

Best Evidence Statement (BESt)

Date published/posted: June 29, 2009

Topic and/or question as originally asked:

What is the best way to share information with families when they cannot be present during rounds?

Clinical Question:

P (population/problem) For parents of hospitalized children
I (intervention) does the use of a structured method of sharing information from hospital patient rounds
C (comparison) versus an unstructured method for sharing information
O (outcome) increase parent satisfaction for the hospital admission?

Target Population

Inclusion: Parents/guardians of pediatric patients in the inpatient setting.

Definitions:

Structured method for sharing information - a standardized way in which the hospital staff shares information with the parents about the plan for the day from rounds-such as a phone call or a form to fill in and leave at bedside. It would be the same way, every patient, every day.

Unstructured method for sharing information - the method by which information is shared from rounds can vary parent to parent, and staff to staff. The information could be from a staff member who was on rounds, conversation from others who were on rounds, or report from previous shift(s).

Recommendations:

1. There is insufficient evidence and lack of consensus to make a recommendation regarding the use of a structured method for sharing information from hospital patient rounds to increase parent satisfaction.
2. It is recommended that a study be conducted that evaluates a structured method for sharing rounds information with parents/guardians, and measure the effect on patient/family satisfaction.

Discussion/summary of evidence

Although there were no studies identified that directly examined structured methods for communicating information from rounds, several studies identified the importance of communication between inpatient pediatric healthcare providers and the parents/guardians of patients.

Rotman-Pikkielny, Rabin, Amoyal, Mushkat, Zissin, and Levy (2007) [4b], conducted a longitudinal study on the attitude of staff and family members about families being present on rounds. Questionnaires were given at the end of rounds to staff, patients, and family members. In phase one, family members were not included on rounds. In phase two, family members were included. Once staff experienced family inclusive rounds, they saw the value of family being present (53.8% vs. 82.6%). Families expressed strong preferences about participating in decision-making (73.3% before being present on rounds vs. 92.5% after being present on rounds), and patients felt strongly the staff attitude towards them improved following family participation in rounds (66.7% vs. 91.4%).

Latta, Dick, Parry and Tamura, 2008, (4b) conducted a descriptive study interviewing parents about what they wanted from rounds. Several themes were described, including wanting an exchange of information, having the plan of care explained, and feeling included and invited in rounds.

Scott, 1998 (4a) conducted a descriptive study describing the needs of the parents of critically ill patients. The nurses and parents agreed on the general concepts of concern, but the specific value of the concerns differed. For instance, there was one concern that the parents “feel that hospital personnel care” which was ranked first with parents but tenth with nurses. Concerns included talking to the same physician and the same nurse, having questions answered honestly, and receiving information once a day tie into the process of rounds.

Three articles revealed information regarding communication between patients/families and healthcare providers. Wanzer et al., 2004 (4a) reported that patient centered communications (PCC) strongly related to patient satisfaction in patient surveys.

McGilton et al., 2006 (4a) published a longitudinal study which showed that the use of a communication enhancement tool improved nurses’ job satisfaction and relationship with patients.

Teare and Smith, 2004 (2b) used focus groups to identify what parents of hospitalized children valued in their communication with the staff. The themes described included the importance of being listened to, staff recognizing the stress of staying at the hospital (away from home), feeling safe, partnering with staff and waiting with their child. The authors found that getting parents to focus groups was more challenging than they anticipated. Parents did not want to leave their child nor did they want to take what limited time they had at the hospital to do something other than being with their child and getting information from the staff/doctors.

Four additional articles provide insight into mechanisms to improve rounds from the parents’ perspective. Birtwistle et al., 2000 (4b, conducted a descriptive study of physicians, nurses, parents and patients, using a questionnaire to ask each group about their satisfaction with the present format for rounds on three inpatient units . The study concluded that all parties believed the present format for rounds needed to be changed, with specific concerns including that rounds were too time-consuming for staff and too intimidating for families and patients.

Elisa Sobo, 2004 (5) described a rapid cycle improvement project which developed a parent communication preference form they entitled PIINT-patient/parent information and involvement assessment tool. Parents filled out this form on how they wanted information and how they wanted to be involved in the decision making process.

Maisels and Kring, 2005 (2a) described a randomized controlled trial with the use of a patient facilitator for the intervention group, and no facilitator for the comparison group. The facilitator met with the patient/families daily to respond to any questions the family might have. Patient satisfaction was significantly raised for the intervention group versus the comparison group with both nursing and physicians in survey results at the time of discharge, or after discharge, On a 5 point scale, patient satisfaction had a

mean score of 4.75 for intervention group versus 4.18 for comparison group. Although these studies do not directly include rounds, one method of communication is the practice of rounds. If satisfaction is linked with improved communication, and rounds is a practice used at a particular institution, there is indirect evidence in these studies linking communication (of information from rounds) with satisfaction.

Landry et al., 2007(2A), conducted a randomized controlled study to answer the question: “Which format of rounds is preferred by residents and parents, bedside rounds or conference room rounds?” Patients who were planned to have 2 consecutive mornings in the PICU were randomized on Day One into either conference room rounds or bedside rounds. On Day Two rounds were conducted in the other method. Parents clearly preferred bedside rounds, so they could be included in discussion (81% wished all rounds were at the bedside), and residents were satisfied with either site, with comfort in asking questions slightly higher in the conference room setting (84% vs. 69%).

A NACHRI electronic mailing list set of questions was sent out in August 2008. There were four responses which answered the questions in some part, but did not directly address the clinical question regarding a structured method for sharing information. The questions sent out were “Does your unit/hospital have bedside rounds? If parents are present at the time of rounds, are they given the option to participate? If parents aren’t there, is there a structured way for the parents to receive the information from rounds? Does your unit/hospital participate in a survey for parents regarding satisfaction with their stay in the hospital?” The responses indicated that the hospitals did indeed have rounds in some format, but they did not have any structured methods for sharing information to families if they were not present on rounds.

In conclusion, the literature review did not find any research study directly addressing the use of a structured method to share information from rounds (the plan for the day) with families who are not present for rounds. There is evidence that family members want to be present on rounds, want to be able to understand the plan, and participate in decision making. (Rotman-Pikkielny et al., 2007 [4b], Latta et al., 2008 [4b].) Parents want information and assurance from the health team and are much more satisfied when they are included in rounds. Parents value partnering, being listened to, and want to feel safe with the care of their child. (Landry et al., 2007 [2a], Scott, 1998 [4a], Teare and Smith, 2004 [2b].) Despite evidence addressing rounds, communication and satisfaction, there was no research directly stating there should or should not be a structured method for sharing information from rounds.

The grade for the body of evidence cannot be assigned. Studies have not been done directly addressing the PICO question, and published studies found have inconsistent results in answering the PICO question.

Using the search word “rounds”, in the Nursing Policies, Procedures and Standards manual, the Medical Center Policy manual, and the Clinical Practice policies, there is no policy present which addresses rounds.

Health Benefits, Side Effects and Risks

Health Benefits-Having a structured method for sharing information could reduce the stress of the hospitalization and help the parent focus on their child achieving a level of wellness in order to be discharged to home. (Teare and Smith, 2004 [2b])

Side Effects-The introduction of a new method for sharing information from rounds to parents or guardians may cause concern or confusion as the learning process unfolds.

Risks-There is no significant risk identified.

References/citations

- Birtwistle, L., Houghton, J. M., & Rostill, H. (2000). A review of a surgical ward round in a large paediatric hospital: Does it achieve its aims? *Medical Education*, 34(5), 398-403. (4b)
- 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. (2a)
- Latta, L. C., Dick, R., Parry, C., & Tamura, G. S. (2008). Parental responses to involvement in rounds on a pediatric inpatient unit at a teaching hospital: A qualitative study. *Academic Medicine*, 83(3), 292-297. (4b)
- Maisels, M. J., & Kring, E. A. (2005). A simple approach to improving patient satisfaction. *Clinical Pediatrics*, 44(9), 797-800. (2a)
- McGilton, K., Irwin-Robinson, H., Boscart, V., & Spanjevic, L. (2006). Communication enhancement: Nurse and patient satisfaction outcomes in a complex continuing care facility. *Journal of Advanced Nursing*, 54(1), 35-44. (4a)
- Rotman-Pikielny, P., Rabin, B., Amoyal, S., Mushkat, Y., Zissin, R., & Levy, Y. (2007). Participation of family members in ward rounds: Attitude of medical staff, patients and relatives. *Patient Education & Counseling*, 65(2), 166-170. (4b)
- Scott, L. D. (1998). Perceived needs of parents of critically ill children. *Journal of the Society of Pediatric Nurses*, 3(1), 4-12. (4a)
- Sobo, E. J. (2004). Pediatric nurses may misjudge parent communication preferences. *Journal of Nursing Care Quality*, 19(3), 253-262. (5)
- Teare, J., & Smith, J. (2004). Using focus groups to explore the views of parents whose children are in hospital. *Paediatric Nursing*, 16(5; 5), 30-34. (2b)
- Wanzer, M. B., Booth-Butterfield, M., & Gruber, K. (2004). Perceptions of health care providers' communication: Relationships between patient-centered communication and satisfaction. *Health Communication*, 16(3), 363-384. (4a)

Note: Full tables of evidence grading system available in separate document:

- Table of Evidence Levels of Individual Studies by Domain, Study Design, & Quality (abbreviated table below)
- Grading a Body of Evidence to Answer a Clinical Question
- Judging the Strength of a Recommendation (abbreviated table below)

Table of Evidence Levels (see note above)

<i>Quality level</i>	<i>Definition</i>
1a† or 1b†	Systematic review, meta-analysis, or meta-synthesis of multiple studies
2a or 2b	Best study design for domain
3a or 3b	Fair study design for domain
4a or 4b	Weak study design for domain
5	Other: General review, expert opinion, case report, consensus report, or guideline

†a = good quality study; b = lesser quality study

Table of Recommendation Strength (see note above)

<i>Strength</i>	<i>Definition</i>
“Strongly recommended”	There is consensus that benefits clearly outweigh risks and burdens (or visa-versa for negative recommendations).
“Recommended”	There is consensus that benefits are closely balanced with risks and burdens.
No recommendation made	There is lack of consensus to direct development of a recommendation.

Dimensions: In determining the strength of a recommendation, the development group makes a considered judgment in a consensus process that incorporates critically appraised evidence, clinical experience, and other dimensions as listed below.

1. Grade of the Body of Evidence (see note above)
2. Safety / Harm
3. Health benefit to patient (*direct benefit*)
4. Burden to patient of adherence to recommendation (*cost, hassle, discomfort, pain, motivation, ability to adhere, time*)
5. Cost-effectiveness to healthcare system (*balance of cost / savings of resources, staff time, and supplies based on published studies or onsite analysis*)
6. Directness (*the extent to which the body of evidence directly answers the clinical question [population/problem, intervention, comparison, outcome]*)
7. Impact on morbidity/mortality or quality of life

Supporting information

Introductory/background information

Bedside rounds are routine for inpatient units at Cincinnati Children’s Hospital Medical Center. Due to a variety of factors, parents aren’t always present for rounds. How they get information from rounds differs and is not formalized in any way. This literature review process was undertaken to identify pertinent studies relating to sharing information from rounds to parents and if this positively impacted the satisfaction parents had for the hospital stay.

Group/team members

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Search strategy

OVID MEDLINE, OVID CINAHL. **Search terms:** communication, patient rounds, parent satisfaction, rounds, multidisciplinary, pediatric.

Search limits: publication date of 1999 or sooner, English language.

NACRHI electronic mailing list-Questions submitted to answer the clinical question.

Applicability issues

An organizational barrier could be that each unit has unique methods of work flow. Introducing a new way to convey information from rounds to parents may meet resistance on units if this process does not fit in within their culture. How to distribute and how to sustain this information are other potential barriers. Positive outcomes may be measured if unit parent surveys reflect improve satisfaction of parents based on information sharing from rounds. No significant financial cost would be associated with modifying the rounds process.

Copies of this Best Evidence Statement (BESt) are available online and may be distributed by any organization for the global purpose of improving child health outcomes. Website address: <http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/ev-based/default.htm>
Examples of approved uses of the BESt include the following:

- copies may be provided to anyone involved in the organization's process for developing and implementing evidence based care;
- hyperlinks to the CCHMC website may be placed on the organization's website;
- the BESt may be adopted or adapted for use within the organization, provided that CCHMC receives appropriate attribution on all written or electronic documents; and
- copies may be provided to patients and the clinicians who manage their care.

Notification of CCHMC at HPCEInfo@cchmc.org for any BESt adopted, adapted, implemented or hyperlinked by the organization is appreciated.

For more information about CCHMC Best Evidence Statements and the development process, contact the Center for Professional Excellence/Research and Evidence-based Practice office at CPE-EBP-Group@chmcc.org.

Note

This Best Evidence Statement addresses only key points of care for the target population; it is not intended to be a comprehensive practice guideline. These recommendations result from review of literature and practices current at the time of their formulation. This Best Evidence Statement does not preclude using care modalities proven efficacious in studies published subsequent to the current revision of this document. This document is not intended to impose standards of care preventing selective variances from the recommendations to meet the specific and unique requirements of individual patients. Adherence to this Statement is voluntary. The clinician in light of the individual circumstances presented by the patient must make the ultimate judgment regarding the priority of any specific procedure.

Reviewed by Clinical Effectiveness