# Morning report: an Australian experience

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## ABSTRACT

- In January 2001, a daily morning handover meeting ("morning report"), involving medical staff and students, began at the Launceston General Hospital, Tasmania.
- Periodic questionnaire surveys have been conducted to assess whether the morning report is fulfilling the quality improvement and educational needs of medical staff. The format of meetings has been successively modified in response to feedback.
- Participants have expressed a preference for patient-focused meetings, with less emphasis on formal teaching.
- A 12-month pilot study beginning in January 2004 has assessed the impact of adding a bed-management focus to the morning report.
- Over the period of the pilot study, there has been reduced bed access block, reduced average length of stay and increased bed availability. This suggests that a longer, more formal study may be warranted.


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After-hours work in hospitals is sometimes indirectly supervised and not formally handed over to the day doctors. One way to monitor the quality of such work is to conduct a formal morning handover meeting ("morning report"). This can ensure continuity of care, provide a mutual learning experience for both after-hours and day medical staff, and give physicians the opportunity to assess the quality of after-hours work.

Morning report has been an important educational tool in most internal medicine training programs in the United States for many years.[1-3] Most studies of morning report refer to the teaching and learning value of the meeting, but another benefit reported in one study was the enhancement of adverse-event reporting by prompting doctors at morning report.[4]

To the best of our knowledge, conducting morning report is not common practice in Australian hospitals, and published data are limited.[5,6]

Morning report was established as a quality improvement project in the Launceston General Hospital Department of Medicine in January 2001. Here, we detail our experience of establishing morning report, evaluating its contribution to quality improvement, and modifying the content of meetings in response to feedback from participants. We describe how the program has evolved through three different formats to reach its current form. In addition, from January to December 2004 we conducted a pilot study to assess the impact of introducing a bed-management focus into the morning report.

## Setting

Launceston General Hospital is a 280-bed, university teaching hospital, classiified level 3 for physician training. Medical patients are directly admitted to the hospital via the emergency department and from physicians' consulting rooms to a general medical unit under the care of a general physician. Sub-specialists are consulted as required.

There are 28 physicians representing most specialties. Twelve physicians, divided among three units, participate in general medicine. Each unit is supported by a physician trainee, a Year 1 postgraduate (PGY1) doctor, and a Year 2 or Year 3 postgraduate (PGY2 or PGY3) doctor. Units are ward-based, with 32 patients per unit.

After-hours work is performed by a physician trainee covering general medicine and sub-specialties. The physician trainee admits new patients via the emergency department and also manages inpatient medical emergencies. It is this work that is presented at the morning report.

## Initiation and evaluation of morning report

Since January 2001, morning report has been a regular meeting within the Department of Medicine at the Launceston General Hospital.

Formal feedback about the morning report was provided by questionnaire surveys conducted in May 2001, March 2004 and March 2005. The content of the questionnaire, which was approved by the quality improvement committee, was the same each time.

Informal feedback was sought from time to time at morning report, at Department of Medicine meetings after formal presentation of questionnaire outcomes, and, notably, in September 2003, after a period of declining attendance at meetings.

From 2004, we have assessed bed management by analysing average length of stay of medical patients, occurrences of bed access block (measured by the Australian Council of Healthcare Standards clinical indicator[7]), and the number of cancellations of elective surgery due to bed unavailability. Average length of stay is obtained from hospital reports by dividing the number of occupied bed days by the number of separations.

## Format 1

### Conduct

The initial format of the morning report was a small meeting with PGY1–PGY3 doctors and medical students. It was supervised by the senior advanced physician trainee and conducted between 08:00 and 09:00 in the Department of Medicine. This meeting was attended by an average of 20 people, including medical students and the physician on call. One or two selected cases, based on their educational value, were presented along with investigations. Discussion centred on issues highlighted by the case. After the meeting, other patients admitted overnight were briefly handed over to the day doctors. The meeting was also conducted at

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**1 Change in bed management measures, 2003–2004**

| | 2003 | 2004 |
|---|---|---|
| Average length of stay for medical patients (days)* | 3.3 | 3.1 |
| Access block in emergency department (average number of patients/day) | 4.6 (95% CI, 3.9–5.3) | 3.9 (95% CI, 3.7–4.1) |
| Cancellations of elective surgery due to lack of beds | 17 (95% CI, 10–30) | 0 (95% CI, 0–5) |

* Average length of stay was calculated as occupied bed days divided by separations; therefore confidence intervals could not be calculated. ◆

weekends, when it was attended by the on-call physician, a PGY1 doctor and the physician trainee on duty.

### Evaluation

In May 2001, the first quality improvement questionnaire was conducted. All morning report participants completed the questionnaire.

The key findings were that most PGY1–PGY3 doctors and physician trainees preferred physicians to be present to improve the teaching and learning value of the meeting. A majority of participants (15/22) reported that they learned something new each day. The self-perceived learning value was highest among students, followed by PGY1–PGY3 doctors and then physician trainees. These results were presented to all the staff at morning report and Department of Medicine meetings.

The findings suggested that reports on all patients admitted overnight should be presented, as participants expressed a dislike of lengthy theoretical discussions centred on one or two cases that seemed to have little relevance to patient management.

## Format 2

### Conduct

In response to feedback from the first questionnaire, the morning handover format was modified to include formal teaching, which consisted of presentations by physician trainees or physicians during the second half-hour of the meeting. A formal schedule was constructed.

Meetings initially functioned well in 2002. However, attendance in 2003 gradually dwindled from 20 down to 5–10 participants. Hence, a further, informal survey in September 2003 was conducted at a morning report and a Department of Medicine meeting to assess the status of the meeting.

### Evaluation

As a consequence of including formal teaching, case presentations had become abbreviated. Further, the night physician trainee left early (before detailed presentation of cases). As only limited numbers of cases were presented, critical cases and "near misses" (ie, potential adverse events) were sometimes not presented at all.

As concerns regarding privacy had been raised, patient names were withheld in presentations. This led to significant difficulties for day medical staff in relating cases presented at the meeting to patients later seen on the ward.

Scheduled teaching became unsustainable because PGY1–PGY2 doctors, on 3-monthly rotation, required repetition, whereas PGY3 doctors, physician trainees and specialists were present all year. Senior physician trainees and physicians found the meeting a burden and began to start their ward rounds early, effectively removing the PGY1–PGY3 staff from the meeting.

Overall, the second morning report format was thought less effective than the first because of the focus on formal education rather than on patient handover.

## Format 3

### Conduct

The third and current format was implemented in January 2004. It is similar to the original format but with a stronger focus on punctuality, leadership, physician presence and patient-focused discussions. The Director of Medicine coordinates the meetings, and attendance by on-call physicians and representatives from all units is compulsory. An attendance sheet is maintained.

This format has become popular, with an average of eight consultants attending daily along with PGY1–PGY3 doctors and physician trainees.

Case presentations are made from photocopied or electronic notes, eliminating errors of recall. Complete, uninterrupted presentation of each case, including investigations, takes about 5 minutes. All photocopied notes are then handed over to the day staff at the end of the meeting.

A further change has been the implementation in January 2004 of a focus on bed management. A daily review is conducted of medical patients in surgical beds, and overall medical patient numbers are compared with available beds. Patient numbers per ward and the type of patient (ie, medical or surgical) are displayed on a whiteboard. When each patient is reviewed, a discharge plan is formulated. A daily emphasis on discharging has been promoted.

Change in practice has been brought about by:

- actively accepting surgical patients who do not require an operation onto medical wards; and
- actively promoting transfer of medical patients on surgical wards to medical beds the day after admission.

### Evaluation

Further formal questionnaire surveys were conducted in March 2004 and 2005.

In 2004, the 26 respondents (a 100% response) comprised six students, seven PGY1–PGY3 doctors, seven physician trainees and six consultants. Most (22/26) attended the meeting daily, and most (92%) were in favour of the existing format. Despite the absence of organised teaching, 14/26 reported learning something new daily, while 10/26 reported learning something new weekly. The self-perceived learning value was highest among PGY1–PGY3 doctors. Aspects regarded favourably by the respondents were physician presence, quality discussion and debate among experts.

The findings of the 2005 questionnaire were similar, suggesting that the current meeting format is appropriate. Since the beginning of 2005, further refinements have included the introduction of digital radiology images that are accessed from the hospital network and projected from a laptop computer onto a screen.

**2 Tips for establishing, organising, running and evaluating morning report**

Establishing meetings

- Evaluate the existing handover procedure and recognise the need for improvement.
- Get support from the Director of Medicine, the hospital administration and the quality improvement unit.
- Allocate an hour for meetings and protect it from interruptions, ward rounds and conflicting meetings.

Organisation

- Choose a location within the department to maximise attendance.
- Choose a room that is small enough to encourage active participation and personal interaction.
- Make attendance compulsory for the on-call physician, physician trainee and Year 2/Year 3 postgraduate doctors on night duty. Encourage all physicians to attend.
- Provide facilities such as a television, video player, data projector, x-ray viewing box and whiteboard to encourage enhanced case presentations.
- Provide coffee, tea and breakfast to create a friendly atmosphere and encourage social interaction.

Running a meeting

- Insist on complete, accurate case presentations and discourage casual, brief presentations. A complete, uninterrupted presentation takes only 5 minutes.
- Focus discussions on management of the patient in question.
- Give positive feedback in public, saving any negative feedback to be discussed privately after the meeting. This avoids public humiliation, embarrassment or intimidation.
- Start the meeting on time and finish early wherever possible. The chairperson should ensure the meeting does not extend unnecessarily.
- Education should be a by-product of case discussions and not the primary focus.

Evaluation

- Conduct periodic formal evaluation by questionnaire-based surveys.
- Obtain ongoing informal feedback by involving the group in discussions about improvement of the handover process.
- Implement changes in response to feedback to complete the quality improvement cycle. ◆

## Pilot study

Since implementing a focus on bed management, there have been zero (95% CI, 0–5) cancellations of elective surgical cases due to bed unavailability. This compares with 17 (95% CI, 10–30) cancellations in 2003. There was a 16.2% reduction ($P = 0.01$) in instances of bed access block in the emergency department, from 4.6 (95% CI, 4.0–5.5) patients per day in 2003 to 3.9 (95% CI, 3.0–4.5) patients per day in 2004. The average length of stay for medical patients in 2004 was 3.1 days, representing a fall of 6.1% compared with 2003 (3.3 days) (Box 1).

## Recommendations

The evolution of morning handover meetings in our hospital highlights the difficult balance to be achieved between quality improvement and formal education. Morning report has changed the culture within our department, resulting in increased participation from physicians, greater supervision of after-hours work and improved educational value.

We agree with Nair and colleagues[5] that morning report should be an essential part of training and patient care in internal medicine, and offer our tips for establishing, running and evaluating a morning report (Box 2). Further, we agree with Welsh and colleagues that morning report could be improved by recording and discussing adverse incidents.[4]

Introducing a focus on bed management during the morning report coincided with improvement in some measures of bed management. However, we acknowledge that bed management is a complex process and that other simultaneous changes could have influenced our findings. Furthermore, we assessed the potential effect over only a short period of time. A more comprehensive, prospective study of the impact of a bed management focus during morning report is required and is planned at our institution.

Our report lacks patient outcome data and comparisons with other hospitals in Australia, but these aspects are the subject of ongoing research in our department. We hope our report will encourage other Australian hospitals to relate their experience of morning handover meetings.

## Competing interests

None identified.

## References

1 Harris ED Jr. Morning report. *Ann Intern Med* 1993; 119: 430-431.
2 Wenger NS, Shpiner RB. An analysis of morning report: implications for internal medicine education. *Ann Intern Med* 1993; 119: 395-399.
3 Amin Z, Guajardo J, Wisniewski W, et al. Morning report: focus and methods over the past three decades. *Acad Med* 2000; 75 (10 Suppl): S1-S5.
4 Welsh CH, Pedot R, Anderson RJ. Use of morning report to enhance adverse event detection. *J Gen Intern Med* 1996; 11: 454-460.
5 Nair BR, Hensley MJ, Pickles RW, Fowler J. Morning report: essential part of training and patient care in internal medicine [letter]. *Aust N Z J Med* 1995; 25: 740.
6 Carruthers A. General practitioner participation in 'Morning Report' at a major teaching hospital. *Aust Fam Physician* 1997; 26 Suppl 2: S96-S98.
7 Australian Council on Healthcare Standards. Determining the potential to improve quality of care. 5th ed. Sydney: ACHS, 2004: 52. Available at: http://www.achs.org.au/content/screens/file_download/DPI%202004.pdf (accessed Jan 2006).

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