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Volume 12, Number 1, 2021

URI: <https://id.erudit.org/iderudit/1076156ar>

DOI: <https://doi.org/10.36834/cmej.70481>

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Publisher(s)

Canadian Medical Education Journal

ISSN

1923-1202 (digital)

[Explore this journal](#)

Cite this document

Ibrahim, S., Shuster, S., Aina, D. & Wijeratne, D. (2021). Seven ways to get a grip on facilitating bedside team rounding. *Canadian Medical Education Journal / Revue canadienne de l'éducation médicale*, 12(1), e85–e88.
<https://doi.org/10.36834/cmej.70481>

Article abstract

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Seven ways to get a grip on facilitating bedside team rounding

Sept façons de faciliter le travail de l'équipe de chevet

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Published ahead of issue: December 21, 2020; published: February 25, 2021. CMEJ 2021, 12(1) Available at <http://www.cmej.ca>

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Abstract

Although classically considered a cornerstone of inpatient care, rounding at patients' bedsides is increasingly being replaced by rounding in workrooms. Workroom rounds may provide a sense of efficiency and comfort, however bedside rounds have multiple benefits for patients, trainees, and staff physicians. Alongside its benefits, there are human and institutional challenges when incorporating bedside rounding. This article aims to draw on our own experience of implementing bedside rounding at Kingston Health Sciences Centre, to guide staff physicians and institutions on how to implement bedside rounding effectively while overcoming its challenges. The following seven tips provide a framework to avoid pitfalls when implementing bedside team rounding on inpatient services.

Résumé

Bien que classiquement considéré comme la pierre angulaire des soins aux patients hospitalisés, les tournées médicales au chevet des patients sont de plus en plus remplacées par les tournées dans les salles d'enseignement. Bien que les tournées en salle de travail puissent procurer un sentiment d'efficacité et de confort, les tournées au chevet présentent de multiples avantages pour les patients, les apprenants et les médecins superviseurs. Parallèlement à ses avantages, il existe des défis humains et institutionnels lors de l'intégration des tournées au chevet du patient. Cet article vise à tirer parti de notre propre expérience de la mise en œuvre des tournées au chevet au Kingston Health Sciences Centre, pour guider les médecins superviseurs et les institutions sur la façon de mettre en œuvre efficacement les tournées au chevet tout en surmontant ses défis. Les sept conseils suivants fournissent un cadre pour éviter les pièges lors de la mise en œuvre des tournées en équipes au chevet des patients hospitalisés.

Introduction

Bedside rounds have historically been considered a cornerstone of clinical care and medical education. In recent years, however, more than 75% of rounds have been occurring outside the patient's room, often in team workrooms.¹ One of the most notable reasons for workroom rounding is time.² On a busy clinical teaching unit (CTU) where time may be limited, workroom rounding provides a sense of efficiency, comfort and decreased time burden compared to bedside rounding.² Another benefit of

workroom rounding may be a patient's lack of desire to participate in bedside rounds, as complex or sensitive clinical discussions may overwhelm patients.³ Moreover, workroom rounding has technological advantages such as dedicated computers for viewing radiologic images and lab values and proximity to telephones for calling consulting services and ability to answer pages.

The benefits of bedside rounds can be explored from three perspectives: patients, trainees, and staff physicians. Most patients and families prefer bedside rounding as it allows

them to understand that their voice is being heard.⁴ They have the opportunity to meet the entire team, directly express their concerns and be actively involved in clinical decision-making.²⁻⁴ Patients also benefit from knowing they are helping teach future clinicians. Additionally, bedside rounds provide valuable educational opportunities for trainees to explore physical findings (e.g. heart murmurs), learn communication skills (i.e. complex family discussions) and practice communication (i.e. patient presentations).²⁻⁶ Bedside rounds also facilitate teamwork as each team member plays a valued role in the process. Moreover, by seeing the patient as a team and making real-time collaborative decisions, orders and requisitions can be completed at the same time thereby promoting time efficiency.⁶ Lastly, it allows staff physicians to teach clinical skills, evaluate trainees and provide timely feedback.⁶ On a broader scale, bedside rounding can improve collaboration,³ fulfilment,² and patient-centered care.⁶

Despite its benefits, bedside rounding also presents challenges. Bedside rounds may cause patient discomfort in situations such as repeated physical exams or incorrect wording used by providers. Furthermore, trainees may be nervous about making mistakes, or may be frequently interrupted during bedside presentations (i.e. by pagers).^{2,4} Staff physicians may have difficulty answering spontaneous questions, lack confidence if unfamiliar in this rounding style and be unmotivated to change if there is no perceived benefit.²⁻⁴ As well, institutional barriers include increased time between patients in scattered locations, wasted time due to unavailable patients (i.e. if patient has gone for testing) and limited space for teams in small patient rooms.^{2,3,7,8} Rounds may also increase the risk of infection if precautions are not observed.^{4,7}

We have piloted bedside rounds on the CTU service at Kingston Health Sciences Centre (KHSC). Based on our experience, and suggestions from peers and the literature,^{1,2,4,7} we present some practical tips to help facilitate structured bedside team rounding.

1. Assign team roles

We recommend assigning each team member a role: teacher/mediator, presenter, examiner, electronic medical record (EMR) operator, note-taker, timekeeper and a runner who is responsible for placing new orders, requisitions and addressing distractions. For ease of administration we assigned these tasks among house staff in a predefined cyclic manner starting with the patient presenter and with rotating responsibilities that change

with every patient encounter. The staff physician or a senior learner is usually assigned the teaching role, while other team members take on the remainder of the roles. This helps invoke responsibility and engagement among all team members.⁹ Depending on the number of team members, roles may be collapsed or swapped throughout rounding (Figure 1). Bedside rounds may also include additional members of the interdisciplinary team who can provide additional information and assist in decision-making.

2. Prepare for rounds

Preparation for bedside rounds is essential to efficiency. The teacher may prepare an outline of key teaching points for each patient's clinical situation.⁴ Each trainee should gather information on patients for which they have been assigned. Noting the patient's pertinent vitals, investigations and issues, will help the presenter have a focused patient presentation and the note-taker to have a concise note. The progress note can be pre-initiated.

The other roles do not need extensive preparation. The teacher should help the examiner focus their physical exam. The EMR operator's role is to have the software ready with the selected patient chart open. The note-taker may find it more effective to complete an issue-based patient note. The timekeeper ensures each component of rounds is timely. Lastly, the runner should have blank orders and requisitions forms on hand. Together this makes for a more efficient rounding process.

3. Prioritize and involve patients

It is important to involve patients in the discussion during bedside rounds.^{2,3,5} Patients must be alerted about bedside rounding in advance, be taken through what to expect and be given an opportunity to decline. During rounds, the team should engage patients and their families in decision-making discussions, avoid using medical jargon and answer any questions they may have. Basic medical courtesy should be demonstrated by introducing team members, asking for permission to discuss the patient's case and to examine them and thanking them at the end of the encounter. If needed, sensitive or technical information can be discussed in the team workroom before or after the encounter.

4. Round geographically

Another strategy to overcome the challenge of time constraint involves geographic rounds, where the team rounds on all patients on one ward before moving onto the

next.² Teams aim to complete rounding on each patient within 5-10 minutes. The team may select to engage in bedside rounding for patients who are more medically active, or alternatively the team may alternate between 10-15 patients each day.

5. Promote teamwork

Promoting teamwork is essential to making team rounds more successful.¹⁰ We found that giving a brief orientation to participants allowed for a smoother transition when implementing team rounds.¹⁰ This included discussion on benefits and challenges of team rounds, strategies to overcome those challenges and an invitation to provide feedback. Teamwork is also strengthened through collaborative discussion about critical clinical decision-making and cognitive reasoning.^{11,12} This can enhance patient engagement, promote trainees' learning and ensure all team members are on the same page.¹¹

6. Adopt reflective practices

Although bedside rounding has several benefits, it is crucial to adapt rounds to patient preferences. We suggest asking patients whether they would like bedside rounds during their hospital stay. Additionally, eliciting feedback from patients and the clinical team helps to improve rounds for future patients.

7. Consider COVID-related changes

The COVID-19 pandemic has had an unprecedented impact globally. Guidelines put in place to curb the spread of the

virus include stricter visitor policies and procedural changes to patient care. We suggest several modifications to our practical suggestions to facilitate bedside rounding while prioritizing safety. Firstly, preparation before rounds is important to limit exposure time. Next, only the staff physician and assigned trainee should round on COVID-19 positive patients, while other trainees' participation may still occur virtually with the patient's permission. Despite stricter visitor policies, involving families is still a priority and this can be done through telephone or video connections during the encounter. Furthermore, although geographic rounds may still continue, it is imperative to round on COVID-19 positive patients last to reduce spread. Lastly, it is important to consider additional stressors that patients may be experiencing during the pandemic (i.e. loss of a loved one or financial instability) and eliciting this information would allow the team to better understand the patient and advocate for appropriate supports.

Conclusion

It is evident that bedside rounding provides several benefits for both patients and learners. It allows patients to feel as though they are part of their clinical team and engage in decision-making about their care and it provides learners with an enhanced educational experience. We have demonstrated our strategy for effective and efficient bedside rounding including its advantages and disadvantages, which will help rejuvenate a dying practice.

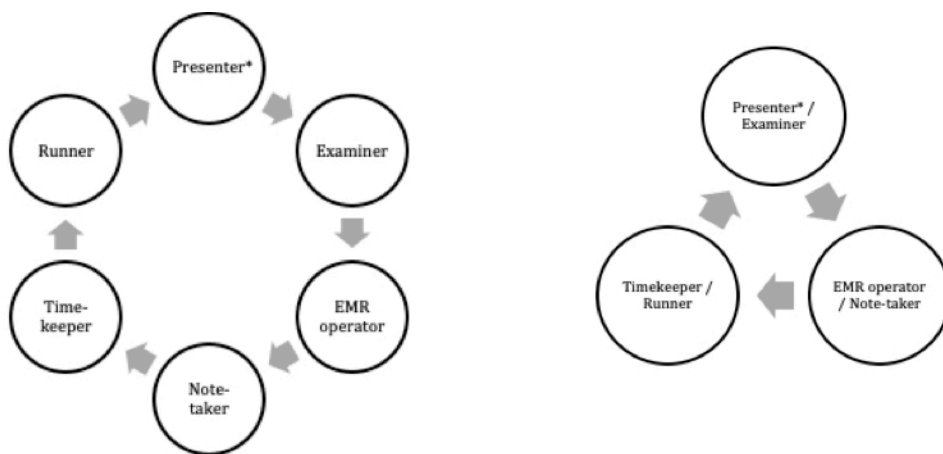


Figure 1. Collapsible team roles with six members (left) vs three members (right).

* Prior to rounds, we recommend assigning the presenter role by allocating patients, as well as deciding the order of other roles seen in this diagram. Hence when the presenter is assigned the other roles fall into place and can rotate with each patient.

Conflicts of Interest: There are no conflicts of interest.

Funding: There was no funding for this project.

References

1. Gonzalo JD, Heist BS, Duffy BL, et al. The art of bedside rounds: A multi-center qualitative study of strategies used by experienced bedside teachers. *J Gen Intern Med.* 2013;28(3):412–20. <https://doi.org/10.1007/s11606-012-2259-2>
2. Lichstein PR, Atkinson HH. Patient-Centered Bedside Rounds and the Clinical Examination. *Med Clin North Am.* 2018;102(3):509–19. <https://doi.org/10.1016/j.mcna.2017.12.012>
3. Ruopp MD. On being a doctor: bedside rounds. *Ann Intern Med.* 2019;170(5):344–5. <https://doi.org/10.7326/M18-3413>
4. McGee S. A piece of my mind. Bedside teaching rounds reconsidered. *JAMA.* 2014;311(19):1971–2. <https://doi.org/10.1001/jama.2013.286201>
5. Gonzalo JD, Chuang CH, Huang G, Smith C. The return of bedside rounds: An educational intervention. *J Gen Intern Med.* 2010;25(8):792–8. <https://doi.org/10.1007/s11606-010-1344-7>
6. Gonzalo JD, Heist BS, Duffy BL et al. The value of bedside rounds: a multicenter qualitative study. *Teach Learn Med.* 2013;25(4):326–33. <https://doi.org/10.1080/10401334.2013.830514>
7. Gonzalo JD, Heist BS, Duffy BL et al. Identifying and overcoming the barriers to bedside rounds: A multicenter qualitative study. *Acad Med.* 2014;89(2):326–34. <https://doi.org/10.1097/ACM.000000000000100>
8. Huang KTL, Minahan J, Brita-Rossi P et al. All together now: impact of a regionalization and bedside rounding initiative on the efficiency and inclusiveness of clinical rounds. *J Hosp Med.* 2017;12(3):150–6. <https://doi.org/10.12788/jhm.2696>
9. Ruch W, Gander F, Platt T, Hofmann J. Team roles: their relationships to character strengths and job satisfaction. *J Posit Psychol* 2018 Mar 4;13(2):190–9. <https://doi.org/10.1080/17439760.2016.1257051>
10. Rosen MA, DiazGranados D, Dietz AS et al. Teamwork in healthcare: Key discoveries enabling safer, high-quality care. *Am Psychol* 2018 May 1;73(4):433–50. <https://doi.org/10.1037/amp0000298>
11. Ervin JN, Kahn JM, Cohen TR, Weingart LR. Teamwork in the intensive care unit. *Am Psychol* 2018 May 1; 73(4):468–77. <https://doi.org/10.1037/amp0000247>
12. Babiker A, El Hussein M, Al Nemri A et al. Health care professional development: Working as a team to improve patient care. *Sudan J Paediatr.* 2014; 14(2): 9–16. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/27493399> [Accessed on Oct 4, 2020]