Care home handovers

“It's part of our job. It's part of our care and we can't do right and do good care if we don't have... handover”.

Research Team

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Handovers – a black box
Aims:
Investigate the **content, purpose** and **effectiveness** of the handover of information between care home staff.

Questions:
- How are changes in individual residents’ needs, wishes and circumstances communicated between shifts?
- What are the dynamics between the staff giving and receiving handover?
- What do staff and stakeholders see as key elements of an ‘effective’ handover in a care home?
- For today – relevance to medication matters
Methods

1) Literature review

2) Case-studies *in 5 purposefully selected Care Homes* Interviews (n=30) and Observations (n=12)

3) Focus group with SCWRU service user & carer advisory group (n=15) and additional stakeholder interviews (n=2)
   - With an experienced care assistant
   - With an employee of company supplying care homes with electronic care plans and handover systems
Handovers studied extensively in the hospital clinical settings with nurses and doctors and about transfers (e.g. between home & hospital).

Little attention to care homes and non-nursing staff

Studies address:-

- Poor handovers - one of the major contributors to medication and diagnostic error/accidents/delays/poor safety/poor patient satisfaction.
- Face-to-face/verbal/notes/IT
- Location of handovers (e.g. bedside or over-computer)
- Guidelines/Standardised models (e.g. verbal or bedside)
- Other functions of handover (e.g. information, social and educational)
Handover in care homes
(16 studies identified/ 5 met criteria)

1) Tariq et al. (2015) explored records from three residential homes in Sydney, Australia, and found that poor handovers contributed to prescribing errors.

2) Lynhe et al, (2012) Hybrid paper/electronic system in a care home in Australia. Found duplication of information, a lack of standardisation and a lack of obvious guidelines and protocols and information sources. Electronic systems have potential.

3) Zhang PhD (2011) Australia - staff opinions on benefits of introducing an electronic record system (positives).

4) Gaskin et al. (2012) – Information exchange in 5 care homes in Australia. Ranged from all paper to paperless (mobile devices). IT has the potential to enhance handovers, in care homes. But complex – some unexpected outcomes – actually increased documentation time or made no difference.
In England (5th study)

- Wheeler and Oyebode (2010) asked about the quality and effectiveness of communications for people with dementia in 9 homes in West Midlands using staff focus groups.
- Found handovers typically took place three times a day, were brief, relaying only pertinent information from the previous shift.
- In one third of homes (3), handovers only involved the senior carers (care workers) on duty, although in one home a key worker system was in place for handovers.
- Some homes separated handovers for nurses and care assistants - this ‘demarcation’ might be a potential source of conflict.
What is read in care homes - CQC

CQC guidance for providers – handovers referenced 14 times as part of the Key lines of enquiry (KLOEs) (CQC 2015)

• CQC says handovers are an important tool for assessing lots of things (e.g. safety, effective communication, working together, person-centred routines) – but no guidance that says what constitutes good practice.
Case study sites

Site 1) Private care home - (residents = 50) Family-run. Mostly paper.

Site 2) Small chain - (n = 60 residents). Part of a chain of three homes which are independently managed. Hybrid; care plans electronic, other documentation paper.

Site 3) Small not for profit care home (residents n = 26).

Site 4) Part of a large well-known Chain (residents n = 100) Gujarati clientele. Hybrid; care plans electronic, other documentation paper.

Site 5) Small privately owned (residents n = 22) - Staff use mobile phone application to update daily handover notes at point of care.
Ethnography – what we saw

Other paperwork: care plans, handover sheets, progress reports, daily resident reports, daily notes, handover book, communication book, GP book, home maintenance book (for the handyman), medication charts, medication books, day book, diary, check list, progress notes, fluid chart, positioning chart, reposition chart, cream chart, hoist need chart, body map, general food charts and specific food charts for residents losing weight. Those most often referred to were the communications book and diary (we also saw bundles of keys & phones).
## Analysis - variations in handovers

**Example Care Home 1, privately owned**

<table>
<thead>
<tr>
<th>Timings?</th>
<th>Who hands over?</th>
<th>Location?</th>
<th>Processes</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>8am</td>
<td>RN hands over to RN; RN to CA</td>
<td>Nurses station/ or walk around room by room.</td>
<td>Mostly paper</td>
<td>Systematic</td>
</tr>
<tr>
<td>9am (sometimes)</td>
<td>Nurses handover to CAs after breakfast.</td>
<td>(If room by room, CAs listen outside the door no need for 9am handover)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2pm (sometimes)</td>
<td>Handover to CA coming on shift.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8pm</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Care Assistants’ perspectives on handovers - purpose and effectiveness

Summary:

• **Verbal context** – interpersonal communication
• **Resident safety paramount** - surveillance
• **Being prepared** – ‘I’m not going into the wilderness!’
• **Part of the job**, but not necessarily paid for it...
Communication improves resident safety: ‘it’s part of the job’

It’s a rolling and on-going thing. If a staff member was off for 3 days and if a resident is on antibiotics and should not be given milk, the concerned caring staff should know about it. So if this information is not handed over then it is risky. To keep residents safe. (CH3, I2, CA)
Handover as surveillance

‘The team went from room to room checking nails (for any faeces) and heels for sores. The toilets were checked for cleanliness and room temperature’. (observation)

The handovers focussed on 3 aspects mainly: pressure sores, daily living and medication. The handover process also included checking the paper work for updates.
Safety and continuity

‘The night nurse in the morning will handover to us all the findings which he has been through all the night. So who has slept well, who has opened bowel, who has not had medications, who was agitated, whose dressing is changed, who had a fall, things like that, yeah. So it's like a continuity of the care, so that we can follow (CH2, I2, RN)
Policy
Two Care Assistants are paid to come on duty at 7am every day and leave later each night which allows additional time for CAs to hand over to each other while there still being staff available for residents.

Practice:
‘Some of them, they are saying, oh, we don't get paid, this and that. I say, look, I come in my own time, specially early morning, they didn't ask me, so I just say, look, at least the work in the morning is not too heavy, because I start a bit early’. 
Manager and RN perspectives on handovers – purpose and effectiveness

Managers and Registered Nurses also interested in:-

• Teambuilding
• Personnel issues
• Staff training
• RNs also more focused on clinical issues and medicines.
Building up a picture of key elements of an effective handover

• Handovers are viewed as important by management

• Opportunity to ask questions; feedback not ignored

• Timeliness encouraged

• Being able to listen/hear - not too many distractions or interruptions

• Residents’ dignity respected

• Production of clear and accessible written records (enable family to review and monitor quality of life changes)

• Guidance on handover available and known by staff

• Open discussion about variables about handover and what suits certain care homes or whether flexibility acceptable e.g. timing, location, who hands over to whom, participation, content.
Decisions about timing, attendees, duration and location

- **Timing of handovers** – A ‘continuous’ process throughout shift or something that happens at the end?
- **Duration** – speed versus thoroughness?
- **Content** – exception reporting or systematic approach?
- **Who hands over to who/ Attendees** – balance between team building when all staff attend v. speed of handover if RNs and CAs handover separately?
- **Need to balance risk of staff attending handover and residents being left alone** (costs of providing shift cross-over to ensure all can attend v. staff not being paid for handovers).
- **Location** – room by room may improve safety but time-consuming (which also has safety implications).
Relevance for medication practices

- Don’t assume handovers will be the same in all homes – they are variable with implications for practice.

- Understanding the culture of the home – are handovers personalised or is it a mechanised process? Who does what?

- Handover documents vary, but may be a good source of information about monitoring of residents e.g. pressure ulcers – do notes correlate with allegations?

- If handover notes are not available, is information updated in care plans or elsewhere?
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References


