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ORIGINAL ARTICLE

Implementation of multidisciplinary reflective rounds within a children's hospital before and during the COVID-19 pandemic

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Aim: Regular reflective practice within a large group setting has been shown to reduce levels of burnout in healthcare professionals. We describe how regular reflective rounds were designed and implemented within an existing educational program at a UK children's hospital and report on the feedback received from participants.

Methods: Eight face-to-face reflective rounds took place in Southampton Children's Hospital, UK, from September 2017 to February 2020 with a further virtual round in July 2020 during the COVID-19 pandemic. Each round was facilitated by a clinical psychologist and consultant. For each round, up to three volunteer panellists from different staff groups were invited to share their personal experiences on a pre-selected subject to the large group. The group would then contribute to the discussion by offering their own reflections. Feedback forms were distributed to attendees and collated.

Results: Eight rounds were held with mean attendance of 32 (range 19–47). Across the eight rounds, the total attendance was 256 staff members. The virtual round had 20 participants. Feedback was received from 202 participants. The majority (98%) would recommend the rounds to colleagues with 64 participants (32%) rating the rounds as 'exceptional' and 91 (45%) as 'excellent'. The virtual round received similar positive feedback.

Conclusion: Large group reflective practice can be implemented within an existing regular educational program. Rounds have been well received by participants and are likely to be of relevance and value to other healthcare groups. The rounds can also be delivered effectively virtually, which may increase participation.

Key words: healthcare; paediatrics; reflective practice.

What is already known on this topic

1 Burnout is widespread within healthcare, including paediatrics, and can contribute to reduced professional efficacy and impaired patient care.
2 Regular reflective practice within a large group setting with a facilitator and planned subject matter has been shown to reduce levels of burnout and stress and improve staff well-being.
3 There are several different formats of reflective practice that have been shown to be effective within health care.

What this paper adds

1 Regular reflective practice can be designed, facilitated and maintained within an existing educational program at a large children's hospital.
2 Rounds should be considered as part of standard practice for healthcare workers to reduce levels of burnout.
3 Rounds can be delivered effectively virtually, which may make them more accessible with wider participation.

Burnout is a psychological syndrome that occurs as a result of continued exposure to chronic interpersonal stressors while working.[1] It was first mentioned as a phenomenon in 'helping' professions by Bradley in 1969 and popularised by Maslach with the Maslach Burnout Inventory as a validated scale for burnout.[2–5] In 2019, burnout was added to the International Classification of Disease revision 11 (ICD-11) as an occupational phenomenon (Table 1).[6] Within health care, there are significant consequences of burnout including job dissatisfaction and exhaustion, precipitation of burnout in colleagues and an increased long-term risk of hospital admission for cardiovascular disease or mental health problems.[7] Furthermore, it has been shown that burnout is associated with a reduction in patient safety and patient satisfaction.[8] The challenges of maintaining staff well-being and its impact on patient care and staff retention have been highlighted by Health Education England.[9]

Paediatrics is a specialty that often burdens staff with high levels of stress from both patient and familial perspectives and thus engenders staff to a greater likelihood of burnout. There has been a reduction in the number of applications for paediatric

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Table 1 ICD-11 definition of burnout (Data taken from ICD-11 – Mortality and Morbidity Statistics[6] with permission.)

Burnout is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions:
- Feelings of energy depletion or exhaustion
- Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
- Reduced professional efficacy

Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.

training and a disproportionately high number of paediatric trainees and consultants who are referred to mental health services. Potential reasons for this include the increase in complexity of paediatric patients, shortfalls in resources for managing them and the associated dilemmas for paediatric staff which results in more distress for staff and families alike.[10] The proportion of paediatric trainees reported to have shown features of burnout has been reported as greater than 50%.[11,12] Burnout is also reported within paediatric nursing to at least moderate to severe levels.[13,14] Staff working in paediatric specialities such as oncology and intensive care have been described as having high levels of burnout.[15,16]

There are a number of different established methods to potentially counteract or reduce levels of burnout. These include opportunities for group reflective practice such as Schwartz Rounds and Balint groups or smaller clinical supervision groups. Schwartz Rounds are meetings open to all members of staff, which enable and encourage reflection on the social and emotional challenges of caring for patients; panellists present stories centred around a particular theme, and afterwards an open discussion is facilitated among the audience.[17] Balint groups are meetings that convene every 1–4 weeks over a period of 1–3 years and are predominantly aimed at doctors; they are led by doctors and they present a case in which they had difficulty.[18,19] Balint groups have been effective within paediatrics as relevant for trainees with the benefit of peer reflection.[20] Clinical supervision groups offer a similar experience to Schwartz Rounds, but usually on a smaller scale and often as a closed group so that the same professionals meet together regularly. Individual clinical supervision has been shown to reduce stress among midwives and doctors.[21]

Group reflective practice using the Schwartz Round model has been shown to have a positive impact on staff well-being and coping with individuals reporting reduced stress levels including in a paediatric setting.[18,22–26] Other models such as structured social activities including reflective rounds and staff support meetings following difficult events have been reported as useful in promoting resilience and normalising reflective practice.[27–29]

However, while there is a strong movement towards promotion of staff support and wellbeing within paediatrics, many are not aware of the opportunities available.[30] Funding available for staff wellbeing may be a prohibitive factor for models such as Schwartz Rounds whereas Balint groups are encouraged to be self-funded which has been identified as a challenge in their establishment and continuation.[31–33]

To reduce levels of burnout and to improve staff well-being within a large children's hospital, a model of large group multidisciplinary reflective practice was introduced as part of an existing paediatric educational program.

Methods

Reflective round facilitators

JMB is a Consultant Paediatric Oncologist and AS is a Clinical Psychologist working within Southampton Children's Hospital. They identified an unmet need for a multidisciplinary staff support forum within Southampton Children's Hospital through informal discussions with different staff groups. JMB and AS were responsible for planning each reflective round, providing support to panellists before and after, facilitating the discussions and collating the feedback from round attendees. AS has received training in facilitating reflective supervision and receives her own clinical supervision. JMB has received training in psychological first aid. The feedback form was modelled on the form used for Schwartz Rounds.[34]

Reflective round setting

The rounds were held during the designated day and time for the Children's Hospital educational Grand Round meeting (Thursday mornings from 08:30 to 09:30). This schedule had the advantage of a well-established time and place (Lecture Theatre within the Children's Hospital). A final round was held on Microsoft Teams during the COVID-19 pandemic in order to observe social distancing and to see if the rounds could be conducted virtually.

Reflective round promotion

Once dates were set for a reflective round, email invitations were sent to all Children's Hospital staff with the round title, panel members and a brief overview of the format. Posters were created advertising each round and displayed around the Children's Hospital. AS and JMB also used Twitter to further advertise the rounds. The rounds were open to all clinical and non-clinical staff working in the Children's Hospital.

Selection of round topics and panellists

Topics chosen were based on recent issues affecting staff. Each email invitation for a round also included a request for panellists to participate and to contact AS or JMB directly. As the rounds became more established, staff members contacted the facilitators themselves with an idea for a future round or to take part themselves. AS and JMB also directly approached staff members to ask if they would be willing to participate in a round. Following each round, AS and JMB provided each panellist with a personalised certificate of appreciation with direct quotes from the feedback received for their particular round. Consent was obtained from attendees to share their feedback with the panellists. These certificates served as a thank you to panellists for their participation

and also to highlight the positive impact they had on other staff members.

Structure of round

AS and JB provided fruit and baked goods for each round for attendees and panellists on arrival. The rounds were structured with a different topic at each round. The first round took place in September 2017. This round showed three different videos from the Patient Voices website (www.patientvoices.org.uk) as a virtual panel to introduce the concept of reflective rounds. This enabled attendees to understand the structure and format of the rounds without the additional pressure of a real panel. Each video was approximately 5 minutes long. Following the three patient stories, attendees were encouraged to reflect on the stories they had heard, share experiences and poignant parts of the story that had resonated with them. AS and JMB facilitated discussion and concluded each round within the designated hour slot.

A total of eight reflective rounds took place between September 2017 and February 2020 approximately every 3–4 months. Following the first virtual panel, the remaining seven reflective rounds have had 2–3 panellists per round with representation from consultant staff, speciality trainees, allied health professionals and nursing staff. During the COVID-19 pandemic, a virtual round was held on Microsoft Teams during which the panel discussed some of the challenges of the pandemic including home-working and redeployment.

Reflective round topics

- The patient I will never forget
- Working at night
- Hindsight is a wonderful thing
- When someone complains
- When health professionals become patients
- When we get it right
- Dealing with anger and aggression
- Are we too busy?
- Reflections on the pandemic – how has it been for you? (virtual round)

Feedback and attendance monitoring

A sign-in sheet was used to monitor attendance of different staff groups at each round. Feedback sheets were placed on each chair and distributed prior to the round starting to facilitate immediate feedback and reflection to be captured. The feedback form comprised Likert scales to record attendees' perception of the round and a free text box for comments and feedback with a request for future panellists. SP analysed the feedback forms and collated themes, which were also reviewed by AS and JB.

Results

Between September 2017 and February 2020, eight rounds were held with mean attendance of 32 (range 19–47). Across the eight rounds, the total attendance was 256 staff members. Two hundred and two feedback forms were completed across the eight rounds; 20 people attended the virtual round with all of them providing feedback. Feedback was collated and specific feedback from the free text boxes was integrated into a 'Certificate of Appreciation', which was given to each of the panellists to highlight how useful their participation had been to others and to provide evidence for their own continuing professional development record. The breakdown of the types of staff member who attended the rounds is shown in Table 2. The variety of staff types increased as the Rounds became more established to include a greater cross-section of the paediatric multidisciplinary team (MDT).

Table 2 Attendance across eight reflective rounds according to staff role

	Total	Percentage
Consultant	38	14.8
Nurse/midwife	71	27.7
Junior doctor	37	14.5
Other	8	3.1
Psychologist	9	3.5
Social worker	2	0.8
Healthcare assistant	4	1.6
Medical student	1	0.4
Nursing student	9	3.5
Occupational therapist	3	1.2
Temporary nurse aid	1	0.4
Administration	1	0.4
Attended but did not complete feedback	72	28.1
Total	256	

Feedback received demonstrated that 191 attendees (94%) agreed that they would attend rounds again with 198 attendees (98%) stating that they would recommend the rounds to colleagues. The majority of participants agreed that the rounds increased their understanding of how colleagues feel about work (196, 97%); that they had an increasing understanding of how they themselves felt about work (179, 88%) and that the rounds helped them to work better with colleagues (193, 95%). The helpfulness of the group discussion and relevance of the stories presented to daily work was agreed by 196 (97%) and 195 (96%) of participants, respectively. Furthermore, 188 (93%) participants agreed that they gained insight that will help them meet the needs of patients.

In terms of rating the rounds, 172 (85%) rated them good to exceptional, with 64 (32%) of those being 'Exceptional' and 91 (45%) being 'Excellent'. No 'Poor' ratings were received, with two 'Fair' ratings and 27 missing and one unclear.

The feedback for the virtual round was similar: with 19 participants (95%) agreeing that they would attend a round again, would recommend the round to colleagues and increased their understanding of how their colleagues felt. The virtual round was rated well with 100% of participants rating it good to exceptional with six (30%) participants rating it as exceptional and 11 (55%) as excellent.

The free text feedback box provided an interesting insight into what staff typically found the most useful about rounds. Many

participants reported finding the rounds 'thought provoking', 'informative' and 'powerful and engaging'. Often staff members remarked on the variety of panellists; commenting that it was helpful to have colleagues of all seniority share their experiences and own stories of vulnerability. Both these aspects resonated with staff as it showed them they were 'not alone' and that others at work may experience struggles at different time points of their career. One participant specifically commented on the 'powerful role modelling' the rounds had demonstrated. Another participant reflected on their own emotional 'armour' and revealed how the rounds had made them observe 'how emotional I felt when I stopped and thought'.

Other participants commented on the ethos of the rounds including observing that the rounds would 'encourage staff to speak in a safe environment', that the 'non-judgmental environment' encouraged sharing and that rounds will be a 'small step in a positive culture change'.

Many participants remarked on the usefulness of the group discussion aspect of the round and how 'enjoyable and engaging' it was. The feedback from the virtual round gathered similar responses, importantly that the round 'worked very well on teams', but also that individuals felt 'reassured that we have all been experiencing similar emotions and challenges'. The feedback about the group discussion revealed that it was still useful despite not being able to meet face to face.

Limitations

Our rounds have been less regular (every 3–4 months) than recommended in other structured rounds (one per month), which may influence how much staff trust the process. However, we have found that even infrequent rounds have prompted helpful conversations that have encouraged sharing of experiences and more open acknowledgement of the impact of working in healthcare on staff well-being. We have not yet been able to formally assess the impact of the rounds on staff morale nor have we yet received any external more objective oversight of how the rounds are run and managed. This is planned for the future.

We acknowledge that non-clinical staff groups have not been well-represented within the rounds to date. It is important to widen participation in rounds to recognise the perspective of different roles and to share in the human experience. This is arguably harder to achieve during the pandemic as some staff groups may not be able to easily access a computer at work to attend. However, it may be that as the rounds grow, adoption across the larger hospital may encourage non-clinical staff groups to attend in the future.

It is important to acknowledge the time commitment required of the facilitators to ensure the rounds are sustainable and this is a limitation for our current model. It will be necessary in the future to have a larger team available to run the rounds to ensure the model remains sustainable.

Discussion

This study has shown that regular reflective practice can be designed, facilitated and maintained within an existing educational program at a large children's hospital. During the COVID-19 pandemic, it was possible to continue the reflective rounds virtually. Participants highlighted three main themes through the feedback received: the impact of hearing colleagues share their own vulnerability, the importance of a safe, non-judgemental environment and the power of group shared reflection.

The rounds are likely to contribute to improved patient care as the majority of attendees felt that the rounds helped them gain insight into the needs of their patients. Furthermore, the rounds fostered better understanding of different staff roles and participants reported that the rounds would help them to work better with colleagues from across the multidisciplinary team, which may lead to improved team effectiveness.

Attendance varied throughout the time period rounds were carried out. This may be a result of varying workload of staff. As the rounds become more established, it is hoped that attendance will increase and staff will perceive the opportunity for large group reflective practice as a beneficial addition to working life. The majority of staff who attended the rounds had an increase in understanding of how their colleagues feel about work. We expect this to improve team-based working and sharing of emotional workload, which in turn may help to reduce burnout and improve patient care.

Staff rated the rounds very highly and were keen to attend again. The variety of topics covered and relevance to work for staff are likely to be key factors in this continued interest and would be vital to maintaining interest in the rounds. It is important to foster a culture of openness and sense of safety in the discussion after rounds to encourage further attendance.

Our rounds have been attended by the clinical lead for the children's hospital and the divisional manager. We acknowledge the importance of the benefit of executive board engagement and support for staff well-being initiatives and provision of funding where appropriate. An authentic collaborative institutional approach to providing psychological care for staff before, during and after the pandemic will have tangible benefits for the safety and quality of paediatric care delivered.

Conclusion

There are a number of established methods that can be used to support staff wellbeing and reduce burnout within the healthcare setting. This program of large group reflective practice within an existing educational forum is one example of an intervention, which has been of significant value to the staff who have attended. We have demonstrated that such rounds can be implemented without significant financial investment. During the COVID-19 pandemic, when levels of stress and burnout are likely to be higher than normal, alternatives to face-to-face meetings were sought. A pilot virtual round during the pandemic received excellent feedback and further virtual rounds are planned. Feedback for the single pilot virtual round was very similar to that of the regular rounds, signalling that virtual rounds are feasible and as effective as face-to-face reflective practice.

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References

1 Maslach C, Leiter MP. Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry* 2016; **15**: 103–11.
2 Bradley HB. Community-based treatment for young adult offenders. *Crime Delinq.* 1969; **15**: 359–70.
3 Freudenberger HJ. Staff Burn-Out. *J. Soc. Issues* 1974; **30**: 159–65.
4 Maslach C. *Burnout: The Cost of Caring*. Englewood Cliffs, NJ: Prentice-Hall; 1982.
5 Maslach C, Jackson SE. The measurement of experienced burnout. *J. Organ. Behav.* 1981; **2**: 99–113.
6 ICD-11 – Mortality and Morbidity Statistics. Available from: https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/129180281 [accessed 23 August 2020].
7 Ahola K, Hakanen J. Burnout and health. In: Leiter MP, Bakker AB, Maslach C, eds. *Current issues in work and organizational psychology. Burnout at work: A psychological perspective*. Psychology Press; 2014; 10–31.
8 Garcia CDL, De Abreu LC, Ramos JLS *et al*. Influence of burnout on patient safety: Systematic review and meta-analysis. *Medicina* 2019; **55**: 553.
9 HEE. A framework for improvement through reflection, curiosity and change. Available from: https://www.hee.nhs.uk/sites/default/files/documents/Workforce_Stress_and_the_Supportive_Organisation_0.pdf [accessed 23 August 2020].
10 Cass H, Barclay S, Gerada C, Lumsden DE, Sritharan K. Complexity and challenge in paediatrics: A roadmap for supporting clinical staff and families. *Arch. Dis. Child.* 2020; **105**: 109–14.
11 Reed S, Kemper KJ, Schwartz A *et al*. Variability of burnout and stress measures in pediatric residents: An exploratory single-center study from the pediatric Resident burnout–resilience study Consortium. *J. Evid. Based Integr. Med.* 2018; **23**: 1–7.
12 Kemper KJ, Schwartz A, Wilson PM *et al*. Burnout in pediatric residents: Three years of National Survey Data. *Pediatrics* 2020; **145**: e20191030.
13 Pradas-Hernández L, Ariza T, Gómez-Urquiza JL, Albendín-García L, de la Fuente EI, Cañadas-de la Fuente GA. Prevalence of burnout in paediatric nurses: A systematic review and meta-analysis. *PLoS One* 2018; **13**: e0195039.
14 Buckley L, Berta W, Cleverley K, Medeiros C, Widger K. What is known about paediatric nurse burnout: A scoping review. *Hum. Resour. Health* 2020; **18**: 9.
15 Roth M, Morrone K, Moody K *et al*. Career burnout among pediatric oncologists. *Pediatr. Blood Cancer* 2011; **57**: 1168–73.
16 Jones GAL, Colville GA, Ramnarayan P *et al*. Psychological impact of working in paediatric intensive care. A UK-wide prevalence study. *Arch. Dis. Child.* 2020; **105**: 470–5.
17 Robert G, Philippou J, Leamy M *et al*. Exploring the adoption of Schwartz Center Rounds as an organisational innovation to improve staff well-being in England, 2009-2015. *BMJ Open* 2017; **7**: 14326.
18 Taylor C, Xyrichis A, Leamy MC, Reynolds E, Maben J. Can Schwartz Center Rounds support healthcare staff with emotional challenges at work, and how do they compare with other interventions aimed at providing similar support? A systematic review and scoping reviews. *BMJ Open* 2018; **8**: 24254.
19 A very short introduction to Balint groups. The Balint Society. Available from: https://balint.co.uk/about/introduction/ [accessed 23 August 2020].
20 Any other word than resilience – Balint groups for paediatric trainees – RCPCH. Available from: https://www.rcpch.ac.uk/news-events/news/any-other-word-resilience-balint-groups-paediatric-trainees [accessed 23 August 2020].
21 Wallbank S. Effectiveness of individual clinical supervision for midwives and doctors in stress reduction: Findings from a pilot study. *Evid. Based Midwifery* 2010; **8**: 65–71.
22 Goodrich J. Schwartz Center Rounds: Evaluation of the UK pilots. Are you seeing the person in the patient? The Point of Care. June 2011. Available from: www.kingsfund.org.uk. [accessed 23 August 2020].
23 National Institute for Health Research. New research reports that attending Schwartz Rounds reduces psychological distress – Point of Care Foundation. Available from: https://www.pointofcarefoundation.org.uk/news/new-research-reports-attending-schwartz-rounds-reduces-psychological-distress/ [accessed 23 August 2020].
24 Hughes J, Duff AJ, Puntis JWL. Using Schwartz Center Rounds to promote compassionate care in a children's hospital. *Arch. Dis. Child.* 2018; **103**: 11–2.
25 Adamson K, Sengsavang S, Myers-Halbig S, Searl N. Developing a compassionate culture within pediatric rehabilitation: Does the Schwartz RoundsTM support both clinical and nonclinical hospital workers in managing their work experiences? *Qual. Health Res.* 2018; **28**: 1406–20.
26 Flanagan E, Chadwick R, Goodrich J, Ford C, Wickens R. Reflection for all healthcare staff: A national evaluation of Schwartz Rounds. *J. Interprof. Care* 2020; **34**: 140–2.
27 Jane Lee K, Forbes ML, Lukasiewicz GJ *et al*. Promoting staff resilience in the pediatric intensive care unit. *Am. J. Crit. Care* 2015; **24**: 422–30.
28 Flanders S, Hampton D, Missi P, Ipsan C, Gruebbel C. Effectiveness of a staff resilience program in a pediatric intensive care unit. *J. Pediatr. Nurs.* 2020; **50**: 1–4.
29 Macaulay C, Conniff H. Developing a programme of staff support in a children's hospital. *Arch. Dis. Child.* 2020; https://doi.org/10.1136/archdischild-2019-318523.
30 Kase SM, Gribben JL, Waldman ED, Weintraub AS. A pilot study exploring interventions for physician distress in pediatric subspecialists. *Pediatr. Res.* 2020; **1**: 398–403.
31 Hard Truths: The Journey to Putting Patients First: Volume One; 2014. Available from: https://www.gov.uk/government/organisations/department-of-health [accessed 23 August 2020].
32 Starting a New Balint Group including working online The Balint Society. Available from: https://balint.co.uk/find-a-group/how-to-start-a-new-balint-group/ [accessed 23 August 2020].
33 Kjeldmand D, Holmström I. Difficulties in Balint groups: A qualitative study of leaders' experiences. *Br. J. Gen. Pract.* 2010; **60**: 808–14.
34 Preparing Your Schwartz Round. Available from: https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/getting-started/ [accessed 14 September 2020].