patients' needs and planning and determining which organisation should take the responsibility for providing care. This model is suitable for insurance companies but not so relevant for nursing care for patients with complex health situations. In addition to tasks included in the minimal model, the coordination model includes being the patients’ advocate, working with them and their support system and also continuous assessment and re-planning. In addition, the case manager may be involved in the care process and provide interventions of various kinds. This model is suitable for cancer patients with a complex health situation and perhaps during the treatment process until discharge. The comprehensive model also includes being an advocate for developing resources, monitoring quality, public intervention and crisis intervention. This model is perhaps most suitable for very vulnerable patients with a complex health and treatment situation, for instance palliative care or end of life care.

In most studies evaluating the case management model in geriatrics, registered nurses trained for the role have been the case managers. When selecting case managers, the professional competence needs to be considered and related to the tasks to be included. The competence required also depends on the knowledge in the team behind the case manager, which should be able to provide advice and guidance and also education to strengthen the case manager’s competence. So far, the research outcome of the case management model has been inconclusive, mainly due to the fact that it is not one model – context and target groups differ. Patients and families, however, favour this model, but more research is needed in the same context and the same target group to establish its effectiveness in providing high-quality care to a vulnerable group of cancer patients. Thus, in my view, this model, combining CGA and CM is worth trying in geriatric oncology nursing care.

The importance of staff wellbeing and the patient experience

We have a crisis in nursing in the UK and in some other parts of Europe – more patients with increasingly complex needs but a shortage of nurses, with more nurses leaving the profession because they don’t believe they can deliver the high quality care they came into nursing to give to patients and/or they burn out. This has important implications for care quality and patient safety.

Jill Maben

To deliver safe care we need to retain staff and support them, help protect them against burnout. In 2010, colleagues and I argued that “really relating to patients takes courage, humility and compassion, it requires constant renewal by practitioners and recognition, re-enforcement and support from colleagues and managers. It cannot be taken for granted” (Maben et al 2010).

Staff need a good work environment to flourish and enable them to give good care, to give safe care. Ten years ago I completed my PhD: I wanted to know if we were preparing student nurses to be resilient and whether they could nurse in the way that they had been taught.

In a questionnaire at the end of their course, my study asked nurses:

“As a qualified nurse, what do you anticipate will be your ideals for practice? That is, if you were able to choose how to practice, what would be the kind of care you would like to give?”

I then followed up 26 of these students as they became qualified nurses – 22 women and four men. I analysed the fate of their ideals and values over this period of time. I wanted to understand what the experience was like for them and how this might change over time.

Newly qualified nurses emerged from their education with a strong set of values and ideals. Patient centred holistic care, giving high quality care, using their nursing knowledge and research/evidence-based, safe care. Effectively, the study demonstrated that over time these nursing ideals and values in most cases eroded and I identified three groups:

1. Sustained idealists
2. Compromised idealists, and
3. Crushed idealists.
and you are dissatisfied… you’re just too busy to show people that you’re being compassionate and that’s so important to patients, you just need to remember how every little thing you do is so frightening to them… But when you’re tired, I don’t think it’s that I care any less - sometimes I just haven’t got the energy to show it.’ [Janet: Interview 1]

What we know is that:

Burnout strikes precisely those individuals who had once been among the most idealistic and enthusiastic… and they would be more susceptible to the most severe burnout. We have found over and over again that to burn out, a person needs to have been on fire at one time. Stressed and burnt out staff cannot deliver safe and compassionate care.’ (Pines and Aronson 1988).

Stressed and burnt out staff cannot deliver safe and compassionate care, and staff shortages and high turnover is also a threat to safe care. So, how do we support staff better and how do we get happy staff: there is an evidence base that suggests happy staff means happy patients.

In 2008, I led a nationally funded NIHR study examining relationships between staff wellbeing and patient experience that had eight case studies – four acute hospitals and four community sites. Our study was one of the first to examine this in the UK NHS and to link patients at the team and individual level.

Our three-year study found that:

- There is a relationship between staff wellbeing and (a) staff-reported patient care performance and (b) patient-reported patient experience. Staff wellbeing is an important antecedent of patient care performance.
- It is the experience of healthcare staff that shapes patient experiences of care for good or ill, not the other way round.
- Seven staff variables (“wellbeing bundles”) correlate positively with patient-reported experience:
  1. Local/work-group climate
  2. Co-worker support
  3. Job satisfaction
  4. Organisational climate
  5. Perceived organisational support
  6. Low emotional exhaustion, and
  7. Supervisor support (Maben et al 2012).

So, where patient experience is low, so too is staff wellbeing and vice versa. In terms of interventions to support staff, there are a variety of approaches: restorative supervision; buddying staff; emotional resilience courses.

Schwartz Rounds

I am currently working with Jocelyn Cornwall at the Point of Care Foundation to evaluate Schwartz Rounds in the UK. Kenneth Schwartz died of lung cancer in his 40s. He noticed that some caregivers (doctors and nurses) were able to connect with him and share something of themselves and their lives, whilst others did not. He also noticed that some staff could do it one day and not another, which helped him think what it must be like to be a caregiver in an oncology setting. He spoke of staff who connected with him and shared his pain ‘making the unbearable bearable’. His oncologist and family members established the Schwartz Centre for Compassionate Healthcare in his memory and set up Schwartz Rounds: a multidisciplinary forum, where staff from across the organisation come together to discuss the non-clinical aspects of caring for patients, i.e. the emotional, ethical and social challenges. Rounds typically take place once a month and provide a safe and confidential environment for staff to talk about their work. There are over 300 organisations in the USA and 123 in the UK, now running rounds.

Schwartz Rounds might be one way; role modelling and supporting our junior colleagues is another – but most importantly, my research tell us that it is critical that we do support nurses, particularly oncology nurses who encounter patients facing a cancer diagnosis, treatment and potentially death, all stressful experiences that could lead to burnout and staff leaving the profession.

Sustained idealists – those who because of support, good role models, good staffing and skills mix and a philosophy of care that promoted compassionate care were able to retain their ideals – numbered just four out of 26 newly qualified nurses. The majority’s ideals became crushed or compromised.

Those (n=14) who were compromising their ideals on a daily basis were suffering most as they were still trying hard to implement their ideals, whereas the eight whose ideals were crushed were already leaving nursing just 15 months after qualifying (Maben et al 2007).

One interviewee said after just six months: “Burnout - I can see it happening already (laughs) I think it’s just the fact that it’s a very stressful environment… you can see yourself getting worn out and your energy level depleting