Family-Centered Rounds in Theory and Practice: An Ethnographic Case Study

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Abstract

Background: Family-centered rounds (FCR) seek to incorporate principles of family-centered care—including clear and open information sharing, respect, participation and collaboration—into inpatient settings. Although potential models designed to translate these principles into everyday clinical practice have been reported, few studies explore how FCR practices align with principles of family-centered care.

Methods: We conducted an ethnographic study, observing over 200 hours of FCR on a general pediatrics inpatient service from January to August 2010 (185 distinct rounding events). To complement observation, we conducted interviews with 6 family members. Qualitative analysis entailed applying codes to data from observation and interviews and deriving themes using the principles of family-centered care as an interpretive lens.

Results: Four themes emerged that suggested incomplete alignment between FCR practices and principles of family-centered care. 1) FCR provided a forum for information sharing; nonetheless, medical jargon sometimes limited communication. 2) Medical teams approached families with practices intended to demonstrated respect, but contextual factors served to undermine this intent. 3) FCR gave family members the opportunity to participate in care but did not guarantee their involvement. 4) FCR were a starting point for collaboration around plan making, but did not guarantee that collaboration occurred.

Conclusions: Although FCR practices may set the stage for family-centered care, they do not necessarily ensure that the principles of family-centered care are upheld. Efforts to more effectively deliver FCR should consider physical, organizational, and cultural factors that influence both patient/family and medical team behavior.

Keywords: bedside rounds; communication; family centered rounds; family-centered care; patient centered care

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What's New

Family-centered rounds (FCR) seek to incorporate family-centered care into clinical settings. This ethnographic study suggests that although FCR may set the stage for family-centered care, contextual factors may mediate how family-centered care principles are translated into practice.

FAMILY-CENTERED CARE IS defined as health care delivery that focuses on the patient in the context of the family.[1] Principles of family-centered care, as outlined by the Institute for Patient and Family-Centered Care,[2] the American Academy of Pediatrics,[3] and the nonprofit organization Family Voices,[4] include information sharing, dignity and respect for the patient and family, participation by the patient and family in patient discussions and decision making, and collaboration among medical teams, patients and families. Although there is consensus around the principles of family-centered care, there is a lack of consensus on how to translate these principles into everyday clinical practice.[5,6]

Family-centered rounds (FCR) seek to incorporate the principles of family-centered care into the inpatient setting.[3,7,8] Built around the tradition of "bedside rounds," FCR involve balancing the needs of the family with the needs of the medical team, including learners.[8] Potential models for FCR provide a template that medical teams can use to translate the principles of family-centered care into practice. In one model, authors suggest the following: 1) giving families a choice to participate in rounds; 2) introducing themselves to family members; 3) forming a circle inclusive of the patient and family in order to make eye contact; 4) verbally inviting families to participate in the patient discussion; and 5) avoiding the use of medical jargon during patient presentations and translating necessary jargon into lay terms.[9,10]

There is a growing body of literature on family perspectives regarding FCR,[11–14] yet few studies explore if, and how, FCR practices align with principles of family-centered care. Thus, we conducted an ethnographic study of FCR at one institution focusing on the interactions between patients/families and medical teams for the purpose of understanding the alignment between the principles of family-centered care and FCR in practice.

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PATIENTS AND METHODS

SETTING

We conducted the study from January to August 2010 on a general pediatrics inpatient service at a children's hospital at a large urban academic medical center. The hospital has 89 non–intensive care unit licensed beds; 53 are in single-bed rooms, 24 are in double-bed rooms, and 12 are in 4-bed rooms. During the study period, the service had an average census of 16 patients per day, split between 2 teams, with approximately 1400 discharges per year.

FAMILY-CENTERED ROUNDS

At the time of this study, medical teams on the general pediatrics inpatient service had conducted FCR for more than 3 years. The structure of FCR was based on a reported model for FCR.[9] The model was presented to medical teams formally during orientation to the inpatient rotation and informally through feedback from attending physicians during the rotation.[9] All members of the medical team were instructed to follow standard isolation precautions when entering patient rooms for FCR. A description of FCR was shared with family members at the time of admission to inform and prepare them for rounds. FCR typically started at 7:45 AM and lasted for approximately 2 hours each day.

STUDY PARTICIPANTS

Participants included English-speaking patients and family members on the general pediatrics inpatient service and the medical team caring for those patients (Table 1). For the purposes of this study, "family member" was defined as the caregiver present at the bedside at the time of rounds. Spanish-speaking patients and family members were excluded in order to avoid potential confounders related to language barriers. During the 8-month period of observation, 185 distinct rounding events with 140 distinct patients and families were observed. Family members were given an information sheet about the study at the time of admission, including how to opt out of the study. No documented consent was required to participate in the observation. To get a sense of family members' perspectives on FCR, we complemented observation with semistructured interviews of 6 family members after they were observed on rounds. Those family members who were interviewed provided written informed consent. The Columbia University Medical Center institutional review board approved this research.

Table 1. Characteristics of the Patient Population (n = 140)

Characteristic	Value
Age, y, mean (SD)	4.5 (5.6)
Gender, % male (n)	59 (82)
Patient race/ethnicity, % (n)	
Non-Hispanic white	10 (14)
Hispanic	32 (45)
Black	13 (18)
Asian	1 (2)
Other/unknown	44 (61)
Patient insurance type, publicly insured, % (n)	69 (97)
Previous admissions to general pediatrics inpatient service, % (n)	22 (31)
Previous admissions to study hospital, including general pediatrics inpatient service, % (n)	33 (46)

Each medical team consisted of an attending pediatrician, 2 senior residents, 4 interns, and 2 to 3 medical students. Attending pediatricians and medical students rotated every 2 weeks and residents and interns rotated every 4 weeks. During the study, 21 pediatric attendings, 32 senior residents, 64 interns and approximately 90 medical students were observed.

DATA COLLECTION

Ethnography is a qualitative research tradition that uses close, prolonged observation to create a detailed description of naturally occurring, relatively routine—but nonetheless complex and dynamic—situations involving interactions.[15] In this tradition, a single researcher typically conducts the observation and complementary interviews to deepen their understanding of the phenomenon of interest.[16–20] The lead researcher (AS) directly observed rounds, taking an observer participant stance; that is, her role as pediatrician was secondary to her role as an information-gatherer.[21] As both a pediatrician and researcher, AS uniquely had access to the medical team, knowledge of clinical practice, understanding of the rounding process, and training in ethnography.

Over the 8-month study period, AS observed FCR for 2 hours per day for a total of 200 hours. She took detailed notes during observation, including structured data (eg, location, participants, language, and duration of FCR) and unstructured data related to interactions between the patient/family and the medical team (eg, tacit information about discussions on rounds and synopses of verbal communication). AS transcribed notes immediately after observation and incorporated them into a qualitative research database (Atlas.ti). Demographics were collected from the electronic medical record and entered into an Excel spreadsheet.

Preliminary findings from observation were used to construct an interview guide. AS interviewed a convenience sample of 6 family members after their rounds were observed to gain an understanding of how they perceived their interactions with the medical team. Family members were asked questions about their experience on FCR; for example, family members were asked how they participated in FCR and how the medical team encouraged or discouraged their participation. These semistructured interviews lasted from 20 to 90 minutes; they were audiotaped, transcribed, and entered into the qualitative database.

DATA ANALYSIS

Consistent with qualitative methods, data analysis occurred concurrently with data collection.[22] AS created an initial code list based on the principles of family-centered care. As patterns emerged from incoming data, she inductively created new codes and expanded the list. Once the saturation point was reached (ie, when no new

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