

Family-Centered Bedside Rounds: A New Approach to Patient Care and Teaching

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ABSTRACT

The importance of patient-centered care and the role of families in decision-making are becoming more recognized. Starting with a single acute care unit, a multidisciplinary improvement team at Cincinnati Children's Hospital developed and implemented a new process that allows families to decide if they want to be part of attending-physician rounds. Family involvement seems to improve communication, shares decision-making, and offers new learning for residents and students. Despite initial concerns of staff members, family-centered rounds has been widely accepted and spread throughout the institution. Here we report our experiences as a potential model to improve family-centered care and teaching.

THE COMMONLY ACCEPTED view of patients as passive recipients of health care is changing. The Institute of Medicine highlighted the importance of patient-centered care in *Crossing the Quality Chasm: A New Health System for the 21st Century*.¹ In a joint policy statement, the American Academy of Pediatrics and the Institute for Family-Centered Care noted that children's and family's perspectives are important in clinical decision-making and encouraged hospitals to make conducting attending-physician rounds in patients' rooms, with the family present, standard practice.² They further noted that the process would make a lasting impression on students and housestaff. The Accreditation Council for Graduate Medical Education has declared that residents must be able to provide family-centered patient care that is culturally effective, developmentally and age appropriate, compassionate, and effective as part of their core competencies.³

However, many institutions are concerned that including patients and families in rounds will significantly increase the time spent rounding and disrupt the usual workflow. There are also concerns that rounds may not be the best avenue to convey information and solicit family input in decision-making.⁴ Families, unfamiliar with the process, may be too intimidated, by the large group or their own lack of medical training, to actively participate.⁵⁻⁸ Conversely, there is a fear that the presence of parents might inhibit open discussion among

staff. Residents and medical students may fear appearing ignorant in front of patients and families.⁹⁻¹¹

Until 2002, our institution conducted traditional attending rounds, usually in conference rooms or hallways. Families were either not included or only briefly involved. Support staff usually carried on their work while physicians conducted rounds. Physicians communicated with staff after rounds via written orders, telephone calls, conversations, or notes in the patient's charts. Attending physicians communicated separately with families after rounds. Questions and concerns regarding the plan developed on rounds were dealt with later in the day and often involved the nurse paging a physician. Families were not witnesses to the decision-making process and rarely were active participants.

Teaching on rounds focused on developing a care plan and medical information relevant to each patient's condition. There were few opportunities for faculty or attending physicians to witness or model patient interaction.^{10,12} Patients had little opportunity to make clari-

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fications or present their point of view while the care plan was developed. This marked discrepancy between recommendations in the American Academy of Pediatrics/Institute for Family-Centered Care policy statement² and our own practice led us to test and then implement a new type of attending teaching rounds.

CASE REPORT

Cincinnati Children's Hospital Medical Center is an academic teaching hospital with 475 registered beds and nearly 24 000 admissions per year. Approximately 300 residents and medical students receive general pediatric training. Faculty and staff hospitalists have a large teaching role. In 2001, Cincinnati Children's Hospital Medical Center became involved in the Pursuing Perfection initiative,¹³ which is funded by the Robert Wood Johnson Foundation. As part of that project, a multidisciplinary team, including parents, was formed to redesign the care system for children with acute conditions, with a focus on family-centered and evidence-based outcomes.

The team used the "model for improvement" as a framework for developing and testing rapid changes.¹⁴ The model has 4 key elements: aim, measurement, ideas for change, and tests of change. The first 3 elements are exemplified by 3 key questions: (1) What are we trying to accomplish? (2) How will we know that a change is an improvement? (3) What changes can we make that will result in an improvement? The final element is a disciplined approach to rapid testing and learning from change called the plan-do-study-act cycle. Large-scale improvement projects can be broken down into manageable pieces and addressed through a series of small-scale plan-do-study-act cycles.

Family representatives on the team were the first to suggest involving parents in attending teaching rounds to improve communication between staff and families. The team started with small changes and learned from its experiences. Initially, 1 physician with 1 group of residents tried the new approach for 2 weeks. Families were interviewed daily regarding their experiences, and there was near-unanimous support for the effort. This was particularly true for families who had experience with the old rounding method. Nurses, particularly those with years of experience, immediately sensed the improved communication. Residents were initially reluctant to make the change, but after gaining experience and confidence over the 2-week test, they expressed greater support. The rounding process evolved on the basis of feedback from parents, housestaff, nurses, and attending physicians. Additional attending physicians adopted the method and, after just 1 year, family-centered teaching rounds were considered standard procedure on an entire general pediatric unit. Since then, this approach has spread and fundamentally changed the way we provide patient care and teach throughout the hospital.

COMPONENTS OF THE NEW ROUNDING PROCESS

- The family decides how rounds are conducted. At admission, staff members explain the rounding process and how families can participate. They may choose to have the team enter the room during rounds, or the family may come into the hallway. They also may choose not to participate but have physicians and nurses meet with them later in the day. Concerns about confidentiality are addressed, and the family's preference is marked on a card that is posted outside the patient's door. Approximately 85% of our families choose to be actively involved in rounds.
- The choice card also identifies whether the family wishes to be awakened for rounds. The intern or medical student responsible for the patient enters the room first to wake the family and reconfirm their wish to participate.
- Introduction is a key component to improving communication and making families feel they are truly partners in the care-giving process. How those introductions are handled is left up to each team. In general, if the team is small, all members are introduced. However, to save time and to keep from overwhelming families, if the team is large, only 4 or 5 key members are introduced. The team forms a circle that is inclusive of the family.
- Team efficiency is important to allow time for family involvement. Team members are assigned roles and complete their work during rounds, including orders, discharge summaries, home health care plans, and prescriptions.
- The intern or student assigned to the patient briefly clarifies the purpose of rounds and welcomes family involvement. Families have helped to identify phrases that promote participation, such as "I'm going to tell his story, but if there is anything you feel is inaccurate, please speak up" or "We are not speaking at you; we want to talk with you. We are the medical experts, but you are the experts on your child; together we can do a better job." Students and residents are encouraged to begin with these phrases.
- The intern summarizes medical status and treatment options using both medical terminology and lay language. All test results and information are shared openly. Eye contact is made with both the team and family members. The family is then invited to participate in developing a plan for the day, including discharge goals. Family involvement in setting discharge goals decreases the likelihood of delay and confusion at discharge.
- Efficiency is further increased by the presence of nurses and other key ancillary staff who contribute valuable information regarding the patient's condition

in the last 24 hours and progress made toward meeting discharge goals.

- Families are active participants in decisions made on rounds. By the time the team leaves, everyone is aware of and comfortable with the treatment plan. Therefore, orders can be conducted in a timely manner with less risk of confusion or change later in the day.
- Throughout rounds, the teaching attending witnesses the intern's understanding of the patient's condition and the family's and staff's level of comfort. For example, a look of concern could indicate a nurse's discomfort with part of the care plan, or a tearful parent may be afraid of caring for a child at home. Although young learners may not yet know how to read these verbal and nonverbal cues and nuances, an experienced teaching attending can sense and immediately diffuse any concerns or communication complications.
- The teacher can also model appropriate behaviors so that residents and students learn how to engage families (asking questions, making eye contact, nodding, leaning forward), address any fears, anger, confusion, or misunderstanding, and develop their confidence and expertise.
- Senior residents and teaching attendants ask families for permission to conduct additional teaching in the room. Most parents welcome this additional teaching and find it very helpful. This is also an opportunity to involve parents in teaching, particularly regarding unusual conditions or experiences. These encounters with families can later serve as discussion and teaching points.¹⁵ For example, a teaching attending may ask residents and students, "How did that encounter go?" "Why do you think the father said that?" or "How could we have done better?"

DISCUSSION

When considering family-centered rounds, 3 common concerns arise. The first is teaching.^{6,7,9,10,16} Our residents and students initially believed that teaching would be pushed aside if the rounding team focused on the family. Although not all teaching can occur with families, residents now believe that teaching is better and that they are learning in ways that were not possible in the conference room or lecture hall. Of course, teaching styles need to be adapted, and participants must be willing to observe and be observed during crucial patient interactions. Direct observation is a valuable tool in teaching communication skills and is required by the Accreditation Council for Graduate Medical Education outcomes project. Participants must also be confident in their ability to deal with uncertainty.^{9,10} In our experience, physicians who are particularly uncomfortable with uncer-

tainty are also uncomfortable with family-centered rounds.

The second concern is time.^{6,10} All staff members worried that family-centered rounds would take more time and be difficult to carry out in an already-busy day. We have found that family-centered rounds take ~20% longer than traditional rounds. However, all participants believe that their time is used more efficiently and that family-centered rounds saves time later in the day. Nurses have described a marked decrease in the need to page residents to clarify orders. They also report that families are less likely to question the care plan. Of great significance is the improvement in discharge timeliness. Because of the focus on discharge goals, families are aware of the probable time for discharge and are more confident in the decision to go home, and staff are able to complete preparations. On units using family-centered rounds, we have seen a significant increase in the percentage of children discharged during the first shift (7 AM to 3 PM), which allows the entire hospital staff to prepare for and concentrate on new admissions later in the day (Fig 1).

The third concern is confidentiality.¹⁰ We now have a particular advantage at our hospital in that almost all rooms are private, but the change began on a unit with shared rooms. It is crucial to explain confidentiality issues to the family and be sure they understand that conversations may be overheard. Aware of risks, families choose how to be involved. By respecting their choice, concerns over confidentiality are allayed. Concerns over spreading infection and patient fear and modesty should also be addressed by allowing families to choose how to be involved.

As we have discussed this new method with visitors from other hospitals and at national meetings and other institutions, we have met with healthy skepticism. This improvement project was not conducted as a controlled study, and outcomes and processes were not systematically evaluated. By reporting our experience, we hope other institutions will conduct their own studies to evaluate family involvement in rounds.

Meanwhile, at our institution, the experience has been dramatic. We believe it is very significant that ~85% of families request involvement in rounds when given the option. All our pediatric hospitalists have enthusiastically adopted this rounding method, and it is now being adapted for children with complex and chronic conditions, with the focus at rounds expanded to include discussion of both daily goals¹⁷ and discharge goals. It is also being tailored for use in our outpatient clinics. This spread has been assisted by the development of a training program with video vignettes to address the most common questions and concerns of attending physicians (information is available at www.cincinnatichildrens.org/family-centered-rounds).

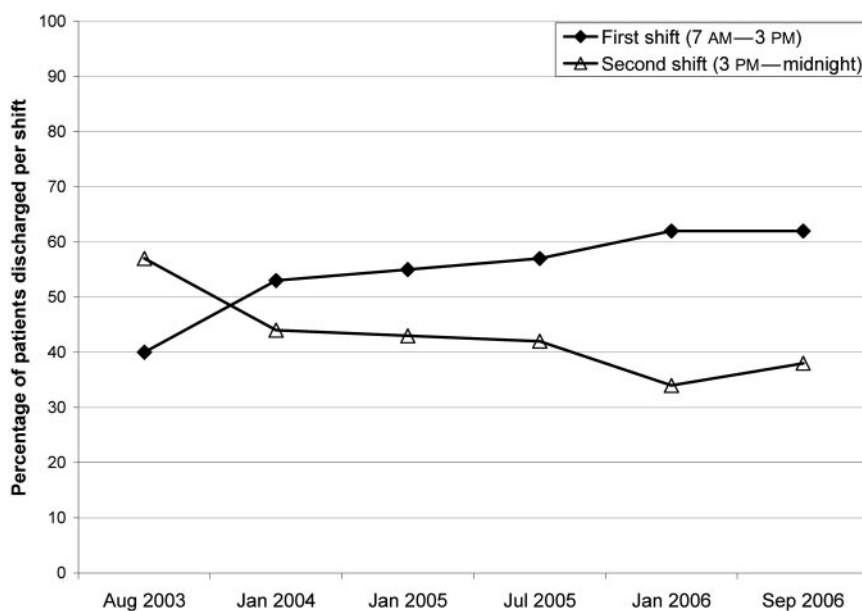


FIGURE 1
Time of day of discharge.

CONCLUSIONS

As an academic institution, we are committed to teaching residents and medical students the core attitudes of respect and interest in the concerns and opinions of patients and parents and the relationship skills that foster partnerships with them. We believe that these techniques cannot be adequately taught by using just a lecture or discussion format. We have noticed that any reluctance to family-centered rounds among residents has all but disappeared. Many residents now praise the process when promoting their program to future residents.

We look forward to other institutions building on our initial experience. In addition to documenting improvements in efficiency and satisfaction, we believe that family-centered rounds increases the potential for more significant improvement for patient safety and improved clinical outcomes.

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