



APPLYING PATIENT- AND FAMILY-CENTERED CONCEPTS TO BEDSIDE ROUNDS

The manner in which rounds are conducted is changing. Increasingly staff and faculty are including patients and families in the process of rounds. The following serve as guidelines for conducting rounds to accomplish a variety of purposes successfully within a context of respect and support for patients and their families.

- ▼ Develop practices for the process of rounds that respect privacy and confidentiality.
 - Think through the definitions of privacy and confidentiality and the implications for rounds.
 - In order to comply with HIPAA regulations especially when conducting rounds in semi-private or multi-bed rooms, a hospital or a clinical unit should have a written philosophy of care that acknowledges the importance of patient and family access to information and affirms that their participation in care planning and decision-making is essential to the best clinical outcomes and to quality, safe health care. This statement documents that patient and family participation in rounds is standard operating procedure.
 - The term “family” is broadly defined. Ask the patient at the beginning of a hospital stay to define his/her family and how they will be involved in care and decision-making. The patient should be asked to identify family members who should or should not be included in these discussions. For patients who are not able to participate in planning and decision-making, family members should be asked.
 - In addition, at the beginning of a hospital stay, ask the patient and family if there are key issues that should be protected.
 - Include information about the hospital’s policy regarding patient and family participation in rounds on routine consent forms. This provides an opportunity to encourage patients and families to take an active role in their health care and to tell them of the possibility of incidental disclosures.
 - Consider adaptations in the configuration of the unit or patient rooms that might enhance privacy.

- ▼ Structure the format and setting for planning and teaching clinical care so that bedside rounds are used in a way that addresses the needs and priorities of all constituencies—patients, families, staff, physicians-in-training, and faculty. Separate “sit down” rounds or other teaching formats may be more appropriate for some aspects of education and daily communication about patients, and thus can be targeted more specifically for students and residents.

- ▼ Decide and clarify whether this is the primary time for the patient or family to ask questions and obtain information.
 - If this is **not** the primary time for this communication, determine the alternatives.
 - If this **is** the primary time for communicating with patients and families, consider the timing of rounds and its convenience to families.

- ▼ Consider the process of rounds as an opportunity to model open communication and clear and supportive language with patients, families, and health professionals from all disciplines.
 - Set a tone from the beginning that everyone is a learner.
 - Avoid language that is patronizing ... “my unit ... “
 - Convey respect for the individuality, capacities, and vulnerability of each patient.
 - Convey respect for patients and families and recognize them as members of the care team. Include them in the rounding process. Affirm the positive contributions that patients and families can make to care planning and decision-making.
 - Do not use a family’s participation in rounds as a way to evaluate “family involvement.”

- ▼ Briefly explain the purpose of rounds to the patient and family—clarifying whether the purpose is primarily teaching or the coordination of clinical care or both.
 - In addition, at the time of admission, have patient/family consultants or other staff help prepare patients and families for the way that rounds are done. Written or audiovisual materials may be helpful as well.
 - With the primary purpose of the rounds clear, choose the appropriate language, topics, and level of detail to use at the bedside.
 - Greet the patient and family upon entering the room. When necessary, remind students and professionals-in-training to greet the patient and family.

- In discussions with the rounding team, refer to the patient or family by name, rather than as a disease, or a room number, or Mom or Dad. Avoid discussing the patient in the third person—“this 63-year old patient...”
- When the patient’s condition permits, help the patient in bed to be at eye level with the rounding team.
- Ask for insights and observations from the patient, when the patient’s condition permits, and from the family. These questions could relate to the patient’s condition and treatment or they could focus on other kinds of issues, such as their experiences at the hospital and any suggestions for improvement.
- When examining the patient during rounds, ask the patient and/or family if this is an appropriate time.
- Provide patients and families with an opportunity to debrief or process what they have heard on rounds.
- When leaving, ask if the patient or family have questions. If they do, either respond to them then or have a plan as to how to respond to them later.

▼ Choosing language that sets the tone for partnership.

- Introducing the concept of rounds as part of the admission process:

During your hospital stay, Mrs. Jones, doctors, nurses, and other health care providers spend time together as a team to plan and coordinate your care. You and, if you wish, your family are a very important part of this team. We call the process “rounds.” You can decide how you will be involved in rounds, and if there are sensitive issues that we should not discuss in your room.

Rounds is a time for you to receive and share information about your care. It is not the only time that you can talk with us about your care.

Rounds is sometimes a time for teaching residents and students. You can help us in teaching. Rounds is a time of learning for everyone. You will learn things about care. You can ask that the teaching time be limited if you wish. Sometimes teaching rounds involves a physical exam. You can also ask for this exam to be delayed or limited.

Sometimes doctors make rounds very early, around 6 a.m. Do you want to be awakened? If you wish to sleep, you can leave us a note with questions or with information that you would like us to have.

Are there family members or a friend who you would like to be with you during rounds or spend time with you in the hospital and help you when you go home?

You and your family are very important members of your health care team ... partners in care and decision-making. Your observations, concerns, and preferences will help us make the best decisions together.

We have shared rooms on this unit. We ask all of our staff and doctors, as well as our patients and families to respect the privacy of each patient. You may hear things about other patients during your hospital stay. We ask you to respect their privacy as we try to respect yours.

- Suggestions for the conversation during bedside rounds:

Good morning Mrs. Brown. Mr. Brown we are glad you are here today. I am Dr. Jones, the doctor following Mrs. Brown's care. There are other members of the team who will introduce themselves ... I am Susan Blake, the unit nurse manager; I am Dr. Hernandez, the resident; I am Christine Woo, the medical student; I am Dr. Jenkins, the attending doctor; and we have already met, I am Meredith, the nurse who will be taking care of you today.

We are going to talk now about the changes that were made yesterday and you can help us understand how things went and how you are feeling today. Before we begin, do you have any concerns and worries that you want us to discuss first.

Mrs. Brown is 68 year-old woman, who was admitted three days ago with pneumonia and high blood pressure. You have had a fever for the last 24 hours. You are receiving 2 liters of nasal oxygen and IV Levaquin to treat your pneumonia. How is your breathing today? We have added a new medication for your blood pressure. . . Lotensin. Have you noticed any difference since you started taking Lotensin?

Yesterday we stopped giving you extra IV fluids. Are you eating and drinking now? You have been getting a regular diet. Is that correct, Mrs. Brown?

Let's review the plan for the day. You will be getting a chest x-ray. We will wean you off the oxygen. Let us know if you get short winded or have trouble breathing.

Mrs. Brown, we think you may be able to go home tomorrow. As we discussed earlier this week, we want to see that your temperature stays down, and that you are comfortable without oxygen before you go home. Let's see how you do today without the nasal oxygen. Tell your nurse how you feel when you walk to the bathroom. Have you ever had a pneumovax, a vaccine to prevent pneumonia? It will be important for you to have this vaccine before you go home to prevent pneumonia in the future. We will also make plans for you to follow-up with your regular physician to make sure that you are doing well.

Have we addressed your worries and concerns? Are there goals that you would like to accomplish before you go home?

Were there any glitches in care yesterday? Any ways that we could have improved care?

In teaching rounds: Thank you for helping with our teaching process OR Thank you for letting our medical student listen to your lungs.

If the patient or family asks many questions or a question requiring a response that will take considerable time, one possible response is: That is a really good question that will take more time than I have right now. I can come back when we finish rounds about 9:30. Will that work for you? OR A nurse or one of the other physicians will come back and discuss this issue with you.

Resources

For the most recent references on this topic, please see the *Bedside Rounds Bibliography* in the Institute's Compendium of Bibliographies at <http://www.familycenteredcare.org/advance/supporting.html>

For information about HIPAA and patient and family participation in rounds: The summer 2004 issue of *Advances in Family-Centered Care*, "Responding to HIPAA: Hospitals Confront New Challenges, Devise Creative Solutions," is available from the Institute for Family-Centered Care. One of the articles in this issue, "HIPAA—Providing New Opportunities for Collaboration," is available on the Institute's website at http://www.familycenteredcare.org/advance/topics/Advances_HIPAA.pdf.

The videotape, *Collaborative Rounds in Cardiology*, presents a non-hierarchical process for including adult patients, families, and staff and physicians from a variety of disciplines in the rounds process. In addition to portraying collaborative care planning, a model for identifying problems and solutions is shared.

Additional information about this collaborative rounding process is featured in the following article: Uhlig, P. N., Brown, J., Nason, A.K., Camelio, A & Kendall, E. (2002). System innovation: Concord hospital. *The Joint Commission Journal on Quality Improvement*. 28(12), 666-672.

A videotape, *Partnerships with Families in Newborn Intensive Care: Enhancing Quality and Safety*, highlights how family-centered concepts can be integrated within a NICU, beginning with a philosophy of care developed collaboratively by families, staff, and faculty. Family participation in rounds is featured along with other collaborative endeavors. This video won first place in the "Working Together" category of the 2003 Dartmouth Clinical Microsystems Film Festival.

The videotape, *Newborn Intensive Care: Changing Practice, Changing Attitudes*, has two discrete segments titled "A Neonatologist's Thoughts" and "Rounds."

Parent Participation in Rounds: The Reflections of a Pediatric Intensivist is a 9-minute videotape that captures the perspectives of the Director of Pediatric Intensive Care at the Children's Hospital at Dartmouth for including parents in rounds in a PICU. It describes his change in practice, potential benefits, the value of parent observations and learning from parents, and the importance of collaboration to formulation of the accurate "patient story."

The above videotapes are available through the Institute for Family-Centered Care, 7900 Wisconsin Avenue, Suite 405, Bethesda, MD 20814. www.familycenteredcare.org

Dreams and Dilemmas: Parents and the Practice of Neonatal Care. [Videotape]. (1998). Green, R. M. and Little, G. A. (executive producers) and Kahn, R. (filmmaker). Hanover, NH: Trustees of Dartmouth College. Available from Fanlight Productions, 4196 Washington Street, Suite 2, Boston, MA 02131.

Davidson, J. E., Powers, K., Hedayat, K. M., Tieszen, M., Kon, A. A., Shephard, E., et al. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit: American college of critical care medicine task force 2004-2005. *Critical Care Medicine*, 35(2), 605-622.

Hardart, G. & Truog, R. (2003). Attitudes and preferences of intensivists regarding the role of family interests in medical decision making for incompetent patients. *Critical Care Medicine*, 31(7), 1895-1900.

LaCombe, M.A. (1997). On bedside teaching. *Annals of Internal Medicine*, 126(3), 217-220.

Simmons, J. M. (2006). A fundamental shift: Family-centered rounds in an academic medical center. *The Hospitalist*, 10(3), 45-46.

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