DOI:
10.1108/WWOP-05-2019-0010

Document Version
Peer reviewed version

emerald PUBLISHING

Working with Older I

What makes a good handover in a care home for older people?

Journal:	*Working with Older People*
Manuscript ID	Draft
Manuscript Type:	Research Paper
Keywords:	information, care homes, technology, handovers, information exchange, shifts

What makes a good handover in a care home for older people?

Abstract

Purpose

The study aimed to investigate the content, purpose and effectiveness of the handover of information between care home staff beginning and completing a shift.

Design/methodology/approach

This was an exploratory study drawing on ethnographic methods. A total of 27 interviews with a range of care home staff, including managers, registered nurses, senior care workers and care workers were undertaken in five care homes selected to give a good contrast in terms of size, ownership, shift patterns, and type of handover.

Findings

Most handovers were short – lasting 15 minutes or so – and were held in the office or secluded area in which staff could talk privately. They lasted longer in one home in which the incoming and outgoing shift physically visited each resident's room and the communal spaces. Staff felt that handovers were important for the efficient running of the home as well as to alert everyone to changes in a resident's health or important events, such as a hospital appointment. In one home, hand-held devices enabled staff to follow a resident's care plan and update what was happening in real time.

Research limitations/implications

This was a small scale study based on data from a limited number of care homes.

Practical implications

The increasing popularity of 12 hour shifts means that many homes only hold two short handovers early in the morning and in the evening when the night staff arrive. There appears to be a trend to reduce the number of staff paid to attend handover. Despite this, handovers remain an important component of the routine of a care home. The information contained in handover relates to the running of the care home, as well as residents' wellbeing, suggesting that, while their content overlaps with written records in the home, they are not superfluous.

Originality/value

Although the literature on handovers in hospitals is extensive, this appears to be the first published study of handover practices in care homes.

Keywords

Handovers, care homes, information exchange

Introduction

There are nearly 16,000 registered care homes in England, according to the independent regulator for health and social care, the Care Quality Commission (2018). The term 'care home' refers to facilities providing short and long-term accommodation, meals, and personal care. Care homes with nursing additionally offer qualified nursing care (Orellana *et al.*, 2017).

Care homes have been described as 'information intensive settings responsible for the daily recording, maintenance and reporting of a wide range of information that relates to the administration and operation of their facility and the care of each resident … [This]

require[s] information systems and processes which are able to meet both the information needs of the organisation and a range of external stakeholders [and which are] … largely borrowed … from hospital and general practice systems with limited modifications to account for the [care home] environment and work processes (Gaskin *et al.*, 2012, p. 2).

Despite evidence that a considerable amount of staff time in care homes is spent on recording information (Warmington *et al.*, 2014), we still have very little idea about the effectiveness of this activity. This article focuses on one aspect of this process – what happens when one shift of staff hands over to another?

Handovers (or, as they are sometimes termed, handoffs) provide an example of the process described by Gaskin et al (2012) of a healthcare practice that has been adopted in care homes. In hospitals, handovers are:

> … episodes in which control of, or responsibility for, a patient passes from one health professional to another, and in which important information about the patient is also exchanged.
>
> (Cohen and Hilligoss, 2010, p. 493)

There is a substantial literature on hospital handovers, of which the majority focuses on nursing handovers (for example, Smeulers *et al.*, 2014; Tobiano *et al.*, 2018). Other types of handover include:

- from one department to another (for example, Randmaa *et al.*, 2016);
- between different professionals (for example, Manias *et al.*, 2016); and
- from one setting to another (for example, Groene *et al.*, 2012).

Handovers can be verbal, non-verbal, or a combination of the two and take place either in an office, nurse's station, or at the patient's bedside. No type of handover has been shown to be more effective than another (Smeulers *et al.*, 2014) but most research has concluded that they contribute to better patient safety because they reduce the risk of failing to pass on essential information or observations about changes in a patient's condition (for example, Popovich, 2011; Drach-Zahavy and Hadid, 2015). Dissenting voices argue that handovers need to become less ritualistic to be truly effective (Kerr *et al.*, 2011) and that long overlaps between shifts to allow for handovers are unproductive (for example, Sexton *et al.*, 2004).

The widespread practice of 12 hour shifts for nurses and healthcare assistants on hospital wards in England has reduced the number of handovers that take place. Reactions to this have been mixed, with some staff seeing this as making better use of their time, while others regret the loss of camaraderie and teamwork created during handovers (Ball *et al.*, 2014; Thomson and Hare Duke, 2015).

Given that care homes provide 24 hour support involving different shifts of staff, it is surprising that so little research has examined what happens during change of shift handovers in care homes (Moriarty *et al.*, 2019). A few studies have referred tangentially to handovers as one of the many activities in which care home staff are involved (Kerr *et al.*, 2008; Bennett *et al.*, 2015; Killett *et al.*, 2016). Others have discussed them in the context of comparisons between paper based and electronic information systems (Gaskin *et al.*, 2012; Zhang *et al.*, 2012). However, we were only able to identify one Australian study (Lyhne *et al.*, 2012) specifically examining handovers in aged care settings (the equivalent term for care homes for older people) in Australia. To the best of our knowledge, ours is the first

published study in which the sole focus was on change of shift handovers in care homes in England (Norrie *et al.*, 2017).

Aims

The study was funded by the Abbeyfield Foundation. Its aims were to investigate the content, purpose and effectiveness of the handover of information between two different sets of care home staff – those leaving a shift and those arriving to begin a shift. Ethical permission was obtained from King's College London Ethics Committee (LRS15/162118).

Methods

An exploratory, qualitative study was undertaken drawing on ethnographic methods. This approach was chosen as handovers were conceptualised as social interactions influenced by organisational culture (Luff *et al.*, 2011). We were interested in 'shared understandings,' 'tacit knowledge' and meaningful 'artefacts' as a way of shedding light on work practices (Hammersley and Atkinson, 2007).

The number of care homes in England and their diversity in terms of size and ownership meant that no small scale study could ever attempt to achieve a nationally representative sample. We recruited a purposive sample of five care homes for older people in south-east England designed to capture contrasts in terms of:

- Size;
- Type (with and without nursing);
- Ownership (private and voluntary sector)
- Shift patterns (two and three shifts per day);

- Type of handover (bedside, office based, or electronic);
- Funding (self-funding, 'top up' residents and funded by their local authority)
- Quality, as indicated by the home's Care Quality Commission rating.

A topic guide for interviews and an observational template for recording what was happening during handovers (for example, who was participating, what materials such as observation charts for temperature, blood pressure or fluid intake were used and the length of time they lasted) were developed. Semi-structured, audio-recorded interviews were undertaken with a cross-section of 27 staff (8 owners/managers; 4 nurses, 6 care workers and 9 senior care workers) and 17 observations of handovers, including those taking place in the early morning and at night. Verbal communication during handovers was recorded in note form and observational fieldnotes were written up as soon as practically possible and converted into full-length field notes as soon as possible after the handovers were completed.

The interview transcripts and observational notes were entered into the NVivo qualitative software package. Data were analysed using a matrix approach (Miles and Huberman, 1994). Each matrix consisted of a series of columns for each care home. The rows consisted of quantitative data (such as the size of the care home, and frequency and length of time of each handover), and qualitative data (such as topics discussed in handovers and views about the purpose of handover). The themes were both theory and data driven. The analysis involved all team members.

Findings

Only care home managers of establishments that had received 'good' ratings from the Care Quality Commission agreed to take part in this study. The five pseudonymised participating care homes consisted of:

1. Ash Lodge, a medium sized family owned care home with nursing
2. The Beeches, a medium sized nursing home, part of a small chain
3. The Chestnuts, a small not for profit care home
4. Douglas Hall, a large nursing home, part of a large chain
5. The Elms, a small privately owned care home

Their physical environments ranged from a converted Victorian house (The Elms) to purpose built facilities (Douglas Hall). The number of residents in each home ranged from 20-150.

Number, timing, and location of handovers

Box 1 describes the number and type of handovers in each of the participating homes. As with hospitals, care homes in England have increasingly moved to 12 hour shifts (Burton, 2013) as these are viewed as cheaper and offer greater continuity for residents. Three of the five homes ran on two shifts (day and night) which meant that handovers only occurred twice a day. The Elms ran on three shifts (07.15–14.30, 13.30–21.30; 21.15pm–07.30am) so a third handover was held during lunchtime. Importantly, this shift overlap was mainly used to expand the total number of care staff to support the residents rather than to attend a handover meeting. Day shifts at The Beeches ran from 08.00-14.00, 14.00-20.00, and 08.00-20.00 so they sometimes held lunchtime handovers too, depending on whether there were any staff coming on duty at 14.00 or if everyone was working through until 20.00.

Handovers were usually held in the office or a secluded area in which staff could talk privately with less risk of being overheard. The exception was Douglas Hall where oncoming and outgoing staff in the dementia and nursing units went to each resident's room separately. In the hospital literature, these are termed 'bedside handovers' and their purpose is to achieve a more patient-centred approach by enabling patients to take part in handovers directly (Tobiano *et al.*, 2018).

While most handovers were short – generally only lasting 15 minutes or so, the room by room handovers in Douglas Hall could take about 30 minutes. When they occurred, lunchtime handovers in The Beeches took as long as 40 minutes. Here, the all staff gathered together in the office for more detailed discussions about individual residents, with the exception of one person who was assigned to stay outside to ensure all the residents were safe.

> [Handover] continues for all 50 residents. Very impressive how [nurse] remembers all the detail - food, continence, sleep, medication, additional things such as appointments. [Nurse] is very experienced and efficient - seems absolutely second nature to run through everything remembering all the details about the residents. Good communicator.
>
> (Researcher note from The Beeches)

Who hands over to whom and who should participate in handovers?

Managers had to balance decisions about whether information was transmitted more accurately if all staff were present during handovers and the incidental opportunities they created for team building and training versus the greater speed and segmentation of

responsibilities when handovers were restricted to nurses and senior care workers who would then pass on separately any essential information to the care workers. Importantly, the only home in which all staff were paid to attend morning and evening handovers was The Elms. In the Beeches no staff were paid for handovers. In the remaining homes, some senior staff involved in handovers were expected to arrive early for their shift and were paid for their time.

In The Chestnuts, Douglas Hall, and The Elms, the night staff only handed over to the registered nurse or the senior care worker. The oncoming nurse or senior care worker would then hold a further handover with the care workers. In Ash Lodge, and sometimes in The Beeches, the registered nurse or senior care worker would hand over to all care workers and registered nurses coming on duty.

Where afternoon handover meetings were observed, all staff were present in Ash Lodge and the Beeches but never in The Elms. In the evening, the care workers updated the registered nurse/senior care worker at the end of their shift, who then handed over to the oncoming registered nurse(s)/senior care workers individually or together as a group with the care workers.

The atmosphere during handover was observed to be collegiate, rather than social:

> Friendly atmosphere, but professional and business like. Not too much chat. Doorbell rings – one of the care staff goes to get it. [Nurse] says 'You stay for handover, let someone else (get it).'
>
> (Researcher note from The Beeches)

Where all staff took part in the handover meeting there was an acknowledged possibility of residents being left alone. Managers attempted to solve this dilemma in various ways, for example leaving a 'floating' member of staff on duty who was updated later, scheduling cross-over time for handovers, or scheduling visits or entertainment during the handover period:

> I arrive for midday handover. The lounge is busy now, there is an activities manager with a guitar who tries to engage the residents in conversation/songs. She puts up a sign celebrating the Queen's birthday. She has cards of famous people and asks residents if they recognise them. There is also an aromatherapist. Despite this, there is a slight frenzied atmosphere now as one resident sings constantly while caring for a doll and another is pacing and requesting cigarettes throughout the handover.
>
> (Researcher note from The Beeches)

By contrast, the room by room handover system in Douglas Hall was an opportunity for staff to personally greet and say goodbye to the residents:

> Staff take handover seriously and appreciate it as a way of greeting the residents and checking up that they were OK.
>
> (Researcher note from Douglas Hall)

Some researchers have reported that the exclusion of care workers from handovers can be used to reinforce status between senior staff, which might include senior care workers, and direct care workers (Moriarty *et al.*, 2019). The care homes participating in this study emphasised that – even if there was a two-stage handover in which the more senior staff

handed over to each other and the oncoming senior member of staff then handed over to the care workers, it was important that all staff took part in handovers and had the opportunity to contribute their views:

> But I have known [care workers] in the past who didn't even know what a handover was; never been involved in care plans. They're only just [care workers]. They're only there to change the pads and wash the residents, which I think is wrong.
>
> (Manager, The Chestnuts)

Systematic versus exception reporting

As Box 1 shows, handovers in Ash Lodge, The Beeches and Douglas Hall involved systematically discussing each resident (and, in the case of Douglas Hall, a 'physical' handover as the staff went to each resident's room) whereas staff at The Chestnuts only discussed residents for whom there was something new to report. The Elms operated a mixture of the two. Exception reporting meant that handovers could be shorter but nurses especially favoured systematic reporting as they were responsible for all the residents while they were on duty. In the context of our complementary study of handovers from the perspective of relatives and residents, another advantage was that all staff were in a better position to answer relatives' queries, even if they had not been allocated to work with their relative for that shift:

> … [otherwise] how you will know if some family is coming in the afternoon and will ask you, 'did my mother [eat] … breakfast?' … And any skin problem, [if] any patient had a fall, or any patient has been constipated,

> has not pass[ed] urine, things [like] that, so they will be aware of it. So, handover is very important for everyone.
>
> (Nurse, The Beeches)

Handovers were also an opportunity to pass on other information about the running of the home, such as problems with equipment or other factors contributing to the smooth running of the home:

> The manager talks about kitchen issues, particularly about fruit being available in bowls [for residents] and not left in the fridge. She mentioned some are past best before date causing food waste.
>
> (Researcher note, The Chestnuts)

Are handovers necessary to ensure quality of care?

All the participants were strongly convinced of the importance of handovers and questioned the assumption that they were unnecessary if staff had access to written information about residents:

> So, handover[s] are always important for each and every one … because some staff [don't] have the time to read the communication book. They may be on holiday and they come back [so] we need to do verbal handover, and it is important because every staff member should know what happened to the resident at night or morning [and] during the daytime.
>
> (Deputy Manager, The Chestnuts)

Managers and nurses tended to discuss handovers within narratives about quality and as a way of distinguishing between homes in which handovers took place from those in which they did not:

> I've got feedback from one of the staff … and she said to me, 'You know, I'm so happy to be here because, when I worked in the previous home, they didn't even handover, so we don't know what's happening, what's going on, so... but here, we get a handover from the carer and then after that the nurses also will handover too, so it's just like a two-way []process].' She said, 'It's good, I can't express how [positively] I feel about it.'
>
> (Nurse, Ash Lodge)

Other participants saw handovers as less intrinsic to quality and more idiosyncratic to particular homes:

> Some places it's quite different. I worked at a home before, you just do a [brief]... handover. Like, if you go there, they don't waste a lot of time; … and they said, okay, you know what, there's changes in x, y, rather than to just go through everything. Okay, Mrs. A or B, fine, so let's just go to the ones who we need to talk about, and you know that the other person slept perfectly well, there's no changes, and that's it … because there's nothing really to talk about, to be honest. It all depends on where you go; different policies, how they deal with their own stuff.
>
> (Care worker, The Beeches)

Handovers in the context of wider information systems

Across the homes we observed a wide range of artefacts involved in handovers and recording or communicating information. These included care plans, handover sheets, progress reports, daily resident reports, daily notes, handover book, communication book, GP book, home maintenance book (for the handyperson), medication charts, day book, diary, progress notes, fluid chart, positioning chart, cream chart, hoist-need chart, body-map and food charts. Those items most often referred to and physically consulted were the communications book and diary. Written information acted as an aide memoire to the verbal handover:

> A lot of the nurses, they have a … book … so that they know what they're going to discuss, write the name of the [residents] and then tick certain boxes. That's something that has worked very well because it's … well, it's time-consuming, this is the problem and they want to do [handover] quickly because … they want to finish it within 15, 20 minutes so that they can go off their shift and go home.
>
> (Manager, Ash Lodge)

Distinctions were also made between the broad brush information recorded in care plans and transitory needs reported during handover:

> Well, it might be that somebody's not been very well on the morning shift and they haven't had a lot to eat and drink; we would be told that in handover and then we can encourage that person to maybe have a light snack in the afternoon, because we know they've missed their dinner and they don't feel very well, but if it's not handed over, we don't know that that person's missed their meal, and we'll think, oh, they're alright, they've eaten for the day when actually they haven't.
>
> (Deputy Manager, The Elms)

The Elms was the only home participating in this study in which information about residents was recorded on hand held electronic devices. This enabled staff to flag up any changes or other cause for concern. Once resolved, the flag was removed:

> I have to say we are very good at recording things down at handover … If anything, I think people tend to … flag up more than necessary, and I think it is because it is easy, because it is right there. They think to themselves, I'll just put that in the notes now. So, we tend to have more [information recorded] than less.
>
> (Senior care worker, The Elms)

At the same time, handovers were shorter because it was easier to identify essential information.

By contrast, completing paper records was more time consuming, as one of the managers in Douglas Hall explained:

> We have handover sheets in every single unit and the nurse in charge … prepare[s] all the information … about every single resident and [passes] the message to the next team. If it's day team, the nurse, they give the information for night team … We keep all the handover sheets, we have a file in every single unit.

Discussion

Only care home managers of establishments that had received 'good' Care Quality Commission ratings agreed to participate in this study so our sample may be biased in terms of representing practice in care homes that are deemed to be well run. Individual staff's practice may have changed due to the presence of a researcher, a form of Hawthorne effect (Levitt and List, 2011). However, many care homes are accustomed to observation since this is used as one method of data collection by the Care Quality Commission so this may have lessened the risk of bias.

A further limitation of this study is that the observations were undertaken by different team members. This may have led to an uneven or inconsistent approach; the risks of this were addressed in team meetings and data sharing. The different professional backgrounds of the team may also have influenced perceptions. As Scales et al. (2017) observe, team ethnography entails considerable trust between researchers who are required to share potentially intimate thoughts and reactions with team members in the form of notes and jottings.

Our observations and interviews highlighted the complex decisions care home managers are faced with when determining handover styles in their particular home. Different approaches

were observed in relation to handover timings, participants, locations and content – and these all have implications for resident safety. It might be expected this would be the case given the variability of residents' dependency levels and the aim of offering personalised care and the key role of a manager in shaping care home culture (Orellana *et al.*, 2017). Alternatively, Bennett et al. (2015, p. 1996) argue that service provision in care homes for older people 'should be seen as a specialist area' and it would therefore be expected there might be some agreement on good practice founded on evidence. By contrast, participants were more inclined to draw on their own experience and practices reported by colleagues in determining what constituted good practice in handovers.

Our observations indicate the multiple meanings to the term 'handover' which was used to refer to information about residents and the day to day administration of the home as well as 'handing over' physical indicators of responsibility, such as medicine keys. An alternative perspective to viewing handover as 'one action' or 'event' focuses on it as part of the continuous processes which occur throughout a shift. This 'event' conceptualisation was particularly inappropriate in The Elms where staff updated handheld devices at point-of-care throughout their shift. Proponents of electronic handover systems argue they provide more accurate reporting of information and save time because staff do not need to search for information from different locations (Gaskin *et al.*, 2012). In The Elms, documentation had been reduced, but managers had taken the opportunity to discontinue the whole staff handover rather than use the time for 'soft' functions such as group interactions, shared purposes, and improving collegiality that we observed in other settings.

Handovers were generally perceived as effective by participants in all the care homes. Observational data confirmed that staff were able to listen without too many distractions;

and information was communicated in an understandable and clear manner. Some homes provided greater opportunities than others to ask questions and some prioritised resident privacy more than others, others valued handover as including residents to some degree.

Staff across the homes in this study voiced their commitment to the importance of handovers and they shared an understanding of them as an intrinsic part of care work needed to ensure continuity of care and safety of residents. That staff in some of the care homes were willing to attend despite not being paid for this possibly indicates their importance to staff but simultaneously raises questions about a degree of ambivalence among the home's owners about their importance.

The findings of this study are particularly relevant when staffing costs are increasing in UK care homes (with rises in wages) and some economies are being made about deployment (Burns *et al.*, 2016). In this study, non-payment of some staff for handover attendance seemed to be standard, which risks handover moving to a 'grey' area in which contracted hours and the actual hours worked diverge. In The Elms and The Chestnuts handovers had changed to exception reporting in order to reduce their duration and in The Elms senior staff had recently started handing over to each other rather than to the whole group. The reason given for this latter change were to save time and improve safety for residents and that the prior need for a thorough handover was declining with the introduction of the handheld devices. The cost-effectiveness of this change is a topic for future research.

Conclusion

Ethnographic methods shed light on shared group understandings about handovers in the context of five different care home cultures. There was great variety in handover norms in

the homes and managers are faced with difficult decisions about balancing the need for staff to be prepared for their shift versus costs of staff time and risks to residents. Notwithstanding, handovers were observed as embedded interactions within the routines of the care homes and were valued by care workers, senior care workers and managers alike. Further research is needed to identify if outcomes for residents can be linked to handover practice in care homes for older people.

References

Ball, J., Maben, J., Murrells, T., Day, T. and Griffiths, P. (2014), *12-Hour Shifts: prevalence, views and impact*, London, King's College London, National Nursing Research Unit.

Bennett, M.K., Ward, E.C., Scarinci, N.A. and Waite, M.C. (2015) 'Service providers' perceptions of working in residential aged care: a qualitative cross-sectional analysis', *Ageing and Society*, Vol. 35 No. 9, pp. 1989-2010.

Burns, D., Cowie, L., Earle, J., Folkman, P., Froud, J., Hyde, P., Johal, S., Rees Jones, I., Killett, A. and Williams, K. (2016), *Where Does the Money Go? Financialised chains and the crisis in residential care*, Manchester, Centre for Research on Socio-Cultural Change (CRESC).

Burton, J. (2013) 'It ain't necessarily so – staffing rotas and the 12-hour shift', *Caring Times*.

Care Quality Commission (2018) "Using CQC data", available at: https://www.cqc.org.uk/about-us/transparency/using-cqc-data#directory (accessed 12 November 2018).

Cohen, M.D. and Hilligoss, P.B. (2010) 'The published literature on handoffs in hospitals: deficiencies identified in an extensive review', *Quality and Safety in Health Care*, Vol. 19 No. 6, pp. 493-497.

Drach-Zahavy, A. and Hadid, N. (2015) 'Nursing handovers as resilient points of care: linking handover strategies to treatment errors in the patient care in the following shift', *Journal of Advanced Nursing*, Vol. 71 No. 5, pp. 1135-1145.

Gaskin, S., Georgiou, A., Barton, D. and Westbrook, J. (2012) 'Examining the role of information exchange in residential aged care work practices-a survey of residential aged care facilities', *BMC Geriatrics*, Vol. 12 No. 1, pp. 1-11.

Groene, R.O., Orrego, C., Sunol, R., Barach, P. and Groene, O. (2012) '"It's like two worlds apart": an analysis of vulnerable patient handover practices at discharge from hospital', *BMJ Quality & Safety*, Vol. 21 No. Supplement i, pp. i67-i75.

Hammersley, M. and Atkinson, P. (2007), *Ethnography: principles in practice*, Routledge. London.

Kerr, D., Lu, S., McKinlay, L. and Fuller, C. (2011) 'Examination of current handover practice: evidence to support changing the ritual', *International Journal of Nursing Practice*, Vol. 17 No. 4, pp. 342-350.

Kerr, D., Wilkinson, H. and Cunningham, C. (2008), *Supporting Older People in Care Homes at Night*, York, Joseph Rowntree Foundation.

Killett, A., Burns, D., Kelly, F., Brooker, D., Bowes, A., La Fontaine, J., Latham, I., Wilson, M. and O'Neill, M. (2016) 'Digging deep: how organisational culture affects care home residents' experiences', *Ageing and Society*, Vol. 36 No. 1, pp. 160-188.

Levitt, S.D. and List, J.A. (2011) 'Was there really a Hawthorne effect at the Hawthorne plant? An analysis of the original illumination experiments', *American Economic Journal: Applied Economics*, Vol. 3 No. 1, pp. 224-238.

Luff, R., Ferreira, Z. and Meyer, J. (2011), *Care Homes. SSCR Methods Review 8*, London, NIHR School for Social Care Research.

Lyhne, S., Georgiou, A., Marks, A., Tariq, A. and Westbrook, J.I. (2012) 'Towards an understanding of the information dynamics of the handover process in aged care settings - a prerequisite for the safe and effective use of ICT', *International Journal of Medical Informatics*, Vol. 81 No. 7, pp. 452-460.

Manias, E., Geddes, F., Watson, B., Jones, D. and Della, P. (2016) 'Perspectives of clinical handover processes: a multi-site survey across different health professionals', *Journal of Clinical Nursing*, Vol. 25 No. 1-2, pp. 80-91.

Miles, M.B. and Huberman, A.M. (1994), *Qualitative Data Analysis: an expanded sourcebook*, Sage Publications, Inc. Thousand Oaks, CA.

Moriarty, J., Lipman, V., Norrie, C., Elaswarapu, R. and Manthorpe, J. (2019) 'Handovers in care homes for older people - their type, timing, and usefulness – findings from a scoping review', *Ageing & Society*, Vol. 39 No. 4, pp. 851-871.

Norrie, C., Lipman, V., Moriarty, J., Elaswarapu, R. and Manthorpe, J. (2017), *How Do Handovers Happen? A study of handover-at-shift changeovers in care homes for older people*, London, King's College London, Social Care Workforce Research Unit.

Orellana, K., Manthorpe, J. and Moriarty, J. (2017) 'What do we know about care home managers? Findings of a scoping review', *Health & Social Care in the Community*, Vol. 25 No. 2, pp. 366-377.

Popovich, D. (2011) '30-Second Head-to-Toe Tool in pediatric nursing: cultivating safety in handoff communication', *Pediatric Nursing*, Vol. 37 No. 2, pp. 55-60.

Randmaa, M., Swenne, C.L., Mårtensson, G., Högberg, H. and Engström, M. (2016) 'Implementing situation-background-assessment-recommendation in an anaesthetic clinic and subsequent information retention among receivers: a prospective

interventional study of postoperative handovers', *European Journal of Anaesthesiology*, Vol. 33 No. 3, pp. 172-178.

Scales, K., Bailey, S., Middleton, J. and Schneider, J. (2017) 'Power, empowerment, and person-centred care: using ethnography to examine the everyday practice of unregistered dementia care staff', *Sociology of Health & Illness*, Vol. 39 No. 2, pp. 227-243.

Sexton, A., Chan, C., Elliott, M., Stuart, J., Jayasuriya, R. and Crookes, P. (2004) 'Nursing handovers: do we really need them?', *Journal of Nursing Management*, Vol. 12 No. 1, pp. 37-42.

Smeulers, M., Lucas, C. and Vermeulen, H. (24 June 2014) 'Effectiveness of different nursing handover styles for ensuring continuity of information in hospitalised patients', *Cochrane Database of Systematic Reviews*(Issue 6), available at: http://dx.doi.org/10.1002/14651858.CD009979.pub2 (accessed 4 March 2019).

Thomson, L. and Hare Duke, L. (2015), *The Impact of 12 Hour Shifts on Health Care Assistants: exploratory interview study*, Nottingham, University of Nottingham, Institute of Mental Health.

Tobiano, G., Bucknall, T., Sladdin, I., Whitty, J.A. and Chaboyer, W. (2018) 'Patient participation in nursing bedside handover: a systematic mixed-methods review', *International Journal of Nursing Studies*, Vol. 77 No. 1, pp. 243-258.

Warmington, J., Afridi, A. and Foreman, W. (2014), *Is Excessive Paperwork in Care Homes Undermining Care for Older People?*, York, Joseph Rowntree Foundation.

Zhang, Y., Yu, P. and Shen, J. (2012) 'The benefits of introducing electronic health records in residential aged care facilities: a multiple case study', *International Journal of Medical Informatics*, Vol. 81 No. 10, pp. 690-704.

What makes a good handover in a care home for older people?