

SHORT COMMUNICATION

SURVEY OF PATIENTS' PREFERENCE FOR THE LOCATION OF REHABILITATION WARD ROUNDS

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Objective: To survey inpatients in a rehabilitation hospital regarding their preference for ward rounds to be conducted at the bedside or in a consulting room.

Design: Before-after trial. Patients were seen on ward round at the bedside during one week and then in a consulting room the following week. Patients were asked about their preferred setting and their reasons for their preference.

Patients: Rehabilitation inpatients ($n=45$) in Melbourne, Australia with predominantly acute neurological and orthopaedic impairments.

Methods: Age, gender and impairment category of respondents were noted. Ward round preference was analysed assuming a binomial distribution.

Results: A statistically significant number ($p=0.04$) of patients preferred to be seen in the consulting room ($n=29$, 64%). There were 13 (29%) who preferred the bedside and 3 (7%) indicated no preference. There was no influence of gender ($p=0.1$) or impairment category ($p=0.3$) on preference, but younger patients preferred the consulting room ($p=0.03$).

Conclusion: Most rehabilitation patients in hospital would rather attend a ward round held in a consulting room than at the bedside. The consulting room has many advantages over the traditional bedside location for ward rounds in a rehabilitation hospital.

Key words: rehabilitation, ward rounds, consultation, patient preference, patients' rooms.

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INTRODUCTION

Ward rounds are the cornerstone of patient management and teaching medicine in hospitals. Traditionally, doctors and nurses visited patients at the bedside (1). Over the years there has been a trend towards case presentations in a conference room (2). Nowadays, especially in rehabilitation, ward rounds are more likely to be multidisciplinary.

Ward rounds are an opportunity to perform many important inter-related tasks. These include the following: (i) review

patients clinical status (3, 4); (ii) perform examinations (3, 4); (iii) teach clinical and patient–healthcare professional relationship skills, including ethics (5) and dignity-conserving care (6); (iv) exchange information between patient, doctors, nurses and other healthcare professionals; and (v) review patient care and discharge planning.

Despite the importance of ward rounds, there has been relatively little research on the location and conduct of hospital ward rounds (4, 7–12). A literature search on ward rounds in a rehabilitation medicine setting using the EMBASE and Medline databases located only one study, which examined the participation of family members in ward rounds (13). Rehabilitation patients are usually medically stable. Only in rare situations, for instance if they have a sacral pressure ulcer, do they routinely need to be confined to bed. In a rehabilitation setting, therefore, it is possible to conduct ward rounds with patients seen in a consulting room.

The aim of the study was to conduct a ward round in an inpatient rehabilitation unit at the bedside, and the following week in a consulting room, and to survey patients regarding where they preferred to be seen. The study hypothesis was that patients would rather be seen on ward rounds conducted in a consulting room than at the bedside.

METHODS

Setting

A survey was conducted of inpatients in a 28-bed rehabilitation unit in Melbourne, Australia. The unit cares for patients with a range of neurological (e.g. stroke, acquired brain injury), orthopaedic (e.g. arthroplasty, lower limb fractures) and general impairments. Most patient bedrooms in the unit were shared, with beds separated by curtains. Two consultant physicians in rehabilitation medicine each performed weekly ward rounds at the bedside.

A trial was planned to conduct ward rounds in a consulting room approximately 30 m from the ward area. The patients were directed or transported to a waiting area outside the consultation room prior to being seen. Patients arrived in groups of 2 or 3. Patients who could follow directions and were mobile made their way independently to the consulting room area at a designated time. Supervision was provided if required and those not able to safely mobilize were assisted. Because of the perceived benefits, if patients consented, family members were permitted to also attend the ward round (13). The format of the ward round was otherwise the same as that conducted at the bedside, except that the background and clinical update was presented and discussed in detail before the patient entered.

Survey process

Patients were surveyed about their preference for the location of ward round regarding either, (i) the traditional bedside, or (ii) the consulting room. Patients were also asked to nominate the reason for their preference. Demographic and clinical details were collected, including age, gender, and impairment category (neurological, orthopaedic or general).

The survey was conducted within 3 days of the consulting room ward round trial. Patients were excluded for the following reasons: cognitive or communication disabilities that prevented comprehending the survey question; medical reasons for not being able to attend the consulting room; or they were not an inpatient for the traditional bedside ward round the previous week.

The survey was repeated to increase the sample size and the power of this study. None of the participants from the first survey were included in the second. For the repeat phase the ward round reverted to the bedside format for one week and the following week it was held in the consulting room. The same exclusion criteria applied and the survey process was the same.

No identifying information was collected in the survey and confidentiality was maintained. No formal written consent was obtained from participants. Verbal consent was obtained from all potential participants. Local ethics committee approval was given for the study.

Analysis

Descriptive statistics were calculated. This study required 29 participants for a power of 80% to detect a significant difference in proportions of 25% between preferences. Patient preference and 95% confidence intervals (CI) for ward round location was analysed assuming a binomial distribution. Patient preference was tested for associations with impairment group, survey sequence (first or second) and gender using the χ^2 test, and the Wilcoxon rank-sum (Mann-Whitney U test) for association with age.

Initial database entry was performed using Excel 2002 (Microsoft Corp, Redmond, WA, USA). Statistical analysis was performed using Stata, intercooled version 9.0 for Windows (Stata Corp, College Station, TX, USA). p -values of 0.05 or less were deemed statistically significant.

RESULTS

Forty-five patients completed the survey. No eligible patient refused to participate. Patients tended to be relatively young (median age 55.5 years, interquartile range 43–65.5), male (67%, $n=30$) and have neurological (64%, $n=29$) or orthopaedic (27%, $n=12$) impairments (general 9%, $n=4$). Twelve patients were excluded from the survey (severe cognitive or communication deficits $n=7$, not an inpatient when the comparison bedside ward round was conducted the previous week $n=4$, and confined to bed $n=1$).

A statistically significant proportion ($p=0.04$) of respondents preferred ward rounds conducted in the consulting room ($n=29$, 64%, 95% CI 49–78%) compared with the bedside ($n=13$, 29%, 95% CI 16–44%). A few indicated no preference ($n=3$, 7%, 95% CI 1–18%). There was no influence of gender ($\chi^2_1=2.4$, $p=0.1$), impairment category ($\chi^2_2=2.7$, $p=0.3$), or whether respondents participated in the first or second survey ($\chi^2_1=2.3$, $p=0.1$) on patient preference. There was, however, an influence of age on preference, with younger patients having a significantly greater preference for the consulting room (Mann-Whitney $z=2.2$, $p=0.03$).

A justification for their preference was given by 31 (69%) of the respondents. Of these, the reasons for preferring the consulting room were: better privacy (55%, $n=17$); miss less therapy (23%, $n=7$) and a perception that doctors listened more (10%, $n=3$). The only reason given by those who preferred the bedside was that it involved less effort on their part to attend (13%, $n=4$).

DISCUSSION

This survey has shown that most rehabilitation patients would rather prefer ward rounds be held in a consulting room than be conducted at the bedside. The 31% (4/13) of respondents who preferred bedside ward rounds because they required less effort revealed a sentiment that runs contrary to the principles of rehabilitation in encouraging patient independence and activity. It could be argued that it is ethically justifiable, following the moral principle of beneficence, to disregard this preference.

The results of this survey contrast with the preferences given by patients in non-rehabilitation hospitals, where obstetric (4), general medical (8, 14), and psychiatric (11) patients all preferred the bedside ward round. Possible reasons for this difference could be the attention to patient activity and participation in rehabilitation and the different ward environments and focus of these other units. A survey of Japanese medical patients did not indicate any difference regarding their preference for either a bedside or conference room ward round (10). In the bedside group, however, a significantly greater proportion found the medical terms used by doctors too confusing. The hospital residents attached to the unit reported a 95% preference for the conference room. Similarly, the rehabilitation consultants ($n=2$) and hospital residents ($n=4$) involved with this present trial all indicated their preference for the consulting room over the bedside.

Advantages of consulting room ward rounds in rehabilitation

In a rehabilitation hospital setting the consulting room has many advantages over the bedside for ward rounds.

When patients are in shared accommodation the consulting room provides privacy for discussions between patients, their family, and medical or other staff. In particular, discussions involving sensitive areas such as prognosis, emotional and behaviour responses to disability, continence, and sexuality can be discussed in a more appropriate setting than the open ward environment.

The consulting room format can be integrated into the therapeutic rehabilitation programme where it can be used to promote mobility. Attendance by patients with cognitive or spatial orientation impairments can be used to help improve independence around the ward environment.

More efficient use can be made of patients' time. Instead of all patients waiting in their bed until they are seen on ward round days and missing out on therapy time, patients are able to commence therapy sessions sooner. They can be directed

to the consulting room waiting area at staggered intervals and return to their therapy sessions after they have been seen.

This format is in keeping with rehabilitation fostering a transition to community-based activities and independence, rather than the more restrictive arrangements in a traditional acute hospital. There is increasing acknowledgement of the need for healthcare to be patient-centred (15, 16). Adopting the consulting room setting for ward rounds is an example of implementing this in an inpatient rehabilitation setting.

The potential for patient anxiety or misunderstanding that can occur with hearing the medical jargon and terminology used when presenting and discussing a patients' background and clinical status can be eliminated by doing this before the patient enters (3, 8, 10, 14).

Finally, this format for conducting ward rounds facilitates teaching and training opportunities on ward rounds to a much greater extent than alternative methods (9, 10).

Disadvantages of consulting room ward rounds in rehabilitation

It has been necessary to have a clinic nurse assist in coordinating the attendance of patients at the consulting room in a staggered fashion. The nurse provides supervision with mobility, orientation for those who need it, and prompting if patients have cognitive problems or just forget to present at the waiting area. It is necessary on ward rounds to still see some patients in bed because of problems with medical illness, incontinence, pressure ulcers or other problems. Typically, only 2–3 patients a week would not be able to attend the consulting room.

Limitations and implications

Although this study had a small sample size, there were an adequate number of participants to meet the number required to achieve the specified power calculation parameters. Because older patients tended to prefer the bedside for ward rounds it is not possible to generalize the findings of this study to geriatric rehabilitation units. In addition, the results must be interpreted in the context of the ward environment consisting mainly of shared rooms. Different results might arise where rehabilitation patients have their own room.

The implications of this study are that further research is required in different rehabilitation settings to determine if other patient groups produce similar results. It is believed that the advantages of this format, as outlined above, far outweigh the disadvantages. It is suggested that where a suitable room, even a temporary one, exists for this format of ward round,

rehabilitation programmes should consider establishing the necessary system changes and processes to allow patients to be seen in a consulting room for ward rounds.

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