INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
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APPLYING PATIENT- AND FAMILY-CENTERED CONCEPTS TO BEDSIDE ROUNDS IN NEWBORN INTENSIVE CARE

The manner in which rounds are conducted is changing. Increasingly staff and faculty are including patients and families in the process of hospital rounds. In newborn intensive care units (NICU), families can offer their observations, questions, and expertise. The following serve as guidelines for conducting rounds to accomplish a variety of purposes successfully within a context of respect and support for families in the NICU.

- 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 multi-bed rooms, a hospital or NICU should have a written philosophy of care that acknowledges the importance of 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 family participation in rounds is standard operating procedure in the NICU.
    - The term "family" is broadly defined. Upon admission to the unit, ask the parents to define their family and how they will be involved in care and decision-making. Parents should be asked to identify family members who should or should not be included in these discussions.
    - In addition, upon admission to the unit, ask the family if there are key issues that should be protected and not discussed during bedside rounds.
    - Include information about the hospital's policy regarding family participation in rounds on routine consent forms. This provides an opportunity to encourage families to take an active role in their infant's health care and to tell them of the possibility of incidental disclosures.
    - Consider adaptations in the configuration of the unit 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—families, staff, trainees, 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 family to ask questions and obtain information.
    - If this is not the primary time for all communication with the family, determine the alternatives.
    - If this is the primary time for communicating with 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 families, and health professionals from all disciplines.
    - Set a tone from the beginning that everyone is a learner and that everyone has expertise to share, including the family.
    - Avoid language that is patronizing (e.g., "my unit," "my baby," "my patient")
    - Convey respect for the individuality, capacities, and vulnerability of each infant and family.
    - Convey respect for families and recognize them as members of the care team. Include them in the rounding process. Affirm the positive contributions that families can make to history, assessments, care planning, and decision-making.
    - Do not use a family's participation in rounds as a way to evaluate "family involvement." Some families may choose not to participate in rounds.
- Briefly explain the purpose of rounds to the family—clarifying whether the purpose is primarily teaching or the coordination of clinical care or both.
    - In addition, at the time of admission, inform families about the way that rounds are done and how they can participate. Family consultants and other staff can then help prepare families to participate in rounds to the level they choose. 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 family upon entering the room. When necessary, remind students and professionals-in-training to greet the family. Greetings should include introduction of staff with their names and roles.
    - In discussions with the rounding team, refer to the family by name, rather than "Mom" or "Dad." May I call you Maria or do you prefer Mrs. Reyes? Avoid discussing the baby in the third person—"this 3-day old patient…" Use the baby's first name whenever possible.
    - Ask for insights and observations 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 infant during rounds, ask the family if this is an appropriate time. If the physical exam cannot be delayed, explain this to the family and offer ways that they can support and comfort the infant during the exam.
- Provide families with an opportunity to debrief or process with a staff member what they have heard on rounds. This debriefing is often helpful to families, but it also offers an opportunity for staff and physicians to learn from families about how the rounding process is working.
- When leaving, ask the family if they have questions. If they do, either respond to them then or have a plan as to how to respond to them later.

◆ Choose language that sets the tone for partnership.

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

  During your baby's hospital stay, Mrs. Jones, doctors, nurses, and other health care providers spend time together as a team to plan and coordinate your baby's 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. Let us know if there are sensitive issues that we should not discuss during rounds.

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

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

  We have open rooms on this unit. We ask all of the staff and doctors, as well as 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. We are glad you are here today. I am Dr. Patel, the doctor following your baby'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 your baby 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 your baby is doing today. Before we begin, do you have any concerns and worries that you want us to discuss first?

Jasmine Brown is a 2-week old baby born at 28 weeks gestation who has been extubated since Friday. She has been on full feeds since the weekend and appears to be tolerating them. Mrs. Brown, how are your baby's feedings going? Have you noticed anything you are concerned about?

Yesterday we stopped the rate on the CPAP. She is on caffeine and had two episodes of apnea and bradycardia and her heart rate slowed down. Were you aware of these episodes, Mrs. Brown? Do you understand what they are? This is about the same number of episodes Jasmine has each day

Let's review the plan for the day. We will continue to watch the Jasmine's feeding tolerance and apneic episodes.

Mrs. Brown, what are your goals for Jasmine at this time? Have we addressed your worries and concerns?

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

For teaching rounds: *Thank you for helping with our teaching process OR Thank you for letting the medical student examine your baby.*

If the 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.

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.

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 at 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

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

Cincinnati Children's Hospital. (March, 2007). Changing the outcome with family-centered care [Online exclusive]. *Pediatric Insights*. Retrieved December 3, 2008, from http://www.cincinnatichildrens.org/health/subscribe/ped-insights/03-07/family-centered-care.htm

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.

Green, R. M. & Little, G. A. (Executive Producers) & Kahn, R. (Filmmaker). (1998). *Dreams and dilemmas: Parents and the practice of neonatal care* [Videotape]. Hanover, NH: Trustees of Dartmouth College. (Available from Fanlight Productions at www.fanlight.com)

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.

Landry, M., Lafrenaye, S., Roy, M., & Cyr. C. (2007). A randomized, controlled trial of bedside versus conference-room case presentation in a pediatric intensive care unit. *Pediatrics*, 120(2), 275-280.

Muething, S. E., Kotagal, U. R., Schoettker, P. J., Gonzalez del Rey, J., & DeWitt, T. G. (2007). Family-centered bedside rounds: A new approach to patient care and teaching. *Pediatrics*, 119(4), 829-832.

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

Sisterhen, L. L., Blaszak, R. T., Woods, M. B., & Smith, C. E. (2007). Defining family-centered rounds. *Teaching and Learning in Medicine*, 19(3), 319-322.

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.