups, but the description of the benefits of rounds throughout, suggest that Yalom's therapeutic factors (Yalom & Leszcz, 2008) may be a useful framework for understanding rounds' processes. Hartley and Kennard (2009) talk about the helpful presence of these factors in staff support groups and potentially supportive groups of any kind. Universality and cohesion are described across most of the papers, with an overlap between these factors. Yalom talks of the need for multiple factors to occur together; for example, catharsis occurring through the expression of difficult emotion is of benefit when it is held and validated by the group, allowing the group member to experience cohesion and a sense of being accepted as part of the group, arguably an essential need and motivator of all humans (Baumeister & Leary, 1995). George (2016) emphasises the importance of normalisation of emotional responses to difficult situations in reducing withdrawal and isolation from patients and colleagues. The detailed descriptors of Yalom's factors are laid out in appendix A and the applicability to the papers is described. Yalom suggests the factors are

not intended to be considered exclusively; he describes differentiating between them for clarity but considers them to be interconnected.

Results - quantitative evidence

Seven of the studies used the POCF evaluation form to collect routine feedback following rounds, including Gishen et al.'s study of medical students wherein an adapted version was used. The reliability and validity of the measures is not mentioned in any of the papers. Table 3 lays out the questions asked (Goodrich, 2011) and the results from each study. Chadwick et al. (2016) was the only study to give a complete set of results providing a mean score for each of the eight questions based on a Likert scale (1=completely disagree – 5=completely agree). Six other studies reported the results in an unclear manner and therefore these results should be interpreted with caution. Goodrich (2011, 2012) used vague language to describe the results rather than providing numerical data. The response to 'Overall rating' was included in numerical form for the two sites in the study. These were collated and mean scores for the two sites are included in Table 3. Farr and Barker (2017) referred the reader to 'supplementary data' for most of the quantitative results but they included two scores in the write up which were used to triangulate qualitative data.

Table 3: Summary of feedback responses

	Chadwick et al. 2016	Farr & Barker 2017	Goodrich 2012	Gishen et al. 2016	Hughes et al. 2018	Reed et al. 2015
I plan to attend Schwartz Centre Rounds again	4.74		‘Majority’ agreed somewhat/ completely	80%	≥81% agree or above	
I gained knowledge that will help me in caring for my patients	4.17	82% agreed	‘Majority agreed’		85% agree or above	
The case discussed today was relevant to my daily clinical work	4.33		‘Majority agreed’		≥81% agree or above	
Today’s round will help me work better with my colleagues	4.41		‘Majority agreed’		≥81% agree or above	
The facilitator helped the discussion today	4.56		‘They agreed’		≥81% agree or above	
I have gained insight into how others think/feel in caring for patients	4.79	94% agreed		82% (agreed or strongly agreed)	91% agree or above	87% ‘gained insight’
The overview and presentation of the case today was helpful to me	4.57		‘They agreed’	81% agreed/ strongly agreed)	≥81% agree or above	
Overall rating*	4.16		23% good 57% excellent 14% exceptional	3.4	21% good 55% excellent 18% exceptional	78% rated excellent - exceptional

In Gishen et al. (2016) 64% of students agreed rounds should be a part of the medical school curriculum

Likert scale: 1- disagree completely/strongly, 2- disagree somewhat/disagree, 3 neither agree nor disagree, 4 – agree somewhat/agree, 5 - completely/strongly agree

Overall rating: 1 – poor, 2 – fair, 3 – good, 4 – excellent, 5 – exceptional

Reed et al. (2015), Chadwick et al. (2016) and Hughes et al. (2018) analysed data routinely collected at rounds. Reed et al. had a 74% response rate from attendees at rounds. Chadwick and colleagues did not report a response rate, however, based on information provided this was calculated as 62%. Hughes et al. gave an unhelpfully vague description, stating ‘nearly all’ attendees completed feedback (p.12). For all three papers, there was difficulty identifying people who responded multiple times as feedback was given anonymously. Neither Reed et al. nor Hughes et al. reported information about the personal or professional background of participants or the workforce generally. A relative strength of Chadwick et al.’s study was the provision of detailed information about participants’ job roles and their representativeness in respect of the workforce.

Chadwick et al. (2016) was the only study which reported on the quality of the feedback form, though they did not report reliability or validity information. They found the eight questions were correlated highly (Cronbach’s alpha = 0.85) and were seen as forming a single scale (p.4).

Lown and Manning (2010) used a separate quantitative measure which they constructed to assess domains of interactions with patients, teamwork and support for providers. Scale items for each domain were derived from existing measures and the scales were highly correlated as measured by Cronbach’s alpha (0.88). Methodologically there are weaknesses, which ought to be considered in the interpretation of the results. Significant differences in retrospective participants’ self-report responses on measures of insight and teamwork are attributed to attendance at rounds, with increased attendance suggestive of greater improvement. However, significant differences were not found in prospective responders (those who completed measures at two time points) and this was attributed to high initial scores on the measures and not enough attendance at rounds. Consideration of attribution and recall biases was not given for retrospective participants who were comparing their current attitudes to their attitudes ‘pre-

rounds' three years prior. Additionally, selection bias was not discussed despite participants being selected by rounds co-ordinators.

The quantitative component of George's (2016) study looked at changes in participants' scores on the Organisational Response to Emotions Scale (ORES), a scale generated from data collected in the qualitative component of the study. George provided limited information about the process of questionnaire generation. Data on its validity and reliability were not provided. George reported there were insufficient respondents for factor analysis to be completed on the scale. The results of the quantitative component of the study were largely inconclusive and unreported. However, George drew a conclusion that rounds could potentially reduce emotional labour for staff based on the responses to one of at least four questions measuring this construct. The change in response to this question was significant for first-time attenders but not for regular attenders. George suggests this may demonstrate an 'epiphany' moment at the first round (p.11). This should be interpreted with caution given the low number of respondents and that this significant change was not common across all questions proposed to measure this construct. Additionally, Lown and Manning (2010) and Maben et al., (2017) reported a cumulative benefit to rounds contrasting George's suggestion that a measurable benefit of rounds occurs in the first attendance.

Maben et al.'s study collected quantitative data in the form of a survey which looked at factors such as staff well-being, empathy, support and work engagement and compared the responses of attendees and non-attendees of rounds at two time points; implementation of rounds and a year on. They found significant differences in the level of improvement in psychological well-being of staff who attended rounds compared to non-attenders. The GHQ, a clinically validated tool was used to measure this outcome. There were no other significant differences between the groups. This finding of improved psychological well-being following attendance at rounds was strengthened through using a comparison group of non-attenders;

attendance was through choice. The percentage of staff who scored above the clinical cut-off on the GHQ at the first time-point was higher in those who did not attend rounds, though whether this was a significant difference was not reported. This information may be relevant in considering who rounds are useful for. Maben et al.'s primary hypothesis that rounds would enhance work engagement was not supported. Apart from the GHQ they did not provide information about measures used in the study.

Qualitative results on perceived experience of rounds

The qualitative results are outlined below. Five themes were generated; “a safe space”, “a sense of ‘the big picture’”, “emotional resonance”, “being looked after”, and impact on care with the aim of encapsulating the qualitative findings of the studies. The findings were discussed considering the critical review of the papers. The review findings do not incorporate barriers to implementation and attendance as touched on in some papers, including Farr and Barker (2017), Maben et al. (2017) and Reed et al., (2015). However, these highlighted both pragmatic and preferential barriers to attending rounds including resource shortages, time, distance and the questioning of the usefulness of talking about difficult experiences.

Table 2 outlines the sampling methods used in the studies and the participants recruited. In the first American study of rounds, the selection of interview participants, the analysis and the results were not clearly described (Lown & Manning, 2010). Goodrich (2011, 2012) in the first UK studies described a purposive sampling method aimed at eliciting the views of senior leaders and ‘key players’ in rounds implementation. All who were asked to participate in interview did and both good and negative feedback was encouraged. Similarly, Deppoliti et al. (2015) used purposive sampling and identified participants who were active contributors in rounds. The focus in these studies on the experience of those who were highly invested in rounds may have impacted the themes elicited. The qualitative findings of George’s (2016) interview data focused on the experience of staff stress which was used to develop the ORES questionnaire. Description of the collation and analysis of George’s observational findings was limited.

Hughes et al. (2018) clinical audit provided no information about the sampling process. Based on figures provided by Chadwick et al. in their audit it was calculated that a qualitative comment was provided by 20% of respondents (12% of attendees). Neither Gishen et al. (2016) nor Reed et al. (2015) provided information about how participants were selected for focus

groups. Reed et al. stated participants were from a range of disciplines which were not described but their involvement with rounds was stated (Table 2). Gishen et al. stated focus group participants were year 5 medical students who volunteered to participate. Farr and Barker (2017) gave a detailed account of participant recruitment and provided participant information including gender and role in the organisation. No comparison to the general workforce was made. Deppoliti et al.'s (2015) reporting of methods and findings and attention to quality assurance was notably clearer than the other studies. Maben et al. (2017) collected an impressive range of data including observational and interview data from participants with varying roles in rounds as well as non-attenders.

“A safe space”

Farr and Barker's (2017) study into rounds in mental health and community services described the need for facilitators to create “a safe space” (p.1078) where participants could risk sharing their experiences and feelings. In ten of the eleven papers, this idea of rounds creating safety was discussed. The first American study by Lown and Manning (2010), which gave an insufficient account of their qualitative analysis, described how rounds created a space which allowed for “dialogue that doesn't happen anywhere else in the hospital” (p.1077). Goodrich's UK pilot study (2012) described a space for people to speak as well as open themselves to the experience of others “Rounds are a sign that it is safe to speak. It is all very well to say we have an open culture, but this demonstrates that value” (p. 120).

Maben et al. (2017) did not integrate quotes into the presentation of their findings. However, they incorporated safety into the model proposing how rounds work. Reed et al.'s clinical audit of rounds referred to them as a safe environment, however, this was not an explicit finding of the study. Chadwick et al.'s (2016) theme of *conduct of the meeting* describes the atmosphere and facilitation of rounds as being “supportive”, “sensitive” and “without judgement”.

Farr and Barker voiced the concern of one participant in relation to attendees' willingness to be open in the presence of more senior colleagues. However, others reported that the openness of senior colleagues contributed to junior staff feeling permitted to have difficult feelings also (Goodrich, 2012). Goodrich's findings should be considered in the context of their participant selection given that this was largely made up of those who were heavily involved in rounds. Deppoliti et al. (2015), in the second of and more methodologically robust of the American studies, quote participants describing the limitations of what can be spoken about in rounds and the need to remember one is in a professional environment. Additionally, students in Gishen et. al's audit study (2016) talked about the size of the group impacting one's sense of being able to speak in rounds. However, they also described continuing conversations outside of rounds suggesting rounds made the topic of the emotional impact of work safer to talk about; 'One of the most useful things for me was going home and talking about it' (p.4).

“A sense of ‘the big picture’”

This quote taken from Lown & Manning, (2010) highlights a theme common across papers in relation to rounds generating a broader sense of others, the organisation and teams within it. Lown and Manning's participants described rounds as promoting dialogue between people from other teams to which participants attributed increased multi-disciplinary working. Goodrich (2012) described rounds facilitating the potential for increased multi-disciplinary working as attendees witnessed how others felt about their work, including the impact on the organisation through participants perceiving others more equally and in terms of their common purpose; “There is always hierarchy in a hospital but in a room like that you are all carers in a caring environment” (p. 105). Similarly, George (2016) spoke of rounds allowing staff to recognise the challenges and stresses their colleagues face. Maben et al. (2017) in their longitudinal study emphasise the sharing of stories in describing attendees experience of seeing the perspectives of colleagues and hearing organisational stories that are not usually discussed.

In another metaphor used by a participant in Reed et al.'s audit, they described rounds as providing a sense of where they fit in to the organisation; 'I sometimes feel as if you're a little part of a jigsaw and going to a Schwartz Round you see all the other bits of the jigsaw so you actually get the whole picture...' p. 366. Similarly, Deppoliti et al., (2015) quoted participants' experience of 'being part of something a little bigger than themselves' (p.980) as part of the culture change attributed to rounds. Hughes et al. (2018), despite their poorly described methodology, described in line with Chadwick et al. (2016), insight gained by attendees into the experience of others and themselves. Chadwick and colleagues provided quotes from staff highlighting how rounds can close the gap in understanding of other people's perspectives or experiences. Farr and Barker (2017) also described rounds as helping attendees to understand the experience of people from other professions and disciplines; 'I think it is very healthy to be exposed to other networks, other disciplines, other people and go, oh they have the same kind of stresses as we do' p.1659.

'The big picture' was not apparent in Gishen et al.'s study (2016). This may have been linked to the rounds occurring at a university with only medical students, rather than multi-disciplinary attendees.

Emotional Resonance

Both Maben et al (2017) and Farr and Barker (2017) discuss the idea of emotional resonance when describing staff's experience of empathising or connecting at rounds. They talk about participants having the opportunity to see humanness in themselves and others as described by Farr and Barker's participant; "very human emotional issues that perhaps we don't voice that often...being voiced in a wider public forum and everybody being able to relate to it" (p. 1656).

In their clinical audits, both Chadwick et al. and Reed et al. depicted participants' perceived change following emotional resonance with others at rounds which included finding it easier to work with difficult clients and acting towards or seeing colleagues differently respectively. A quote included by Reed et al. epitomises this experience: "Everything just slightly tilts, and the next time you see them, you're different with them...and if what they are saying resonates with you, you feel you have a different connection with them" p. 366. The beginning of this quote hints at the subtlety with which changes can occur. Similarly, Deppoliti et al., (2015) reported changes in behaviour which participants linked to rounds. They also described some participants preference for topics which elicit difficult emotions over more neutral or 'fluffy' topics; 'You wanted a tough one, you wanted an emotional one' (p. 981).

Farr and Barker talked about the need for staff to see common ground for them to attend. They posited from their observations and from participants' responses that multiple experiences from the panel rather than a focus specifically on a single case helped staff to engage with the round. Where a single case was discussed by all panellists, they reported that audience members became more absorbed in the specifics of the case rather than connecting to their own experience in terms of the broader themes or emotions arising from the discussion.

"...my understanding of it was that the case study that was presented was supposed to act as a springboard to everybody chipping in and talking about experiences that they had had...But it became, the whole thing was just focused around that one case." p.1656.

This suggests that the way rounds are run impacts staff's engagement and connection to the themes discussed. Maben et al. (2017) speak of the importance of the way the story is told in creating emotional resonance highlighting the importance of the preparatory session for panellists.

Being looked after

Nine studies described participant responses suggesting rounds gave attendees a sense of 'being looked after', a phrase taken from Farr and Barker (2017). They reported a general sense of this from participants which they felt enhanced staff's ability to care for others. Goodrich describes high-level endorsement of rounds as being important in the meaning attributed to them by staff; "I do see the Schwartz Rounds as having a symbolic value, of saying "we value this"" (p.122). Another participant spoke of rounds as an attempt to redress the balance following a move towards target driven care while another saw rounds as improving staff satisfaction; "Happy staff create happy patients. We haven't done well with our staff or patient survey, so Schwartz is part of creating happy staff." (p.121).

Chadwick et al., had a theme relating to staff's gratitude for rounds. For Reed et al., a participant described rounds as "reassuring, it's comforting" (p.366). Gishen et al. (2016) highlighted the importance of rounds in terms of giving permission to be both professional and have feelings. Deppoliti et al. (2015) also strongly endorse this theme with a suggestion that rounds were an indication of the organisation and administration addressing the needs of staff.

Farr and Barker highlighted some staff's view of rounds being perceived as "fluffy". They quoted two participants describing an emphasis on the psychosocial aspects of care as "touchy-feely" with an implication that rounds would not be seen as a helpful use of time as they were not meeting any target. They also highlighted that staff are more likely to sacrifice things beneficial to their well-being or development for things relating to patient care. These views which may be from a minority of participants are noteworthy, considering Farr and Barker's sample was broader than that of Goodrich's which was largely made up of invested in rounds.

Chadwick and colleagues spoke about facilitators deliberately not giving information about additional support outside rounds to avoid the implication that strong emotion is inappropriate. However, respondents in their study talked about a need for support which may suggest that for some staff, rounds are not sufficiently supportive “I would be interested to see how the organisation will support these people” (p. 5). Similarly, Lown and Manning described additional staff supports which arose from needs identified through rounds. George’s qualitative data about participants’ experience of stress indicated the importance of management in supporting staff. Participants spoke about feeling uncared for as their manager did not appear to have time to give emotional support or support in managing interactions with families which they felt contributed to their stress and engagement at work; ‘We’re a caring profession but no-one cares about us’ p.9.

Impact on Care

All eleven papers suggested that rounds may have an impact on care. While rounds intentionally avoid problem-solving, participants described benefits of learning from others, thinking from different perspectives and having space to think about how they care. Farr and Barker (2017) quoted participants describing an increased ability to empathise due to hearing other perspectives and an intention to draw on learning from the round in the future “I think it helps broaden your mind, your thinking around good patient care.” p.1659. This made up a component of Maben et al.’s (2017) model of rounds, wherein they described how rounds improve perspective taking. Similarly, Chadwick et al. highlighted participants’ intention to use the perspectives of others when they think about and care for patients. Lown and Manning also described participants’ experience of learning from others at rounds through valuing more than medical knowledge “Schwartz models that capacity to be less all-knowing and to value expertise that isn’t medical— [that includes] connection [and] compassion. It creates a new sense of competency, rather than arrogance” (p. 1077). Deppoliti and colleagues talked about

change in the interactions between staff with physicians welcoming the perspectives of other staff.

Goodrich emphasised improved relationships between staff and suggested improved team and multi-disciplinary working as a result “It generates pride in our identity. We need to re-emphasize that we are here to care for patients” (p.121). Similarly, a Lown and Manning participant linked rounds to multi-disciplinary working. Another described a desire to move towards holistic care; “[T]here should be a complete package of care that addresses the psychological, social, and spiritual aspects of care in addition to the medical—that should be the standard” (p. 1077).

Maben et al. suggested that sharing of stories promoted a sense of vulnerability which flattened hierarchies and created a more level playing field between attendees. Reed and colleagues extrapolated improved team working and a reduced hierarchical culture based on participants’ responses. However, a quote to support this was not provided. Reed et al. reported non-attendees’ view that good quality care and the smooth running of the hospice was not dependent on attending rounds and that they could contribute ‘without needing to hear the stark reality of life for the patients and clinicians’ p. 366 (not a participant quote). Maben et al., (2017) also touched on non-attendees questioning of the purpose of discussing feelings of sadness or anger. George’s (2016) study did not look at the qualitative experience of rounds attendees but she extrapolated that rounds may lead to improvements in care based on enhanced recognition of the emotional impact of care post-rounds.

Discussion

This review of the research literature of the efficacy of Schwartz Rounds and the theoretical basis underpinning them has attempted to provide a comprehensive and clear summary of the findings to date. Despite the relatively limited number of papers and the poor quality of many

of these, theoretically and methodologically, this review was considered important and contributory by holding the focus on staff support, an area significantly neglected within the research literature (Robert, 2017). It aimed to delineate what is known about rounds from the work that still needs to be done to improve understanding and demonstrate efficacy.

Rounds appear to have developed out of a common sensical idea about what staff may need and find beneficial rather than having evolved in a more traditional manner through a theoretically-driven approach designed to target maintenance factors of a clearly defined and understood problem (Wight, Wimbush, Jepson, & Doi, 2016). This means the process of evaluating rounds is complicated by a reduced understanding of their intended purpose, how they might work and the potential outcomes worthy of measurement.

The findings of this review suggest relatively coherent and consistent benefits of rounds have been found across the studies. Through the synthesis of the qualitative literature, five themes were developed to describe the perceived benefits of rounds; “a safe space”, “a sense of ‘the big picture’”, “emotional resonance”, “being looked after”, impact on care. The themes were consistent with the communicative, supportive, educative and normative benefits proposed by Hartley and Kennard (2009) of providing support to staff in a group format. Similarly, Yalom’s therapeutic factors (2008), particularly universality, are highly applicable to the findings of the papers at a theoretical and empirical level. George (2016), Farr and Barker (2017) and Maben et al. (2017) in their descriptions of the mechanisms underpinning rounds suggest the benefits are contingent on the connection developed with others based on shared experience of feeling and emotional resonance. Another of Yalom’s factors, ‘developing socialising skills’, is present in the papers on rounds which consistently report staff’s experience of an increase in perspective-taking and empathy for others.

The first study by Lown and Manning (2010), upon which subsequent studies were based, suggested that rounds had an impact by providing a space for staff to talk about things in a way that is dissimilar to the general dialogue of the hospital, described as ‘counter cultural’ by Maben et al. (2017), which enhanced a sense of support, a shared purpose and a broadening of perspective to incorporate the views and experiences of others. This is something which is extremely difficult to do in the current context of high-pressure, target focused healthcare, as incorporated specifically in George’s stress theory. However, the methodological limitations of Lown and Manning’s study, particularly the unacknowledged bias of retrospective, self-reported attribution of change to rounds by attendees, comparing their beliefs at the time of the study to those held up to three years prior, mean the findings should be considered with caution. However, they were largely accepted uncritically throughout the research and grey literature, with Farr and Barker describing rounds as ‘evidenced-based’ interventions (2017, p.1652). Acknowledging the gaps in understanding about the mechanisms and efficacy of rounds, alongside their benefits, could enable funding of research to continue allowing the essence of what makes rounds useful to be established, enhanced and preserved in the face of inevitable competition with future initiatives. Alongside a critical approach to the research, acknowledging and attempting to address one’s own biases as a researcher is an important component of quality assurance which was largely neglected by the papers in this review, with the notable exception of George (2016).

Some of the findings in the papers not focused on in the review were around the accessibility of rounds. Farr and Barker (2017) and Maben et al., (2017) describe some of the barriers to implementation including a broad geographical area and limited resources or time. This begins to highlight some of the pragmatic issues around the accessibility of rounds. Goodrich (2012) and Maben et al (2017) suggest rounds are an important component of a broader initiative to support staff. They recognise rounds are not a panacea for the issues of

lack of compassion and disengagement but must go alongside change on a broader level. Considering Robert et al.'s (2017) findings that some Trusts were introducing rounds to 'tick boxes' or to meet expectations of what they 'should' be doing, it is important that commitment to broader change and support for staff is emphasised in the literature and the promotion of rounds.

Areas for future research

The literature and evidence-base to support the implementation of rounds as a staff support initiative is in its infancy. There are many important areas for future research. As discussed in this review, a clearer understanding of the process of rounds would help ensure the essence of what is useful about them can be maintained. Maben et al.'s first-look summary proposes a model to explain the process of rounds. The full paper will likely contribute significantly to this understanding.

Many of the papers included here acknowledge to a certain degree that some staff do not experience the feelings of safety in a round that others do and not all staff see talking about difficult feelings as helpful. Further research into why some people value and benefit from rounds while others do not or choose not to engage with them may contribute to increasing the reach of rounds.

Clinical Implications

While the quality of the literature on rounds to date is relatively poor, the findings were relatively consistent and indicative of many attendees' experience of rounds as positive and useful. This suggests organisations, management and commissioners may wish to consider piloting and auditing the implementation of rounds as a staff support intervention within their organisations.

The findings also suggest that many attendees experienced support and compassion in rounds as significantly different from their general working environments. This highlights a need for organisations and teams to consider how they can introduce these helpful components of rounds to the broader culture.

Conclusions

The research papers reviewed paint a predominantly positive picture of rounds. This review suggests rounds offer an opportunity to support healthcare staff with the potential to indirectly improve patient care through enhanced staff well-being and connection to their own and others' experiences. Clear themes were repeated across the research about how rounds offer a space and an opportunity to reflect which is different from that offered by other forums. There are methodological and theoretical limitations to the research papers with some authors accepting and building upon the findings of previous researchers uncritically and without acknowledgement of their potential biases and therefore the findings of this review should be considered in light of these shortcomings. However, staff support is generally an under-researched and under-valued component of healthcare. Offering support in the form of rounds could be one aspect of the broader shifts needed to move towards compassionate care. This review contributes to the research on rounds by drawing out the benefits consistently described across the papers, while highlighting the limitations to be redressed by future research.

References

- Abramson, L., Seligman, M., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*, 49–74.
- Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin, 117*, 497–529.
- Bridges, J., Nicholson, C., Maben, J., Pope, C., Flatley, M., Wilkinson, C., ... Tziggili, M. (2013). Capacity for care: meta-ethnography of acute care nurses' experiences of the nurse-patient relationship. *Journal of Advanced Nursing, 69*, 760–772.
<https://doi.org/10.1111/jan.12050>
- Chadwick, R. J., Muncer, S. J., Hannon, B. C., Goodrich, J., & Cornwell, J. (2016). Support for compassionate care: Quantitative and qualitative evaluation of Schwartz Center Rounds in an acute general hospital. *JRSM Open, 7*, 1–8.
<https://doi.org/10.1177/2054270416648043>
- Critical Appraisal Skills Program, (2015). Qualitative Research Checklist. Retrieved from <https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist.pdf>
- Department of Health. (2013). *Patients First and Foremost: The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf
- Department of Health. (2015). *The NHS Constitution – the NHS belongs to us all*. Retrieved from <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment>

_data/file/480482/NHS_Constitution_WEB.pdf

Deppoliti, D., Cote-Arsenault, D., Myers, G., Barry, J., Randolph, C., & Tanner, B. (2015).

Evaluating Schwartz Center Rounds® in an urban hospital center. *Journal of Health Organisation and Management*, 29, 973–987. <https://doi.org/10.1108/JHOM-09-2013-0189>

Farr, M., & Barker, R. (2017). Can staff be supported to deliver compassionate care through

implementing Schwartz Rounds in community and mental health services? *Qualitative Health Research*, 27, 1652–1663. <https://doi.org/10.1177/1049732317702101>

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*

Executive summary. London. Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

George, M. S. (2016). Stress in NHS staff triggers defensive inward-focussing and an

associated loss of connection with colleagues: this is reversed by Schwartz Rounds.

Journal of Compassionate Health Care, 3, 1-17. <https://doi.org/10.1186/s40639-016-0025-8>

Gilbert, P. (2010). *Compassionate Mind*. London: Constable.

Gishen, F., Whitman, S., Gill, D., Barker, R., & Walker, S. (2016). Schwartz Centre Rounds:

a new initiative in the undergraduate curriculum—what do medical students think? *BMC*

Medical Education, 16. <https://doi.org/10.1186/s12909-016-0762-6>

Goodrich, J. (2011). Evaluation of the UK pilots The Point of Care: Are you seeing the

person in the patient? Retrieved from

https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/schwartz-

center-rounds-pilot-evaluation-jun11.pdf

Goodrich, J. (2012). Supporting hospital staff to provide compassionate care: do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine*, *105*, 117–22. <https://doi.org/10.1258/jrsm.2011.110183>

Gurung, R. A. R., & Roethel-Wendorf, A. (2009). Stress and Mental Health. In S. Eshun & R. A. R. Gurung (Eds.), *Culture and mental health: Socio-cultural influences, theory and practice*. London: Blackwell Publishing.

Hartley, P., & Kennard, D. (2009). *Staff Support Groups in the Helping Professions: Principles, Practice, and Pitfalls*. London: Routledge.

Haslam, S. A., & Reicher, S. (2006). Stressing the group: Social identity and the unfolding dynamics of responses to stress. *Journal of Applied Psychology*, *91*, 1037–1052. <https://doi.org/10.1037/0021-9010.91.5.1037>

Hiam, L., Dorling, D., Harrison, D., & McKee, M. (2017). What caused the spike in mortality in England and Wales in January 2015? *Journal of the Royal Society of Medicine*, *110*, 131–137. <https://doi.org/10.1177/0141076817693600>

Hoadley, C. (2012). What is a community of practice and how can we support it? In D. H. Jonassen & S. M. Land (Eds.), *Theoretical foundations of learning environments* (2nd ed., pp. 287–300). New York: Routledge.

Hughes, J., Duff, A. J., & Puntis, J. W. L. (2018). Using Schwartz Center Rounds to promote compassionate care in a children's hospital. *Archives of Disease in Childhood*, *103*, 11–12. <https://doi.org/10.1136/archdischild-2017-313871>

The King's Fund, (2017). What are the priorities for health and social care? Retrieved from: <https://www.kingsfund.org.uk/publications/what-are-priorities-health-and-social-care>

- Lawlor, D. (2009). Test of time: social systems against anxiety. *Clinical Child Psychology and Psychiatry*, *14*, 523–530. <https://doi.org/doi/pdf/10.1177/1359104509339545>
- Lown, B. a, & Manning, C. F. (2010). The Schwartz Center Rounds: evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine : Journal of the Association of American Medical Colleges*, *85*, 1073–1081. <https://doi.org/10.1097/ACM.0b013e3181dbf741>
- Maben, J., Adams, M., Peccei, R., Murrells, T., & Robert, G. (2012). “Poppets and parcels”: The links between staff experience of work and acutely ill older peoples’ experience of hospital care. *International Journal of Older People Nursing*, *7*, 83–94. <https://doi.org/10.1111/j.1748-3743.2012.00326.x>
- Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., ... Foot, C. (2017). A realist informed mixed methods evaluation of Schwartz Center Rounds® in England. Retrieved from <https://njl-admin.nihr.ac.uk/document/download/2011408>
- Martin, L. J., Hathaway, G., Levitin, D. J., Mogil Correspondence, J. S., Isbester, K., Mirali, S., ... Mogil, J. S. (2015). Reducing social stress elicits emotional contagion of pain in mouse and human strangers. *Current Biology*, *25*, 326–332. <https://doi.org/10.1016/j.cub.2014.11.028>
- Menzies Lyth, I. (1960). Social systems as a defense against anxiety. *Human Relations*, *13*, 95–121. <http://moderntimesworkplace.com/archives/ericssess/sessvol1/Lythp439.opd.pdf>
- Ramsay, A. I., & Fulop, N. J. (2016). Why evaluate “common sense” quality and safety interventions? *BMJ Quality and Safety*, *25*, 224–225. <https://doi.org/10.1136/bmjqs-2015-004755>
- Reed, E., Cullen, A., Gannon, C., Knight, A., & Todd, J. (2015). Use of Schwartz Centre

- Rounds in a UK hospice: Findings from a longitudinal evaluation. *Journal of Interprofessional Care*, 29, 365–366. <https://doi.org/10.3109/13561820.2014.983594>
- Robert, G., Philippou, J., Leamy, M., Reynolds, E., Ross, S., Bennett, L., ... Fraser, A. (2017). Exploring the adoption of Schwartz Center Rounds as an organisational innovation to improve staff well-being in England, 2009-2015. *BMJ Open*, 7, 1-10. <https://doi.org/10.1136/bmjopen-2016-014326>
- Robinson, O. J., Vytal, K., Cornwell, B. R., Grillon, C., Paulus, M. P., & Shackman, A. J. (2013). The impact of anxiety upon cognition: perspectives from human threat of shock studies. <https://doi.org/10.3389/fnhum.2013.00203>
- Rynes, S. L., Bartunek, J. M., Dutton, J. E., & Margolis, J. D. (2012). Care and compassion through an organizational lens: Opening up new possibilities. *Academy of Management Review*, 37, 503–523. <https://doi.org/10.5465/amr.2012.0124>
- Schwartz, K. B. (1995). A patient's story. *The Boston Globe*. Retrieved from <https://www.bostonglobe.com/magazine/1995/07/16/patient-story/q8ihHg8LfyinPA25Tg5JRN/story.html>
- Strauss, C., Lever Taylor, B., Gu, J., Kuyken, W., Baer, R., Jones, F., & Cavanagh, K. (2016). What is compassion and how can we measure it? A review of definitions and measures. *Clinical Psychology Review*, 47, 15-27. <https://doi.org/10.1016/j.cpr.2016.05.004>
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8. <https://doi.org/10.1186/1471-2288-8-45>
- Todd, A. R., Forstmann, M., Burgmer, P., Brooks, A. W., & Galinsky, A. D. (2015). Anxious

and egocentric: How specific emotions influence perspective taking. *Journal of Experimental Psychology: General*, *144*, 374–391.

<http://dx.doi.org/10.1037/xge0000048.supp>

Wight, D., Wimbush, E., Jepson, R., & Doi, L. (2016). Six steps in quality intervention development. *Journal of Epidemiology and Community Health*, *70*, 520–525.

<https://doi.org/10.1136/jech-2015-205952>

Yalom, I. D., & Leszcz, M. (2008). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Appendices

Appendix A – Yalom’s Therapeutic Factors (2008)

Therapeutic factors	Relevance to papers
Universality: this helps group members to recognise their problems are like those of others and to feel they are not alone in their experiences	Seven of the papers included participant responses related to a sense that others experience similarly difficult thoughts and feelings in relation to their work with patients (Chadwick et al., 2016, Deppoliti et al., 2015, Farr & Barker, 2017, George, 2016, Gishen et al., 2016, Goodrich, 2012, Reed et al., 2015)
Altruism: a sense of value and meaning coming from helping other group members	Lown and Manning (2010) reported staff had an increased willingness to give and receive support through attending rounds. Studies did not explicitly talk about helping others at rounds.
Instillation of hope: the group providing hope that things will get better/be ok	Only explicitly described in Deppoliti et al. (2015) who include a hope for change through the attendance of administrative (management) staff at rounds.
Imparting information: giving of information or advice. Yalom describes this as occurring in ‘younger’ groups which struggle to be with feelings. However, he describes the imparting of experience of feelings/situations can be more helpful.	Rounds are promoted on the premise that they serve a radically different function from other groups held in the hospital in that they are not about advice giving. However, sharing information about people’s experience of situations and feelings is fundamental to rounds and discussed in all papers.
Existential issues: this deals with issues relating to the reality of life and death.	None of the papers talk specifically about dealing with existential issues. However, many papers give examples of the ‘topics’ at rounds which are often around the complexities of illness, care and loss. Rounds as a space for staff to consider the impact of working with illness and death and its impact on their sense of their own mortality

is not discussed in any of the papers. Cullen, (2015) refers to this in the introduction to her review paper but it is not expanded further.

Cohesion: refers to a sense of belonging, acceptance and being part of the group. The rounds literature describes connection and feeling part of something bigger.

George, 2016 talks of increased cohesion following the recognition of others' difficulties – interlinked with universality. Farr and Barker (2017) talk about improved connections within teams and across the organisation. Goodrich 2012 describe rounds as developing shared values and improving team working and collaboration, Lown & Manning 2010 describe a sense of belonging to a team and improved team work. Reed et al., 2015 quote a participant feeling 'a part of the jigsaw'. Deppoliti et al. 2015 report participants' experiencing a sense of being part of something bigger.

Catharsis: involves the release of emotional tension

Gishen et al. 2016 describe rounds as helpful in the expression of emotion otherwise suppressed. Hughes et al., 2018 do not explicitly talk about catharsis but they talk about the power of exploring feelings within work. Deppoliti et al., 2015 talk about expressing feelings, however they talk about the 'limits' of what can and cannot be said. Farr & Barker 2017 spoke more of discussing emotional challenges as being a risk staff take and was less focused on catharsis. Reed et al. 2015 talk about exploring emotions rather than experiencing a release through the expression of them.

Imitative behaviour: behaving like other groups members which may include openness and self-disclosure.

The structure of rounds, opening with a panel discussing the emotional impact of the work and a facilitator whose role is to keep the focus on the emotional aspects of work, promote imitative behaviour of self-disclosure and openness. Most studies described audience responses which were similarly open. Gishen et al., 2016 and Deppoliti et al., 2015 talk about the audience feeling restricted by the size of the group and the presence of managers respectively. Similarly, Farr and Barker,

(2017), Maben et al (2017) and Reed et al., (2015) highlight that some participants felt this type of disclosure was unnecessary.

Developing of socialising techniques; learning social skills directly or indirectly through e.g. feedback from others. All papers talk about how rounds allow attendees to empathise with speakers and learn about how they work, think and feel. Goodrich speaks of more senior staff role modelling to others the importance of focusing on the emotional impact of care.

Deppoliti et al., 2015 talk about changes, self-reported and observed in how doctors interact with nurses and other professionals. Goodrich's reported participants saw doctors as less cold and hard while doctors respected the work of others more following rounds.

Interpersonal learning

Deppoliti et al., 2015 described how participants can become aware of their own 'supressed' emotions by listening to the experience of others.

Corrective recapitulation of family of origin issues

This was not highlighted in any of the papers.

Appendix B – Critical appraisal skills program: Qualitative checklist**1. Was there a clear statement of the of the research?**

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance

2. Is a qualitative methodology appropriate?

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

3) Was the research design appropriate to address the aims of the research?

HINT: Consider

- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

4. Was the recruitment strategy appropriate to the aims of the research?

HINT: Consider

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

• HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered?

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during (a) Formulation of the research questions (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

7. Have ethical issues been taken into consideration?

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous?

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy? or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

**Section B: Factors influencing attendance and engagement with Schwartz
Rounds: perspectives of attendees and non-attendees**

Marguerite Gallagher

April 2018

Word Count: 7992 (215)

Salomons, Canterbury Christ Church University

A thesis submitted in partial fulfilment of
the requirements of Canterbury Christ
Church University for the degree of Doctor of Clinical Psychology

To be submitted to the peer-reviewed journal '*Journal of Compassionate Health Care*

Abstract

Schwartz Rounds are a staff support intervention which have been adopted in over 100 healthcare trusts in the UK since 2009. They aim to provide a space for staff to come together to think about the emotional impact of the work they do. Research into rounds is in its infancy, however, to date, findings are generally positive. The current study aimed to develop a theoretical understanding of staff motivation to attend or not attend rounds. Interview data from ten NHS employees and one previous employee were analysed using a grounded theory approach. A theory was developed which suggests staff will make the effort to overcome contextual factors of lack of time and resources to attend rounds if they view them as beneficial. Reported benefits of rounds were similar to those described in previous research. Staff are less likely to attend rounds if they do not understand the aims of rounds or if they view sharing emotional experience as risky. High demands and a perceived lack of support may influence the degree to which staff trust and feel able to use rounds. The limitations and implications of the study are discussed, and areas of future research suggested.

Key words: 'Schwartz Rounds', 'Rounds' 'Staff support' 'Motivation' 'staff engagement'

Introduction

The Schwartz Center for Compassionate Healthcare is a US non-profit organisation set up in the memory of Kenneth Schwartz, a healthcare lawyer who lost his life to lung cancer aged 40. He wrote of the importance to him of the moments of kindness and compassion shown to him by healthcare professionals (Deppoliti et al., 2015). Through the centre, Schwartz Rounds, termed 'rounds' hereafter, were developed and in 2009 they were piloted in the UK. Rounds are a forum for staff to come together to think about the emotional impact of their work (Goodrich, 2012). Lown and Manning's (2010) seminal paper describe rounds as aiming to enhance relationships and communication between staff and with patients and to enhance staff's sense of support. Rounds are currently running in over 100 Trusts and hospices in the UK (Robert et al., 2017). While their introduction to the UK preceded the widespread recognition of the need for staff support highlighted by the Francis Report (Francis, 2013), their uptake significantly increased in its aftermath.

Staff well-being in the NHS

Subsequent to the findings of Francis (2013) which highlighted huge systemic failings which led to poor quality, neglectful practices in some NHS services, an update to the NHS Constitution (Department of Health, (DOH), 2015) set out the rights and pledges to patients and staff, including the right for staff to have their well-being supported. Four years on the 2017 staff support survey illustrates the issues facing staff in the NHS. Table 1 displays findings selected from the report due to their relevance to this study (NHS Survey Coordination Centre (SCC), 2018).

Table 1: NHS staff survey responses 2017*

Relevant findings
38% of staff reported feeling unwell due to work-related stress in the previous 12 months
58% of staff worked additional unpaid hours
52.9% of staff attended work despite being unwell in the previous 3 months due to feeling pressure to do so
68% of staff feel their manager takes an interest in their health and well-being
33.5% of staff reported good communication between senior managers and staff
12.6% of staff experienced discrimination in the previous 12 months
28% of staff experienced bullying harassment or abuse from patients
24.3% of staff experienced bullying harassment or abuse from staff
31% of staff were satisfied with their level of pay
71.6% of staff felt their managers valued their work; 43% of staff felt the organisation valued their work
31% 'agree' or 'strongly agree' that there are enough staff in their organisation for them to do their job properly
Staff reported lower satisfaction with the quality of care they can deliver compared to 2016 survey

* Not a copyrighted table

The findings suggest a significant proportion of staff had experienced work-related stress, were working beyond their hours and felt they had to work when unwell. This may be linked to perceived shortages of staff considering 69% of respondents did not agree there were enough staff for them to do their job properly. Almost a third of staff did not feel their manager took an interest in their health and well-being. There were increases in perceived bullying, harassment, abuse and discrimination and reductions in the percentage of staff who felt their managers and the organisation appreciated their work compared to the previous year. These results highlight the significant work to be done to enhance staff well-being in the NHS. Despite this most staff (73.4%) report being enthusiastic about their work.

The emotional challenges inherent in working with people who are ill, physically or mentally, and dying have been acknowledged since at least the time of Menzies Lyth, (1960) a psychoanalyst prominent for her research with organisations and teams. She described organisational defences, which broke up the nurse-patient relationship with the aim of protecting staff from the anxiety caused by the work but these led to further anxiety. Menzies-Lyth suggested the organisation did not appropriately contain staff to allow them to reach more

mature management of their feelings. Traynor, (2017) distinguishes between these challenges intrinsic to healthcare which staff must be supported to manage and those relating to socio-political issues which staff must resist. He argues that staff should resist strategies promoting resilience in managing challenges brought about by cuts in funding and ever-increasing clinical targets propped up by a neo-liberal agenda.

Talking about difficulties

Hartley and Kennard, (2009) suggest support for healthcare staff ought to be offered in a group format to normalise the experience of difficulties. In line with George's (2016) theory that attributing stress and distress to one's own shortcomings rather than the situation leads to withdrawal, Hartley and Kennard suggest staff may feel ashamed or weak because they are struggling and may feel alone in this position. On the other hand, they suggest, the challenges of work may seem so commonplace, like the symptoms of a cold, that individuals feel they cannot talk about how difficult they are to cope with. Hartley and Kennard (2009) also highlight that a manager's inability to provide support over a prolonged period reduces the likelihood of staff seeking help through the organisation. They suggest that the dynamics of a team may lead to a fear, as well as a reality, of an invalidating response to vulnerability which prevents staff seeking support. They suggest staff may also fear becoming overwhelmed by their feelings if they think about themselves.

A problem shared...

The idea that it is helpful to talk about difficulties with others could be considered at the heart of rounds. Research supports the idea that rounds, through the sharing of experiences, enable connection with one's own and others' experience which can positively influence attendees' perceptions of each other (Goodrich, 2012; Maben et al., 2017). George's (2016) theory about how rounds work suggests 'cognitive distortions' (p.12) relating to a dispositional cause of stress are challenged through the recognition that others are struggling too. In

considering the potential for rounds to cause harm through poor containment of emotions, Chadwick, Muncer, Hannon, Goodrich, and Cornwell, (2016) describe rounds as giving voice to emotion which they suggest is elicited through the work rather than through talking about it. They describe organisers choosing not to offer support in managing the emotions discussed in rounds as to do so may imply they are unusual or require intervention.

However, the belief that it is helpful to talk about difficulties is far from universal (Littlewood, 1990). For many and for a variety of reasons, personal, familial or cultural, it can feel more helpful to avoid difficult emotions or experiences and to focus on the practical or the positive (Littlewood, 1990; O'Connell, 2005; Seligman, 1998). It is important to acknowledge that this may be the case for some staff, which serves as a rationale for attendance at rounds remaining voluntary. However, this does not negate the need for organisations to promote a culture which responds appropriately to staff and patients' need or desire to express vulnerability. Hinshelwood and Skogstad, (2000) in their book on observations of organisations caution that a 'demand for friendliness' can over-ride other feelings in staff such as fear, anger and pity and place a similar demand on patients, which denies and neglects their actual emotional experience (p.161).

Staff support within an organisation like the NHS is complex. Rounds appear to fill a gap in providing emotional support in a way that is different from other interventions (Lown & Manning, 2012). However, even when staff view rounds as beneficial, they are underutilised (Devlin et al., 2008). The current study uses a qualitative approach to gain a contextualised understanding of staff's motivation, or lack thereof, to attend and engage with rounds.

Method

This study had a qualitative design following a grounded theory methodology (GTM). GTM was chosen because it is recommended where a gap exists in the literature, allowing new

theory to be developed (Strauss & Corbin, 1998). Understanding about staff motivation to engage with well-being initiatives is an under-explored area. The main aim of the study was to develop a theoretical framework which describes the motivation and intentions of staff in relation to attending to their emotional well-being through rounds. Semi-structured interviews formed the basis of an iterative and systematic process of data collection (Glaser & Strauss, 1967; Urquhart, 2013).

Epistemological Stance

Original GTM held a positivist stance suggesting causal factors existed and the methodology allow those to be observed (Glaser & Strauss, 1967). This research is underpinned by a critical realist epistemological stance (Collier, 1994) The researcher considers that people choose to attend or not attend rounds for various reasons based in their experience. However, the identification and conceptualisation of these reasons will be influenced by the subjective understandings and experiences of the research participants and the researcher.

Participants

There were eleven participants in the study, ten of whom were employees in the NHS and one who left the NHS in the year prior after 30 years of service. Demographic details, years of experience and experience of rounds are detailed in Table 2.

The researcher attended the lunch before a round and introduced the research to attendees. Attendees were invited, if interested, to provide an email, to which the participant information sheet (appendix D) and invitation to participate were sent. An email was sent via rounds organisers at the Trust to the communication list providing the information sheet and inviting both attendees and non-attendees to participate. Seven participants were recruited via these approaches. Four participants from two other trusts and a private organisation were recruited through contacts of the researcher.

Table 2: Participant information

Number	Age	Gender/ethnicity	Role	Band	Years in NHS	Years in current role	Rounds attendance
PP1	49	Female White British	Senior Matron	8a	31	6	Attended 1-2
PP2	31	Male White Irish	Staff nurse	5	3	2	Not attended - Would attend
PP3	58	Female White British	Unit manager	7	19	5	Attended 3 - May go back
PP4	47	Female White Irish	Nurse – suite manager.	7	25	3	Not attended – may attend
PP5	56	Female White British	Matron	8a	23	16	Attended 3-4 Would go back
PP6	52	Female White British	Acting senior matron		30	2	Panellist Attended 2-3 would go back
PP7	52	Female White British	Unit Co-ordinator	7	32	7	Attended 1- Would not go back
PP8	33	Female White British	Co-ordinator – admin	4	13	8	Not attended- Unsure if would attend
PP9	31	Female White British	Assistant Psychologist	5	9	2.5	Attended 1-May go back
PP10	23	Female Asian	Final year nursing student	N/A	3	3	Attended 3- Would go again
PP11	38	Female White British	Clinical Psychologist	8b	15	3	Attended 1- May go back

Procedure

Ethical considerations.

Ethical approval was granted by Canterbury Christ Church University ethics panel (appendix A). As participants were employees of the NHS, approval was also sought through the Health Research Authority (appendix B). This was granted contingent on approval from the Research and Development department of the Trust (appendix C). The researcher followed the ethical guidance of the British Psychological Society, (2009) throughout the study.

Informed Consent

Informed consent was attained by providing participants with information in advance of recruitment. Participants were invited to ask questions before agreeing to participate. A summary of the research, confidentiality and data usage were described to participants at the time of the interview. Participants signed a Consent Agreement Form (Appendix E) before participating.

Sampling

Theoretical sampling was employed in the study. This involved the recruitment of participants based on the concepts emerging from the initial interviews, to see if these concepts emerged across participant data (Urquhart, 2013). It became apparent that participants who had not attended rounds had a limited understanding of them. Therefore, recruitment efforts focused on those who had attended rounds. Once repetition of concepts was observed within the data, a more heterogeneous sample was sought. This allowed the applicability of existing concepts to be checked across a more varied sample of participants. This also provided the potential for new concepts to be developed through the lens of differing experience levels or professional training. Attempts were made also to incorporate the views of staff with diversities beyond their professional training. However, due to the homogeneity of attendees at rounds in the organisations approached in terms of gender and ethnicity, the extent to which a more diverse sample could be recruited was reduced.

Interviews

An initial interview schedule was developed with the aim of collecting information about:

- a) Participants' working context, role, perceived emotional impact of the work and how they manage it, perceived support
- b) Participants' experience of attending rounds, including their perception of how others view rounds

- c) Participants' intentions in relation to attending further rounds and the reasons behind these

Review of existing research with the aim of generating questions was avoided at the outset to ensure questions were appropriately open and unbiased, insofar as possible, by existing theory and research (Glaser, 1978). Interview questions were intentionally left broad to allow participants to speak about their experiences of rounds. More specific questions about their intentions to return to rounds were asked if this did not emerge. An interview schedule was used as a prompt (appendix F). The first participant was invited to comment on the questions and to suggest changes to the schedule; she did not suggest any.

Data collection

Initial data collection involved interviews with four rounds attendees and two non-attendees. Initial memos were written up after interviews (Urquhart, 2013). During transcribing, further theoretical memos were documented with a separate journaling of the researcher's views, thoughts and feelings in relation to the data. At this stage it was decided that the richness of data from those who had not attended rounds was limited and so data collection focused on attendees. One further interview was carried out with a non-attendee to ensure no further concepts arose.

Data analysis

Urquhart's process of data analysis was followed (2013). Data transcription and analysis coincided with data collection to incorporate initial codes and ideas in further interviews. Stages of coding were carried out in line with Glaser, (1978) as outlined in Table 3.

Table 3: Stages of GTM coding

Stage	Description
Open coding	Line-by-line coding of the initial six interviews was conducted to facilitate immersion in the data and to ensure that the researcher's assumptions did not restrict the extraction of codes and concepts at the early stage
Selective coding	As coding continued and initial core categories were developed, the researcher sought out further examples to support and develop these
Theoretical coding	Memos and categories were reviewed and a core category was established. Links between the core category and other prominent categories were developed. Diagrammatic representation of the emerging theory was drawn up. Theoretical memos were referred to throughout this process. *
Refining and substantiating	Subsequent interviews were carried out with the view to refining and substantiating the emerging theory with further data. Where there were gaps or weak categories in the theory, selective and theoretical coding continued until a satisfactory links were developed.

* See appendices G and H for a list of codes and a sample interview respectively.

** For sample diagrams and memos excerpt see appendix I and J respectively.

Discussions between the researcher and two supervisors were useful in enriching category development and theoretical linking of categories. Additional questions were added to the interview schedule following discussions which allowed for focused data collection in the areas of the theory needing clarification. A final interview was carried out to ensure the theory was sufficiently robust and new obvious new themes were emerging.

Theoretical Sufficiency

Theoretical sufficiency was the marker for ending data collection in this study. This refers to the point at which enough data offering sufficient depth of understanding has been collected to develop a theory (Dey, 1999). The idea of theoretical saturation, the collecting of data until new categories or codes do not emerge (Strauss & Corbin, 1998), was not used for

two reasons. The first, as Dey (1999) argues, one cannot know that no further categories will arise with continued data collection. The second, the limitations of time and resources meant that striving towards the idea of theoretical saturation was unrealistic. Constant comparison of new data to the codes, themes and theory generated during data analysis was used to determine theoretical sufficiency. Data collection ceased when the codes and categories generated were sufficiently rich, the theoretical links drawn could be substantiated by subsequent data and the theory accounted for the range of participants' described experience. Discussions in supervision helped to establish the point at which theoretical sufficiency was thought to have been reached.

Quality Assurance

Quality assurance measures were taken to minimise the inevitable influence of the researcher's views and experience on the data analysis. A colleague independent of the study conducted a bracketing interview with the researcher before data collection began. The researcher's views, hopes for the research, and previous experiences linked to the topic which could bias the coding process were identified (appendix K). A reflective diary was used to aid self-awareness throughout the research process (appendix L).

Participants were invited to comment on the initial results and proposed categories and theories. Two participants responded and their feedback was considered and incorporated in the write-up. One supervisor and a peer were involved in quality monitoring of the coding process, coding an excerpt independently before comparisons and discussions about differences between codes were carried out until agreement was reached. Additionally, both research supervisors were involved in discussion about the emerging theory and supported the researcher in staying close to the data.

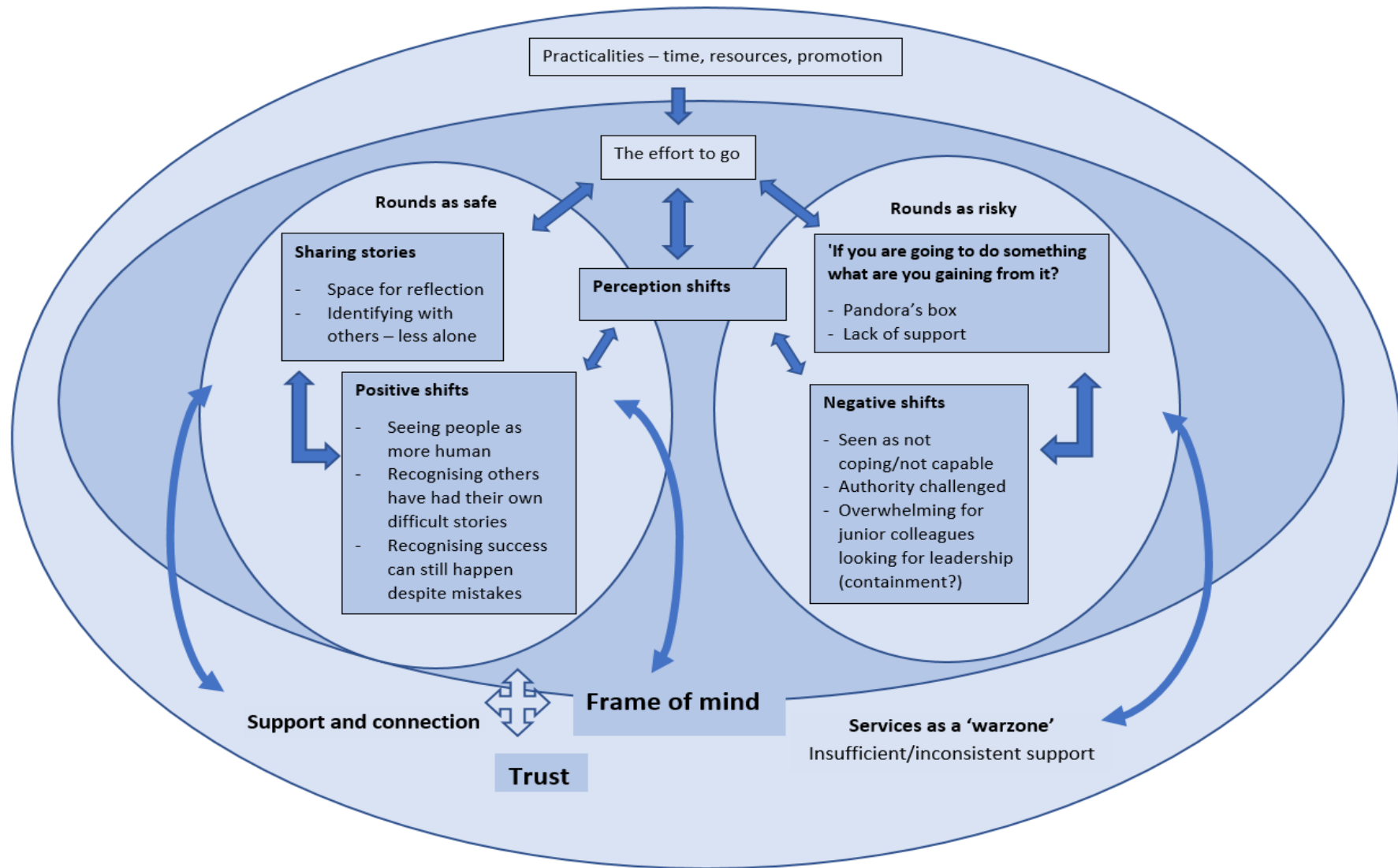


Figure 1: Diagram of theory explaining staff attendance

Results

Summary of the theory

Figure 1 depicts the theory of rounds attendance derived using GTM. A core category, 'effort to attend', acknowledges that it requires effort to overcome contextual practicalities of limited time and resources if staff wish to attend a round. While clinical activity is viewed as the priority, practicalities can be overcome for certain non-clinical activities such as training. This suggests that for staff to make the effort to attend rounds, or for managers to permit subordinates to attend, they must view rounds as valuable.

The proposed benefits of rounds are depicted on the left of the diagram. They include the sharing of stories, connecting with colleagues' emotional experience and the normalising of distress or difficulty. The model predicts that these components of rounds positively influence the way attendees see others e.g. 'everyone has a story'. The effect of the round can transfer to attendees' work life by influencing the way they feel towards and interact with each other. The active nature of rounds requires attendees to access a 'frame of mind' which allows them to 'really listen', connect with and apply the discussion to themselves.

The perceived benefits are affected by the degree to which rounds feel safe. When the sharing of stories is perceived as risky, like 'opening Pandora's box', attendees struggle to access the 'frame of mind' which may be necessary to benefit from the round. This is depicted on the right side of the diagram. A perceived risk is the potentially damaging impact of opening oneself to thinking about difficult experiences. The expression of vulnerability is viewed by some as incompatible with the role of a manager. It is thought to impact negatively on staff who need to see managers as coping and bearing the difficulties of the work. Lack of clarity about the purpose of rounds compounds doubt about their usefulness. The model predicts that without a clear sense of the aims the perceived risks of engaging with rounds outweigh potential benefits. This reduces the likelihood of staff making the effort to attend.

There was recognition of the supportive and humanising values rounds could foster. For some, while the round itself was a helpful experience, it was at odds with the reality of people's working lives. Participants spoke about the experience of rounds giving permission to be vulnerable and to feel, as incompatible with the '*warzone*' of the high-stress, overburdening, working environment. The model suggests that the deprivation of support for staff more broadly leads to a sense of rounds being a tokenistic gesture. Staff and management avoid truly connecting with what staff need as this would require action which, in the short-term at least, would impact priorities such as clinical activity. Broader neglect of staff needs impacts their ability to trust and utilise rounds. Conversely, staff who are supported and may therefore be managing better can shift into the 'frame of mind' which enables engagement with and benefit from rounds. This would increase the likelihood of them making the effort to attend and feeling supported to do so.

A more detailed description of the themes within the theory are described below, incorporating quotes from the data.

Practicalities

The practical reasons for not attending rounds predictably included issues of time, pressure and resources. Matrons described working across multiple teams and had a plethora of clinical and managerial responsibilities. Participants spoke about the priority of clinical activity in services. One participant spoke about how rounds may be perceived as something to be attended when the main tasks of the job have been completed; 'I don't see it as a luxury, but I can imagine to some people, it'd be seen as it's "you can eat your dessert if you eat your dinner" kinda thing', P2. Another participant talked about how others might be critical of her attendance at rounds; 'because you could get chastised later "oh where were you?" "I was at the Schwartz round", they would think "really?"' P1.

Participants spoke about the pressure on resources, including staff shortages. P1 spoke about how attendance at rounds by a member of the team could potentially deprive others of their break. P10 spoke about how difficult it was for qualified members of staff to attend due to commitments on the ward. This would make her feel 'scared' to ask if she could attend. She thought her manager 'might not like it' or may see her as trying to 'escape or sit on [her] bum'. Two others spoke about the lack of opportunity to look after even their physical health needs such as using the bathroom, having a drink and eating.

An issue raised in multiple interviews was around staff understanding of who rounds are for. A non-clinical participant spoke about rounds perhaps being more necessary for nurses and doctors;

'I don't know if any of them would be a topic I could go along to because when you think about what doctors and nurses have to go through and deal with, some of my complaints seem a bit trivial' (P8).

However, she recognised the impact of her emotions on patient care; 'I think sometimes if I am feeling like annoyed or stressed or something it can make me a little less sympathetic to patients'.

The effort to go

Participants spoke about the effort required to make time for rounds within their roles. One participant spoke about how the job will always be busy and there will always be a reason not to take part in new initiatives. She suggested staff do not seek to make time. 'I'm not actually aware that many of them go, often because of the clinical activity, but then I am not actually aware that anybody really makes the effort to go' (P5). Two subthemes were generated as part of this theme; 'sharing stories' and 'If you are going to do something what are you gaining from it?', which represent participants' views about what they did or did not value about rounds.

Sharing stories

Some participants spoke about what they perceived as the inherent value in the sharing of stories for both the person sharing and for those listening;

'For the person that's sharing it's some sort of offloading and the people receiving the information to feel actually that is a similar situation. I'm not on my own and there is that support' P1.

The helpfulness of talking about difficult experiences or feelings was described by participants as 'therapeutic', 'beneficial', 'valuable' and 'powerful'. 'It must help people to bring out emotions rather than sort of have them kept inside' (P6). P5 felt speaking about mistakes could help staff to deal with them.

Participants discussed the benefit to the audience of identifying with speakers who have had similar experiences. P10 described rounds as helping her to 'ease her stress of being stressed' as she heard more senior colleagues talk about finding things difficult; 'when I have been there and they are talking about death or some hardship they have come across, it's not just me finding it difficult with this particular thing, it is difficult and that is why I felt it' P10. P5 suggested the sharing at rounds helps to promote a broader culture of openness and honesty; 'it is very much a brush it under the carpet culture and only when people start speaking out do others follow and I think it is an excellent platform for that to occur on'. P6 felt rounds caused her to think about the experience of others more often, 'perhaps you look at people and think everybody has a story to tell or burden or some sad things they have been through'. P11 experienced connections developing in rounds that transfer beyond them; 'people noticing and acknowledging each other in a kind of personal way really which makes you feel a bit more at home and at ease in your day-to-day work'.

'If you are going to do something what are you gaining from it?'

This theme is represented by the words of a participant who spoke about how she could not see the proposed benefits of rounds. It illustrates some participants' wish for rounds to provide a clear and certain outcome which is attainable for attendees. The following quote from P7 was suggestive of frustration over a perceived lack of purpose in sharing stories and expressing emotion;

'It was uncomfortable to see managers crying on a stage and talking about their experience when I think there was no learning out of that other than what they had experienced...I can understand the concept behind the Schwartz rounds and why maybe people would want to do something along those lines but I think it is poorly thought through'.

She felt it would be more helpful for the rounds to include a discussion of what could have been done differently or acknowledging that nothing else could have been done. This seemed to suggest a preference for resolving difficult experiences rather than sitting with them. Another participant who had attended three times and had found rounds difficult to engage with due to concern for the panellists talked about not making rounds a priority without a clear understanding of their purpose;

'What benefit does it give? What is it supposed to do? ...I am still left with that question and until I get the answer for it and for me to understand its working then I certainly wouldn't put it as a priority' P3.

One participant who valued the space rounds offered in providing support to staff talked about how providing clarity would help the space to feel safer. She spoke about the need for staff to know why they are attending to help them to engage. This will be discussed further in the theme '*Frame of Mind*'.

Rounds as risky

Seven of the eight participants who attended rounds spoke, to varying degrees about the potential risks associated with being open and honest in rounds. Two participants used the idiom of opening Pandora's box to describe the unknown outcome of speaking in rounds. This will make up one subtheme. The other subtheme 'lack of support' was generated to represent concerns for those who attend and participate at rounds.

Pandora's box

Two participants spoke about rounds having the potential to 'open Pandora's box'; one when talking about the potential consequences to the individual;

'I think when you are inviting someone to sit up on stage and recall what tends to be a quite a traumatic event because that's why they have remembered that event you are potentially opening a Pandora's box and you don't know how the person will react once that Pandora box is open' (P7).

The other used it in relation to the potential dynamics which may occur between staff in a round if people connect with their emotions

'Obviously you have to be professional but your emotions are what they are and I think that's why so many staff don't go there with their own emotions, because it is just like a Pandora's box of difficult things that are going to come out' (P9).

Other participants suggested talking about things which were very painful could lead panellists to have ongoing difficulties. Participants described managing difficult or painful experiences in several related ways including, 'burying' them, 'putting lids' on them and having them in a 'little box' in one's head. Additionally, people discussed what might happen to attendees if they did speak about these experiences, including things 'going downhill' for a person, something 'kindling' which 'could be sparked off', people having to 'relive' their experience.

Lack of support

Two participants spoke at length about spending the rounds focused on the needs of those speaking and wondering about how they would be supported afterwards. They spoke about not fully knowing about the process of rounds or the support participants would get but there was an assumption this would not be adequate; 'they need to put in the appropriate resources to support these people rather than do you fancy getting up on stage and having a chat about that?' P7. P3 spoke about her colleague's experience after sharing as a panellist at rounds; 'She said to me she felt embarrassed and that people thought she was stupid because of what she actually did.' This understandably influenced her view of the impact of rounds on panellists.

P7 also spoke about concern for audience members. She talked about television programs with potentially impactful themes offering support information to viewers. She felt this was missing from rounds and worried about the effect on members of the audience. A participant who had presented at rounds as a panellist worried about the impact of what she said on the audience. 'I didn't want to scare people because these people could be the future, could be going to future coroners but of course it is about giving some honesty' (P6).

Perception shifts

Three participants spoke about the positive impact of seeing someone differently following their participation in a round. They talked about how they had previously viewed panellists as not being impacted by the work;

'There is a disconnect I think with managers who tend to be non-clinical... they don't get it from a patient or clinical point of view so actually I don't want to use the word nice, it's not nice to see anybody cry, but I think it's reassuring that there is a human there sometimes, with humanity' P7.

P10 described feeling moved by attendees' engagement with a round; 'I could see that they are not just doing this as a job almost it was something that they really care about'. P6 described the sharing at rounds as challenging assumptions about what one must 'be' to reach senior positions in the organisation while P9 thought it was helpful to hear senior management talk about mistakes which had not prevented them from having successful careers.

Participants also spoke about the potential for vulnerability at a round to have a negative impact. Some thought it would not be good for a manager to be upset publicly. Four participants talked about how this might feel unhelpful for more junior staff. P5, a proponent of rounds spoke about being cautious about what she shares;

'I would perhaps be a bit more selective over what I said because yes if you have people who are technically looking up to you, are they going to continue looking up to you if you have just made some huge confession...that could be perceived that you can't do your job properly or you can't cope or whatever?'

P1 spoke about turning down the opportunity to be a panellist saying; 'if I open up my soul I will just be crying and because I'm a matron they can't see me like that'. She felt it would be 'negative for the audience' and it would be 'unprofessional' to talk about feeling unsupported or the impact of 'awful' treatment from other professionals.

P9 spoke about how seeing a manager talking about the emotional impact of the work could negatively impact colleagues who are feeling very stressed in their roles; 'especially if its people like your boss is sharing and 'you're supposed to be the leader in this' and now I am feeling completely overwhelmed'. P7 spoke about how showing vulnerability clashed with the roles of senior staff;

'To walk out of that room and then maybe go and chair a meeting it's an oxymoron the whole thing. To say, "right ok, you have broken down and everyone has

given you a pat on the back but now you go and be a manager and be in charge" you know.'

Frame of mind

This theme is represented by the words of a participant who spoke about the need for attendees at rounds to be in a place mentally where they can think and reflect. She spoke about how a high-pressure role can impinge on one's ability to use rounds as intended.

'They are going from one safe-guarding problem or risk issue to the next, to kind of just drop everything and then go into a meeting and share things I think it is just incompatible because I don't think you can really access how you feel if you are really kind of stressed and tired and you know really upset about all these other things that people are trying to deal with'. P9

This theme links in with themes above outlining what can be gained from rounds versus the risks of being vulnerable. P9 spoke about her ability to manage her day so she could go to rounds after a quiet morning which she recognised as a relative luxury compared to some professionals.

Other participants talked about the effort to be present emotionally. One participant described rounds as an active process which facilitates reflection and an onus on the audience to engage;

'It's not a stage show, you are witness to somebody being very open and honest and if it is done in the right way it actually causes the audience to sit and think not just about what these people are telling you...but to think about the situations that you have been in that are similar and how they may have influenced your practice' (P5).

This contrasts with two participants who talked about 'watching' others in distress one of whom described it as 'voyeuristic'. One proponent of rounds described questioning why she

had attended while listening to the experience of panellists 'the midwifery one was very difficult to hear and part of me thought 'actually why am I here this is really, really hard' (P6). She found this difficult to relate to as other audience members seemed to; 'suddenly it is hard, thinking, well how do you actually interact with this apart from people then start to ask questions, so why did this happen? So, it probably became more of asking questions'. This could suggest that the emotional temperature of the presentation may impact the audience's ability to think and make connections with their own experience and may move them towards a more familiar, 'fact-finding' response and away from the emotional experience. Another participant spoke about witnessing the struggle others had with being open;

‘The person next to me said she doesn’t know how I do my job as a psychologist because she doesn’t like opening up or bringing herself to work. She would much rather stay professional and it’s really hard to be emotional and she struggled to open up’.

P11.

Resistance to emotionally connecting and letting go of ‘this silly idea of keeping it professional’ (P11), is a challenge for rounds and may influence staff’s motivation to attend.

Lack of support in a ‘warzone’

One participant described the day-to-day within services as a ‘warzone’. She viewed rounds as a step towards staff being able to bring their emotions to their work, which she saw as important. However, she described rounds as reminding her of how difficult it is for people to talk about their feelings, suggesting that without a wider structure of support for staff to do this regularly, the vulnerability and openness promoted by rounds were incompatible with what people were expected to cope with in their roles.

‘It's a minefield in the sense that if you really start to think about the support staff need in order to emotionally cope with their jobs and if you are acknowledging

that they need that emotional support then I think that you have to acknowledge that it's not ok to give them 35 cases for a care co-ordinator...' P11.

Most participants described feeling unsupported beyond their direct team and managers, with a sense that no-one has power to change things. P4 spoke about how frontline staff must 'learn to manage' feelings which arise when they cannot provide the care they want to and patients inevitably complain, something which managerial staff contend with less. Some staff spoke about the importance of receiving recognition for the work they do within the organisation; 'that's all it takes 'I really appreciate your hard work over the last week - that was phenomenal work and I understand how difficult it is'. It's all it takes and that's all I want' P2. One participant spoke about the lack of pay increases for NHS staff while others spoke about services getting 'cheap' staff who work beyond their band.

In the absence of appropriate support from the organisation, participants spoke about having to take care of their own needs. For one this involved leaving the NHS, another spoke about considering private work for the first time and another spoke about how the role he was in could not be maintained in the long-term. Participants witnessed stress and burnout in colleagues and senior staff described helping others to access support; 'virtually every single person I managed I had to do a stress assessment for' (P1). P7 spoke about the impact of the target culture: 'I do believe the NHS by making the target more and more unachievable and pushing patients in and out they are losing that humanity'.

Many participants spoke about 'get[ting] on with it' in spite of a lack of resources and a sense that their needs and the needs of patients were not appropriately met; 'you have to pretend that everything is ok', P1. Participants spoke about ways they manage the challenges of their work for themselves and their patients which may suggest disconnecting emotionally. These included encouraging a positive and happy atmosphere: 'we are generally quite a bubbly

team or positive team and smiling which I think makes a good atmosphere to come in to for a member of the public and that is probably me and we are always positive' P4.

One participant spoke about how staff spend much of their time making the patients and the environment look pleasing;

'if we can make them look neat, I guess it gives us a semblance of ultimate control. Like realistically we can't really, like if the patient's going to pass away they're going to pass away, there's nothing we can do about it but, like if they're stable and there's not much for us to do we can make them look nice so, (laughs) you know, I think that's it, I never really thought of it' P2.

He described how his role in ICU can often be exciting and adrenaline fuelled or mundane, 'like robots'. He gave vivid descriptions of the 'sinking' feelings that occur at times when he connects with the reality of his work and following major incidents said he would 'just want to crawl into the corner and just sleep' if similar incidents were to occur again.

The powerful descriptions of staff's experience highlight why support to cope is needed but also why accessing that support and connecting more fully with the impact of their work may feel frightening and painful.

Discussion

This study sought to develop a theory to explain attendance at Schwartz Rounds, a staff support intervention. It aimed to draw out the individual, social and contextual factors which influence staff attendance and engagement with rounds through exploring participants' experience. Themes were developed representing the positive experiences of participants which encourage them to attend, the contextual or social factors which make attendance more difficult and the aspects of rounds themselves which reduce staff's desire to attend. The

interplay between the values promoted by rounds, the culture, priorities and support within the organisation more broadly and participants' desire to attend and engage was incorporated also.

Contextual barriers such as time and resources described by participants were noted in previous studies (Farr & Barker, 2017; Lown & Manning, 2010). These barriers to attendance were discussed by most participants but few felt rounds were an individual or organisational priority. The model developed therefore suggests that for an individual to be willing to make the effort to attend rounds, they must view rounds as beneficial. The perceived benefits of rounds were in line with those described in previous research including the sharing of stories, emotional connection, normalisation of difficult experiences and positive shifts in perception (Deppoliti et al., 2015; Lown & Manning, 2010; Maben et al, 2017). Social barriers such as the perception that rounds are a luxury or others may view attendees as trying to get out of work, were not described in previous research but this study found that they too need to be overcome.

Negative views of rounds including questioning of the purpose of sharing difficult experiences were touched on in previous studies including Maben et al., (2017) and Reed et al., (2015). The current study expanded on these findings as they may influence motivation to attend rounds. One half of the model was drawn from participant views that disclosure of difficult emotions is risky and could lead to negative consequences for the individual's well-being particularly in their ability to manage feelings which may arise through speaking at rounds, the well-being of the audience and unhelpful changes in perceptions including perceiving managers as unable to cope or do their job. These were in line with Hartley and Kennard (2009) who suggest that staff may avoid disclosing emotional difficulties if they risk feeling overwhelmed by their emotions or being invalidated by others. Several participants raised concern about the negative impact of managers expressing emotion. This contrasts previous research which suggests it may be helpful for managers to model vulnerability (Goodrich, 2012). A need for staff to feel contained by managers was described by participants

in this research. This may suggest that for staff to bear the expression of vulnerability they must feel adequately supported themselves.

Participants' concerns were compounded by a lack of understanding of the purpose of rounds, including some who attended multiple times. Some participants felt that without a measurable learning outcome, there was no point disclosing painful things and they would not prioritise rounds within their roles. In line with Hartley and Kennard (2009), some participants appeared to view the stressors and emotional challenges of their work as so commonplace and fixed that they did not see the purpose of talking about them. Some participants did not value the opportunity to talk about difficulties in general which is significant because it challenges the idea that if the barriers to talking, such as feeling unsafe, are removed that staff will want to use this form of support. This fits with Littlewood's (1990) critique of the perspective that talking through difficulties is universally helpful or experienced as such.

Some participant descriptions of processes and procedures within teams provided insight into potential coping strategies employed at a social level. These include routinized and robotic procedures engaged in by staff without their full understanding of why they are doing so. An example of this was a striving for neatness in an ICU department. One participant gave a vivid description of the lasting image and impact created by an emergency which served to remind him of their lack of control over death. This could be akin to social defences described by Menzies-Lyth (1960). Focusing on retaining neatness in this case, was suggested by the participant to give a 'semblance of ultimate control' (P2).

Similarly, a team manager described promoting a positive atmosphere for the patient despite pressure to meet targets and manage delays and complaints. This description could fit with that of Hinshelwood and Skogstad (2000) who describe friendliness as over-riding other feelings. In this case, an 'always smiling' staff, creating a 'good atmosphere' (P4) may prevent

staff and patients from complaining about resources and delays. These potentially unconscious strategies may suggest staff are avoiding connecting with difficult feelings of fear and anger. Neither of these participants had attended rounds.

Participants described the need to *'get on and just do what they have to do'* (P11), with many staff members describing working beyond their band, with little support or recognition from senior staff beyond their direct manager. This reflects responses in the staff survey (NHS SCC, 2018) which suggested two-thirds of staff felt senior management did not communicate effectively with them and less than half of staff felt the organisation appreciated their work. As described by Hartley and Kennard (2009) poor responsiveness from management may lead staff to resist asking for support. Some staff described concern that participants at rounds would not be offered adequate support following disclosures of a distressing nature suggesting a mistrust of the round.

Deppoliti et al.'s (2015) participants viewed rounds as demonstrating the importance of staff's feelings; representing an acknowledgement of the need to support staff. However, for some participants in this study, rounds were experienced as a tokenistic gesture of supporting staff. Without broader structures of support, including alleviation of demands on staff, rounds were thought to be incompatible with the culture of the organisation. The expectation that staff could shift from a 'doing' mode, wherein they are managing high volumes of work with little time to think, to a 'feeling' mode where they open themselves up to the emotional experience of the work seemed unrealistic to some participants. This may reflect the emotional demand required to engage with rounds.

This contrasts with the views of rounds organisers in Chadwick et al.'s, (2016) study. They suggest offering support outside of rounds may imply that strong emotions are misplaced. It may be the case that staff do not require support to manage feelings outside of rounds if they

are adequately supported in their roles; this was not the experience of most participants in this study. This links to the work of Traynor (2017) who highlighted the distinction between providing staff support for challenges inherent in healthcare and the need for staff to resist supports aimed at helping them to withstand unacceptable conditions.

Limitations

The study attempted to incorporate the experience of a range of staff, however, those who agreed to take part in the study were a relatively homogenous group compared to the NHS workforce. Those who participated were of a similar profession, gender and ethnicity. While qualitative research does not aim to be generalizable via a representative sample, the themes and model could have been strengthened by incorporating the views of a broader range of staff. A challenge during the recruitment, as outlined in the methodology, was that without sufficient experience of rounds through attendance, insight into reasons for non-attendance was limited. As rounds were largely attended by nursing staff and the majority of nurses were female this may go some way to explaining the homogeneity of the sample. A more diverse sample may have deferred the point at which theoretical sufficiency was deemed to be met.

The author's previous experience of working within NHS teams where staff support interventions were offered meant she had certain ideas about staff motivation to attend. Efforts were made to minimise the influence of researcher bias, through quality assurance measures such as a reflective diary and member-checking of results. As with all qualitative research however, the data in this study may have been interpreted in alternative ways. Triangulation of findings with other sources of data could have helped to address this limitation. This could have included incorporation of feedback surveys collected at rounds held at participants' organisations.

Implications

The research highlights implications for organisations, managers and rounds organisers. For those participants who found rounds helpful, practical barriers such as time, resources and, for junior staff, the need to seek permission were obstacles to attendance. Organisations and managers can seek to address these by promoting staff well-being as a priority rather than a luxury; modelling this to junior staff by inviting them to attend rounds.

Attendees described a lack of clarity regarding the purpose of rounds. While the benefits of rounds may become clear over time, staff are not likely to repeatedly prioritise them without a clear understanding of their purpose. Clear promotion and introduction of rounds may help to address this. Similarly, concerns about the psychological safety of attendees could be addressed through explanation of the format and process of supporting speakers and highlighting support for staff. While additional support may not be required in emotionally supportive teams and environments, according to participants in this study, offering support outside of rounds was deemed necessary as working environments were not perceived as focused on staff well-being.

Organisationally and within teams, greater efforts to provide practical support to staff in relation to their workloads is important for rounds, as an emotional support, to be successful. If vulnerability in rounds is experienced as too different from the culture of the team or organisation, it feels incompatible with attendees' experience of their work life. This reduces their ability to engage with rounds, should they wish to do so. Organisations, managers and those in positions of power should resist and advocate on behalf of staff to ensure rounds do not become an intervention to support staff to manage unacceptable conditions rather than supporting the processing of the emotional challenges inherent in healthcare.

Future research

Future research could investigate the impact of contextual factors, such as team and management support, workload and additional spaces for reflection, on the perceived usefulness of rounds and attendees' ability to connect emotionally with the content. It may be that staff who feel more supported generally are better able to engage with the emotional nature of rounds and perceive them as beneficial. The study highlighted the potential on-going relevance of Menzies-Lyth's work on social defences against anxiety, suggesting they may still play a role in the modern NHS. Future research could look at organisational management of anxiety and stress, ways of enhancing containment and the roles rounds may or may not have in this process. Research could also focus on understanding the needs of staff who do not view talking about difficulties as helpful.

Conclusions

This study aimed to develop a theoretical understanding of staff motivation to attend rounds based on the experiences of healthcare staff. The findings suggest that for staff to make the effort to attend rounds they must view them as useful. Staff find them useful when they are felt to be safe and providing an opportunity to reflect through sharing stories. Staff do not prioritise rounds when they do not understand their purpose, particularly if they view the sharing of difficult experiences as risky. Rounds were viewed as helpful when they were perceived to enhance connection with colleagues. They were viewed as less helpful when they were experienced as too different from the general culture of the organisation. There was some indication that organisational defences akin to those identified by Menzies-Lyth in the 1960s, coupled with the rising demands on staff through the target-orientated culture, cause staff to resist connecting with the emotional nature of their work suggesting the need for psychological understandings to be drawn upon in the implementation of initiatives like rounds. Staff need to be in the 'frame of mind' and suitably supported in their roles for attendance and engagement

with rounds to be experienced as worthwhile. This study appears to be the first to highlight the potential mismatch between rounds and cultures into which they are sometimes deposited. If not addressed, this mismatch may ultimately sabotage the organisational attempt to offer this support. Implications and areas for future research were discussed.

References

- British Psychological Society. (2009). *Code of ethics and conduct*. Retrieved from <https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct>
- Chadwick, R. J., Muncer, S. J., Hannon, B. C., Goodrich, J., & Cornwell, J. (2016). Support for compassionate care: Quantitative and qualitative evaluation of Schwartz Center Rounds in an acute general hospital. *JRSM Open*, 7, 1–8. <https://doi.org/10.1177/2054270416648043>
- Collier, A. (1994). *Critical realism: An introduction to Roy Bhaskar's philosophy*. New York: Verso.
- Department of Health. (2015). *The NHS Constitution – the NHS belongs to us all*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf
- Deppoliti, D., Cote-Arsenault, D., Myers, G., Barry, J., Randolph, C., & Tanner, B. (2015). Evaluating Schwartz Center Rounds® in an urban hospital center. *Journal of Health Organisation and Management*, 29, 973–987. <https://doi.org/10.1108/JHOM-09-2013-0189>
- Devlin, J. W., Fong, J. J., Howard, E. P., Skrobik, Y., Mccoy, N., & Marshall, J. (2008). Promoting staff resilience in the pediatric intensive care unit. *Critical Care Medicine*, 15, 555–565. <https://doi.org/10.4037/ajcc2011243>
- Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. California: Academic Press.
- Farr, M., & Barker, R. (2017). Can staff be supported to deliver compassionate care through implementing Schwartz Rounds in community and mental health services? *Qualitative Health Research*, 27, 1652–1663. <https://doi.org/10.1177/1049732317702101>
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary*. London. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf
- George, M. S. (2016). Stress in NHS staff triggers defensive inward-focussing and an associated loss of connection with colleagues: this is reversed by Schwartz Rounds. *Journal of Compassionate Health Care*, 3, 9. <https://doi.org/10.1186/s40639-016-0025-8>
- Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: The Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for qualitative research*. Chigaco: Aldine.
- Goodrich, J. (2012). Supporting hospital staff to provide compassionate care: do Schwartz Center Rounds work in English hospitals? *Journal of the Royal Society of Medicine*,

105, 117–22. <https://doi.org/10.1258/jrsm.2011.110183>

Hartley, P., & Kennard, D. (2009). *Staff Support Groups in the Helping Professions: Principles, Practice, and Pitfalls*. London and New York: Routledge.

Hinshelwood, R. D., & Skogstad, W. (Eds.). (2000). *Observing Organisations: Anxiety, defence and culture in health care*. New York: Routledge.

Littlewood, R. (1990). How Universal is Something we can call “Therapy”? Some Implications of Non-Western Healing Systems for Intercultural Work. *Holistic Medicine*, 5, 49–65.

Lown, B. a, & Manning, C. F. (2010). The Schwartz Center Rounds: evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine : Journal of the Association of American Medical Colleges*, 85, 1073–1081. <https://doi.org/10.1097/ACM.0b013e3181dbf741>

Maben, J., Taylor, C., Dawson, J., Leamy, M., McCarthy, I., Reynolds, E., ... Foot, C. (2017). A realist informed mixed methods evaluation of Schwartz Center Rounds® in England. Retrieved from <https://njl-admin.nihr.ac.uk/document/download/2011408>

Menzies Lyth, I. (1960). Social systems as a defense against anxiety. *Human Relations*, 13, 95–121. Retrieved from <http://moderntimesworkplace.com/archives/ericssess/sessvol1/Lythp439.opd.pdf>

NHS Survey Co-ordination Centre (2018). *NHS Staff Survey 2017*. Retrieved from http://www.nhsstaffsurveys.com/Caches/Files/P3088_ST17_National_briefing_v5.0.pdf

O’Connell, B. (2005). *Solution-focused therapy*. London: Sage Publications.

Reed, E., Cullen, A., Gannon, C., Knight, A., & Todd, J. (2015). Use of Schwartz Centre Rounds in a UK hospice: Findings from a longitudinal evaluation. *Journal of Interprofessional Care*, 29, 365–366. <https://doi.org/10.3109/13561820.2014.983594>

Robert, G., Philippou, J., Leamy, M., Reynolds, E., Ross, S., Bennett, L., ... Maben, J. (2017). Exploring the adoption of Schwartz Center Rounds as an organisational innovation to improve staff well-being in England, 2009-2015. *BMJ Open*, 7, 1-10. <https://doi.org/10.1136/bmjopen-2016-014326>

Seligman, M. (1998). *Learned Optimism*. New York: Pocket Books.

Strauss, A. L., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. London: Sage.

Traynor, M. (2017). *Critical Resilience for Nurses: An evidence-based guide to survival and change in the modern NHS*. London: Routledge.

Urquhart, C. (2013). *Grounded theory for qualitative research: A practical guide*. London: Sage Publications.

Appendices

Appendix A – Canterbury Christ Church University Ethics Approval

This text has been removed from the electronic copy

Appendix B – Health Research Authority Approval

This text has been removed from the electronic copy

Appendix C – Research and Development approval

This text has been removed from the electronic copy

Appendix D – Participant information sheet

Faculty of Social and Applied Sciences Clinical Psychology Doctoral Programme
 Canterbury Christ Church University
 Tunbridge Wells Campus

Information about the research

Research title: Factors influencing emotional self-care and reflection: perspectives of attendees and non-attendees of Schwartz Rounds

My name is Marguerite Gallagher and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide, it is important that you understand why the research is being done and what it would involve for you.

(Part 1 tells you the purpose of this study and what will happen if you take part. Part 2 gives you more detailed information about the conduct of the study).

What is the purpose of the study?

Schwartz Rounds (SR) provide a structured forum where staff of all levels and professions can meet to talk and reflect about the aspects of their jobs which impact them at an emotional level. They have been introduced in over 100 trusts in the UK. The aim of this study is to consider what motivates staff to attend or not attend SR. It is important to consider this because this forum is offered for the benefit of staff and can only be useful if they find attending worthwhile and are able to attend.

Why have I been invited?

You were asked to participate in this study because SRs are provided by your trust. If you attend SR we would like to know what influences your decision to go. Similarly, we would like to know why you choose not to attend or what gets in the way of attending.

Do I have to take part?

It is entirely up to you to decide to take part in this study. If you agree to, I will ask you to sign a consent form. You are free to withdraw at any time without giving a reason.

What will happen to me if I take part?

If you decide to take part in the study:

- you will be asked to participate in an interview with me
- the interview will be audio recorded
- The discussion will last up to 60 minutes

Further participation

- you may be invited to participate at a different point in the study; this would involve being invited to have an additional interview or to attend a focus group with other staff members participating in the research. Further participation will be voluntary.

Expenses and Remuneration

Travel expenses up to £10 will be paid, should you need to travel to participate in the study. A £10 Love-to-shop voucher will also be given in recognition of your time.

What will I be asked to do?

- I will ask you to sign a form consenting to participation in the research
- I will ask you to participate in an interview for up to 60 minutes. This will involve a discussion about the emotional nature of the work you do, any ways in which you take care of your emotional well-being and how you decide to attend or not attend SRs.

- You may be invited to participate in a further component of the study. This would involve a further interview or focus group. We would talk about what motivates attendance or non-attendance in more detail. You can decide if you would like to be asked to participate further by indicating this on the consent form
- I will ask you to agree to maintain the confidentiality of yourself and others surrounding the conversations in the focus group
- Should you wish to participate in this part of the research but not in further parts you can indicate this on your consent form

What are the possible disadvantages and risks of taking part

- We will be discussing what encourages staff to attend or not attend SR. This will include discussion around the emotional impact of the work you do and how you manage it. Some people may find this emotive.

What are the possible benefits of taking part?

- Participation may increase awareness of motivators and influences at work
- Participants will be contributing to research into the implementation of SR in the NHS
- Participants will be contributing to research which may inform policy makers about staff experience of the emotional and social components of their work

What if there is a problem?

Any complaints or issues about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes part 1.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 of the information sheet**What will happen if I don't want to carry on with the study?**

If you choose to withdraw your participation in the research at any point, we would like to still use the data we have collected up to that point. Should you decide that you do not want your contribution to be used as data, it will not be included in study. If it is part of an interview, your recording will be deleted. However, if your participation is recorded as part of a focus group (if you agree to further participation), it will remain a part of the audio recordings but will not be used in the research. It will be kept and stored as outlined in the confidentiality information in this section.

What if there is a problem?

If you have a concern about any aspect of the study, you should ask to speak to me in the first instance, and I will do my best to address the issue to your satisfaction. My contact information is provided at the end of this sheet. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Paul Camic, Research Director (contact information provided at the end of this sheet).

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. The following information outlines how data will be managed over the course of the study.

Data collection

- Interviews or focus groups will be audio recorded
- All participants will be asked to sign the consent form prior to engaging in the study
- If you agree to take part in an additional component of the research and take part in a focus groups you will be asked to agree to keep the discussion and information of other participants confidential and to agree to this on your consent form

Data storage

- audio recording will be encrypted and stored electronically on password protected computers
- conversations will be transcribed and data will be anonymised
- in line with university regulations, following the completion of the study data will be stored on a disc in a locked cabinet at Salomon's Centre and by me the researcher for 5 years after the completion of the study
- the data will then be destroyed
- direct quotes from the audio may be used in the write-up in an anonymised form
- should you wish to withdraw from participating during or after an interview, I will ask you if you would like me to delete the recording and will do so upon your request
- should you wish to withdraw from participating during or after the focus group your input in the discussion may not be used however it will remain part of the audio and will be kept and stored as outlined above

What will happen to the results of the research study?

The results of the study will be made available to participants after its completion. The study will be submitted for publication. Participants' personal information will not be included in the dissemination of the results. Anonymised quotes from interviews or focus groups may be used in disseminated and published research.

Who is organising and funding the research?

The research will be organised and funded by Canterbury Christ Church University.

Who has reviewed the study?

All research with staff in the NHS is looked at by independent group of people, called the Health Research Authority, to protect your interests. In addition this study has been reviewed by the Salomons' Ethics Panel of Canterbury Christ Church University and given favourable opinion.

Further information and contact details

You will be given a copy of this information sheet as well as a copy of the consent form. You may wish to take some time to think about or talk through participating in this research. If you would like more information please use the resources below.

Specific information about this research project

- More information about SR may be found at: <https://www.pointofcarefoundation.org.uk/>

- If you would like to speak to me and find out more about the study or ask any questions about it, you can leave a message for me on a 24-hour voicemail phone line at 01227 92 7070. Please say that the message is for me, Marguerite Gallagher, and leave a contact number so that I can get back to you.

Who to approach if you are unhappy with the study

- If you are unhappy with this study you may wish to contact Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology, Canterbury Christ Church University, One Meadow Road, Tunbridge Wells, Kent TN1 2YG. Telephone: 01227 92 114

Appendix E – Consent Agreement Form

Faculty of Social and Applied Sciences
Clinical Psychology Doctoral Programme
Canterbury Christ Church University
Tunbridge Wells Campus

Centre Number: ~~Salmons~~ CCCU
Study Number: 220693
Participant Identification Number for this study: P11

CONSENT AGREEMENT FORM

Title of Project: Factors influencing emotional self-care and reflection: perspectives of attendees and non-attendees of Schwartz Rounds

Name of Researcher: Marguerite Gallagher

Please initial box



1. I confirm that I have read and understand the information sheet dated 31/08/17 (version 7) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected.

3. I agree to being audio-recorded for the duration of my interview.

4. I agree to be contacted to participate in further components of this research study

5. I agree that anonymous quotes from my interview may be used in published reports of the study findings

6. I agree to take part in the above study.

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

This consent agreement form will be kept and stored in line with the data storage outlined in the participant information sheet. A copy may be kept by you for your records.

Appendix F – Interview Schedule

Interview schedule – version 3 (29/09/16)

Staff perceptions of the emotional component of their work

- Tell me what it's like working here
- What are some of the highs and lows of a day?
- Can you say a bit more about any emotional/difficult aspects of your work?
- How do you think other people in your team view that aspect of the work?
- How do you think managers and the organisation view it?

Staff perceptions of helpful ways of managing the emotional component of their work

- You've mentioned some things that can be emotional/difficult/distressing (will use their own words if possible). What do you do with how it leaves you feeling?
- Do you have some ways of coping with it that work for you? Tell me more about that...
- What do you think other people in your team do?
- What opportunities or support are provided by your managers or the organisation in addressing some of these emotional/difficult parts of the work?

What factors influence staff to attend SCR?

- What makes you/some staff see SCR as valuable?
- What do SCR provide that other forums e.g. supervision, do not?
- Have you observed anything happening after SCR that may encourage/discourage you to return/go?
- What enables staff to prioritise SCR?

What factors influence staff to not attend SCR?

- What might stop/has stopped you/other people from attending SCR?
- What, if any, alternative sources of support do staff utilise?
- What might prevent you/staff from prioritising SCR?
- How might this be addressed?

Impact of attendance or non-attendance by colleagues and managers

- How do other members of the team perceive SCR, as far as you are aware?
- How do the ward manager and/or team leaders perceive SCR?

- How, if at all, do their views influence your decision to attend or not attend SCR?

- Is there anything else that makes people more or less likely to attend?

Would you recommend SRs to other people?

What would you tell them about what it is and what it is for?

What would you tell them you like about it

What would you say you don't like about it?

How do you think those things influence your decision to go back?

What have you heard others say about it

How useful is it?

Appendix G – List of sample codes

Code name	Samples quotes
stress and impact	<p data-bbox="603 349 1107 383">‘so everyone was really really stressed’</p> <p data-bbox="603 416 922 450">‘they were off for stress’</p> <p data-bbox="603 483 804 517">‘she cried a lot’</p> <p data-bbox="603 551 1385 707">‘I do think my job in the NHS and the lack of abilities for things moving forward and just the general feeling of apathy and lack of ability to do your job properly definitely impacts on my mental health and my life at home’</p> <p data-bbox="603 741 1342 819">‘When I’m really upset or burdened the staff can identify that because I’m not as talkative because I’m holding.’</p> <p data-bbox="603 853 1347 976">‘if there was somebody really burning out or stressed and wasting time but I suppose we are all really stressing at some stage or another’</p> <p data-bbox="603 1010 1342 1088">‘There are a lot of pressures in theatre and sometimes the pressures they have got no vent’</p>
Resources	<p data-bbox="603 1126 922 1160">‘there would be no beds’</p> <p data-bbox="603 1193 1002 1227">‘the resources just aren’t there’</p> <p data-bbox="603 1261 1315 1339">‘it really became every year it got worse and worse the resources got worse my workload just exploded.’</p> <p data-bbox="603 1373 1385 1473">‘you are still expected to do the same volume of work regardless of the patient really but I suppose that’s the same across the NHS really.’</p>
positives of the job	<p data-bbox="603 1485 1251 1518">‘the best parts are probably the patient interaction’</p> <p data-bbox="603 1552 1342 1630">‘sort of see their progress so from being quite ill to going home’</p> <p data-bbox="603 1664 1043 1697">‘it’s nice to learn something new.’</p> <p data-bbox="603 1731 1369 1854">‘highs would be probably be things like working to time because in clinical work you have to work to time so that’s satisfying’</p> <p data-bbox="603 1888 1362 1966">‘I find I love the patient care, absolutely love it and I think any nurse you speak to would say the same’</p>

	<p>‘you can actually make a huge difference to somebody's life.’</p> <p>‘when it is all going well as it should do and you have done your job well’</p>
Focus on the practical	<p>so rather than me doing all the problem solving it's putting it out there how would you solve this problem</p> <p>‘how are we going to resolve this? Do I need to go back to pharmacy again, meet with them again and understand there processes a bit more? Do we need to tweak things? To me that's beneficial.’</p> <p>‘Just changing your mind set’</p> <p>‘in the NHS we are driven by expected targets’</p> <p>‘Yeah definitely I don't think people really got too caught up in the emotional side of it. I think people did more naturally fall into a discussion about decision making and that part of it rather than the how it felt’</p>
self-protection	<p>‘I ended up leaving because if anything ended up happening to my mum I didn't want to be in that position.’</p> <p>‘Yes I had to recognize that it was going to make me ill’</p> <p>‘I don't care if you see me drinking water, I just don't care. That's where I draw the line because if I don't I'll keel over’</p> <p>‘for the first time I am looking at doing some private work on the side rather than looking for extra hours in the NHS’</p> <p>‘I feel it is a position now where you have to look after yourself’</p>
vulnerability as negative	<p>‘I will just be crying and because I'm a matron they can't see me like that’</p> <p>‘she would much rather stay professional’</p> <p>‘he gave me a couple of tips and just listened and I didn't feel like a crazy woman’</p> <p>‘there are certainly people that I work with that I know would never in a million years admit to not been able to do something’</p>
Martyrdom v powerlessness	<p>‘I was trying to support everybody and it was really hard.’</p> <p>‘You just have to take it all and cannot say anything.’</p>

	<p>‘I wouldn’t feel like I was fighting in a battle with them but I would be fighting their battles for them.’</p> <p>‘there is a general atmosphere of there is not a whole lot any of us can do, we are all in the same boat’</p>
<p>Feelings don't count</p> <p>- suppression of feelings</p>	<p>‘Obviously, it was not fair and but I am not one for dwelling’</p> <p>‘And when people do get grumpy or complain how does that make you feel?’</p> <p>PP: You always say sorry really, you say sorry for everything. You apologize and try not to retaliate’</p> <p>‘It doesn’t faze me to be fair. I have been dealing with them for too long. I have never felt intimidated or upset by them’</p> <p>‘in regards to the job that is what you will come across eventually so you have got to deal with it’</p>
<p>Frame of mind</p>	<p>‘You know people are really rushed off their feet and things are really stressful you know, are you going to find an hour and be in the frame of mind to sit and take things in and think about your emotions or how something has made you feel’</p> <p>‘we have a lot of time but I really don’t see that same thinking time in the teams like when they are front line staff its, people are just really rushed’</p> <p>‘some of the stories in the teams at the minute are really distressing to hear so especially if they were going to go to a Schwartz rounds and the theme wasn’t on something I think that it might leave you kind of disconnected from everything like you are overwhelmed’</p>
<p>Worry for participants</p>	<p>‘I suppose I was feeling how would I feel being sat up there having shared my experience to then think what would you ask me about it, what could you ask me, who’s going to ask me and to me I thought to me that was very insensitive.’</p> <p>‘I do have a concern about the people who are asked to speak’</p> <p>‘I don’t know happens when it is the end and everyone walks out. What happens to those up there?’</p> <p>‘what is its ultimate aim and my concern about other people is what support is there. What do they do leave them to hang and dry?’</p>
<p>Rounds as supportive</p> <p>- therapeutic</p>	<p>‘There was emotion shared about it and she found it not therapeutic but similar I can’t think of a better word really’</p>

	<p>‘I think because it was something that seemed in some way kind of therapeutic’</p>
<p>Uncontained - Expected to trust</p>	<p>‘people would think ‘Oh my God if she’s not coping how are we supposed to cope’. ‘</p> <p>‘their exposure to you know really difficult emotional situations and no kind of support to process them all of the time which means why would they just suddenly be ok about that’</p> <p>‘its not done as far as I am aware under any controlled circumstances other than somebody might give them a hug or a pat on the back or whatever so there is no psychological support after they have done it.’</p> <p>‘sometimes we have to shut them away to deal with everyday life and I think we all do that as nurses but if you are invited to open it in an uncontrolled manner that’s when things could go downhill for that person’</p> <p>‘I have recently learned like it is a real skill to be able to bring your emotions to a conversation and still be able to keep them in check, I think that if something does touch someone it can escalate really quickly’</p>
<p>Rounds as risky</p>	<p>‘there is the sense that the panel are doing something personal and that it's ok to do something personal but at the same time but because not everyone is doing that and because there is some resistance to that that you don't feel totally comfortable doing it and you're reminded that those experiences when you have perhaps challenged the status quo and it hasn't gone so well.’</p> <p>‘why would you want to open up about the emotional impact of that because it's a minefield’</p> <p>‘they can live with it without talking about it but once you start talking it’s kind of reliving because you recall it. You can deal with so much but you may not deal with 100% because you have buried that last bit but this could be the bit that is pulled up and that’s my concern.’</p> <p>‘I think when you are inviting someone to sit up on stage and recall what tends to be a quite a traumatic event because that’s why they have remembered that event you are potentially opening a Pandora’s box and you don’t know how the person will react once that Pandora box is open’</p> <p>‘what happens to them when they come off stage and they have opened that little box in their head that they have kept closed for twenty five years’</p>

<p>'If you are going to do something what are you gaining from it?'</p>	<p>'I don't believe there was any follow up or anything to say what did we gain from doing this which is sort of to me the point of doing a lot of things ,if you are going to do something what are you gaining from it?'</p> <p>'if someone said 'oh, what's the point?' I might say what I said to you which is well we can't expect more to happen if we don't attend this but I would understand if people had those frustrations'</p> <p>'it was uncomfortable to see managers crying on a stage and talking about their experience when I think there was no learning out of that other than what they had experienced'</p> <p>'I don't know if theatre staff are different to the other staff and see things differently, I don't know they just felt that it wasn't really productive, what did we get out of it I don't know, nobody seems to know'</p> <p>'So I don't know what the premise for it, to share, to be more inclusive, to show managers have feelings too? I don't know. I just find it odd.'</p>
<p>Changes in perception</p>	<p>'well one it would make me as a matron look like I wasn't made of granite'</p> <p>'I could see that they are not just doing this as a job almost it was something that they really care about.'</p> <p>'so you sit back and think 'wow this kind of stuff happens''</p> <p>'you will learn about how people feels and you think 'crikey I work with that person and they are now bringing that out' and you're just like oh my goodness and when you hear the crack in their own voice and you see that person as somebody that is strong, perhaps you look at people differently and I think it helps you look at your colleagues around you somewhat differently'</p> <p>'she talked about that and I think it really changed the way I thought about her'</p>
<p>Connection</p>	<p>'I see that guy now and I feel I connect with him'</p> <p>'my contact with that panellist and my connection with talking about one of the most profound parts of my life'</p> <p>'it is about connecting with the people I work with more directly, or you know I pass in the corridor'</p> <p>'Yes because it makes you think that what I am going through isn't just with me, other people feel it as well'</p>
<p>Rounds as active - Self-reflection</p>	<p>'the facilitator did a good job of supporting that but not everyone engaged in it initially'</p>

	<p>‘I think we can all go in and relate to the things that people talk about and I think that is one of the important things that you know so we are not sitting there; it’s not a stage show’</p> <p>‘the midwifery one was very difficult to hear and part of me thought 'actually why am I here this is really, really hard'</p> <p>‘I think other people could sit there and think “Oh gosh I did that” and it might cause you to do a little bit of self-reflection.’</p> <p>‘I think to enable you to look at yourself, look at your practice and look at the practice that goes on around you and I think perhaps view it slightly differently’</p>
--	--

Appendix H - Coded transcript

		Descriptive code	Analytic code
M	ok just generally do you want to start off and say a bit like your, maybe a general day at work what's that like		
P	<p>em so em so a general day at work is, say</p> <p>we start at about half 7 and we get</p> <p>handover from the nurse in charge of the night staff and we're all allocated patients</p> <p>after that, em depending on how unwell the patients are, cause I work in ICU, the days can kind of vary quite dramatically</p> <p>em if you have a relatively stable patient, it's just kind of routine it's the stuff we're taught and it's drilled into our heads which is we are kind of like robots kind of in some ways and then other days if a patient is particularly unwell and or unstable we could be doing any number of things from multiple scans, multiple procedures on the unit em I'd kind of em I'd separate them, one would be a bit orderly and for want of a better word, mundane</p>	<p>Description of the role</p> <p>Spectrum of stability</p> <p>Variable/unpredictable/to some extent out of worker's control</p> <p>Robotic – over learned – not requiring thought</p> <p>Orderly linking to mundane</p>	
	<p>and then other days can be completely chaotic and eh no structure whatsoever.</p> <p>Purely because the patient's particularly</p>	<p>Patient being unwell – Causes chaos – impacts structure/plan</p> <p>Sense of responsibility to make them well</p>	

	unwell... and depending on what we have to do to make them well		
M	what would the mundane look like then? Would it be just sort of monitoring of obs and		
2	eh just sort of monitoring of obs em basically just monitoring the patient. that's probably the most apt word to use for it, talking with the families when they come in after lunch just making sure that, so far as the mundane days go we try and, any patient we try and prevent any secondary injury to that that they came in with. It's basically where we keep them optimised em in multiple ways em but ya it's just monitoring them basically giving them their medications em as I said talk to the family and just continue with whatever plan	Monitoring, talking to the families – mundane – stick to the plan	
M	and are they usually conscious then?		
2	no, eh well they can be depends what's wrong with them, they can be fully asleep. or they can be awake		
M	um and they can be fully asleep and stable		
2	they could be fully asleep and stable ya... em so when I stay stable they might, they could still be quite, they still could be particularly unwell but we seem to have found just ya know the right amount of whatever we're giving to them and all these other various things we're doing em so, so ya the normal days are just pretty bog-standard. Em and then the other days are completely chaotic	Pretty bog standard – [is when] Found an equilibrium of action/care Chaotic -	
M	ok and on like a chaotic day, how would you, how is the allocation decided		
2	so we have so the rostering basically works where we have a certain skill mix cause we have constant you know, people leaving and then new starter coming in so people decide they don't like doing nights or whatever, so then we have new people start, so we always have a bunch of newbies and a bunch of more senior kind of nurses em as well as the nurses-in-charge and the doctors. Em so invariably somebody is on a course either an introductory course or a full ICU course so	Staff come and go – skill mix Courses – prioritise staff development needs – fill out that part of the book Accommodating needs and development v chucking people in	

	<p>they get precedence over the selection of patients. As in 'oh this patient is really unwell and they're unwell for this really bizarre crazy reason, you can fill that part of your book out, that's you sorted or the person on the other course' em or if say nobody's on a course em depending on how unwell the patient is, more senior nurse might go there or a middle of the road nurse might go there to get a bit more experience em and we generally for new starters and for people who are quite new they are given patients who are relatively stable em and a bit easier to kind of get your head around. Em but there are times when we just chuck them in the deep end to see how they get on...um but invariably it's if you're on a course you get the good patients, we say good, that's a bit morose but the really sick patients or eh if there's nobody on a course it's experience kind of based</p>	<p>Good patients 'morose' - unwell, unusual</p>	
M	<p>um and when you say good do you mean that it's interesting or</p>		
2	<p>ya we eh we it's eh it's a bit of a um it's we have a, I think because of where we work we have a kind of bizarre sense of humour and in kind of ways to kinda cope with some of the things we see. When I say a good patient I mean, well I could mean a good patient in they are totally stable, they're ready to be discharged and they're fine and we don't have to do much or as in they're incredibly unwell they've come in with some say raging sepsis and you are just non-stop trying to keep them alive. that's what we would term probably a good patient</p>	<p>Sense of humour – way to cope</p> <p>Good patient – ready for discharge or 'you're non stop to them alive'</p>	<p>Non-stop Either its over learned and robotic or its adrenaline fuelled – either way no room to think or feel?</p>
	<p>so there's something about being constantly challenged</p>		
2	<p>it's exciting, we tend to um, it's kinda probably more appropriate in places like A and E but we still get, we still have the kind of mentality that when it gets exciting it's kind of 'oh this is interesting', I'm not bored out of my head cause you can be bored in ICU um so ya so we um, the adrenaline is something we (laughs)</p>	<p>Excitement v boredom</p>	
M	<p>something people like, ya ya</p>		

2	some people don't but some people are like 'oh ya this is cool'	'Cool'	Socially exciting
M	and I suppose that probably determines who stays and who goes		
2	eh ya um I guess well, the biggest, issues in nursing are well advertised and it's not a secret but um I think that can only sustain itself for so long um like our shift patterns are bonkers, um and there's a lot of stress involved and you see a lot of horrible things so I think it gets to a point where people decide well 'I'm not actually doing myself any good here' you know as much as it's exciting at times, I'm just constantly knackered and I'm in a bad mood all the time you know but ya to a degree I'm eh still in a place where I like a good exciting patient so far so	<p>Big issues – not a secret</p> <p>Stressors – in a practical sense 'shift patterns are bonkers'</p> <p>Stress in an emotional sense 'see a lot of horrible things'</p> <p>Impact on the individual 'not actually doing myself any good'</p>	
M	mmm ya. Right, interesting so ya so um then the next thing is sort of around well it sort of leads on from that. What are sort of, you said sort of when it's good you're really busy, it's quite exciting what are the highs and lows? What do you..?		
P	right so the highs are the exciting patients where you just kind of, to some degree, as horrible as it is for families, um, I don't know if it applies to everyone but I certainly do myself I like speaking to patient's families because it's incredibly hard to do and especially when they come in and we know they're not going to make it. it is, I don't know, it is oddly comforting to be able to actually try and support them em and you know and they're incredibly unwell and you're doing loads of different things. The bad days are can also involve the same types of patients um and I think somebody's ability to rest enough between shifts and to digest the information that they're receiving um that will decide how, how bad somebody feels at any given point. I definitely have times where, not just because of the type of patient, but because of various other factors whether its stuff going on outside work, whether I'm knackered, doing too many night shifts or whatever where you where you just kinda feel, we see a lot of people dying, dying horribly, and it does	<p>Speaking to families – incredibly hard to do</p> <p>Oddly comforting</p> <p>'doing loads of different things'</p> <p>Bad days 'same types of patients'</p> <p>Somebody's ability to rest</p> <p>Practicalities of job, life challenges</p> <p>Post traumatic stress</p> <p>See people dying horribly – worse in A and E</p> <p>Expelling all your energy I am mortal after all</p> <p>Incredibly draining emotionally – sinking into</p>	<p>Doing a job that's difficult, challenging but being support is comforting</p> <p>Need (responsibility?) for staff to rest and digest – individualised</p> <p>Minimisation of the challenge – worse for others</p> <p>You do all you can but people still die</p> <p>Facing one's own mortality</p> <p>Connecting emotionally can cause you to sink?</p>

	<p>kind of, I'm sure its some kind of, it does feel like some sort of post like traumatic stress or something. I've never looked it up or anything, I'm sure its to, it's probably worse down in A and E but you expel all energy to help somebody and like you see like just horrible stuff and it's not like elderly and it's not like people in massive car crashes its people who come in you know same age as me you know who just for some reason have had some catastrophic illness and you're kind of going oh my god, you know I am mortal after all. so ya it does, so at the same time as its exiting on the other, on the flipside it can be incredibly draining emotionally. And it, it's just very stressful, as much as it's a team effort you feel sometimes as if you're the only one at the bedside. as much as you do have support there um but you're the bedside nurse and you're looking after this patient and it all gets a bit, you know you're just, like it's just kinda like you're sinking into a sinking into an environment that's just not pleasant to be in sometimes.</p>	<p>an environment that just not pleasant</p>	
M	mmm so they're the low days and		
P	they're the low days ya		
M	when you're connecting with sort of maybe what's happening		
P	<p>ya just kind of like, you know I remember I watched 24 hours in A and E years ago and they all used to be you know they'd interview the nurse or the doctor on that episode and they'd be like 'oh you need to cherish your loved ones' and all this thing, 'anything could happen' and at the time I was like 'ya well I know anything can happen' but now it's like 'anything could happen'.</p> <p>um so ya the low days aren't necessarily just to do with the kind of stuff we see, like low days could be your shift patterns are crap and you're getting all the boring patients and you're just not particularly enjoying it (laughs). it's really laborious as well there's a lot of manual labour involved and I think the possibilities to make mistakes are a bit more amplified than in some other parts of the hospital because we give a lot of really crazy drugs</p>	<p>Recollection of prior dismissiveness around fragility of life v connecting with it</p> <p>Practicalities and physicality of work 'boring patients'</p> <p>Anxiety about making a mistake – impact – could kill someone – don't think about it</p>	<p>Moves from talking about fragility of life back to practicalities to the fragility and power back to don't think it</p> <p>Sense of responsibility –</p>

	and if you mess that up you could potential...I like.. you could kill someone and so, I don't think about that a huge amount but I know some people do, I for some reason don't because I'm just like 'well if you do the calculations right it'll be fine'.		
M	ok so you're quite like it'll be alright with that one		
P	ya I'm just kinda like, I've had one or two episodes where I've miss calculated something and or we have so many different IV lines going in to somebody and if you, and there's a drug called noradrenaline and if you give enough of that to someone, you only give smidges of that to keep someone's blood pressure up and if you give even a small, an extra dose, their blood pressure will go through the roof em and there's definitely been times...like if someone's been on norad and then you're using the line you need to flush it to get rid of everything and I remember my first week I accidentally flushed some noradrenaline and the patient was fine but it was 'oh my god how do I get their blood pressure down' luckily we have other drugs that	Story about how precarious it can be	
M	bring it down		
M	that keep people asleep we don't use it specifically to, well we can...we just give them some of that stuff and it came right down, i was like 'ok this is pretty intense stuff so' it's not something I particularly worry about. Luckily enough I've never really had any major...I know in some instances where some people have accidentally done something and it led to some pretty serious consequences but it's not something I see really at all. Every now and again you might hear 'oh somebody gave this antibiotic in this way because they forgot it should be given in that way'	Intensity of the work Impact of a mistake People talk about mistakes	
M	but for some people there's a worry about that happening?		
P	ya massive. Ya ya there's a lot of things to kinda get your head around. I admire a lot of the people who kind of go in to ICU and that's their career. They just stay there and they don't budge because they love it . Like I don't know how they do it. I don't	Intensity of the work Admiration for those who withstand	

	<p>know what I'm going to do in the next couple of years but um it's it definitely... it's weird. Like there's stressors all over the hospital and we have our own unique stresses but it's it's eh it's really intense ya know</p>	<p>Worse/different from other areas -our own unique stresses</p>	
M	<p>so to be able to, it sounds like it doesn't seem for you like something you would do in the longer term</p>		
P	<p>I'm mostly at the moment thinking that I physically can't do it, because, mentally possibly, but physically, I worked as a healthcare assistant in hospitals back home when I was studying in uni back home just for a bit of extra dosh and I just realised I've been doing nights for like 10 years now like I do nights and I'm wiped it's just I can't move you know</p>	<p>Emphasis on physical impact</p> <p>Exhaustion – practicalities e.g. nights</p>	
M	<p>ya ya so the impact of the shift changing and things like that it sounds like, you've mentioned that a few times</p>		
P	<p>they do it, they do it, they do it, I don't understand why they do it the way they do it here it just makes no sense. Either they're trying to save money on the rostering system and they have to do it manually, I'm sure there's a system out there where you tell the computer what to do, it takes 10 minutes and you press a button and it does it perfectly, everybody's happy. I don't know why they do it the way they do it because compared to back home it's, it just doesn't make any sense because you're just making your nurses unhappy, unwell and nobody is happy like you know</p>	<p>Makes no sense</p> <p>There is a better way – we would be happy if..</p>	<p>Intentionality</p> <p>Things could be better but they don't make it so</p>
M	<p>ya, cause when you were planning [to come for the interview] it seemed like it was up and down like you know it was night, day you know changing so quickly</p>		
P	<p>I did, so I finished nights yesterday so I did Monday Tuesday night, well this week's not too bad. I did Monday Tuesday night, em and I'm back in tomorrow (Friday), then I've a day off and I'm back in Sunday Monday em two days off then I'm back in Thursday. That's not too bad because at least you have some opportunities to get some sleep but there are times, I know people who are doing their three nights, they have a sleep day, two long days and then a day off and then three more nights</p>	<p>Shift pattern – practicalities</p> <p>Crazy/insane</p>	

	and I'm just like 'that's crazy', 'that's insane'		
M	the changing around of all		
P	aw we're not designed to be do it. Well we're not designed to stay up all night anyways but to be flipping and flopping it's not cool that's why people leave . Not necessarily because of the.. the types of... the intensity of intensive care or anything	Practicalities make people leave	Minimisation of the intensity of the work – beyond the practicalities
M	ya, so it feels more related to the shift		
P	ya ya there are definitely people who don't cope , I mean we have people who start and they leave again within two weeks. So it's more to do with I guess the exhaustion and stuff than maybe the mental thing. There are some people who suffer from the mental stuff	People don't cope due to exhaustion rather than 'mental thing'	As above
M	ya and thinking about that so the more emotional or difficult side of it, can you say a bit about what they are? You being faced with sort of death and dying		
P	ya it was, so recently, it wasn't my patient but I was opposite the bedspace so I was helping you know the nurse who was taking the admission you know of a gentleman with um necrotising fasciitis so eh basically a flesh eating bacteria um. He walked in to a and e at 4 o'clock in the afternoon and he wasn't alive at 8 o'clock the next morning , like he got so ill so quickly . Em it's not necessarily when they came up. We're, we're really anybody comes into ICU we're really anal about neatness like we hate, like we spend half our time trying to make sure the sheets are tucked in properly more than anything else em just because it feels, em it looks nice and everyone who comes , either new starters or whatever, anybody comes up from a and e they're like 'you guys are nuts ' you know 'you're crazy , I don't know why you spend all your time doing that'. Um it's also for the patient's families . But this gentleman came up and this kinda ties in with the neatness kinda thing um. He came up and they basically did surgery on him and so he had the infection in his arm and it started to spread and basically this infection will kill you um and, he was still bleeding quite heavily so there's blood all over the sheets,	<p>Walked in, wasn't alive at 8 in the morning -fragility of life</p> <p>Anal, neatness making it 'looks nice'</p> <p>Seems 'crazy'/'nuts'</p> <p>For the families</p> <p>Actually trying to die on us - bad patient?</p> <p>Rushing to stave off the inevitable</p> <p>'he just looked a state' – no semblance of order – looked dead</p> <p>Quick deterioration – order goes out the window</p> <p>Incredibly displeasing sight – scar children</p>	

	<p>he was not stable at all, he was actually trying to die on us and we so we basically spent the whole night rushing to try and stave off the inevitable and we were giving drugs I'd never even heard of and it was like 'I've been here two years and what the hell it this stuff'. ya know and you know we brought the family in and that was horr...well actually you know we brought the family in and they were actually alright and I was like 'really wow that's insane' it's just they really didn't have any comprehension of what's going on. Um but he just looked like a state, like there was blood everywhere. He had lines coming out of him everywhere, he looked, he looked like he'd died. He, he had no colour in his face, he was completely grey, he was bleeding out of his mouth, there was no semblance of order about what was going on here except we need...like priorities are just give this drug, give this drug, give this drug and blood pressure, blood pressure, blood pressure... everything else. Obviously this is what we have to do for somebody who is crashing is quickly. You know, everything else goes out the window except your a,b,c,d,e and um, but it's just like, you see the ICU I work on is like quite an old kind of unit. We've all really high tech equipment but the actual surroundings are a bit dank and a bit, it's more like a triage in a and e, well a and e downstairs. He just looked comp., he just looked horrible like there was stuff on the floor, there was stuff you know, there was, it was just an incredibly displeasing sight. Not from an ICU point of view, 'oh he's not neat' just horrible like the type of stuff when you were a kid like it's the type of stuff you wouldn't show a kid. You know it would scar them for life (laughs)</p>		
M	<p>yaya and, and so there's something you're saying, not about the neatness mattering of course, but there's something about the neatness that helps it feel like it's in order in some way</p>		
P	<p>well so when you have the stable sick patients who are incubated and you know they're on a bit of which is a like a really</p>		<p>Making things look neat</p>

<p>strong morphine and it makes people comfortable. So the stuff that puts people to sleep is not going to make them painfree. It just puts them so sleep so they could still be in pain asleep so we give them fentoline to chill them out you know and it also means that if they were to wake up at any minute they're not going to rip the tube out so it's something that's so horrible to have in your mouth. So they're on fentoline, maybe a bit of nora to keep their blood pressure where we want it and we could be just waiting for whatever reason. Eh we're basically just not doing much at that point except monitoring them and you have time to make them look neat and nice and part of it is almost like a mental thing in ICU where, I don't know what it is, I really don't understand it because I, because I'm certainly not that neat at home but it seems as if this thing is drilled in to my head that you need to make them look nice. Because we spend our time talking to them while they're asleep. Because we don't know if they can actually hear anything. We've had reports people come in to, we have clinics so 6 months after you leave ICU, you come in and you give us your experience and we've had people say 'oh I remember this nurse's name and this nurse's name' I felt like I was in, crazy dreams like mental dreams like there is a huge issue with patients who leave ICU and they have really lasting mental like almost like post traumatic stress where they'll have nightmares and stuff – other people leave and are fine. But ya they remember people's names and everything so we communicate with people, so like, I think it's something to do with like if we're talking to people let's make them, there's no point having someone just lying there, sheets everywhere, sideways in the bed you know...let's make them look neat and as comfortable as we can make them. Also cause if the family come in...if, if a family comes in and they see somebody looking fantastic, it might dull the kind of, well it might give them a false sense of hope, but I mean it's almost like, cause the ICU is a</p>	<p>Just waiting – neatness comes in 'mental think in ICU'</p> <p>'Drilled in to my head...make them look nice'</p> <p>Talking to them while they're asleep</p> <p>Traumatic for the patients</p> <p>Neat and comfortable</p> <p>For the family</p> <p>? false sense of hope – ICU is a horrible place.. not for us</p> <p>Responsibility to 'fix them'</p> <p>Semblance of ultimate control</p> <p>If they're going to pass away they're going to pass away</p> <p>I never really thought of it – robotic, learned, drilled</p>	<p>Neatness as something to do, talking as something to do rather than being with?</p> <p>Drilled – something that just gets done without thought</p> <p>Seeking hope, seeking control - doing something - responsibility</p>
--	---	---

	<p>horrible place to be not for us generally but for families and stuff it's not nice and em like anything could happen where you're sitting there with your patient and the patient next door to them could arrest and that's when everything goes out the window and we're literally doing anything we can to fix them ya so if we can make them look neat and I kind of I guess it gives us a semblance of ultimate control. Like realistically we can't really like if the patient's going to pass away they're going to pass away, there's nothing we can do about it but like if they're stable and there's not much for us to do we can make them look nice so (laughs) you know, I think that's it, I never really thought of it. I know people talk about it when they come up um, and they're not use to working in ICU</p>		
M	they notice how neatly		
P	<p>well we have a lot of lines and stuff coming out of patients, I guess sort of a practical reason around that is that we know where everything is so if I need to give them something immediately I know this line is free and it's here everything else is labelled I can see splayed out on the pillow and you just look at it and you know that one works and I know what that is that is and that is and you have everything labelled and stuff in neat handwriting. I guess it came from safety as in a doctor rushes over and somebody's become really unwell and they need to give something they can look at the lines and go 'I know that line is fine' because all these other lines are working, they're nice and neat, I can trust that this nurse here is either completely insane or, because of the neatness, or it's purely just to make my life easier and our life easier too. And I think it just bled into the sheets and stuff</p>	<p>Practicalities – practical reason why</p> <p>Justification of neatness – safety</p> <p>'nice and neat I can trust this nurse' insanity v trying to make life easier</p> <p>Bled into the sheets – bleeding</p>	<p>Practical and logical reasoning – keeping insanity at bay</p> <p>Bleeding in to the sheets – doing things out of rote learning – doing</p>
M	yay a, so the practical side of it is that it helps to sort of see things and it helps to do things quickly		
P	absolutely. We can stand at the end of the bedspace and we can see, I was only looking at one of the nurses the other night when somebody was going on break	Handover – process – systems in place	

	<p>and they were giving handover and I was looking after a patient, it was fine, and I was just looking at them and as they were taking handover their eyes were just kind of tracking around the bedspace and just going 'oh ya' and then they'd say 'why's that like that' kinda thing and you spot things... cause if you need to do something really quickly you know, you know where to go, what to do. It's the same we have safety equipment behind each bedspace and it's like it's kind of like in worst case scenario like either the power fails or for some reason the oxygen supply in the hospital is gone caput, we have oxygen cylinders at the back of the bed that we can hook in to if we need to, we can take them off the ventilator and we can bag them if we need to, all these other safety equipment and if that's not checked, cause it's happened to me twice where I've desperately needed something at the back of the bedspace to save my ass and it's been there because I've checked it and it works and I know exactly where it is and I've grabbed it and diddledeediddle done em it's safety and I think it's sort of bled in to every nurse's latent, eh what would you call it adhd, em like em just em what's the work</p>	<p>Emergency – responsibility to act</p> <p>Worst case scenario – preparing for it</p> <p>To save my ass – responsibility – consequences of an error</p> <p>Latent OCD</p>	
M	OCD?		
P	OCD yay a, just complete craziness when it comes to	Craziness – edge of craziness	
M	but ok so in some ways it's a way of making sure things are safe but compared to the guy where things were everywhere and you mentioned sort of a connection with control as well ya obviously there's no control over him		
P	we have absolutely no control whatsoever over what happened there. We have we are we are basically just trying to keep the tide back it's trying to control ya Mother Nature, it's just, we can do some things if we get to somebody early enough and we can fix it, but this gentleman became so unwell so quickly there was really nothing we were going to do. It was...	<p>Rejecting of responsibility – absolutely no control</p> <p>Keeping the tide back – powerless – nothing they could do</p>	
M	and what were the emotions that you felt? Like that story seems to come quite quick to your mind		

P	when he first came up, I was looking after, I was opposite, I don't know if, have you ever been to an ICU have you?		
M	No		
	<p>so ICU's in general when you go into an ICU's the theme these days is you have cubicles just walls and another bed opposite you so a bed, the wall at the back and walls here, with windows in the walls and another patient and another three walls and then opposite you you'll have, so it's almost like you have a corridor and you have this kind of plan in most modern ICU's and em in our hospital we're we're building a brand new 120 bed ICU building where we're going to have all this new stuff. At the minute we're really, we're in old, really it's just a space to have ICU patients so they're not really mega purpose built. We've all the equipment we need, there's nothing we don't have that other ICU's have. Em so I was looking after a guy opposite quite close, and when he first came up I said 'oh [name of the nurse] who you getting up' and she was like 'oh a guy with necro fasciitis' and I was like 'oh that's quite interesting' you know and she was like 'ya he's incredibly unwell' and I was like 'oh ok' I kinda always kinda clocked probably not going to make it. Em and then when he came up it was just the adrenaline rush cause there's so much to do when they come up and you're trying to take handover and there's several doctors, our doctors are there and then there's nurse-in-charge, there's all these equipment – and for some reason, theatres and a and e have different equipment to us so you can't just literally hook them in to the system, it just boggles my mind, but anyways we have to we have to sort all of that out first. So we possibly have to get new syringes of everything they're using. So then we're like ok get them attached to the ventilator and the monitor, so monitoring first and then the ventilator. Ok so then we have them on our monitor so at least then we can keep an eye on them. And that's kind of exciting. It's kinda like those episodes you know of ER, you know the music is on and</p>	<p>Way of talking – clocked probably not going to make it</p> <p>Adrenaline rush</p> <p>Inefficient system – no sense of reason</p> <p>Kind of exciting – ER – fantasy</p> <p>Starts to dawn on you – reality of the situation</p> <p>Tiredness sets in</p> <p>Less tolerant – the place is a mess</p>	<p>Things would be different if a better system?</p> <p>When reality comes – realisation of lack of control – take control of the mess</p>

	<p>everybody is going 'gah' and this sort of thing. So that's the exciting part you know and then it starts to dawn, you know it just, you're focused on doing the job and then as they kind of, I was going to say stabilise but he was never stable, you have a bit of leeway while he has some drug being pumped in to him, you don't have to worry about manually doing it and then it starts to dawn on ya and then the tiredness sets in and this is a night shift and you have the tiredness, the tiredness automatically starts to creep, so you're starting to feel a bit heavier em you're a bit more, you're a bit fuzzier in your head, you're a bit less tolerant of everything around you and then you start to kind of think, the place is such a mess, the, he's bleeding everywhere, he's not stable, his blood pressure is crap even though we're giving him everything we can, we're throwing everything at him but he's still alive em and because, his heart is still beating em and then it's just kind of, for me I don't know what it is. Like for me I remember when I was a kid, I used to hate the smell of hospitals, it used to be a scary place em, you could show me anything now and I'd be like whatever you know, and I don't know what it is but I think it's maybe just something that something it's nearly this childlike kind of thing like this is terrible, this is horrible, this is scary</p>		
M	so those sort of really normal emotions		
P	it's not necessarily... ya it's normal emotions it's more, ya I guess so, not necessarily oh my god, because this patient just got a scratch em you know, I don't know what it is, it was just a horrible experience, just a terrible terrible thing and		
M	it sounds horrendous		
P	(laughs) it's just kind of like as exciting as it was initially, it was just kinda like this is not nice. The family weren't as bad as I thought they'd be, there was tears there was thing... but then part of me was just like 'what the hell are we doing here' I mean, it's not something I understand fully, I understand the general process but sometimes patients come in and certainly	<p>Exciting to 'not nice'</p> <p>Exciting to reality - what the hell are we doing here'</p> <p>Fear of death</p>	<p>Death as part of life</p> <p>Avoidance of death</p> <p>Responsibility to stop the inevitable</p>

	<p>I'm like myself in my head 'what are we doing?' like can we not, like we seem to have this fear of people dying, like I understand when a patient's well, doesn't matter what age they are, it doesn't matter anything if they were previously well, you should absolutely try and fix them but sometimes we get patients in and it's like 'what the hell' there's all this wrong with them, they have all these things and it's not necessarily me trying to decide who lives and who doesn't but it's kind of like at the end of the day death is a process as much as birth is a process you know.. when somebody's time has come I think... well that's just my belief and it doesn't change my practice at all I'll go hell for leather if I'm told to</p>	<p>Responsibility to extend life 'you should absolutely try to fix them</p> <p>Deciding who lives and who dies chi</p>	
M	<p>yay a ya, but that's interesting as well then, when you're looking at someone and you're thinking, 'they're not going to survive' and you still have to do all of these things to try to make it happen</p>		
P	<p>ya the stuff we're doing and the stuff I didn't even know we did isn't even working so like what's going on, anyways we eventually said to the family, you know we sat them down and we said 'we're not winning, this unfortunately has just got the better of us' and em ya even when I was so we have a process where so adrenaline and noradrenaline and all these drugs to keep somebody to keep their, where we squeeze them to keep their blood pressure better, so we have several different types of that drug, what we do, so when we run out of a syringe, other hospitals do it differently but we double-pump so we have two syringes attached, one is giving the drug and when it comes to the end of one syringes, we start to piggyback so we double the dose and when their bloodpressure goes up a certain amount then we reduce the old syringe. I started to double pump this gentleman and he was already on the maximum we give and then he was on double the maximum we give any one and it's not touching his blood pressure and I'm just like 'ah this is...' we had already discussed in the previous half hour 'ya this isn't working' and I think this,</p>	<p>We're not winning – got the better of us</p> <p>Energy and effort then stop</p>	<p>Process of objectifying illness.</p> <p>Something to be fixed, fought, beaten</p>

	then the doctors came in and we got the family and this, this is just an illustration, and I don't think we would have needed to really convince the family cause I think they worked it out themselves but...so we just kind of stopped and eh ya so he passed away pretty quickly so ya it's weird		
M	ya em and so how do you cope with that then		
P	em eh I work with a good team, I work with a good bunch of people. em we have a very morose way of dealing with all of these things and i think it's quite common. Eh it's not like we treat our patients any different from how we would want our loved ones to be treated but at the end of the day our turnover is so massive you can only become so attached to somebody and we're there to do a job and we do it really well. And if to do it even better, at times when it really goes bad, em I think, we tend to, we joke around a lot, like a lot, and you know if, you know, if you were to publish this in the Daily Mail, it might be seen as you know this is, this is unbelievable (tone change) you know but if it's how we cope it's how we cope. Ya so we joke about stuff, we you know em amongst ourselves, never in front of patients or anything, but we. Em For me I've never really had to, I don't know we talk about things and I'm generally pretty good at leaving stuff but like, like i suffer from anxiety and like i years ago I used to have this issue where I was kinda worried I was going to choke to death or something and my heart like I'd get palpitations and stuff...I think the one thing is for me and I haven't really kind of exercised it but like, for someone in my position I think there are certain things that I've seen that have definitely affected me to the point where I'd be a bit more paranoid about my own personal things and that's definitely affected me, and I do, I have sought kind of, my own, kind of, personal help and that sort of thing em but I've never had to, I think I've	<p>Morose way of dealing with things – unacceptable to outsiders 'daily mail'</p> <p>Justification of unattached 'if it's how we cope, it's how we cope'</p> <p>You can only become so attached...we're there to do a job</p> <p>Certain thing...have definitely affected me</p> <p>'I've never had to...'</p> <p>Justification of attachment</p> <p>'Like my own mother'</p> <p>Loss through attachment – more difficult than 'catastrophic chaos'</p>	<p>Other people don't understand so they can't judge</p> <p>Being attached is not part of the job – perhaps gets in the way of the job</p> <p>Internalisation of the problem</p> <p>Emotion as a weakness</p> <p>As above – someone like me</p> <p>Avoidance of attachment as protection from pain of loss</p>

	<p>only ever cried once there, but that was more kind of an emotional attachment to a patient that we all had cause they were there for a long time, she was the nicest woman in the world and she was slowly passing away in front of us and that was more kind of em eh...pictures of her family and that thing, her family were the nicest people in the world. It almost kind of reminded me eh she's somebody that reminded me of someone like my own mother...and I think, and that was kind of, I remember one night I was looking after her and em she wanted to see a photo from the wall before I turned off the lights and em and she had terminal cancer and I showed her the photo and it was her two kids and she was there just kind of stroking the thing and the tears streaming down her face and I was like 'oh man' it was the first time I'd kind of gone 'fuuuck'... this is like this is almost deeper than stuff that comes in when it's kind of catastrophic chaos...we do not most of the time become that attached to our patients especially the ones who come up and they only spend about 10 hours with us</p>		
M	<p>right ok so the it's so it's a higher turnover and you don't have that same</p>		
P	<p>ya we have some long term patients, like we have one lady at the moment who is kind of similar to this lady em and it's just this kind of slow process for her, it's just she's probably not going to make it but we're doing things to see if we can help...but I'd say the emotional stuff in that regard than the kind of mental side of things. The mental side of things kind of effects me and then I go, I kind of think either myself or I'm getting help myself em I kind of get over that kind of thing. The emotional stuff kind of sticks with ya, kind of, it's em, ya, it's kind of, it's it's ya like we remember her, everybody remembers this so unless they're new starters or stuff ya</p>	<p>Mental thing 'get over that kind of thing' emotional stuff sticks with ya</p> <p>Dumping it in the same lot as my own issues</p> <p>Others don't talk</p>	<p>Challenge of emotional difficulties greater than mental</p>

	so as far as going to get help and stuff, I've always, because I've gotten help with other things in the past, I'm used to, I'm used to, just dumping it in the same lot as my own kind of stuff...so if I've ever had issues with it I've either talked to somebody or, but I know a lot of people don't		
M	em so that would be talking to somebody outside of work and sort of your own personal		
P	ya kind of mixing it in to my kind of personal stuff...because i kind of view it as in, 'oh the reason I'm kind of freaking out is because this long-standing thing that I deal with, not necessarily cause I've suddenly realised that oh god that guys 31 he plays football as well, he kind of looks like me oh his heart just stops (laughs)'...that's more kind of like 'use your brain [name], people drop dead every day of the week'... you know for various reasons...em, so ya	Internalisation of challenge of the work 'long-standing thing that I deal with' 'use your brain'	
M	so you can talk yourself out of that a bit easier just be like, that happens all the time		
P	ya but I definitely think, working in that environment when you when you see what we see all the time em like it's worse than A and E...Like A and E they get horrific stuff coming in, they really get their, they're the first port of call and we see roughly the same stuff as well but as well as that in A and E they have majors and minors, they have like 'oh I've cut my hand' and...and 'oh hey how are you today?' you know and all this when we discharge patients like it's there's a small, not going to say it's a small minority cause like we do discharge a lot of patients but we never have people walk out of here, never like they'll go to a ward to get more better and then they'll eventually, hopefully leave the hospital but they never walk out ever, they're wheeled out on a bed so that kind of ya that's a bit of a drag. em but ya i get i, i, i, ha, I'm quite good at getting help, I don't, I	Them and us – comparison of roles/teams A bit of a drag – minimisation of the impact	

	seem to be a bit of an anomaly amongst men		
M	right ok, and but within the hospital then or within the team, so the team uses humour		
p	we use humour but there is the avenue where you can, I've never used it and I don't think I've ever seen anybody but I know it's there, I know there's support there amongst the senior nursing staff if you wanted to talk to someone. There's also, we have a social worker who deals a lot with families and stuff but who also gives... you have an opportunity to go yourself to speak to and we do have a I don't know if she is actually the new social worker or if it's another role but she's trying to set up a, a monthly... where you go and speak to someone about any caseload and any issues you have with it , purely from a mental side of things em but we got an email from one of our junior sisters saying 'I'm seemingly the only one who's gone to any one of these in the last couple of months' (laughs) and you get it in email and stuff but I don't know that anyone has gone to any of these sort of things so	Humour Avenue's for support unused within the hospital Support offered, not taken	Description of support which goes unused
M	so so it sounds like it's not really spoken about that people go if they do go but it seems like they don't		
P	it's, it definitely seems like people just don't , I cause maybe, I, I, just don't know, maybe people don't I don't get the sense that many people have much issue with sort of stuff maybe it's just me that thinks about this stuff but it doesn't even affect me that much to a degree and I'll happily go to work no problem and I'll leave work most times and I'll leave most of the stuff in work ...I guess it changes, things kind of, especially the last couple of, six months or so when all these horrible things have been happening in London, I do know the Grenfell thing like we got a patient who came in and eh she was desperately unwell , she survived but em she, she's in the papers, in the	Many people don't 'have much issue..maybe it's just me..doesn't even affect me that much'	Internalisation - minimisation

	<p>Daily Mail or something but em where she lost her baby, she was pregnant and I know the nurses looking after her that day like I remember walking by, I had an easy patient that day and I was in the side room so I was kind of kind of far away from all the chaos you know and I can, I could tell that was a rough day, like that was really rough... em and like I'd always go over and say 'are you all right?' and you know pat on the back you know kind of thing. And there is that kind of people recognise when it's really something unusual is going on... em and I think she's fine, you know I was working with her the last time and it didn't seem to have any long lasting effect on her if it did at all you know... Em, but I do, I do, the London Bridge thing, I was at home, I was there half an hour before hand watching the match and then I went home, I live pretty close and eh like they called me at like 12.00 saying 'can you come in' cause they were expecting more and more patients to show up and I was like 'oh crap' my adrenaline hit the roof and I was like 'oh my god this is insane' but I was excited but then it hit me I was kind of like, I opened the window and all I could hear was sirens and choppers flying around and I was like 'uh it's' 'the only way for me to get to work now is to get a cab' like uh</p>	<p>I was excited but then it hit me</p>	
M	<p>to leave your house ya</p>		
P	<p>ya like, I don't necessarily, anyway they rang back 20 minutes later saying 'Oh we don't need ya, it's fine can you come in in the morning?' but and that was the first time I got spooked and to be honest if there was another major incident declared I would just want to crawl into the corner and just sleep. I don't want..not necessarily... It's just because you know it's just going to be chaos and you know it's going to be and you know it's it's and you feel unsafe...Like what they did, the injuries some of these people have</p>	<p>I would just want to crawl into the corner and just sleep.</p> <p>Frickin awesome...oh this is actually happening outside</p>	<p>Avoid/pretend its not happening</p> <p>Excitement to reality</p>

	had in the last couple of months they're horrific, like horrific injuries, a lot of them survived. I looked after one of the patients who died from the Westminster attack...em and that was horrible...Initially you know you're like this is frickin awesome but because it's because you know it's what you train for and so so mentally it was kind of like 'oh this is actually happening outside' you know I could be walking home or something...And this kind of work type thing could happen so em but ya ya		
M	So the unsafeness sort of coming from		
P	Ya I've started to feel it outside work		
M	Ya I suppose the randomness of it		
P	the randomness of all these things going on was just kind of like I don't know if I kind of like London at, at this moment in time... I hope that answered that question	Randomness	It could happen to me – I'm not safe
M	it did em eh, so we were talking about sort of how you manage and you sort of do that outside of work and most people it sounds like most people don't talk that much at work but they will recognise 'this is something out of the ordinary' and maybe this person is finding that difficult and so they check in		
P	and so ya they might just check in and ask them and make sure they're alright you know part of eh..one or two people, I don't know if they're too proud to even remotely show any sort of whatever, I do know a couple of the girls now be going out and getting absolutely pasted em with the booze ya know, but not because of that, you know there's like a they like a party anyways em ya i think I think most people, now I could be completely wrong but I think most people are pretty ok with... ya know. I don't know, I don't know if they would actually seek help... that's the thing. I don't know	Supporting each other they're too proud to even remotely show people are pretty ok...I I don't know if they would actually seek help	Feelings as weakness Minimisation? Poor help seeking
M	and in terms of like what they..eh so you said the organisation, or you		

	know the hospital supply these social workers you could talk to and it sounds, and it feels like the senior staff would be open to it if you did want to go there em is there anything else?		
P	em I do know and it's not necessarily official and it's not like posted up on the board or anything but I do know you can talk to anybody any time you want...but I understand that that's the case and I believe so but I've never had to do it or anything but	Unofficial support I've never had to do	Support as unnecessary?
M	talk to anybody, who do you mean?		
P	any of the nursing staff anyone on your team , your manager em I'm pretty sure anyone is happy to talk even the doctors you know it's it's, we have a consultant we have a group of consultants that are on and off working in our units and stuff and I know who they are, I might not know some of them personally but I think it's there I think it is em I'm not worried that it isn't . I'm the type of person that if I have an issue I generally tend to seek help and I'm not afraid that there isn't any	Help is there if needed	
M P	MG and in terms of, so you have heard of Schwartz Rounds P I have ya M and you haven't attended, P no M do you know of anyone else that you work with that has? P ya one guy, ya he he, he did, I think he presented at them, I think he presented at them M ok and do you think that was the reason he went or he had gone separate to that?		
P	No i think it was, this guy is kind of, kind of real competitive you know wants to go up the ranks kind of thing, now I could be wrong but I but,	Wants to go up the ranks	SR's could lead to career progression

	in my head, my understanding of why, of what he was doing was more to do with 'I went to a Schwartz Round' kind of thing instead of 'this is this really good for me kind of thing' ya know		
M	mmhmm oh ok so that it might have some career benefit to him		
P	yes, ya ya em ya that's my understanding of why he went		
M	and so is he, is he the only person you know that went		
	the only person that I know that went, other people could have, but I'm pretty sure most of the people I work with haven't gone	Most people haven't gone	
M	mmm and so what do you think, why do you choose not to go? Or what is, what do you know about them maybe		
P	so I understand that they are a meeting of em clinical and I'm assuming other members of hospital and it's basically where you, basically you go and meet up and you have like a big group discussion based on a particular theme or patient em eh so as in you know 'are the amount of nights clinical staff are doing affecting their health? What do you think?' kind of thing where you meet up and discuss and kind of em almost kind of understand whatever theme or concept you're discussing better to try and work round things with just by being open and talking about it that's my general understanding of what it is	Clinical staff are doing too many nights A way to 'work around things'	Issues relating to work structure rather than emotional impact of patient work
M	em but and has there been sort of promotion of it or how have they		
P	ya but it's always a flimsy bit of paper on a notice board amongst 4000 other flimsy bits of paper you know on the backdoor of a toilet or something it's it's never really, I don't remember it being you know, kind of the one that would catch your eye and to be honest I think the fact that it's called Schwartz Rounds I don't think people understand actually know what that is	Advertising – not seen as 'catch[ing] your eye' People don't know what it is [based on the name]	

M	ok so people don't really know what it's about		
P	they just see a fanc, they just see a name and rounds and it's just kind of like, 'that sounds like something the doctors would go to' or something else that doesn't apply to me. I know what they are. I haven't seen one in ages, I haven't seen one being published because we have them at [name] so I don't know if they have been going on and I just haven't seen them em so ya I just don't think it's, I think the first thing is just how, how eh if the promotion is readily available to people	'something the doctors would go to'	
M	so it's not that eye catching and it's that you really know it's for you or it's it's		
P	even though they put you know for all staff in the hospital to come to if they want to... it's not just a doctors thing or anything		
M	and so how about em your management or people more senior in your team		
P	em no I do remember getting an email about getting the, uh a going to see the social worker for eh a debrief but I can't remember,, I could be wrong but I can't remember anybody anybody from our senior nursing staff kind of eh emailing us about it or coming out onto the unit and talking, there seems to be more, it's kind of whether the management is that good or not, I think it depends on what kind of manager you have I think that could be something to do with it. The type of person that is your manager or your matron or whatever. Cause I don't think many of them are that interested.	No direct promotion through senior staff – 'I don't think many of them are that interested'	
M	So you don't think many of the matrons are that interested? Or the management people..		
P	Well if they're interested they're not really telling, they don't seem to be telling everyone about it. So i've no idea; maybe they are and just keeping it to themselves; 'this is all for me' or whatever.	Senior nurses are not 'telling everyone about it'	

M	ok right, so if it is, if they are interested they're not broadcasting that		
P	it's not obvious to me that they are interested.		
M	ya ya... and what impact do you think that has on whether you choose to go or not?		
P	It has zero impact on whether I go or not, personally myself. I've heard about Schwartz Rounds for a good long while now, mostly through my mother, but I had seen it and I'm the type of person I love going and talking about stuff em and it seems like my type of thing that I'd be really interested in going to em but I just guess, I don't know it's like it seems to be that the minute I leave the hospital I don't necessarily want to go back til I have to go back in em which is a kind of a, the more I think about it, maybe a bit of a lame kind of excuse, personally myself kind of well that's a bit silly, I mean like cause it seems like a very like there's no reason for me to not have gone like em and like the only reason I can think of why I haven't gone to the last one that I saw which was months ago was because I was either too tired or I had some other stuff to do or I was just on a day I was working	'it seems like my type of thing' There's no reason for me not to go	
M	so so but on a day you were working? you...cause		
P	I'd have forgotten about it or for some reason it just didn't stick in my head enough even though I heard about them	Forget about it – didn't stick in my head	
M	ok so I can see you know it might be quite a struggle to come back in to work for one em if you choose, if you said like 'ok I want to go and do this thing' to you know, on a shift day how how do you think that would go down?		
P	How long do they usually last or does it last for as long as... there's no structure is there?		
M P	M ya there's a structure so it's half an hour lunch, like they give you lunch P but is it a couple of hours		

	been stuff I'd be particularly interested in talking about or listening to other people talking about to be honest it's probably more to do with I've forgotten about it or I just haven't the urge hasn't been strong enough to go but I do see myself going to in the future absolutely	I do see myself going	
M	but apart from individually there's not really talk about it		
P	no, no way		
M	M there's not really promotion of it		
P	No no		
M	why do you think that it		
P	I don't know and especially a hospital like [name] where they, it's, they pride themselves on so many different things and we do things very well other things not so well but it seems like something that [name] would be absolutely all over and almost make it mandatory for you to go (laughs) I don't know; it's just not advertised, I don't know maybe maybe some people don't buy in to the whole Schwartz rounds thing	Organisation don't seem very interested – 'maybe some people don't buy in to the whole Schwartz Rounds thing'	
M	what would you say, what would be your hypotheses about that		
P	I think if you not that we have a lot of old fashioned nurses but a lot of old fashioned nurses are they're as hard as nails as in like they're really like, they're almost like men like in a way as in their mentality is like you know the old fashioned kind of view of like the matron you know she runs the show, she knows everything that's going on she is just made of steel you know em... maybe there's some kind of hierarchical kind of thing like that, but I'm trying to think, even then I know there's one I think she's in her 60s now but she's one of the she's one of the matron, she's really awesome so it's not her I don't know. You see the thing is, I think the Schwartz Round is trying to it's trying to compete in an environment where there's a billion other things that are are kind of commanding the attention of the senior nursing staff for whatever reason	<p>Old-fashioned nurses</p> <p>They're hard as nails...almost like men...just made of steel</p> <p>Hierarchical kind of thing</p> <p>SR's are 'trying to compete'</p> <p>Too many things commanding attention</p>	<p>Matrons viewed as hard, tough, not feeling</p> <p>SR's/feelings not viewed as important</p> <p>Relatively unimportant</p>

M	what kinds of things		
P	Well we recently had a CQC come em which took up a lot of effort, with the senior nurses trying to make sure everything was perfect which doesn't make sense because we're changing all this stuff for this one week period, we get a rating and it all goes back to...you know anyways. But you know that sort of thing the CQC and then we're doing all these audits and we have to we don't have any money and we have to justify our budget you know we've a shortage of nursing staff where em all these management things...maybe. I just think it's probably getting lost in the	Problems of quality control/money/staff shortages	
M	so there are management things to be done and there are big issues within that		
P	I think when they see what's the priority I don't think they see the Schwartz Rounds as a priority. It seems to be like, I'd imagine to some, like I don't see it as a luxury, but I can imagine it's to some people it'd be seen as it's 'oh ya it's kind like you can eat your dessert if you eat your dinner' kinda thing you know... this is, we've all this stuff that's a priority, if you want to go you can go in your own time, or something	SR's viewed as a luxury not priority Go in your own time	
M	right ok, so there's maybe some feeling that it might be a luxury and and especially, well I wonder about leaving clients, leaving patients to go to do it		
P	well i well there's other stuff that people are allowed go to, so I don't see it being an issue that		
M	so people leave to do other things?		
P	Ya, so there's like other kind of em, discussion stuff, like ward meetings and stuff, you get to kind of convey your opinion on how the place was run all that sort of stuff so	Ward meetings – convey your opinion	Possibility of change?
M	do you ever have any other kind of staff support groups or more like even reflective practice groups if you know, if you've heard of that		
P	we have a monthly meeting... a ward round, a ward meeting where you get		

	to, it's only about 15 minutes long you get to go in and get to air your grievances, not really no		
M	and does that help, do people go to that		
P	well you're kind of made go to it, I'd like to go to it anyways but you're made go to it, but then again it's 15 minutes, on my day off I'm not going to come in, I'll just text someone and say 'can you tell them I'm not happy about this'	Mandatory meetings	
M	ya ya, so you wouldn't be expected to come in on your day off		
P	well no they advertise it if you want to come in, come in...They're not going to stop ya, but em the kind of view if 'what the hell are you doing here on your day off?' em but eh it's like there are so many other frustrations about where we work and what we do that we think is an issue, I think the Schwartz Rounds are kind of definitely if people know about it they're definitely down the list of priorities	So many frustrations – SR's are down the list	
M	ya ya, they're not a priority. And would they be seen as around people's well being do you think? Where is people's well-being on the list of priorities?		
P	em I don't know, I guess it's a very personal thing, I take my well-being quite seriously where I'm generally conscious of things that could be affecting me physically and mentally and I eh well realistically I don't think our well-being is necessarily right at the top. There are some things that I just don't understand why it's done. It seems like, not that corners are being cut, but it's just cause we don't have the money, certain things, you know, happen. and it just kind of all gets shoved back to us... and we have to shoulder the burden kind of thing you know. em so eh, I don't know where it is on the list, it's definitely not on the top, definitely. em like our rostering system at the moment is terrible. Like we have a request system where you can request certain days off which	Well-being as a 'personal thing' Well-being not at the top of the list of priorities Well-being not addressed because of money Gets shoved back to nurses...to shoulder the burden I can live with [it]...because its fair	

	<p>more often than not you'll get what you request and you can also put in shift preferences. I never do that either because I forget to do it or because I'm just like I can live with, I'll do my weekends, I'll do my night and I get these days off because I'm just given them. Because its fair. Em but the last rostering for example is fricking horrible, I'm working five weekends in a row and I was like, well as much as I didn't request not to work five weekends in a row, I didn't request TO work five weekends in a row. you know what I mean. And I've heard, as I said earlier on about of the shift patterns are just bonkers like its going to make people call in sick its going like it plays with my head you know. So in that regard no it's not right at the top of the list. It's how do we staff this shift. it's like oh screw, somebody gets there ass kicked. And i think generally we're a bit, I am anyway, we're too good, I'm way too good. Em ya in that regard it doesn't seem like we're at the top of the list and it would seem like that we'd do a better job and we'd be better carers for our patients and we'd be happier if that was at the top of the list. Actually, the more I think about, no way, no no our well being, no way (laughs)</p>	<p>Shift patterns – plays with my head</p> <p>We're too good</p> <p>We'd do a better job and be better carers if [well-being] was at the top of the list</p>	<p>Good nature/trust – taken advantage of</p>
M	<p>and so it sounds like managerially, not mana, well however, the organisational, you're well being is not at the top of the list but you said for you personally, you know you take care of it or you, sort of are aware of it</p>		
P	<p>i try to and I am going to be talking to you know trying to sort my next couple of months shift patterns out because to be honest I've gotten to the stage now where I'm just not happy to be doing that. I kind of think I'm being taken advantage of a bit do you know</p>	<p>Taken advantage of</p>	
M	<p>ok and so when you said you're too good, is that what you mean that people take advantage of that</p>		

P	ya people just walk all over me kind of thing... which to the most degree I'm like fine it doesn't bother me , I don't care what they as in, once it starts to become a problem for me that's when I go mmm	Walk all over me	
M	ok so now you're going to do something		
P	well it's been that case in the past, I haven't but now I am because I am just generally I'm thinking it's going to affect me , I'm not going to be happy (laughs)		
M	ok and just about other people then where do you think they would see their well-being		
P	personally themselves, I think everyone thinks they're not getting... I think the well-being thing is can relate to the rostering which everyone complains about , everyone thinks you get crap rosters, everyone thinks they're working too many nights , not enough weekends off em but like we don't get thanked enough , like I don't think we're appreciated , the work we do and em we recently had an issue where a patient complained about seeing one of our nurses drinking some water . Now we have, like, I sympathise with patients because like you can't drink, most of the time and you have a tube in your mouth and you feel really dehydrated even if we are giving you fluids, I sympathise with that and more often than not if a patient is complaining to me about seeing someone drinking water I'd say I'd generally try to just explain to them and divert their attention to somewhere else because frankly, personally myself, I'm a caring individual , I think of others feelings, I feel for people , but frankly, I don't care if somebody is, personally myself, it's the one think, I don't care if you see me drinking water , I just don't care. That's where I draw the line because if I don't I'll keel over . Like it's one of the biggest problems we have in clinical shift workers is you'll either develop some gastric	<p>Lack of appreciation/recognition</p> <p>I sympathise with patients</p> <p>Expectation of sacrificing physical well-being for patient satisfaction</p> <p>Nurse management prioritising patient experience - unfair</p> <p>Competition between staff well-being and patient</p> <p>We kill ourselves</p>	<p>Patient needs over staff needs – limited resource. All needs won't be met</p> <p>Challenge of the work – physically mentally</p>

	<p>issue, some kidney issue and you'll have some mental health problem, that's the three, that's the triad and I seem to have all three (laughs). But we had push back from the nursing management saying 'oh you can't have water at the bedside' and like other units you can for some reason and I find it drastically and utterly wrong and things and anyway separate conversation (laughs)... in that regard, in that regard, I think it's, it's, I still do it anyways, I just do it til I'm told not to do it and then i'll go 'oh sorry'. They can't do anything em but in that regard I think our well-being is prioritised or the patient, you see that's the thing, who do you prioritise and in my mind you need to prioritise the nurse, clinical staff, the doctors. How the hell are we supposed to do our job like, we kill ourselves, we ram ourselves in to the ground looking after patients and we do really well. Like we coped really well with all the incidents in the last year and that's mentally eh de-stabilising and it's traumatic and we came on our day off we came in the middle of the night we we answered the call you know, and to some degree the behaviour of some of the more senior kind of members didn't seem to meet my standard. You're the leader, you should lead by example, it shouldn't be us be leading, you know. em so in that regard no I don't think they do take our</p>	<p>Work can be 'mentally de-stabilising, traumatic'</p> <p>We answered the call</p>	<p>Desire for leadership</p>
M	<p>so in the standard in sort of appreciating or?</p>		
P	<p>Either, to some degree they don't appreciate the work we do even though they've done it themselves or they or they haven't led by example, some of them. Some of them have come in and they went above and beyond the call of duty...but the one's that I would have expected to perform better didn't. And especially this water thing, that's an example of them not, i'm telling you if you went to the</p>	<p>Don't appreciate the work</p> <p>Physical needs not met</p> <p>Lack of recognition</p> <p>Difference between managers</p>	

	<p>papers with that it'd probably be everywhere, so no I don't think they do, they don't thank us enough, they don't... and the assistant director of nursing who I spoke about she was our previous matron, she was fantastic and she'd send out emails thanking everyone</p>		
M	and there's something about that..		
P	<p>you know and that's all it takes, you know that's all it takes 'I really appreciate your hard work over the last week - that was phenomenal work and I understand how difficult it is'. It's all it takes and that's all I want</p>	Appreciation and understanding	
M	<p>to be recognised. Ok I'm aware of the time, P No no you're fine</p> <p>M my alarm didn't go off..</p> <p>P fine, grand</p> <p>M it's going to go off in one minute... I'm just going to have a look through these questions and</p> <p>P ya ya ya... I'm happy to keep going like I don't know if it has to be in</p> <p>M we've talked about that ok that's pretty much it... because some of the questions are about the impact of seeing other people going to Schwartz Rounds or things like that it just sounds like you haven't seen that.</p>		
P	<p>Ya I think, ya I can't even remember what you said to me when you asked me about it but there's just almost no. It just doesn't seem to be in anyway valued enough</p>	Schwartz rounds – not valued enough	
M	so it's not in people's sort of minds		
P	<p>no, i think we're terrible at cause i'm, there's a reason I'm sure we do schwartz rounds cause it's been proven to help, I'm sure that's the reason. There's other things we take in from other fields and other</p>	Struggle to implement change	

	professions where you know it's been a struggle to implement it and when we have it's just worked.		
M	so can you give an example		
P	<p>so checklists. from the airline industry. So back in the 70's or 80's when planes started falling out of the sky due to human error, somebody decided 'ok stop we need to rethink what's going on in the cockpit' you know and they came up with checklists and that's the reason anytime you see a plane crash and you'll see most of the people walk out alive it's because there was a checklist and the pilots follow the checklist because that's their religion it's just, light goes off, they get a book out and they go through a checklist light number 542 here's the checklist and they do it, you know. Like that plane that landed on the river in New York that was all to do with checklist. Now part of it was because they need to make a split second decision what kind of route they're going to go down and then they made the decision and followed the checklist and that was it. All the engines cut-off - checklist. It's not 'shit we've no engines' it's just like checklist. I'm sure there's we have a solution in here for that problem and we brought that in because too many there were too many incidents happening with surg - happening with surgical patients and em they got the checklist so eh what's his name Gwande wrote a book called checklist and most medical people well people who read this kind of stuff, I read the book and it's fantastic like the rate of, the mortality rate and everything in surgery and everything just friggin dropped like a stone like when they brought in a checklist. You hear all these like - we had a recent incident in the last month where a patient passed away in A & E dept because they couldn't get an air way in... and when they reviewed what they needed to review - we have a brand new checklist, and that's all from the</p>	<p>Checklists – incorporated in hospitals</p> <p>Reduction of decision making</p> <p>Anxiety management – 'we have a solution'</p> <p>Mental well-being – not even remotely jesse god you must be joking</p> <p>Need for a 'whole sea change'</p>	<p>Mental well-being not important, not valued</p> <p>Basic physical well-being felt as unimportant</p> <p>No culture of valuing well-being</p>

	<p>airline industry you know. So as far as like mental well-being which I associate with Schwartz Rounds because I think it's good to talk about things, no, not even remotely jeese god you must be joking. Like when it comes to even physical like being able to drink water like no way. I think it's, in my organisation I think it's a struggle to, I think there needs to be a whole sea change. Until they start to value that sort of stuff at a basic level, NAME 'oh it looks like you're stressed come in to my office we'll have a chat'. You know til like even basic level, it's getting a bit better, like I know there are avenues there if I needed help but it's definitely not emblazened</p>		
M	it's not encouraging it or		
P	No		
M	and there's, I'm just struck by the thing that you said about the sort of nurse who's the matron who keeps, you know, who is steel		
P	ya they're nuts but not everyone's like that		
M	and it's like that's... is that the goal?		
P	<p>but it's that's the thing, not everyone is like that. I work with some people who are like that but there are other people who aren't you know and I'm like I'm pretty timid. And I find it hard to speak up sometimes even though I know the right answer and I'm you know, I'm getting better, but like so I'm not the archetype kind of you know matron you know made of brick you know but I'm a good nurse and so it doesn't have to be everyone you know so</p>	<p>Archetype matron – made of brick</p> <p>I'm a good nurse</p>	<p>Can be a good nurse without being unaffected</p>
M	but is that something that's valued?		
P	<p>I think so, I do think so because over the last, cause I just finished my course and I was really busy with study and I was in a bad mood because my shifts were all over the place and I wasn't going out enough and seeing friends sort of thing so I was in a terrible mood but you see my mood doesn't generally transfer to work but I had people saying to me</p>	'Made of brick' as valued	

	'oh you seem to be in a bit of a rough mood these days' and i'm like 'oh'		
M	people at work said that		
P	and people associate I know people associate me with being chilled, really chilled out and happy you know just joke around kind of thing but generally it will take something horrific for me to flip (laughs) and I think it's, ya I think it's valued... well no they have when I've done appraisals and stuff they're pretty happy but it's not said enough you know. If I was in charge I'd be going around I'd be spending the whole day going around telling people you guys are amazing , (laughs)	People see me as chilled out	Uni-dimensionality to staff – pressure to always be happy/chilled
M	you're great		
P	Ya you're great (laughs)		
M	but the thing about people saying to you 'oh you're in a bad mood, what did that mean to you		
P	it came from a caring point of you, it wasn't 'oh you're in a bad mood' you know... Cause I kind of had a, there was one day where I was particularly not feeling great and em I couldn't really do much that day. It was only when I went to work the next day I felt completely out of sink you know and it was only when I was chatting to one of the girls, she had similar experience in her life and I was like 'oh ya this is.. brilliant ' you know. That's when I was like 'oh I need to have a rest or go and see someone again ' kind of thing but yeah it's kind of i don't know, on the other hand it kind of feels until somebody falls on the floor until there's a kind of collective... if I said it , if I said 'oh I'm having issues today' which my manager said cause I remember telling her roughly about em kind of things that happen she said if there's any issues just tell me ' you know. Em so I know the support is there but it's more as a general kind of and you know there's good vibes , it's infectious you just kind of feel great you know everyone's smiling and	Care from others e.g. sharing experience with another colleague – permission granting responsibility to seek help 'if I said it' until somebody fall on the floor emphasis/ responsibility to be smiling/joking 'good vibes' ' it helps everyone' Everyone's a bit more stressed out	People are not attuned to each other's needs unless very apparent or told Emotional labour Accumulative effect over

	<p>everyone's joking no matter what's going on em it helps everyone.</p> <p>Like when I first started there, I don't know if it was because I was a newbie and I was just amazed by everything and I remember there was just such a cooler vibe there. It was almost more like being at college you know just kind of more like, it's kind of weird to say but when we went for a Christmas party it was like the event and everyone went out and got wrecked and all these stories and it was crazy and everyone had a good time and i think I think that vibe has disappeared you know and everyone's a bit more stressed out</p>		time/now its more stressful?
M	ok so this was a couple of years ago to now...		
P	ya this was a couple of years ago to now ya it seems to have changed you know		
M	And do you think that's something to do with, if a new person came in now would they feel how you felt do you think or do you think somethings actually different?		
P	I think something's actually different... I don't think people would feel the same way as I did. I don't know em I think I generally gauge it so I have a group of people that I started with and we sort of hang around and there was a group ahead of us em and there's a group behind us and when a new group starts it's kind of do they seem to be forming the same type of group or not. And if they're not kind of like oh well there's something wrong as in oh ok they don't want to start a group or general 'oh we start together let's kind of... what would you... support each other' so		
M	but it feels like that's changed?		
P	a bit yeah a bit and I don't know why, well I have my theories about it but eh. But ya Schwartz Rounds, no way (laughs)... ya not a chance em. ya no it's eh. I think it would help people I really do em. I think cause i'm eh applying to do my masters and when i		

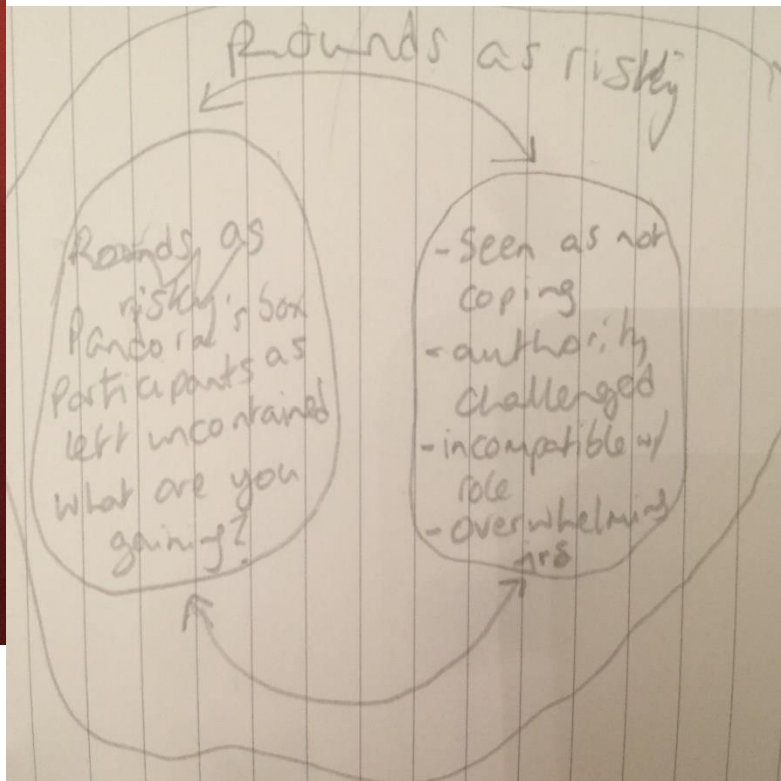
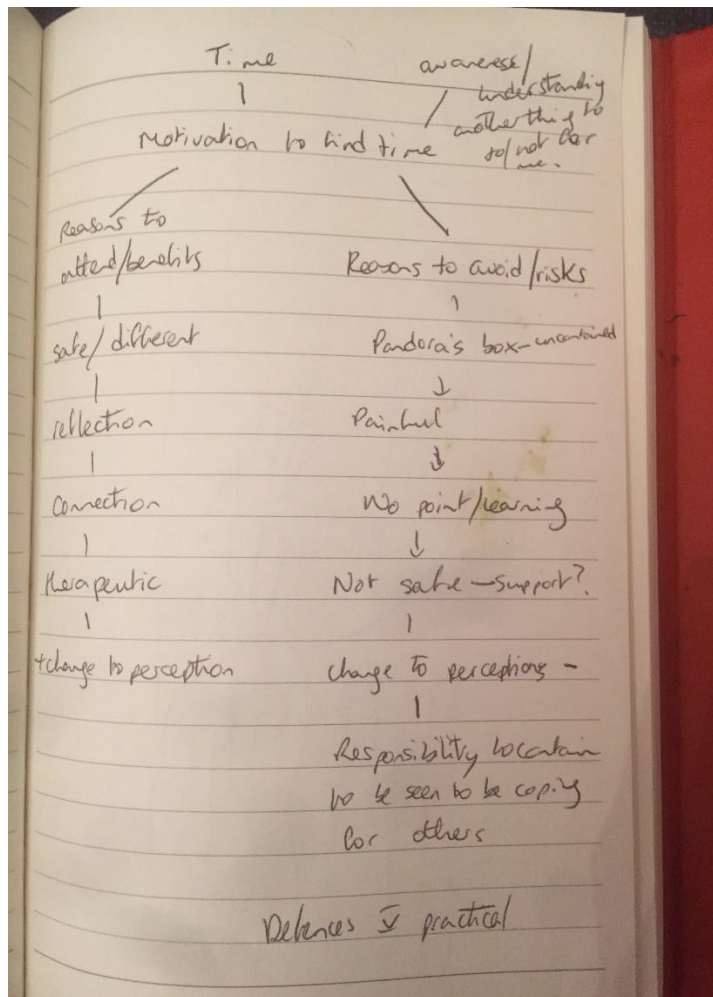
<p>talk to people about doing a masters they're like no way 'what are you doing, that's insane, it's more work'. I don't know if people are really, there seems to be a lot of course that we do there seems to be a lot of 'oh I'm just getting it out of the way so I can just do this and this and this' em like all nurses do mentorship and every nurse has to do it to progress to the next Band which I think is wrong because I think some people are terrible mentors and they're just doing it just to as a career progression...it should be seen as, if you want to mentor students you're not going to have a shortage of people who want to mentor, I would love to teach, I would love to teach and I want to do it em and I know loads of people who want to do it but I know other people who maybe who don't want to do it and wouldn't be good mentors... but it's forced upon them. So some people see these things as a burden and I think the same thing with the kind of Schwartz Rounds thing. I see the masters, I do see it as predominantly a professional thing. I get to say I did a masters and it will make me more employable. But also I'd be interested in doing a masters because I think it would be very, i think it'd be like cause i have the opportunity to just do a dissertation because of my post graduate diploma I did at [name] you can do the top up and you're awarded an MSc em and it's a year long and i'm like it'd actually be cool to take a topic and a proposal and go with it and see how far I get. Other people just see it as 'no way'. And I think they might kind of lump the Schwartz Round thing in with that even though it's not college based I think...intellectual, intellectually stimulating kind of thing. I don't know. That makes me sound like I'm calling everyone stupid or something but I don't know I just think it's more...it's an academic thing.</p>	<p>Roles e.g. mentor – for career progression – a burden</p> <p>Schwartz Rounds as more work – what's the benefit</p> <p>Schwartz rounds as intellectual and academic</p>	
--	---	--

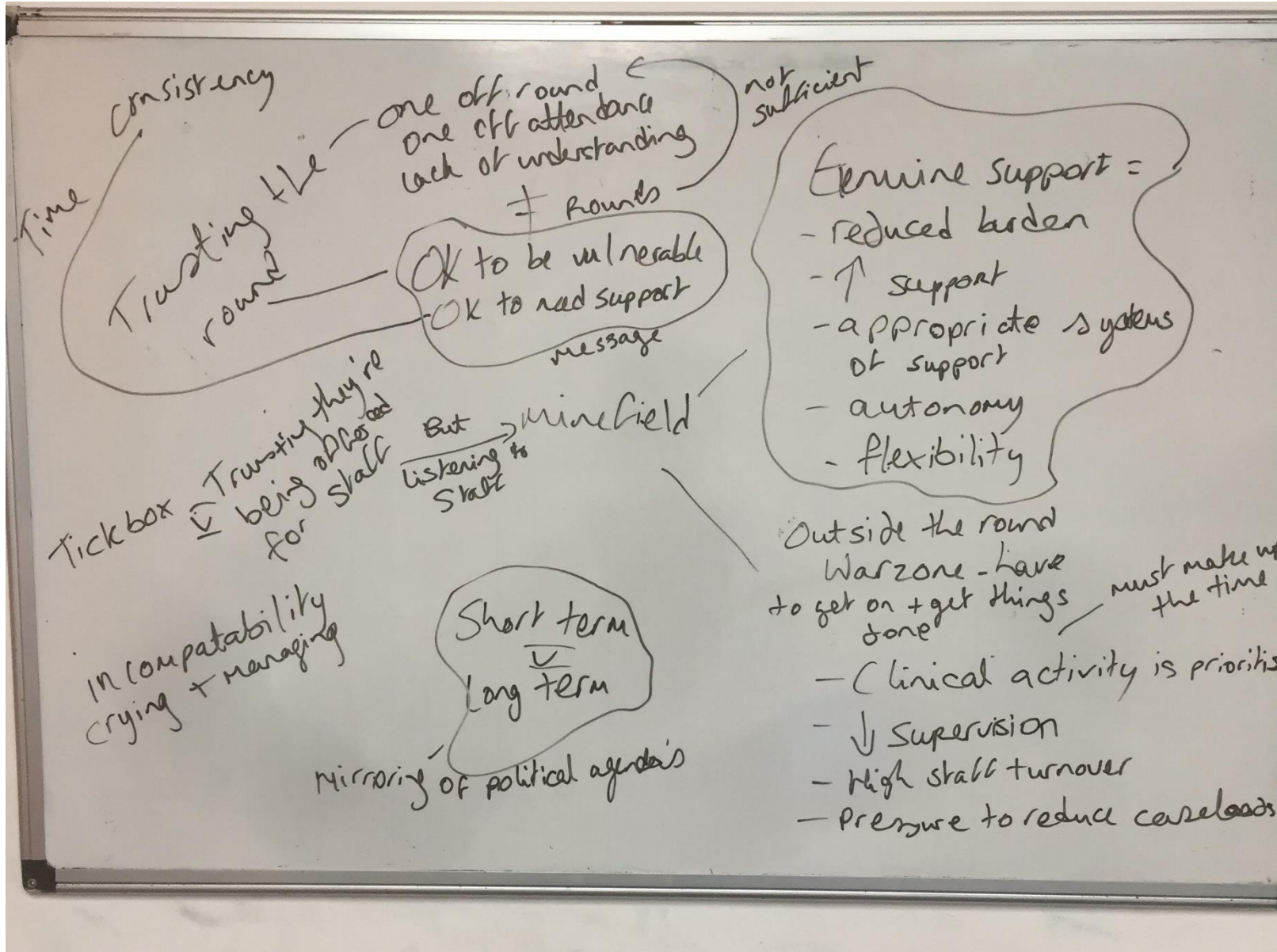
M	ok it feels more academic. And it sounds like people don't have the space for more		
P	Either they don't have the space or they just don't want ... which is fair enough...But I think there are definitely, I know people I trained with who I'm still friends with that have never gone to one and I'm like 'you're the type of person who would love this kind of stuff' so I don't know if they actually know about them . They're in different hospitals and stuff so i don't know	People just don't want to Knowledge of SRs	
M	right so whether they're there or whether they know or what stops them		
P	ya so, I don't know		
M	right well cool, thank you very much for all that. Any last thing you wanted to say		
P	No I think that's ok, that's everything em ya no I've seen it at work, it's not really enforced , it shouldn't be enforced but I mean it's not really rammed down our necks em the reason I haven't gone is to be brutally honest, laziness or em I've forgotten about or something but it's something I would be... I hear about all the time from my mum so it's kind of something that's thing... I think it's good but.. whatever	It's not encouraged enough Easy to forget Effortful	
M	it's good it's just		
P	I guess it's a thing with.. it's a voluntary thing , people kind of prioritise other things over these sorts of things but yeah. I think it sounds, I think it sounds to some people like... I do remember back home in NUI there was a... I went to a couple of debates and stuff, the debating society... So either it was the debating society or they just hold these debates. They were great, they were brilliant we had all these crazy people come in. I remember the one I went to and I was kind of thinking if this was going on it wouldn't happen today, man I feel old. They had these Muslim clerics come in and this was back in 2006 or	Other things are prioritised	

	<p>something and the debate was there.. what do you call it... wasn't a question, wasn't a theme it was there statement was the 9/11 attacks were justified. At the time I was kind of like 'oh ya sounds interesting' ya know... that wouldn't happen today like. Universities would run them out that's... but I do remember it was a very stimulating and it was like.. he was like.. It was an horrific event to be talking about but it was kind of like... it's the thing about universities that, and I've heard about it in the States that it doesn't seem to be being preserved, it's like they're places, they're meant to be intellectually stimulating, you should have people from all sides being able to have an avenue to give an opinion but ya I was thinking about that, that was... so I guess in a kind of a,, I guess you can kind of lump it in to the same kind of stuff because it's sort of stuff that I know loads of people who just wouldn't have bothered going to not the topic of the debate</p>		
M	to go to a debate		
P	like a society things. Like if it wasn't sport they wouldn't bother their arse going... that kind of thing. Yeah, I get made fun of for reading the Financial Times		
M	by who		
P	<p>people at work... because you know you see the FT and it's boring as fuck. I don't read any of the business stuff I only get the weekend edition and it's there's loads of stuff, it's great reading opinion pieces and everything... And i guess it connects to that sort of mentality I don't know. One of the nurses said 'I'm too stupid to read that paper' (laughs) and i said 'what are you talking about'. ...It's just English.. It's talking about everything. So I don't know if it's like the same sort of mentality I don't know.</p>		
M	So it's in some ways, 'I'm not clever enough for that' or		

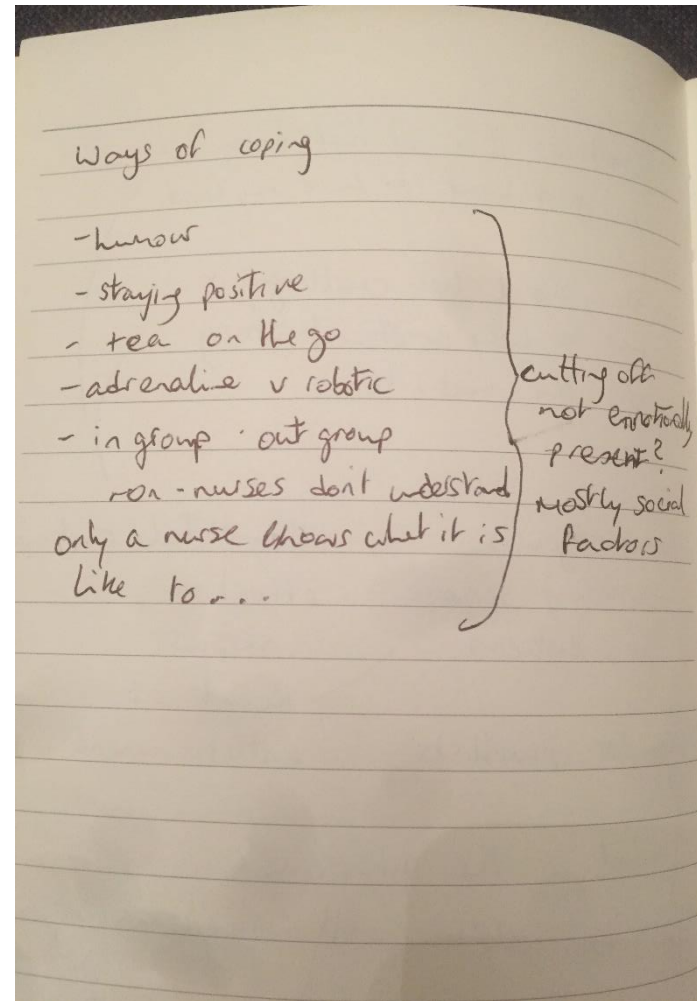
P	Maybe I don't know, it's like 'I'm not clever enough if that's the way you're putting it I shouldn't be clever enough to read the FT if that's the way you look at it... I didn't go to Cambridge or..	People feeling like they are not clever enough for SRs	People excluding themselves because of view of not for me, I'm not clever enough
M	Right so people exclude themselves in some way		
P	Yeah and it's like 'well what are you doing that for? ' not that they're not open minded. Maybe they're just so comfortable and they like what they like you know. They like the Daily Mail celebrity section or whatever and that's fine if that's what you... I don't know it's not advertised , it's not pushed and it's completely voluntary and it's not very... yeah I associate it with the backdoor of the toilet I use at work (laughs) I mean like... a bit better than this	They are comfortable they don't want any more SRs not promoted	

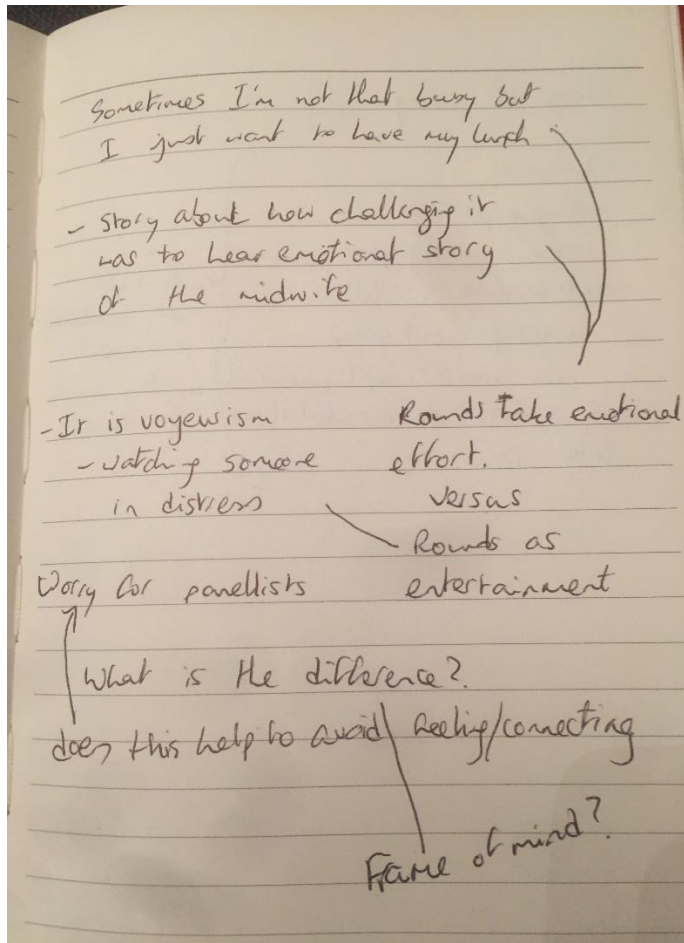
Appendix I – Diagrams

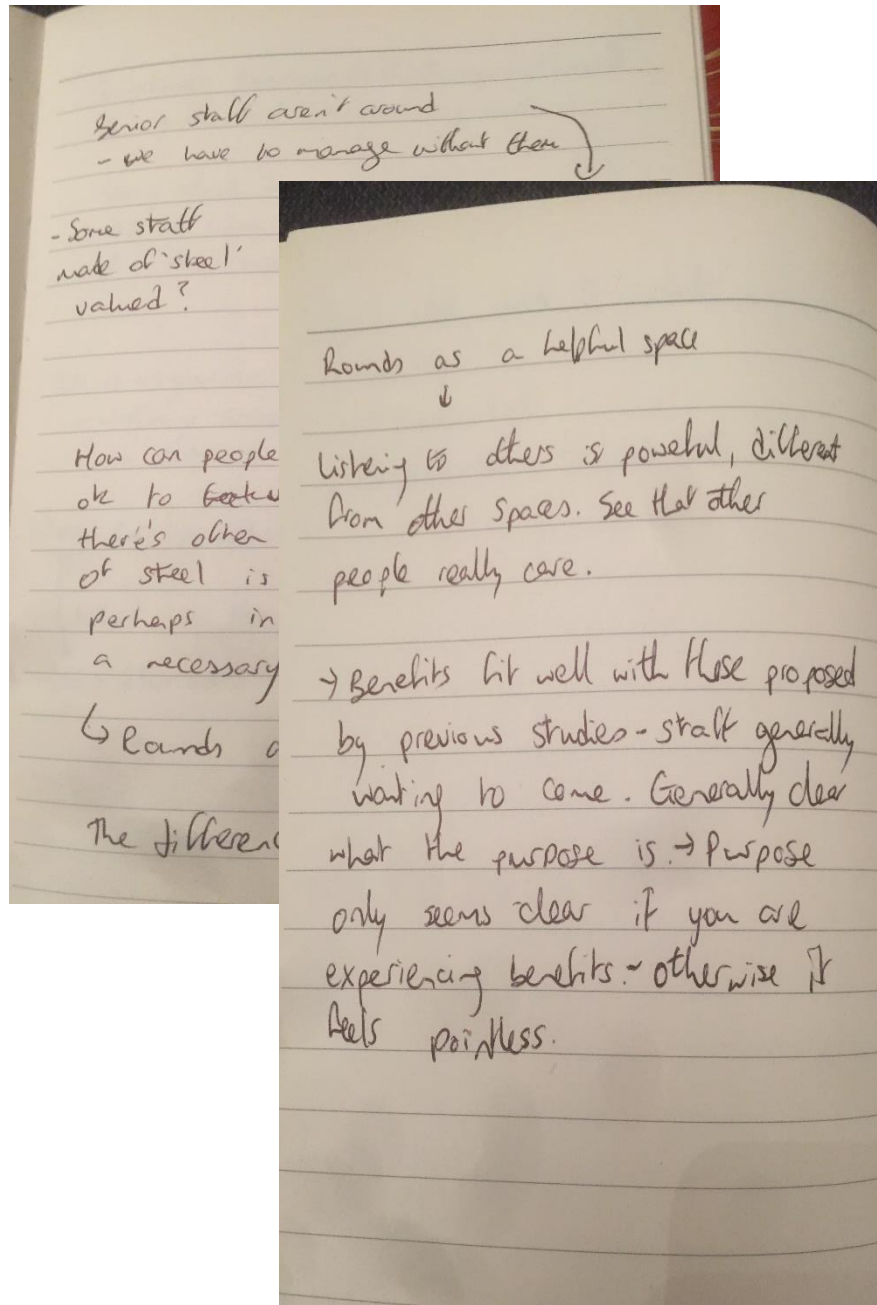




Appendix J – Memos







Appendix K - Excerpt from bracketing interview

Interviewer: How did you become interested in this question?

MG: Based on previous experience when I worked on a ward of reflective group spaces, so we had a reflective practice group on our ward and that staff used to nearly run away when the facilitator would come in and they would be like 'oh I can't I have to do xyz..' and I remember them saying 'oh what's the point in this, nothing changes'. So I suppose one of the things I was interested in was, how do we get people to go, if this is a helpful thing, how do we support people to attend.

Interviewer: Ok and something which I guess links to the secondary questions you've got is what's getting in the way of people attending is it fear of exposing themselves or that they'll be judged as weak if they go to a reflective group?

MG: So ours, on the ward it was compulsory, well compulsory in a sense, one person had to stay out and make sure that the ward was safe, but people would nearly be fighting to do that, they would want to do that or to get to take somebody out, you know. But my sense was that it wasn't necessarily about, and I suppose that's a different thing as well, but there was a sense that 'we go in and think about things that are annoying or problems and nothing is different'. So people's even understanding about what it was about and why it might be useful seemed to be.. I don't know.. if it fit, fit in with what people thought was useful or what they thought they needed.

Interview: It's making me think about our reflective groups at Uni and how, their purpose is not to solve and a problem and we don't actually know what the purpose is and how

uncontaining that can be and the conversations we have about oh what is this and what are we doing

MG: How do we use it? What do we talk about? and given that we have somewhat maybe more of an interest or to some extent more of a knowledge that reflection can be helpful maybe that some other professions then it might feel even more alien. You can still see some resistance from us and we're a bit like 'what is the point of this?' 'I feel like I'm wasting..' sometimes it can feel a bit like I could be doing other things or

Interview: So, there's some motivation behind this from a lived professional experience but also, something from a lecturer has said about a member of staff. What has made you interested in the questions you've asked.

MG: Again, probably to do with the people I had worked with in the past who said 'I'm not interested in this' who didn't see a point in it. And I suppose part of me was wondering who does go to the Schwartz Rounds, who shows up, who attends, and are they maybe the people who are better at reflecting anyway? Are they the people who are going? Are they the people who are benefiting? The people who might, well the people who might or might not, benefit from, or the people who it is targeted to, so maybe the people who aren't reflecting or who can't think about how their feelings might be affecting their work, are they the people who are even going? And I suppose that was slightly compounded by the fact that the first Schwartz Round I went to, it felt to me, it felt like it was largely white, female attendants which to me did not reflect the work group, which I didn't think reflected the staff group more generally. So, it made me think, hmm, who is going and who is not? Are there differences around that. And part of me is thinking well if people don't think this is interesting or helpful to go to,

then it's not really, in some ways it's not good enough to just go 'oh well there are Schwartz Rounds for your well-being and either you go or you don't go and that's what we offer' when that's not really necessarily helpful for everybody and different people find different things helpful.

Interview: It's making me think about people being defended and that's why they are not going?

MG: I think the really obvious reason for people is 'there's no time' and that's the really easy thing to say in some ways and there is definitely truth to that but part of me, I'm slightly going on to talk a bit about my hopes or maybe expectations or more hopes I guess, is to find maybe that it is more than that, and that it's not just about time but actually, maybe people have defences, well people do have defences and the institution has defences, that maybe people are, that maybe different people are more or less willing to sort of lower and experience something else. So ya, definitely that sort of thing is in my mind and is maybe one of the things that I'm looking out for

Interviewer: So would that be that you're expecting to find that or that you're hoping to find that?

MG: I think I'm hoping to find that. I think I'm expecting the reasons that people will say they don't want to go are around time related and that somewhat has been the experience and in some ways I'm hoping that when people say 'I don't find it helpful' or that 'it doesn't really solve a problem' that in that way, that when people talk a bit more about it in those terms then I suppose I'm hoping to hear a bit more about why it's not helpful to just talk. So I suppose

the intolerance of sitting with something that is really hard and maybe not being able to do anything about it. Not being able to change it. In some ways I am expecting that they are there and hoping that they can emerge because I suppose if people are defended against those things then are they, how able will they be to reflect on the fact that that's stopping them from going.

Interviewer: It will be interesting to see if there are layers in your interview, to see what people are saying. So are there any other things you are expecting to find?

MG: One of the things I am expecting to find is that within a culture or a team that promotes Schwartz Rounds, people will be more open to going, where managers feel it's useful sort of staff will be more, staff will feel its more worthwhile and the opposite, where managers don't talk about it, where managers aren't up for it, that staff won't find it so easy to go or maybe won't be so interest to go. So I guess that there will be some group effect to some extent around whether it's worthwhile or not.#

Interviewer: Anything you want to say about what you are hoping to find?

MG: Hoping to find. Ya I suppose in some ways I feel like I have to mind myself because in some ways, I feel like I can be quite negative in the sense of like, maybe rubbishing, well not rubbishing but kind of going 'oh well people don't want to go and the people who do go are the people who are already reflective so what's the point'. And so, to hold back from that. Maybe that's part of my own, hopelessness about some of the situations. It's kind of two sides. In one way, I want staff to feel supported, I want staff to feel helped, I want these things to be available for them but then in other ways I'm kind of going, well is it going to

happen; will people go, will people benefit from it? I suppose in this research rather than going 'oh why do you go? What do you find helpful about it?' Am I more like 'tell me why you don't go' and maybe looking from a more negative angle. And so part of me is wondering, is my research about showing that people that don't go and I'm also thinking that's not really that helpful ultimately because this is something that could be really useful. So how do I move away from just sort of..because I think the thing around you know people being defended and not wanting to go because of the defences is quite interesting, so how do I not get sort of, side-tracked into going 'oh all these defences are at play and people don't want to have their defences lowered by a Schwartz Round and so they don't go'. Or you know whatever those hypotheses might be that might move me away from looking at maybe even interviewing more people who do go and find it helpful or ya overly focusing on that element of things rather than about why people do go.

Appendix L - Reflective diary excerpts

Section A

19/01/18

Struggling with finding papers, is that because there are not very many or I am bad at looking for them. Conversation with B due to frustration with articles and trying to find a viable section A.

What argument are you trying to make?

I want to know how SRs are any different from other staff support groups... are we marketing something that already exists or are they fundamentally different.

What are the things getting in the way of making the argument?

Difficulty finding papers of decent quality connected to SRs. Difficulty finding papers that are similar enough about staff support groups to use as a comparison. Difference in the emphasis of staff support and SRs papers. Psychodynamic papers for staff groups are most often written from the facilitators' perspective, they most often give an analytic understanding of the group and what might be going on/how they are helpful. They are less outcomes focused.

Some of the SRs papers don't have substantial theory underpinning them. Some of the literature is methodologically poor. The focus of the papers is on outcome rather than theory underpinning it. Exception George and maybe Farr and Barker.

Section B:

18/07/17

Following the first interview I feel quite sad for the participant and the way that she was treated. I feel angry that she felt forced to leave the NHS. Also wondering why she didn't say 'no' to what was happening. What stopped her from saying I won't be treated like this after 30 years? Was she that powerless or did she find it hard to say 'no' or both? Individual versus systemic? More senior staff bullying and abusive. I was interested in the inability to be present with what people were saying due to a fear of being needed outside of rounds and checking phone. The idea that couldn't possibly turn the phone off for one hour. Sense of martyrdom in some ways?

05/10/17

A sense of in-group out group with this participant. Nurses wouldn't mind attending rounds on their own, nurses are independent thinkers and won't be influenced by other people's opinions so they would definitely go to rounds if it wasn't for the time pressures. However, healthcare assistants will only go if they are forced to. They'll only want to go if their friends are going and they will usually come back and say 'you were right, it was good' but then the next week they would have to be convinced to go again. Perhaps it could be mandatory for them so they will go. Interested in the, perhaps projection?, into non-nurses that they don't make autonomous decisions and that they don't know what is good for them while nurses are too pushed to be able to access rounds otherwise they would be there.

03/10/17

Transcribing of interview two is upsetting. The horror of the work is pouring out of him as he tells story after story. Yet describes himself as not too affected by the work. Describes any impact of the work as being related to pre-existing difficulties. Sources of coping – adrenaline, wanting an exciting patient, morose humour, mentioned the Daily Mail three times about what they might think about various things, how a headline might read, perhaps a sense of fear that the things they do to cope would be perceived as wrong by outsiders. Insiders and outsiders. Are they wrong? Is it ok to say things that you wouldn't say in front of an outsider, does that suggest you need to find another way to manage? Can compassion co-exist with that? I get a sense that being an excellent nurse is about doing. Description of senior staff as infallible and like this is something good.

Conversation with nursing colleague about issues relating to staffing – staff talking in the office e.g. instead of brushing someone's teeth... fear of having to do it for everyone/being presented with more 'jobs to do'. I remembered my old workplace where the psychoanalyst said that for as long as he had been coming to the ward to run reflective group, people complained about not having enough staff. How much is staffing used as an avoidance versus genuine issues? Is it ok that people need to have a break in the office or should they be filling their time the whole shift?

14/11/17

While in the interview today, felt like the participant was somewhat hostile as if wanting to tell me that I don't understand what they need. I felt like I was being associated with Schwartz Rounds and she wanted to give me a strong message that she wasn't interested in them. She talked about things not bothering her in the slightest e.g. people shouting at her 'God complex', and not being affected is a good thing. Again idea of ingroup – outgroup. Maybe we in this department doing this kind of work are different from other people. I felt like I was being told I was being in the outgroup. Difficulty battling with the my ideas about what people need, thinking they are just very defended, taking in some ways an expert position versus people are allowed to not find certain things helpful.

16/04/18

While coming up with the theory I'm thinking about the Psychologists for Social Change work and how it might be relevant to the context of the NHS. I'm wondering about how the 'symptoms' of the problem, staff burnout, staff disengagement, stress, lack of compassion are being treated with support groups rather than changes in their circumstances which is more helpful and validating. It's reminding me of individuals being offered therapy when they are depressed because they don't get their benefits. How do rounds transfer into people's working lives? Can people really be emotionally vulnerable when they are so overburdened. I feel a bit of concern that maybe rounds aren't very safe for people who might be left feeling very exposed in an environment where they aren't very well supported.

feeling very angry about some of the pressures on staff and some of the dismissal of staff's needs. Feeling protective of participants and wanting to write an article about their experience for wider awareness.

Appendix M – Ethics Outcome Letter

Dear Ethics Chairperson

‘Factors influencing attendance and engagement with Schwartz Rounds: perspectives of attendees and non-attendees’.

This is a letter to notify you that the above study, originally titled ‘Factors influencing emotional self-care and reflection: perspectives of attendees and non-attendees of Schwartz Rounds’, given ethical approval on 27th October 2016, has now been completed. Enclosed is a summary of the findings of the research. Please do not hesitate to contact me if you have any queries.

Yours sincerely

Trainee Clinical Psychologist

Appendix N – Summary of research for participants and the ethics panel

Background: Schwartz Rounds are a staff support intervention running in over 100 Trusts in the UK. Rounds are a forum where staff come together to reflect on the emotional impact of their work. Research to date suggests that staff perceive rounds to be beneficial, however they have also been found to be underused. The aim of the present study was to develop theory relating to staff's motivation to attend and engage with rounds.

Summary of results: The diagram attached depicts the theory of rounds attendance derived using a grounded theory methodology. A core category, 'effort to attend', acknowledges that it requires effort to overcome contextual practicalities of limited time and resources if staff wish to attend a round. While clinical activity is viewed as the priority, practicalities can be overcome for certain non-clinical activities such as training. This suggests that for staff to make the effort to attend rounds, or for managers to permit subordinates to attend, they must view rounds as valuable.

The proposed benefits of rounds are depicted on the left of the diagram. They include the sharing of stories, connecting with colleagues' emotional experience and the normalising of distress or difficulty. The model predicts that these components of rounds positively influence the way attendees see others e.g. 'everyone has a story'. The effect of the round can transfer to attendees' work life by influencing the way they feel towards and interact with each other. The active nature of rounds requires attendees to access a 'frame of mind' which allows them to 'really listen', connect with and apply the discussion to themselves.

The perceived benefits are affected by the degree to which rounds feel safe. When the sharing of stories is perceived as risky, like 'opening Pandora's box', attendees struggle to access the 'frame of mind' which may be necessary to benefit from the round. This is depicted on the right side of the diagram. A perceived risk is the potentially damaging impact of opening

oneself to thinking about difficult experiences. The expression of vulnerability is viewed by some as incompatible with the role of a manager. It is thought to impact negatively on staff who need to see managers as coping and bearing the difficulties of the work. Lack of clarity about the purpose of rounds compounds doubt about their usefulness. The model predicts that without a clear sense of the aims the perceived risks of engaging with rounds outweigh potential benefits. This reduces the likelihood of staff making the effort to attend.

There was recognition of the supportive and humanising values rounds could foster. For some, while the round itself was a helpful experience, it was at odds with the reality of people's working lives. Participants spoke about the experience of rounds giving permission to be vulnerable and to feel, as incompatible with the '*warzone*' of the high-stress, overburdening, working environment. The model suggests that the deprivation of support for staff more broadly leads to a sense of rounds being a tokenistic gesture. Staff and management avoid truly connecting with what staff need as this would require action which, in the short-term at least, would impact priorities such as clinical activity. Broader neglect of staff needs impacts their ability to trust and utilise rounds. Conversely, staff who are supported and may therefore be managing better can shift into the 'frame of mind' which enables engagement with and benefit from rounds. This would increase the likelihood of them making the effort to attend and feeling supported to do so.

Implications: The research highlights implications for organisations, managers and rounds organisers. For those participants who found rounds helpful, practical barriers such as time, resources and, for junior staff, the need to seek permission were obstacles to attendance. Organisations and managers can seek to address these by promoting staff well-being as a priority rather than a luxury; modelling this to junior staff by inviting them to attend rounds.

Attendees described a lack of clarity regarding the purpose of rounds. While the benefits of rounds may become clear over time, staff are not likely to repeatedly prioritise them without a clear understanding of their purpose. Clear promotion and introduction of rounds may help to address this. Similarly, concerns about the psychological safety of attendees could be addressed through explanation of the format and process of supporting speakers and highlighting support for staff. While additional support may not be required in emotionally supportive teams and environments, according to participants in this study, offering support outside of rounds was deemed necessary as working environments were not perceived as focused on staff well-being.

Organisationally and within teams, greater efforts to provide practical support to staff in relation to their workloads is important for rounds, as an emotional support, to be successful. If vulnerability in rounds is experienced as too different from the culture of the team or organisation, it feels incompatible with attendees' experience of their work life. This reduces their ability to engage with rounds, should they wish to do so. Organisations, managers and those in positions of power should resist and advocate on behalf of staff to ensure rounds do not become an intervention to support staff to manage unacceptable conditions rather than supporting the processing of the emotional challenges inherent in healthcare.

