

Introducing Structured Bedside Teaching for Resident Doctors PDSA 1

REASON WHY?

Bedside teaching has declined despite being recognised as an effective method of clinical education; high patient turnover and administrative demands limit opportunities to teach at the bedside. Unlike classroom teaching, it builds clinical reasoning, examination and communication skills at the patient's side and role-models safe, patient-centred care, supporting patient safety and experience. Resident doctors at **Princess Royal Hospital** reported limited access, with time pressures and staffing the main barriers.

PLAN

Baseline:

October 2025 – January 2026

Bedside teaching sessions = 0

Junior doctor survey:

- Insufficient bedside teaching
- Time constraints
- Staffing pressures

Cycle 1 Intervention

Introduced two bedside teachings every month

DO

Six bedside teaching sessions (two each month), were delivered between February and April 2026.

Feedback highlighted that learners valued bedside teaching but identified several areas for improvement.

Common themes included:

Sessions were occasionally either too long or too short

Learning objectives were not always explicit

Teaching sometimes deviated from the intended topic

More interaction was desired

Month	Topic	Attendance	No. Of Feedback
Feb	Heart failure & ITU escalation	3	1
	Dementia vs delirium	3	2
Mar	Investigation of hyponatraemia	3	2
	Hyperkalaemia management	2	2
Apr	Hypercalcaemia in malignancy	4	2
	Acute Kidney Injury	2	2



To increase structured bedside teaching for resident doctors from a baseline of 0 sessions per month to at least one structured session per month, and to improve learner satisfaction, by July 2026 through stepwise PDSA cycles.

STUDY

Outcome measure: structured bedside teaching sessions increased from 0 per month at baseline (Oct 2025 - Jan 2026) to 2 per month (6 sessions in total) between Feb and Apr 2026, with 17 attendances and 11 feedback forms.

What worked: monthly bedside teaching was feasible, attendance remained good despite busy clinical commitments, and learners valued the opportunity to learn at the bedside.

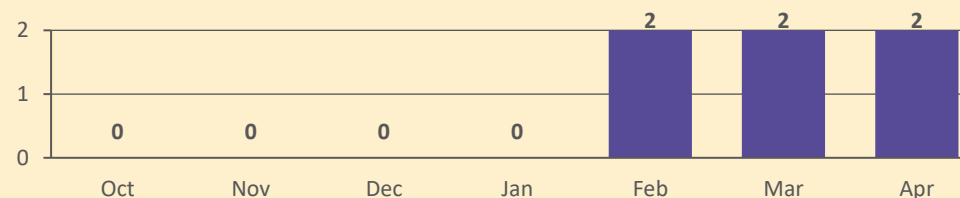
Feedback received

Heart failure & ITU escalation: "Session too long." Dementia vs delirium: "More learner interaction needed."

Hyponatraemia: "Learning objectives a bit unclear. Session too long." Hyperkalaemia: "Teaching deviated from learning objective."

Hypercalcaemia: "Fast paced, session finished quick." Acute kidney injury: "Unclear learning objective, took too long with differentials & management."

Three recurring issues: (1) objectives lacked focus - too many points covered, sessions sidetracked; (2) duration varied - workload interrupted teaching and longer sessions reduced engagement; (3) learning was not formally assessed.



ACT

Learner feedback identified three key changes for the next PDSA cycle.

1- Limit every session to one or two clear learning objectives.

Rationale: focused objectives improve learner engagement and reduce cognitive overload (Ramani, 2003).

2- Standardise sessions to approximately 20 minutes.

Rationale: focused teaching is more achievable in busy clinical environments (Ramani, 2003).

3- Introduce an end-of-session learning assessment: add one question to the feedback form,

"What is one key learning point you will take away from today's session?"

This evidences learner engagement and whether objectives were achieved (Angelo & Cross, 1993).

Next steps: **ADAPT** and retest in PDSA 2 (May-Jul 2026); **ADOPT** twice-monthly bedside teaching as ward standard once objectives and duration are refined. No element abandoned.

ACKNOWLEDGEMENTS & REFERENCES

Ramani, S. (2003) Twelve tips to improve bedside teaching. Medical Teacher, 25(2), 112-115. | Angelo, T.A. & Cross, K.P. (1993) Classroom Assessment Techniques: A Handbook for College Teachers. 2nd ed. San Francisco: Jossey-Bass. | With thanks to the resident doctors and ward teams at Princess Royal Hospital and the SaTH Improvement Hub.