

# **The contribution of Schwartz Center Rounds® to hospital culture<sup>1</sup>**

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## 1. Introduction

The King's Fund Point of Care programme aims to improve the experience of patients in hospital and to support staff to provide high-quality, patient-centred care. Hospital staff are working in highly pressurised environments and the nature of their work is complex, intense and emotionally challenging. This has an impact on staff wellbeing, which in turn affects their ability to care for patients with compassion.

We describe here one intervention which we believe makes a positive contribution to hospital culture and to relationships between staff and patients. Schwartz Center Rounds ('Rounds') are a multidisciplinary forum designed for staff from across the hospital to come together once a month to discuss the non-clinical aspect of caring for patients – that is, the emotional and social challenges associated with their jobs. Rounds have been running for 14 years at more than 200 sites in the United States, and The King's Fund introduced them to this country in 2009.

## 2. The hospital context

In order to understand why Rounds are of interest and how they might contribute it is necessary to set out the factors that currently shape hospital culture and the impact this has on staff who work there.

2.1. In recent years hospital activity, especially unplanned work, has been steadily increasing. In England, the number of inpatient hospital admissions, both elective and non-elective has increased to more than 9 million and 5 million respectively per year. There are now about 20 million accident and emergency (A&E) attendances a year, and 20 million outpatient attendances a year.<sup>2</sup>

2.2. The number of people working in hospitals over the past 10 years has also increased significantly, with more hospital consultants, nurses and allied health professionals. Non-clinical NHS staff, including managers, porters and administrative staff, traditionally account for about half of all personnel in the NHS, and has also increased.<sup>3</sup> This growth in size and staff numbers, along with the use of new technology and the increased pace of organisational life, have had knock-on effects on relationships

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<sup>1</sup> This paper was written for the 8<sup>th</sup> International Organisational Behaviour in Healthcare Conference, Dublin April 2012

<sup>2</sup> HESOnline (IP) and DH (A&E & OP) Oct 2011

<sup>3</sup> NHS Information Centre (2011) *NHS Workforce: Summary of staff in the NHS: Results from September 2010 Census*. London: The Health and Social Care Information Centre.

between individuals and colleagues and patients. Staff say they miss the personal relationships, face- to-face contact, corridor conversations and informal meetings in the canteen.<sup>4</sup>

2.3. However, in spite of the increase in staff numbers, relationships between staff and patients are more short-term, with less time to get to know patients individually. The increasing specialisation in medicine, nursing and the allied health professions, in the context of the continuous striving for greater efficiency, has reduced contact time between individual patients and individual members of staff, and patient care has become more fragmented. The average length of stay has fallen.<sup>5</sup> Patients over 65 account for 70 per cent of hospital bed days and 80 per cent of emergency readmissions. Of these older people admitted to hospital, 60 per cent will have a mental disorder (depression, delirium, dementia). Older frail patients are often seen by the hospital as 'in the wrong place'.<sup>6</sup> More people, in more specialties and departments, are involved in looking after the same patient. The typical inpatient day is increasingly broken up; patients spend less time on their own ward and more time being transported around the hospital to investigations and treatment.

2.4. There have been changes in working arrangements – working hours have been affected by the European Working Time Directive, so that junior doctors no longer work very long hours, and patterns of working for nurses has changed so that they often work fewer, but longer shifts. This means that both doctors and nurses may not follow a patient's progress as they used to. There have been changes in skill mix, with fewer ward staff being trained nurses, and more health care assistants. There have been changes within and between professions. The boundaries between doctors' and nurses' work have shifted, meaning that nurses now perform more technical tasks, leaving more patient care to health care assistants.

2.5. With the emphasis on targets, financial efficiency, and throughput, staff are under stress personally, working in big, very busy, pressurised environments with little opportunity to establish good relationships with their patients and colleagues. We also know that stress is caused by a sense of lack of control. The current uncertain environment with job insecurity, the threat of organisational mergers and redundancies, all add to the pressure already there for staff. Reported stress of health service staff in general is greater than in the general working and accounts for more than one quarter of staff absence, which itself is higher than in other sectors.<sup>7</sup>

### 3. The nature of the work

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<sup>4</sup> NHS Confederation and Joint Medical Consultative Council ( 2007). *A Clinical Vision of a Reformed NHS*. London: NHS Confederation.

<sup>5</sup> HES online October 2011

<sup>6</sup> Tadd W *et al* (2011). *Dignity in Practice: An exploration of the care of older adults in acute NHS trusts*. London: Department of Health.

<sup>7</sup> Department of Health (2009). *NHS Health and Well-being Review*. London: Department of Health.

....The job of hospitals is to cope with human bodily and mental vulnerability, death and destruction. In its highly acute form, this is not pretty or easy work.....As society collectively displaces its discomfort to hospitals and health workers, requiring them emotionally to launder the unspeakable and uncontrollable, it is not surprising that those institutions and workers are under a lot of pressure ....<sup>8</sup>

3.1. As shown, the pressurised context in which staff are working makes it challenging to provide high-quality individual care. But theoretical and qualitative research helps us to understand that the very nature of the work staff are doing is incredibly difficult. Continuous contact with patients who are ill, in distress, maybe disfigured or dying means that staff, especially nurses and health care assistants who are with patients continuously, are constantly confronting their own mortality and vulnerability.

Psychologists and others have observed that death and disease, physical and mental degeneration generate a primitive fear in us, particularly in western cultures. The more serious or terminal the illness, the stronger are the fears and taboos, and one immediate strategy that staff may adopt to deal with this is to distance themselves. Menzies-Lyth has described how people withdraw, perhaps for their own emotional protection, and the uniforms, procedures and targets of modern health care provide organisational barriers to retreat behind.<sup>9</sup> This natural avoidance, or self-protection strategy, means that compassion and good communication are unlikely to occur unless staff are supported to confront these difficult issues.

3.2. Teamwork and opportunities to reflect can mediate some of the pressures and help individuals to cope. Studies have shown that members of good teams have lower levels of stress. Unfortunately teamwork does not occur spontaneously and has to be worked at. Although staff do work in teams, they are only loosely organised and we know from staff survey data that staff feel isolated, there is a lack of supervision and appraisal.<sup>10</sup>

A large proportion of staff work in 'pseudo-teams'– in other words, their teams do not meet the criteria that demonstrate the quality of a team, defined by Carter and West, which include having clearly defined tasks and clear objectives; meeting regularly to review objectives, methods and effectiveness; trusting each other; having a shared commitment to excellent patient care.<sup>11</sup>

In a busy day, reflective practice is hard to sustain, and our own research with hospital staff revealed that typically they did not talk to colleagues about patients' experience of care or what constitutes 'good care'.

The consequence for individual members of staff if they are isolated is that they reflect on their own or away from work. They may experience guilt, anxiety and possibly burnout, which itself effects relationships with colleagues and patients.

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<sup>8</sup> Sanders K, Pattison S, Hurwitz, B (2011). 'Tracking shame and humiliation in Accident and Emergency'. *Nursing Philosophy*, vol 12, pp83-93.

<sup>9</sup> Menzies-Lyth I (1988). *Containing Anxiety in Institutions*. London: Free Association Press.

<sup>10</sup> Care Quality Commission (2011). NHS Staff Survey 2010.

<sup>11</sup> Carter AJ, West M (1999). 'Sharing the burden: teamwork in health care settings' in Firth-Cozens J, Payne RL (eds), *Stress in Health Professionals*, pp 191–202. Chichester: Wiley.

3.4. The training that doctors, and increasingly nurses receive actually emphasises the need for detachment, perhaps to the detriment of empathy. It has been shown that junior doctors, for example, feel less empathy as their training progresses.<sup>12</sup> Again this may be a case of self-defence - becoming 'case hardened' to survive, as well as the dominance of the biomedical model that frames their training, which tends to objectify patients.

3.5. Depression levels in health care staff are high. Depression and high stress affect the ability of staff to provide high-quality care in a variety of ways. With depression in particular, people withdraw, perhaps for their own emotional protection. Burnout is at the extreme end of stress, consisting of three key areas of a lowered sense of personal effectiveness, emotional exhaustion, and depersonalisation – which is the area most likely to limit compassion or, worse, to produce cruelty in dealings with patients.

3.6. We know that there is a clear relationship between the wellbeing of staff and patients' wellbeing, with staff reporting that how they feel affects how they care for patients.<sup>13</sup> In the recent Boorman review it was reported that 80 per cent of staff felt that their health and wellbeing impacted on their care for patients, but only 40 per cent of staff felt that their employer was proactively trying to do something to improve their health and wellbeing.

We believe Schwartz Centre Rounds are one intervention which helps to address these issues.

#### 4. Schwartz Center Rounds

4.1. Developed by the Boston-based Schwartz Center for Compassionate Care,<sup>14</sup> Schwartz Center Rounds ('Rounds') are a multidisciplinary forum, led by a senior doctor, designed for staff from across the hospital to come together once a month to discuss the non-clinical aspect of caring for patients – that is, the emotional and social challenges associated with their jobs. The Rounds typically take place once a month and are held at lunchtime, with lunch provided. They last one hour: a patient's case or story is presented by the team who cared for him or her, and then the themes that emerge are opened up for discussion, guided by a skilled facilitator, for the rest of the hour.

Very often the Rounds raise issues for discussion which are about caring for difficult or challenging patients and their families – and have included Rounds where the issues of caring for frail elderly patients have been explored. For example, one patient's story recently told in a UK hospital started with this:

*.....It was hard to care for him, an ongoing battle, because he was delirious. He screamed every time he was moved, but the family were always at the bedside, asking questions, asking him to be moved constantly. Dr A's lasting memory is of seeing him on the Monday and his heart sinking as he realized there was little he could do for him. He*

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<sup>12</sup> Riess H (2010). 'Empathy in medicine - a neurobiological perspective'. *JAMA*, vol 304, no14, pp1604–5.

<sup>13</sup> Boorman S (2009). *NHS Health and Well-being Review: Interim Report and Final Report*. London: Department of Health

<sup>14</sup> [www.theschwartzcenter.org](http://www.theschwartzcenter.org)

*did settle down but continued to deteriorate. His last admission was for six weeks. The dilemma was how long to go on treating.*

*N [one of the nurses] described how looking after this patient was very challenging - biting, spitting (nurses had to wear masks when caring for him) and kicking. It took four members of staff to lift him or do any interventions. It was distressing for staff. The family were questioning staff day and night – for example they were keen for him to be got out of bed and put into the chair, even though staff disagreed that it was the best thing. Nurses started to avoid the patient because of the pressure from the family and it was hard as ward manager to allocate staff to look after him. Staff felt they had got to the stage where they were treating the family and not the patient. There was almost a sense of relief when he died.*

Other Rounds have had titles which illustrate the typical dilemmas staff have to deal with: 'Caught between the patient and the family'; 'Balancing reality with hope'; 'A question of mental capacity', 'A patient I will never forget'.

4.2. The underlying theoretical foundation for Rounds, as first articulated by Kenneth Schwartz during his experience of treatment for an aggressive form of terminal lung cancer,<sup>15</sup> was that the compassion shown by staff to patients can make all the difference to a patient's experience of care, but that in order to provide that compassion, staff must, in turn, feel supported in their work. Rounds are designed to provide this support, giving staff an opportunity to reflect on their experiences of delivering care, including both its rewards and frustrations – on what the Schwartz Center calls the 'human dimension of medicine'.<sup>16</sup> Rounds aim to improve relationships and communication both between staff and patients and, within the hospital hierarchy, among teams and staff.

4.3. Rounds have been running in hospitals in the United States for more than 14 years now, steadily expanding from the Northeast, where they were first piloted at Massachusetts General Hospital in Boston, to more than 230 sites spread throughout the country, including a small number of nursing homes, community health centres and outpatient practices.

## 5. Impact of Rounds

5.1. In 2009 The Point of Care signed an agreement with the Schwartz Center to pilot Rounds in the UK. The pilot period for the Rounds was one year – between October 2009 and October 2010 – and Rounds were implemented in two hospitals: the Royal Free Hospital and Cheltenham Hospital. Since then other hospitals have implemented, or are planning to implement, Rounds. Before they do so they have to meet certain criteria: demonstrable support from the trust's chief executive and board; a skilled facilitator available; a senior clinical person to lead the Rounds; dedicated administrative support; a commitment by the hospital to provide lunch for those who attend; a multidisciplinary

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<sup>15</sup> Schwartz KB (1995). 'A patient's story'. *The Boston Globe Magazine*, 16 July. Available from [www.theschwartzcenter.org/ViewPage.aspx?pagelid=50](http://www.theschwartzcenter.org/ViewPage.aspx?pagelid=50)

<sup>16</sup> [www.theschwartzcenter.org/ViewPage.aspx?pagelid=20](http://www.theschwartzcenter.org/ViewPage.aspx?pagelid=20)

steering group to plan ahead the topics and cases to be presented, manage the advance publicity for the Rounds, and evaluate each month.

Rounds are now running at seven sites,<sup>17</sup> with good attendance, ranging from 40 to 140 attending at any one time. Six more hospitals are planning to start Rounds soon.

5.2. In 2006/7, the Schwartz Center commissioned research to evaluate the impact Rounds had on participating staff, on their beliefs about patient care, on teamwork, on staff perceptions of their levels of stress and support in the workplace, and on changes in institutional practices and policies. In their statistical analysis of this research, Lown and Manning found that following Rounds<sup>18</sup>:

- participants reported better teamwork and perceived themselves as experiencing less stress
- Rounds enhanced participants' 'likelihood of attending to psychosocial and emotional aspects of care'
- Rounds 'enhanced their beliefs about the importance of empathy'
- the impact of Rounds on these outcomes increased with the number of Rounds participants attended.

We have evaluated the pilot Rounds in England to see how easily they transfer to this country and whether they are achieving a similar impact to that in the States. The evaluation shows that staff attending the Rounds feel supported and that relationships are improving among staff and with their patients. We have seen that Rounds have successfully transferred to England, are firmly established with support from the top of the organisations, have demonstrated a need, and are greatly valued by staff who take part:

*I have really enjoyed them as they have helped me realise I am not alone! We all do a difficult job as well as we can. (Rounds participant)*

*People are taking the concerns of staff seriously - opening ourselves to hear what people are struggling with. And in the context of mid-Staffs staff are expressing things and the Rounds are a sign that it is safe to speak. It is all very well to say we have an open culture, but this demonstrated that value.  
(Trust board member)*

*The Rounds are consciously linked to work on culture change, and will be linked to patient experience work. Also linked to how we look after our staff, who then give better care; there is good evidence for this. There is also good evidence that if staff*

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<sup>17</sup> Cheltenham Hospital, Gloucestershire Royal Hospital, The Royal Brompton Hospital, Harefield Hospital, Stoke Mandeville Spinal Injuries Unit, Musgrove Park Hospital Taunton.

<sup>18</sup> Lown BA, Manning MA (2010). 'The Schwartz Center Rounds: Evaluation of an interdisciplinary approach to enhancing patient-centered communication, teamwork, and provider support. *Academic Medicine*, vol 85, pp 1073–81.

*are very stressed and can't process things, that affects them cognitively and they make mistakes. With the increasing workload, that also makes it a patient safety issue. (Trust board member and participant)*

*Schwartz rounds were new to me, but from what I understand about the philosophy, it is reconnecting people with what we are here to do. It is a reminder of how bloody tough it is. (Rounds participant)*

*Everyone else has benefited from doctors talking about the emotional impact on them. It is not part of the culture of medicine to talk about the emotional content, and these are senior consultants talking too. It is important for staff to hear it. Having the Round made it happen. (steering group member)*

*I really appreciated the language. You hear words used you don't normally hear such as anger, guilt, shame and frustration. They are obviously there but there is no outlet for them. (Rounds participant)*

## 6. Conclusions

6.1. Hospitals are very challenging environments and the nature of the work staff do is very difficult, complex, and requires attention. We believe that Rounds are one way that senior staff and trust boards can signal that care is a priority and show that they recognise the demands on individuals.

6.2. Evidence from those attending Rounds is that they find them beneficial and want to attend. Rounds do not replace good teams but they do provide space to reflect on the nature of work.

6.3. We are convinced that staff need to be given the means and the support to withstand the pressures of working in a highly pressurised hospital environment, caring for the very sick with the attendant emotional challenges. However, questions remain: Do Rounds build resilience? change culture? impact on patient care? strengthen compassion? Our experience suggests that they do all these things, but we are continuing to explore these questions through further research.