

Faculty Supervised Surgical Morning Report: A Method for Evaluating Residents Performance

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ABSTRACT

Background: The purpose of this study was to evaluate the perceived efficacy of a daily surgical morning report meeting on improved physician communication, and as a means of evaluating resident performance of the ACGME core competencies.

Methods: Anonymous web-based surveys of involved house staff were given before and after the implementation of the surgical morning report meeting. This study was conducted at New York Hospital Queens in Flushing, New York. This institution is a university-affiliated community teaching hospital. Surgical house staffs present at the morning report meeting were surveyed.

Results: The majority of surgical house staff surveyed believed that this meeting improved the quality of hand-offs and communication between shifts. The presence of a faculty member, review of radiological studies, and case discussions were perceived as important elements. This meeting allowed an on-going assessment of resident performance in several important core competencies.

Conclusion: Morning report is a valuable addition to surgical training programs, in that it improves Communication and hand-offs between resident shifts. The meeting provides an additional point of measurement of resident performance of the ACGME core competencies.

KEYWORDS: Communication, Resident performance, Surgical morning report.

INTRODUCTION

Daily morning report meetings have been utilized in internal medicine training programs as both a teaching tool and to facilitate house staff interaction for decades¹. The session typically takes place in the morning, bringing together the on-call admitting team, the incoming residents, medical students, and service attending. A case presentation format is generally followed by a discussion of the disease process and teaching points. In training programs utilizing a night-float service or structures in which the admitting physicians may not provide longitudinal care of patients, methods to decrease errors from insufficient or inaccurate hand-offs become critically important. Much like the internal medicine morning report, a similarly pre-scripted surgical forum in which all overnight admissions, consults, and patients with significant changes in clinical status are discussed can contribute to the reduction of such errors. Moreover, with the advent of work-hour limitations, the ability to develop seamless longitudinal care requires the

implementation of structured hand-off mechanisms. In 2006, Stiles et al.² presented a model for a surgical morning report session, which appeared to provide such a forum within a university-based residency program. The purpose of our report is to describe the application and two-year findings of such a surgical morning report program in a community-based teaching program.

The Accreditation Council for Graduate Medical Education (ACGME) system of core competencies set forth in 2001 has provided a useful framework for resident training and evaluation³. Yet opportunities for faculty observation of some of these characteristics can be few, especially given the time constraints also imposed by the same ACGME. Finding sufficient circumstances where quality interactions between residents and faculty occur.

Within the context of the enumerated competencies can be difficult in the 80-hour world. Many programs adopted a night-float system or other similar cross-cover system to meet the work-hour restrictions⁴. Yet

utilization of night-float systems, further limits the available interactions with the faculty, and decreases the frequency with which these residents attend daytime educational meetings. We propose that a daily surgical morning report provides an excellent opportunity to develop to formative evaluations of the residents, including those on night shifts.

METHODS

A faculty supervised morning report meeting was implemented in June 2006 in our community-based university-affiliated teaching hospital. This institution has a freestanding surgical residency that graduates four chief residents per year. The department also trains medical students and physician assistant students from our university affiliate.

Each weekday morning, prior to team work rounds, the entire house staff, including students, meets to discuss all overnight admissions and consults to the surgical services. The following services are presented: general, pediatric, and vascular surgery, trauma, otolaryngology, neurosurgery, and urology. Also presented are all patients that suffered any deterioration in their clinical status or required operative intervention overnight. When appropriate, radiological studies are reviewed. Specific pre-scripted data points are included with each presentation in order to ensure that important data and responsibilities are appropriately transferred between teams. The minimum data that is required to be transmitted includes: the patient's name, medical record number, age, gender, working diagnosis, assigned team, responsible attending, pertinent care already rendered, and subsequent issues and care requiring the immediate attention of the receiving team. These data points are displayed on a dry erase board, and recorded in a computerized database.

The overnight chief resident presides over the session and presents the cases. It is the expectation of the program that the chief resident sees all cases. The residency program employs a night-float service for junior residents, and an in-house on-call rotation for senior residents. The duration of the meeting varies depending on the number of cases discussed, but is generally less than thirty minutes. Present at all meetings is a faculty attending surgeon whose task is to facilitate the conduct of the meeting, and ask relevant questions of the house staff to both highlight teaching points and ensure that appropriate care is delivered. Additionally, the faculty member takes attendance and completes a formative evaluation of the presenting resident, thus providing instantaneous feedback. The faculty member is scheduled to be present on a rotating basis. The house staff is then discharged to complete work rounds, having been informed of the new patients for whom they are assuming responsibility.

Prior to the initiation of the surgical morning report in 2006, an anonymous web-based survey was given to the house staff to determine their attitudes toward such a structured sign-out meeting. A five-point Likert scale was used to measure the degree to which the resident agreed or disagreed with the question posed. Possible responses included: strongly agree, agree, don't know or neutral, disagree, and strongly disagree. Components of the survey included attitudes regarding the utility of such a session, the importance of having an attending physician present, the allotted time, and whether the performance of the core competencies would be achieved. After approximately one-year, the housestaff was surveyed again to determine if resident perceptions of the utility and efficacy of the morning report had changed. At two-years, the meeting was reexamined by a modified third survey delivered to the housestaff.

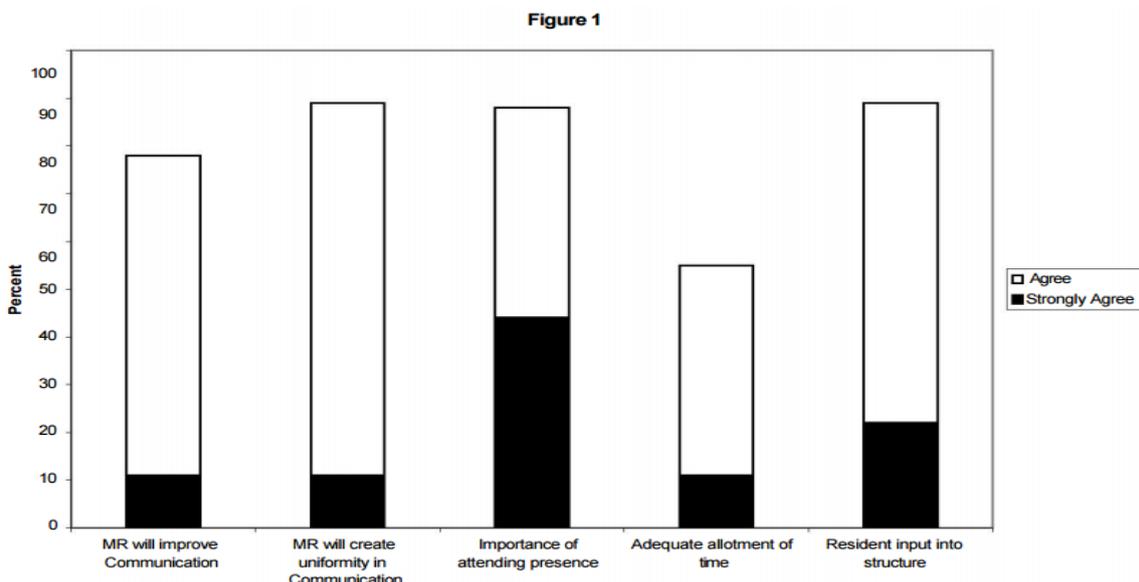


Figure 1: Morning report structure: Survey prior to inception.

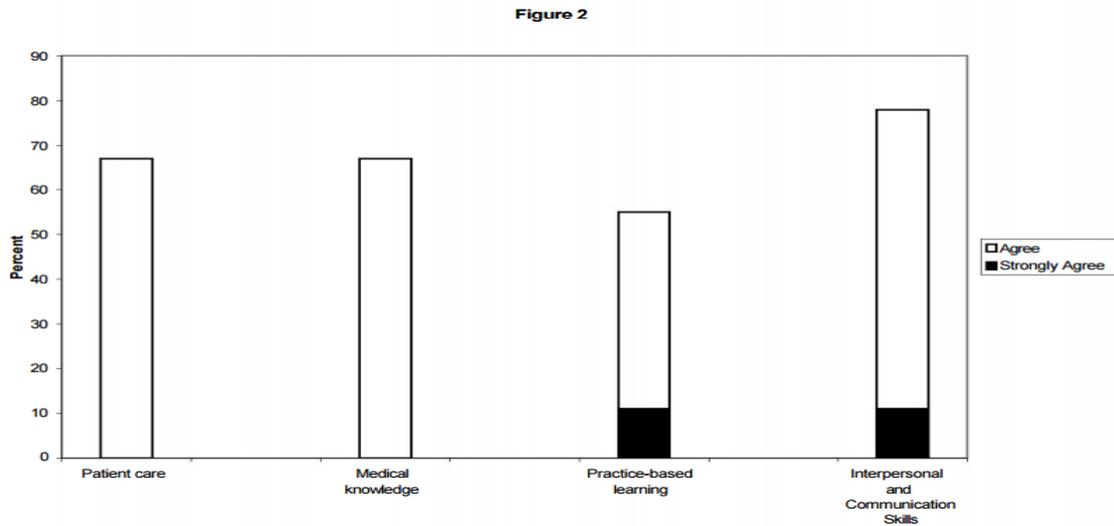


Figure 2: Resident competencies: Survey prior to inception.

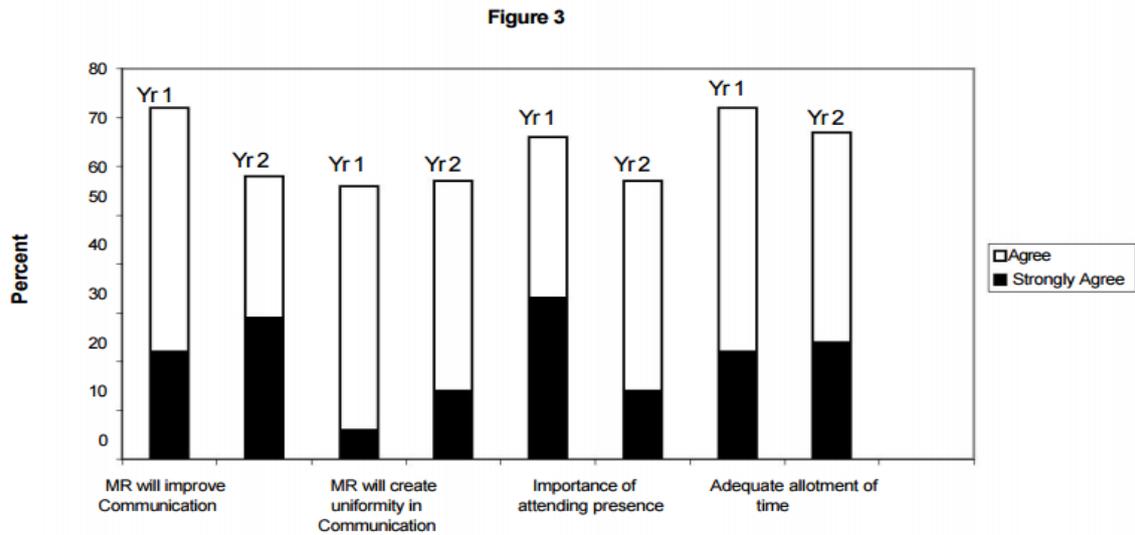


Figure 3: Morning report structure: results at years 1 and 2.

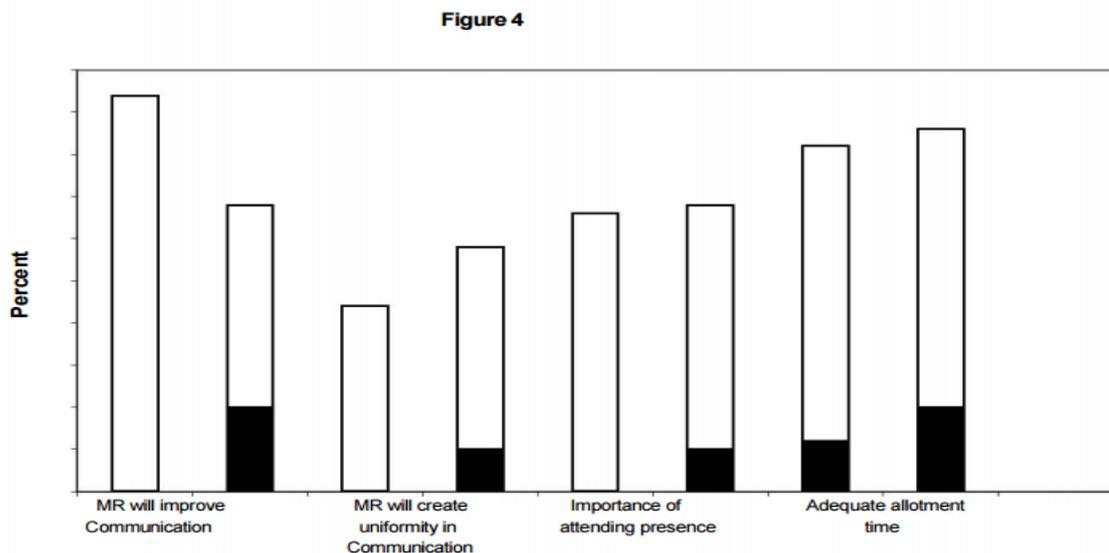


Figure 4: Resident competencies: results at years 1 and 2.

RESULTS

Prior to the initiation of the morning report sessions, an anonymous web-based survey was sent to the entire housestaff (n=29). The survey evaluated resident's perceptions regarding the utility and efficacy of such a meeting. Specifically addressed were issues related to the ACGME core competencies. Nine residents (31%) responded to the survey. Figure-1 shows the resident's responses to the structure of the proposed meeting. Specifically addressed were beliefs that the meeting would improve communication between shifts, provide uniformity to hand-offs, the importance of having an attending present, whether enough time would be available to discuss the patients, and the degree to which the residents will have input into the evolution of the meeting's structure. Seventy-eight percent of respondents agreed or strongly agreed that the morning report session would improve housestaff communication. Eighty-nine percent of resident felt that the session would yield greater uniformity in the sign-out process. When questioned about the presence of a faculty member, 88% either agreed or strongly agreed that this was an important factor in the success of the session. Based on the findings of this assessment, an attending was required to be present at every session. The housestaff also reported that resident input into the structure of the meeting was important, and that the proposed time frame was adequate to discuss the patient roster. Since the session was also being used to evaluate proficiency in the core competencies, the survey queried the residents' attitudes toward the ability of the meeting to help achieve such competencies (Figure 2). Not surprisingly, the consensus was that the morning report session would help resident gain competency in these core areas.

After approximately one year, a modified survey was distributed to the housestaff. Sixty percent of the surveys were completed. A new group of interns had started the program, and the prior chief residents had graduated, therefore, the surveyed population changed.

At year-two of the morning report program, the housestaff was once again surveyed to determine if attitudes toward the process had evolved. The response rate to this survey was 75%. Again, a new group of interns had begun, and the prior chief residents had graduated. Figure-3 shows comparison data regarding the responses to the first and second year surveys with regard to the efficacy and structure of the meeting. The overall positive responses (agree and strongly agree) with regard to improved communication, the importance of attending presence, and time allocation demonstrated a trend toward decreased agreement. Only attitudes toward uniformity in communication showed a slight increase. Statistical analysis was confounded due to varying response rates, small sample sizes, and the fact that there were slight modifications to the survey.

Figure-4 shows the results of the first and second year surveys evaluating the resident's perceptions of whether the meeting affects their performance improvement in the core competencies. Interestingly, the housestaff felt that competency in-patient care was influenced to a lesser degree in year two. Medical knowledge was perceived as positively affected by the meeting from year one to two. Positive responses to the questions pertaining to practice-based learning and communication skills showed an increasing trend between the first and second years. It is worth noting that a significant increase in hospital volume, especially emergency room consults and admissions, during year two, were the result of hospital closings in our geographic area. The observed patient volume increase has continued beyond the period studied in this report, and has strained the resources of the hospital and its staff. The effect of these challenges on the housestaff and their perceptions of workload and systems efficiency have certainly played a role in the findings of this study.

DISCUSSION

In 1999, the Institute of Medicine released its landmark publication *To Err is Human: Building a Safer Healthcare System*⁵. Its authors estimated that nearly 98,000 deaths occur annually in hospitals due to preventable medical errors. Moreover, these errors have been estimated to result in nearly \$17 billion in additional costs per year in hospitals nationwide. The document identifies miscommunication among healthcare providers as an important cause of preventable errors. In addition, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), a private sector non-profit organization that provides health care accreditation to hospitals to promote performance improvements, offered its own strategies for improving communications. Among these were "processes and procedures designed to improve the timeliness, completeness, and accuracy of staff-to-staff communication, including communication with and between resident and attending physicians" and "implement face-to-face interdisciplinary change-of-shiftdebriefings"⁶. This type of structured debriefing was not heretofore commonplace in surgical training programs. As surgical residencies struggled to incorporate night-float systems and other 80-hour work week compliant mechanisms, quality change-of-shift debriefings were severely lacking. This led many programs to express concern that forcing residencies into a shift-worker paradigm would engender more errors rather than reducing them.

In response to the ACGME mandated work-hours limitations, our program adopted a night-float system for junior residents. The senior and chief residents continued in an hours compliant in-

house overnight call structure. It soon became clear that some patients "fell through the cracks" between the night and day shifts. Delays in communicating necessary facts to the incoming residents and attendings responsible for the admitted patients exacerbated the problem. The timing and quality of the "sign-out" was dependent on a variety of factors such as the availability of the transmitting and receiving residents, the completeness of the information transmitted, and the appropriateness of the level of resident receiving the information. Because of often-unforeseen circumstances, it was not always clear that the relevant information was transmitted to the responsible attending physician.

In spite of widespread utilization of morning report sessions in internal medicine training programs, sign-out meetings of this type are only rarely utilized in surgical programs. The University of Virginia was the first to describe such a meeting in a surgical training program². A morning report meeting would provide the type of face-to-face sign-out in a structured fashion with faculty oversight as proscribed by JCAHO. In 2006, our surgical residency adopted a morning report meeting in which inter-shift communication through a standardized protocol sought to diminish preventable medical errors. Much like the often-described SBAR (Situation Background Assessment Recommendation)⁷ information transfer protocol borrowed from the military, we attempted to define the minimum required patient factors that needed to be communicated. Obviously, additional information could be transmitted as needed, but the minimum was inviolate. Of equal importance was ensuring that the entire housestaff was present at the meeting to guarantee that each member of the team gained familiarity with the patients for which they were assuming responsibility.

Much like the findings published by Stiles et al.², our housestaff believed that the presence of a faculty attending was important to the conduct of the meeting. The attending could ensure compliance with the tenets of the meeting, highlight important teaching points, and provide input regarding the completeness and appropriateness of the initial management. The joint presence of a faculty member and the night-float residents allowed an additional opportunity for a "teachable moment" and formative evaluation, generally not available to the evening shift. The results of the aforementioned surveys demonstrate that the incorporation of morning report sessions into our

training program was met with enthusiasm by the housestaff and continued to be an important component of their communication process.

In conclusion, surgical morning report is a valuable addition to the training and education of surgical residents, which affords the opportunity to improve inter-shift communication and therefore patient care. Structured hand-offs such as this are believed to decrease the number of preventable medical errors in complex healthcare environments. These important benefits are realized in the context of an improved mechanism for evaluating residents within the ACGME core competencies.

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