INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
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APPLYING PATIENT- AND FAMILY-CENTERED CONCEPTS TO BEDSIDE PEDIATRIC ROUNDS

The manner in which rounds are conducted is changing. Increasingly pediatric staff and faculty are including 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 children 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 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.

- Ask the family at the beginning of a hospital stay if there are key issues that should be protected.

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 health care decision-making and to tell them of the possibility of incidental disclosures.

- Ask the family at the beginning of a hospital stay to identify family members who should or should not be included in these discussions.
- 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, physicians-in-training, faculty, staff, and children and families. 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 this communication, 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 children, 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 child.
    - 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.
    - Discuss with the family if they wish the child to participate in rounds. When developmentally appropriate, include the child or adolescent in this discussion.
    - Do not use a family's participation in rounds as a way to evaluate "parental involvement."
- Briefly explain the purpose of rounds to the child 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 family consultants or other staff help prepare families for the way that rounds are done. Written or audiovisual materials may be helpful as well.
    - With the primary purpose for the rounds clear, choose the appropriate language, topics, and level of detail to use at the bedside.
    - Greet the child and family upon entering the room. When necessary, remind students and professionals-in-training to greet the child and family.
    - In discussions with the rounding team, refer to the child or family by name, rather than as a disease or room number, or Mom or Dad.
    - When the child's condition permits, help the child in bed to be at eye level with the rounding team.
    - Ask for insights and observations from the child, when the child's condition permits, and from the family. These questions could relate to the child'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 child during rounds, ask the child and/or family if this is an appropriate time.
    - Provide families with an opportunity to debrief or process what they have heard on rounds.
    - When leaving, ask if the child or family have questions. If they do, either respond to them then or have a plan as to how to respond to them later.

Resources

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

For information about HIPAA 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," will be available on the Institute's Web site after August 1, 2005.

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."

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."

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 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.

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

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.

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, February 1). On bedside teaching. *Annals of Internal Medicine, 126(3)*, 217-220.