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The Challenges and Strategies to Improve Family-centered Round: A Literature Review

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The importance of family-centered care and the role of families in decision making are becoming more recognized today. Several studies have supported the implementation of family-centered care and its role in enhancing quality of care. Family-centered rounds are one of family centered model of care that brings together multidisciplinary team as well as family to discuss the patient's condition and care management, coordinate the patient's care management, and make decisions on care plan for the patient (Sisterhen et al., 2007, Aronson et al., 2009). As part of innovations to enhance family-centered care, family-centered rounds have been adopted and implemented in many hospitals. This model of rounds is popular and widely applied in the neonatal and pediatric intensive care unit (Aronson et al., 2009, Kleiber et al., 2006, Mittal et al., 2010). However, other units have also begun to implement it (Schiller and Anderson, 2003, Mangram et al., 2005).

The benefits of family-centered rounds have been presented in several studies. They reported that family-centered rounds have been improved communication between staff and family members (Mittal et al., 2010, Jacobowski et al., 2010, Rosen et al., 2009, Vazirani et al., 2005), understanding of the patient's care plan (Rosen et al., 2009), staff and family satisfaction (Rappaport et al., 2010, Rosen et al., 2009); and decreased need for care plan clarification (Rosen et al., 2009).

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However, there are also multiple concerns related to the implementation of family-centered rounds, namely: timing of rounds, multidisciplinary team composition, use of medical jargon, privacy and confidentiality, inconvenience to the health care team in asking or receiving questions, ignorance in front of families, families feeling intimidated by large groups of healthcare staff, and hesitance of healthcare staff to discuss sensitive issues in front of families (Mittal et al., 2010, Rosen et al., 2009, Muething et al., 2007, Lehmann et al., 1997, Kleiber et al., 2006, Jacobowski et al., 2010). These concerns often lead health care teams to be reluctant to implement family-centered rounds. Therefore, in this article I would like to analyze the challenge of family-centered rounds and identify some strategies that can be used to overcome those challenges so that the implementation of family-centered rounds could be improved.

Timing is the concern most often raised related to implementation of family-centered rounds. The implementation of family-centered rounds would take more time and be difficult to implement in a day that is busy with other activities (Rosen et al., 2009, Muething et al., 2007, Lehmann et al., 1997, Wang-Cheng et al., 1989). With the presence of the family in the round, allocation of time should be added in order to answer questions from the family meaning that the round time will take longer and affect other interventions. This is evident in research conducted by Muething et al. (2007). They found that family-centered rounds take 20% longer than traditional rounds.

A previous study by Lehmann et al. (1997) also found that conducting rounds at the bedside did increase time spent with the patient from six minutes to ten whereas research by Rosen et al. (2009) claimed family-centered rounds added 2.7 minutes per patient compared with traditional rounds. However, although the time spent in the round increased, the time needed for other actions decreased. There was less time spent in following up, clarifying orders, and delivering information to patient and families (Rosen et al., 2009, Muething et al., 2007). Moreover, the patient's plan care can be decided much more quickly and efficiently because everyone who is involved in family-centered rounds hears the information at the same time and the same place. Thus, it can be concluded that family-centered rounds save time later in the day and does not change the workload.

Scheduling is also a big challenge of family-centered rounds which is related to the timing issue (Palmer, 2009). During the rounds, all health care teams will be focusing their attention on the patients who have their chances in the round so other patients who do not get a

turn at that time will be neglected and as result this may affect their outcomes. Moreover, one physician may have patients in different units (Palmer, 2009). This means it could be difficult for his or her to attend the rounds in each unit.

The best time to do the rounds is still unanswered. One hospital scheduled the rounds right after handover in the morning shift, between 8.30 AM and 11.00 AM (Palmer, 2009). This time allocation could be said to be the busy hours in the unit. One study examines the correlation of admission of patients during morning rounds with mortality. It found that patients admitted to the ICU during morning rounds have higher severity of illness and mortality rates (Afessa et al., 2009). This was probably because the patients admitted to ICUs during rounds do not get timely care, because the teams focus on the rounds, causing poor outcome. Thus, this evidence should be considered in making strategy to improve the implementation of rounds.

There are several strategies that can be done to minimize the use of time in the implementation of family-centered rounds or at least to be able to carry out the rounds in accordance with a set time. Firstly, it is necessary to develop a structured family-centered round process and communicate it to health care teams and family. With a clear structure, the process of round turns to a more structured walk so, as to minimize the activities that prolong the process of rounds. Besides containing the steps of rounds, this structure should also include the allocation of round time for each patient. Furthermore, everyone involved in the round should have an understanding about the structure of the family-centered round. Training and workshops about family-centered rounds might be could be done for health care teams whereas patients and families are given an explanation about family-centered rounds at admission. Secondly, develop information tools that help information organization, communication, and process management during the rounds. Gurses and Xiao (2006) have reviewed literature that examines the use of information tools in multidisciplinary rounds. They concluded that information tools have improved the effectiveness of multidisciplinary rounds. They review and compile several types of information tools in multidisciplinary rounds (see Table 1).

These tools present in manual and computerized forms and are used to provide information, support communication and facilitate decision making before, during and after the rounds (Gurses and Xiao, 2006). Thirdly, make pre-round preparation. Teams who are involved in family-centered rounds should prepare and collect information needed for rounding before conducting the rounds, according to their roles and responsibility. This information could be

obtained from a patient's chart, a patient's medical record, nursing flow sheets and other information tools used in the units. Being well prepared would improve the process during the rounds. Team members will be much more ready to do the rounds and the time could be maximized for discussion rather than being busy making notes about the patient. The last strategy is related to round scheduling. To set a schedule that is really ideal is hard, so the unit should set the schedule of rounds. This schedule is communicated and discussed with other units so each unit has a different schedule of rounds. This will allow physicians to attend multiple rounds if they have patients on different units. If the schedule of the round is agreed, the schedule should be decided on permanently.

Table 1 Types of Information Tools in Multidisciplinary Rounds (MDR)

Information Tools	Design	Description
Patient-centric Information Tools		
Patient medical record	Manual, Computerized	Contains of medication list, vital signs, and laboratory results
Variance tracking form	Manual	To identify variances of patient outcome and to discuss action care plans
Progress notes	Manual, Computerized	To record rounds discussion about patients' progress and plan of care
Nursing flow sheet	Manual	To record discharge planning
Bedside monitoring devices	Machine	To obtain vital signs, respiratory status on ventilator, and fluid infusion dosages
Process-oriented Tools		
Rounding list	Computerized	Contains of list of patients and all information related to patients' condition and treatment
Rounding and sign-out Tool	Computerized	To automatically extract summary information from clinical information system for rounding and sign out
Daily goals form	Manual	To remind care providers to define patient goals
Needs assessment tool for discharge	Manual	To record patient needs discussed during discharge rounds
Decision-support Tools		
Evidence cart	Computerized, CD-ROM	Contains of compact disk to improve access to information used in patient care decision
Online evidence-based medicine resources	Electronic, web-based	Contains of online versions of the American Academy of Pediatrics Red Book and PICU BOOK
Clinical pathway	Manual	To assess and discuss clinical pathway and to aid care planning
Graphic display of laboratory results and functional tests	Computerized	To visualize laboratory findings and functional test

Source: Gurses, A. P. & Xiao, Y (2006).

The next concern about family-centered rounds is the composition of team members. The ideal interdisciplinary team includes the representative across disciplines, including the following: physicians, nurse practitioners, medical residents, bedside nurses, case managers, social workers, pharmacists, nutritionists, and chaplains (Curley et al., 1998). However, each hospital has different components of health care teams so it would be different between hospitals. Thus, the composition of the health care team who attends the family-centered rounds is flexible. It must not always involve all team care members but it must involve the key health personnel who are involved in the patient's care (Curley et al., 1998) and also consider up-to-date issues related to the patient's condition. As a minimum, family-centered rounds should involve attending physicians, bedside nurse, case manager and family (Curley et al., 1998). Bedside nurses attend only for the time it takes to discuss their patients so that after or before rounds, they can do their work.

Feel uncomfortable during family-centered rounds expressed either by care team members, especially junior teams, or family (Mittal et al., 2010, Muething et al., 2007, Lehmann et al., 1997). Health care teams, especially junior teams, were worried if they could not answer the question of the patient and family and it would make them looked down upon by patient and family. Moreover, they also fear they will be ignored in front of the patient and family (Wang-Cheng et al., 1989). A study by Wang Cheng, et al. (1989) reported the preference of physicians to conduct bedside rounds compared with conference room. They found that physicians who have been in the role of attending for less than ten years prefer the conference room (57%) whereas physicians who have been attending more than ten years prefer bedside rounds (82%). This demonstrates that the confidence in conducting rounds in front of patient and family will increase as time passes. The longer team members perform family-centered rounds, the more confidence they become with the process of family-centered rounds. To increase confidence in conducting family-centered rounds, team members, especially juniors, could do role-plays about the process of family-centered rounds with other team members. Being well prepared before conducting rounds could also increase the confidence of team members.

Physician worried that patients and family members will be uncomfortable sitting in on rounds and sharing personal information with large groups. Patients and families may feel intimidated by health care teams (Lehmann et al., 1997). Preparing the patient and families for the way that rounds are done is important. Lack of information often makes patient and family

feel frightened (Henneman and Cardin, 2002, Davidson, 2009). At admission, staff members should explain the rounding process and how families can participate. Written or audiovisual media may be helpful to deliver the information. These media contain information regarding the patient and family participation in rounds and the way the process of rounds is done. This strategy provides an opportunity to encourage family to take an active role in the rounds. Numerous of studies have reported the correlation between information giving with service user participation (Gore et al., 2005, O'Connor Annette et al., 2009). Furthermore, a bedside nurse or junior physician informs the patient and family before conducting the rounds to ask their permission to round at the bedside and inviting them to participate. It means teams pay attention to the priorities and the needs of each individual patient and family (Sisterhen et al., 2007). If the patient and family refuse to have rounds inside the patient's room, it can be done in the hallway or conference room.

During rounds, team members should be able to create a comfortable and friendly atmosphere so that patient and family do not feel afraid. Introduction is a key element to improving communication and making families really feel as partners in the patient's care management (Muething et al., 2007). If the team is small, all members are introduced. However, if the team is large, only a few of members are introduced. This is considered to save time. One team member should explain briefly the purpose of the rounds by using language that is understandable by the patient and family. It has been reported that the use of medical jargon by members of healthcare teams make patients and families confused (Lehmann et al., 1997). Thus, healthcare team members should limit the use of medical jargon during presentations and discussions in front of patients and families. The body language of healthcare team members also influences the emotions of patients and families during rounds. One study reported that patients become more comfortable with bedside presentations when the medical team listens, demonstrates good attention, and appears relaxed (Fletcher et al., 2005).

The last concern is regarding confidentiality and privacy. Both staff and patient expressed concern about these issues (Mittal et al., 2010, Muething et al., 2007, Kleiber et al., 2006, Wang-Cheng et al., 1989). It is important to explain confidentiality issues to the family. They must understand that conversations related to the patient may be overheard by others. A patient's confidentiality could be ensured by conducting the rounds entirely inside patients' rooms, minimizing others access to hallways near the patient's room, and identifying sensitive patient-

related issues before rounds. At the beginning of a hospital stay, the patient and family should be asked if there are key issues that should be protected. Moreover, modifying the unit or patient rooms that might improve privacy should be considered by hospital.

In summary, family-centered rounds were designed to improve communication and collaboration between patient, family and healthcare teams (Rosen et al., 2009). The family-centered rounds are a planned intervention that should needs the permission of patients and families as well as the support of multidisciplinary team (Mittal et al., 2010, Wang-Cheng et al., 1989). It challenges healthcare professionals to move beyond the comfort zone and move toward the uncertainty of the bedside. Well-planned and well-organized rounds could improve the quality of care. Even though many challenges are faced in the implementation of family-centered rounds, there are always strategies that can be done to overcome those challenges (table 2). Working together is better to achieve a better quality of healthcare service.

Table 2 Strategies for Effective Family-centre Rounds

Strategies for Effective Family-centered Rounds
• Developing a structured family-centered rounds process includes the steps and timing • Creating information tools which improve family-centered rounds • Giving information about related family-centered rounds to patient and family upon admission • Being well prepared before rounds • Identifying sensitive issues before rounds • Identifying key personnel and making sure the right people attend the rounds • Conducting rounds entirely inside patients rooms • Introducing all team members and explaining the purpose of rounds • Asking permission from patient and family before rounds • Changing presentation to less medical jargon • Practice with a script to improve confidence

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