Received: 1 July 2022 | Revised: 10 March 2023 | Accepted: 15 March 2023

DOI: 10.1002/nop2.1740

EMPIRICAL RESEARCH QUALITATIVE

NursingOpen Open Access WILEY

Nurses' perspectives on shift-to-shift handovers in relation to person-centred nursing home care

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Abstract

Aim: The aim of this study was to gain insight into nurses' perspectives on the shift-to-shift handover in relation to providing Person-centred care (PCC) in nursing homes.

Background: PCC is perceived as the gold standard for nursing home care. To preserve the continuity of PCC, an adequate handover during the nurses' shift change is essential. There is, however, little empirical evidence for what constitutes best shift-to-shift nursing handover practices in nursing homes.

Design: An exploratory qualitative descriptive study.

Methods: Nine nurses were selected purposively and through snowball sampling from five Dutch nursing homes. Semi-structured face-to-face and telephone interviews were conducted. Analysis relied on Braun and Clarke's thematic analysis.

Results: Four main themes were identified related to enabling PCC informed handovers: (1) knowing the resident to be enable to provide PCC was key, (2) the actual handover, (3) additional ways of information transfer and (4) nurses' knowledge of the resident prior to start shift.

Conclusion: The shift-to-shift handover is one way that nurses become informed about residents. Knowing the resident is essential to enable PCC. The fundamental underlying question is to what extent nurses have to know the resident in order to enable PCC. Once that level of detail has been established, in-depth research is needed to determine the best method for conveying this information to all nurses. Only then can we start to rethink the role of the shift-to-shift handover in conveying PCC-driven information.

No Patient or Public Contribution.

KEYWORDS
continuity of care, handoff, handover, nurses, nursing homes, person-centred care, shift-to-shift

1 | INTRODUCTION

In the nursing home setting, the shift-to-shift handover (also called handoff) between the outgoing and incoming nurses occur frequently: two, three, or more times daily, 7 days a week. Handover can be defined as a process in which information about a resident's care is communicated in a consistent manner from one health care provider to another (Centre for transforming health care, 2017; Riesenberg et al., 2010). During handovers, responsibility and accountability for a resident's care components are transferred

(Anderson et al., 2015). In general, information exchanged during handovers consists of information about the patient's current condition and possible changes or complications that might occur (Abdellatif et al., 2007). Multiple reviews consistently show that handover is essential in preserving the quality and safety of care (Abdellatif et al., 2007; Desmedt et al., 2021).

In the recent years, the concept of the patient as the driving force in his or her own healthcare decisions has become the gold standard in long-term care settings (McCormack & McCance, 2016). This concept, known as person-centred care (PCC), is built around the needs of the individual and is contingent upon knowing the person through an interpersonal relationship (Fazio et al., 2018). In PCC, care providers elicit an individual's values and preferences, which once expressed guide all aspects of that individual's health care (Brummel-Smith et al., 2016). Individual care is written down in the nursing care plan, as part of the nursing process. The nursing process is a widely accepted problem-solving cyclic method in which critical thinking plays an important role in analysing a patient's situation systematically and in planning and implementing tailored individual care (Bjorvell et al., 2000; De Groot et al., 2021). Other documents are available to facilitate the nursing process, such as daily progress reports, needs assessment forms and medication charts. The handover is an element within the nursing process to secure tailored individual care.

2 | BACKGROUND

Much literature is written about PCC definitions and the models to redesign services towards ones that are focused upon and responsive to the needs of older people, rather than the medical oriented model and the maintenance of institutional norms, routines and rituals. The individual care plan is always mentioned as instrument to describe individual's assessments, values, beliefs and goals. The American Geriatric Society (AGS) expert panel on PCC elicits eight essential elements of realizing PCC, of which one element pertains to the information exchange of the individual resident between nurses (Brummel-Smith et al., 2016). Including the information exchange as an essential element of realizing PCC, emphasizes the importance of continual information sharing in daily practice during the shift-to-shift handover.. In the information exchange, the shift-to-shift handover plays a pivotal role. Unfortunately, literature concerning the content and quality of handovers in nursing homes and residential homes seemed to be scares, we only found one review which concluded that the contribution of handovers in raising the quality of care is neglected (Moriarty et al., 2019). Studies related to nursing documentation, in general, reveal that inadequacies are often found, in hospital setting (Paans et al., 2010) and in long-term institutional care (Tuinman et al., 2017). Most concerning are the findings of just one traced paper on PCC and nursing documentation, describing that the transfer of residents' information was suboptimal and that nursing staff had inadequate knowledge about the residents' beliefs and values (Broderick & Coffey, 2013). Furthermore, residents' beliefs, values and needs were often poorly documented, biographical information was lacking, and care plans and progress reports failed to be person-centred (Broderick & Coffey, 2013).

Since 2017, the Dutch administrative authority has required that nursing home facilities deliver PCC and this has to focus on four themes, namely, compassion, uniqueness, autonomy and shared decision-making (Zorginstituut Nederland, 2021). The nursing handover commonly takes place during a 15-min overlap between shifts. The nursing staff comprises mainly of certified nursing assistants with an education level of 3 conform the European Qualification Framework (EQF-3) (European-Commission, 2008). The staff is usually complemented with nurse aides (EQF-level 2), vocationally educated registered nurses (EQF-4), and some bachelor-educated nurses (EQF-6). All of them take part in the handover which usually takes place in a separate office. Furthermore, 76% of the nurses in Dutch nursing homes use electronic patient records (EPRs) for documentation (Wouters et al., 2018). The nursing handover comprises oral information and written daily reports. With regards to the daily reports, it is important to know that, under Dutch law, residents and their family have the right to access their EPR so they can read what is written down by the nursing staff in the resident's nursing records.

In sum, the challenge in nursing home care is to implement and conduct individual nursing care plans based upon PCC principles, 24/7, for several months or years. The handover is an essential moment of PCC information transfer from one nurse to another. Unfortunately, there is currently little empirical evidence for what constitutes best shift-to-shift handover practices in nursing homes. To enable optimal PCC, in this study, we aimed to gain insight into nurses' perspectives on the shift-to-shift handover in relation to providing PCC in nursing homes.

3 | METHODS

We adopted a qualitative exploratory approach using semi-structured interviews. The reporting of the study is conform to the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

3.1 | Setting and sample

This study was carried out in one Dutch long-term care organization located in East of the Netherlands providing nursing home care to 600 residents in seven regional locations, offering residential care in both small-scale facilities (6–8 residents per unit) and traditional facilities (20–30 residents per department). In the Netherlands, nursing home units are differentiated between psychogeriatric residents and somatic residents and both types of care are provided by this organization. Several types of aides, assistants and nurses provide daily care (EQF 2-6), all of whom participated in the shift-to-shift handovers. The organization has used Electronic Patient Records (EPRs) since 2013.

Assistants, nurses and activity coordinators were eligible for inclusion if they had adequate command of the Dutch language. In this study, we use the term 'nurses' for all types of respondents. Student nurses were excluded. We selected nurses purposively and through snowball sampling by managers via e-mail. We sought maximum variation in terms of level of nursing education, type of shift worked (day, evening and night shifts), location and resident population (i.e., psychogeriatric or somatic). Subsequently, we also included an activity coordinator. The researcher APO (nursing science student) sent each participant an information letter explaining the goal of the study, the rationale, the interview procedure and the confidentiality of data.

3.2 | Data collection

We collected data from February to May 2020 by means of one-time, individual and semi-structured interviews. Originally, we had intended to conduct only face-to-face interviews. However, during data collection the COVID-19 pandemic emerged, so we modified our data collection method to telephone interviews.

To focus the data collection, we used an interview guide; the main question we asked was: *How would you shape a PCC handover?* We elaborated on the four PCC themes as described in the Dutch Quality Framework for Nursing Home Care—namely, compassion, uniqueness, autonomy and shared decision-making (Zorginstituut Nederland, 2017). Researcher APO conducted a pilot interview to explore the clarity of questions, resulting in minor adjustments. For the pilot interview, she interviewed a vocationally educated registered nurse employed in one of the included nursing homes. Data from this pilot interview were used in this study.

Researcher APO conducted and audio-recorded all interviews. The face-to-face interviews were held in a private room in the nursing home. The participants interviewed by telephone were either at home or at work and not in the presence of others. The researcher made field notes during and immediately after the interviews describing the setting, the behaviour of participants and the researcher's own reflections (Holloway & Galvin, 2016).

3.3 | Data analysis

Data analysis relied on Braun & Clarke's six-phase thematic analysis, in order to establish meaningful patterns (Braun & Clarke, 2022). The researcher APO analysed data after every two interviews to examine whether we needed to include more participants, which interviewees we needed to include to reach maximum variation, and whether we needed to adjust the interview guide. The researcher wrote analytical notes during this process, gaining insight into the steps taken (Holloway & Galvin, 2016). ATLAS.ti supported data analysis.

In the first phase, the researcher transcribed the interviews verbatim and thoroughly read and re-read the transcripts to become familiar with the content. In the second phase, relevant text fragments were identified and assigned with a code. Researcher APO and researcher APE (female, experienced with qualitative research) coded the first two interviews together. Codes were discussed until consensus was reached. In the third phase, codes were sorted into several potential themes resulting in a thematic map. In the fourth phase, researchers APO and APE refined themes. Themes were defined and named in the fifth phase, and the final report was produced in the sixth. Although data collection took place in a tight time schedule, the interviews were rich with data and expressing a range of views from different type of nurses.

Example of coding analysis.

	Code	Theme
"I do not know what her care plan says, because I do not actually look … I know it all by heart."	Care plan	Written documentation
"That's why I come in earlier, to read back through stuff, because I've had three days off, for example."	Not enough time	Procedures

3.4 | Rigour

We based the study's rigour on the quality criteria credibility, dependability, confirmability and transferability (Lincoln & Guba, 1985). To strengthen credibility participants received the transcript of their interview by e-mail. The participants did not express any disagreements. To ensure dependability and confirmability, the researcher APO kept notes (i.e., field notes, analytical notes, and critical reflections of the researchers own role), thereby enabling others to judge the researcher's decision-making process and objectivity (Holloway & Galvin, 2016). We presented the sample and setting in such a way that the reader can judge the transferability. With respect to the study's trustworthiness, it is important to address that researcher APO is a bachelor-educated nurse employed in two nursing home locations included in the study APO observed in daily practice the important role of handovers as a method to ensure PCC. Prior to the study commencement, relationships existed between researcher APO and the managers responsible for recruitment, but not between researcher APO and the participants. Researcher APE was unfamiliar with both the participants and the managers; APO is a senior nurse and focuses on the nursing process and collaboration among nursing team members.

3.5 | Ethical considerations

The research ethics committee for the Arnhem-Nijmegen region, the Netherlands, declared this study not to be subject to the REDACTED (registration no. 2020-6127). Data handling and storage complied

with the data management policy of the Radboud Institute for Health Sciences. We obtained written informed consent prior to face-to-face interviews and verbal informed consent (audio-recorded) prior to telephone interviews.

4 | RESULTS

4.1 | Population

Nine nursing staff members participated in the study, see Table 1. We conducted three face-to-face and six telephone interviews. Interviews lasted 45–65 minutes. The last two interviews yielded no new information, so data saturation was reached.

Four main themes emerged from the data when discussing the handovers in relation to enabling optimal PCC: (1) knowing the resident to be enable to provide PCC, (2) the actual handover, (3) additional ways of information transfer and (4) nurse's knowledge of the resident prior to start shift. These themes are interrelated. Knowing the resident extensively is perceived key to enable providing PCC. The actual handover describes the transfer of this PCC information. However, not all PCC information of the resident was considered as suitable to be transferred in handovers and additional ways were mentioned. Even so, handovers were modelled on nurses'knowledge of the resident already established prior to the start of the shift. The main themes and sub-themes are displayed in Figure 1.

TABLE 1 Demographic data ($n = 9$).

Age (in years)	
Mean (SD)	44 (11)
Min; max	24; 56
Gender, *n*	
Female	9
Worked in nursing homes (in years)	
Median (SD)	15 (12)
Min; max	3; 38
Nursing staff member[a], *n*	
Nurse aide (EQF-2)	1
Certified nursing assistant (EQF-3)	3
Vocationally educated registered nurse (EQF-4)	3
Bachelor-educated nurse (EQF-6)	1
Activity coordinator[b] (EQF-6)	1
Type of department, *n*	
Somatic department	4
Psychogeriatric department	5
Type of shifts conducting, *n*	
Day and evening shift	5
Day, evening, and night shift	3
Night shift only	1
Type of facility	
Small-scale facility	5
Traditional facility	4

[a]The nine included nursing staff members were permanent workers on a unit, but five of them performed additional stand-in work on other units.

[b]The activity coordinator is considered part of the nursing staff.

4.2 | Knowing the resident to be enable to provide PCC

All the nurses mentioned that knowing the resident was crucial for providing PCC. Nurses found knowledge about a resident's uniqueness, compassion, autonomy and participation in care goals important elements in providing PCC.

> If you know the resident just a bit better; well then, I know they can react in one way or another. Yes, then you can sort of anticipate things a bit better than when you don't know that.
>
> (vocationally educated registered nurse, #1)

To meet a resident's needs, nurses wanted to connect with the resident, which requires familiarity with that resident's 'unique way of life', including culture, religion, personal character, habits, coping strategies, lifestyle, family traditions and medical background.

> What they've always sort of done in terms of what their family was like, what they thought was important, are they religious. Do they really enjoy helping people, did they work, did they take care of their family at home?
>
> (vocationally educated registered nurse, #5)

To achieve a compassionate approach, it is essential to know a resident's life history, wishes, and needs. In addition, nurses stated that showing compassion is truly about the little things that matter.

> 'When I'm sad I really want an arm around me, or maybe I find it just great if someone sits with me.' Those are the sorts of things we try to capture.
>
> (activity coordinator, #2)

Participants perceived the resident's autonomy as an important element of PCC because it signifies the resident's control over his or her life. Participants also wanted to know the resident's wishes regarding autonomy to enable a pleasant last phase of life.

> If someone always wanted to be made up but is not able to say so anymore, then the care plan will definitely say that she still has make-up and that she gets made up in the morning or wears a scarf or something.
>
> (certified nursing assistant, #3)

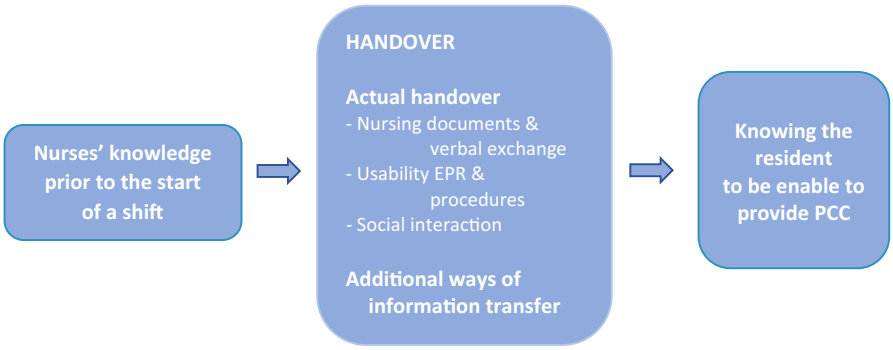

FIGURE 1 Nursing staff perspectives on handovers related to enabling PCC.

4.3 | The actual handover

The second main theme was the handover itself. We distinguished three important elements for handovers: written nursing documents and verbal information, usability of EPR and procedures and social interaction.

4.3.1 | Written nursing documents & verbal information

Nurses practiced a combination of different types of handovers: written nursing documents and verbal information. Most nurses valued reading all types of nursing documents, such as resident activity agendas, daily progress reports, nursing care plan, needs and preferences and goals. Especially reading a resident's calendar and daily progress reports contributed extensively to nurses' knowledge about the resident. Nurses found it important that nursing documentation contained up-to-date information that was clear and structured.

However, regular staff did not feel it necessary to check residents' goals and care plan daily because they do not change daily.

> I don't know what her care plan says, because I don't actually look … I know it all by heart.
>
> (certified nursing assistant, #3)

During the handover, nurses could verbally explain and discuss written documents and look for missing information. Nurses considered this verbal handover important and experienced it as pleasant as it gives a deeper understanding of the written reports.

> Reading [it] is not always easy. Sometimes things get taken differently than intended, and it's just nice to see someone's facial expressions [and hear the] intonation in their voice.
>
> (vocationally educated registered nurse, #5)

Nurses felt that receiving a large amount of information during the handover was undesirable, as it was hard to remember everything. Receiving too much information resulted in a loss of overview, especially when the nurse was responsible for a large number of residents.

> That two colleagues are responsible for the information transfer of one unit (……). So that we actually split that up, that we are not responsible for all of the care for twenty people but we have split it up so to speak.
>
> (vocationally educated registered nurse, #6)

4.3.2 | Usability EPR & procedures

Nurses identified the limited time of 15 min as an important negative factor in the handover procedure. They considered this time frame insufficient for both reading the EPR and providing verbal comments. To solve this problem, some nurses came in before their scheduled shift to read the EPR.

> That's why I come in earlier, to read back through stuff, because I've had three days off, for example.
>
> (certified nursing assistant, #3)

Nurses appreciated reading and writing in EPR. However, the EPR would be more user friendly if it were to alert users to changes in certain types of documents such as the setting of care goals, which do not frequently change in long-term care.

> That doesn't immediately stand out. You should have an alert or something to give you a heads-up that data has changed or something.
>
> (vocationally educated nurse, #6)

Initially, it was difficult to find certain information back because the EPR was too complex. The recent adjusted back tracing system improved the usability of EPRs quite a lot.

> But with us the focus is really on stated goals, and I do have to say QIC [the type of EPR used] has now completely changed and adapted, also with that page from today. That's really super, because the most important goals are all on there. So that's what you report on.
>
> (vocationally educated registred nurse, #5)

Some nurses mentioned the use of so-called running lists. The EPR can delineate running lists, which provide a compact overview of all resident-related tasks listed in a certain time slot. This was appreciated as after the handover, the nurses had this information by hand while caring for their residents.

Furthermore, the nurses felt they needed to be able to directly check or report something during care provision to avoid loss of information. They thought portable EPR devices would be handy.

Finally, nurses noticed that there were no specific guidelines for the handover and as a consequence the content of handovers varied.

> There is currently no instruction manual for what's important in a transfer. I think that's also a limiting factor, that it's not set down on paper, or that there are no guidelines about that.
>
> (vocationally educated registered nurse, #6)

4.3.3 | Social interaction between nurses

Finally, the relationship between the nurse whose shift was ending and the nurse whose shift was beginning affected the handover. For instance, nurses in one department experienced the handover from evening shift to night shift as a pleasant social interaction and a shared responsibility. This led to more informal interactions between the colleagues and a faster residents' knowledge exchanges. Meanwhile, in other locations, nurses did not experience the interaction during handover as pleasant, which caused frustration and decreased interaction and collaboration.

> There is not always the same amount of attention when we are going to transfer. And that's indeed a big point of irritation. And I just thought it was important that everyone listen to each other. And especially when you're going to transfer, that faces are directed at you and not at the computer. And that some attention is being paid to what happened that night.
>
> (nurse aid, #7)

4.4 | Additional ways of information transfer

Novice nurses and stand-in nurses did not have enough information from the shift-to-shift handover to be able to provide PCC. They rely on the regular nurses and therefore work together with them.

> I worked together with my colleague and they took me along and explained that you can do this and that. In this way, I've already made a lot of progress.
>
> (vocationally educated registered nurse, #1)

Not every detail essential for providing PCC was suitable to be transferred verbally or through documentation. Participants stated that the handover and the written documents were just elements to enable providing PCC but sometimes additional ways of information transfer are needed.

> But you must really know them, I always tell a student or colleague. I know you can manage with the care, but this is just specifically about the interaction. Just walk along with me, watch what I do and what I say and what I don't say. Or what I do completely nonverbally.
>
> (certified nursing assistant, #3)

Some nurses mentioned the use of the so-called shadow lists. Shadow lists were handwritten by nurses themselves and thus not connected to the EPR. The organization advised against using shadow lists since they yielded errors and duplicate information. Nevertheless, stand-in nurses and nurses working night shifts felt a need for shadow lists because of incomplete information in the EPR. Nurses often saw the EPR as lacking details important for PCC, such as whether a resident with dementia prefers to sleep with her door open or closed.

> Shadow lists are more extensive than client dossiers in terms of the little details you need to know about a client. What that person likes is not always mentioned in QIC [EPR]. But it is on the shadow lists. We actually spell them out in detail. Just like whether the client keeps the door open or closed.
>
> (nurse aid, #7)

Even e-mail was used to excange information, often written before the handover. They mainly used e-mail to describe more sensitive issues about residents, like information involving the family. Because the nurses knew that relatives could read the daily progress reports in the resident's EPR, they avoided possible confrontation by using e-mail instead.

> And sometimes you want to consult as colleagues before you actually take action. That is the disadvantage of working alone, in principle. You hardly ever see your entire team. And then we often do it all via mail, I've bumped into them here and there, I've responded to them in such and such a way. What's your opinion on this? What do you guys think about that?
>
> (vocationally educated registered nurse, #5)

4.5 | Nurses' knowledge prior to start shift

The fourth main theme involved knowledge nurses already possessed about a resident at the start of a shift. Due to the long stay of residents in the care facility, some nurses knew residents for some months while others met the resident just for the first time. The yet acquired knowledge related to information enabling PCC, such as

preferences and needs of residents, the nursing care plan, activity program of the resident and the individual approach of residents. The degree of knowledge differed considerable between (novice and stand-in) nurses and depended on the established relationship with a resident.

Contact between nurses and the family of residents also contributed to how well nurses knew residents. Contact with family occurred spontaneously (e.g., when relatives visited) and during planned interactions (e.g., meetings to evaluate care).

> Sometimes it takes longer for you to get to know someone through and through, but some people you may never know through and through. And with some people you have a sort of immediate click, or you've gotten so much information from the family.
>
> (vocationally educated registered nurse, #5)

5 | DISCUSSION

This exploratory study aimed to gain insight into nurses' perspectives on the shift-to-shift handover in relation to the provision of PCC in nursing homes. Four themes were identified: (1) knowing the resident to be enable to provide PCC, (2) the actual handover, (3) additional ways of information transfer and (4) nurses' knowledge of the resident prior to the shift .

According to the interviewees, key for enabling PCC is comprehensive knowledge of a resident's preferences, life history, habits and behaviours. This is in line with all PCC literature 'Knowing the person is central to person-centred care' (McCormack et al., 2012). This PCC information is to be found in several nursing documentations, among which the nursing care plan. We found considerable variation in how well the incoming nurses already knew the residents. Some nurses had spent time with residents during previous shifts and also the length of a resident's stay was a factor in how well nurses knew residents. Consequently, the content of the handover should be tailored to the incoming nurse's knowledge of the resident instead of determined by the out-going nurse. We found no literature in which this element was taken into account in handover procedures. If, as expected, more stand-ins provide nursing home care in future, this is elementary (Moriarty et al., 2019).

We also found that during the handover, not all relevant PCC information could be transferred. Some information or approaches were too subtle or too complex to describe or understand simply by reading the EPR or receiving a verbal explanation. Residents and relatives can access their progress report in the EPR, and sometimes nurses wanted to avoid risking confrontations over sensitive matters. Nurses even chose to report via e-mail as a solution for their dilemma how to describe the actual resident's situation while e-mail is not according to the privacy protection regulations (General Data Protection Regulation, without date). De Groot et al. (2021) previously described the subject of adjusting documentation because patients can read what has been written. We suggest to pay attention to this dilemma and study more in detail how nurses and family can cooperate together to establish PCC.

This study brought to light a dilemma that many nurses face. On the one hand, nurses need to know residents comprehensively in order to offer PCC, but it is difficult to grasp the overwhelming quantity of detailed information transferred during shift-to-shift handovers. On the other hand, nurses nevertheless experience the information of the shift-to-shift handover as not detailed enough to facilitate PCC and that other ways of exchange should be included to enable PCC. A fundamental underlying question is to what extent do nurses have to know the resident to enable PCC. Getting to know individual residents well in a facility with a large population of residents is an extensive undertaking, especially for flexible and part-time staff. Moriarty et al. (2019) therefore states, 'It can't be assumed that all those providing care have personal knowledge of all residents' needs'. Still, knowing the patient is essential for enabling PCC, and we have to consider how to organize this optimally in daily practice.

The basis of the actual handover shift-to-shift handover were several nursing documents, in our case written down in EPR. In general, the nurses were positive towards the EPR as digital documentation tool. Participants offered several suggestions to enhance access to the records by refining the EPR, such as built-in alerts to signal that a resident's nursing goal had been adjusted and portable EPR devices. Other literature has advocated involving nurses and residents in further technological refinements of the EPR, as this stimulates implementation (De Groot et al., 2020).

Verbal exchange during the handover which was perceived as indispensable in this study. To support colleagues in getting to know the residents, nurses verbally explained documented information during the handover. Moriarty et al. (2019) found comparable results in their review, asserting that the opportunity to provide feedback and ask questions during the handover is an adequate handover from the perspective of caregivers. In our study, however, nurses felt that 15 minutes was an insufficient amount of time both to read EPRs and verbally transfer information.

5.1 | Recommendations

All things considered, the question arises of how best to organize handovers in order to enable PCC. The existing literature on handovers suggests that the best way of doing so has not yet been established (Desmedt et al., 2021; Riesenberg et al., 2010; Smeulers et al., 2014). Literature on shift-to-shift handovers is mainly concerned with hospital care and focuses on patient safety, patient conditions and complications that might occur. The question is whether the broader focus on wellbeing and PCC means it is time to rethink the role and methods of handovers for the nursing home setting. Up to now, the fundament of handovers are nursing documentation such as nursing care plan. And although a considerable amount of literature exists on how to develop individual care plans guided by PCC principles (Van Haitsma et al., 2020); literature is lacking on the

role of the handovers in conducting the nursing plan, 24/7 in real time by a team of nurses who are herein collaboratively responsible. Therefore, we recommend in-depth studies into conducting individual care plans, including handovers, developed on PCC principles in daily practice. Potential topics for research on care plans include the level of detail required, alternative ways of conveying information (like audiotaping), monitoring care plans and aims of progress reports. In order to develop a deeper understanding of the comprehensiveness of implementing PCC-based nursing care plans, observational studies of handovers, content analysis of all nursing documents and interviews with nursing staff and residents are required. In terms of the handovers, research could focus on the incoming nurse, allotted time frames and involvement of residents (like bedside handover).

In closing, we found that the quality of the handover was influenced by the relationship between the outgoing and incoming nurses. Handovers can have a ritualistic and symbolic character (David et al., 2017; Kerr, 2002). The handover exceeds the mere exchange of information, as a moment of social exchange, team building, peer support and an opportunity for learning (Kerr, 2002; Schneider et al., 2010). Further research is also needed to explore the role of the shift-to-shift handover in shaping team culture and team empowerment.

5.2 | Strengths and limitations

The small sample size and the fact that the respondents were from only one healthcare organization may underrepresent the population; therefore, our results may have limited transferability. Due to corona pandemic we were not able to conduct observations of handovers although this would have provided more and rich data. Conversely, the study was strengthened by the repeated peer debriefing with a second researcher to detect bias or subjectivity (Holloway & Galvin, 2016). Also, the sample of nurses represented maximum variety in several factors, contributing to credibility. The means of conducting the majority of interviews—namely, over the telephone—could affect credibility. However, we attempted to build trust and rapport by reserving time at the beginning of the interview to get acquainted with the participant (Sturges & Hanrahan, 2004). Despite the limitations, we are convinced that the results provide a first good impression of nurses' perspectives on person-centred handovers in nursing homes.

6 | CONCLUSION

The shift-to-shift handover is one way that nurses become informed about residents. Knowing the resident is essential to enabling PCC. However, the quantity of information required to implement PCC poses a dilemma for nursing staff. There are often too many details to read, grasp and cope with, but still not enough to apply PCC. Therefore, the fundamental underlying question is to what extent nurses have to know the resident in order to enable PCC. Once that level of detail has been established, in-depth research is needed to determine the best method for conveying this information to all nurses. Only then can we start to rethink the role of the shift-to-shift handover in conveying PCC-driven information. The process of researching and adjusting the methods of conducting handovers asks for close collaboration with nurses, residents and proxy. Additional research is also needed to explore the role of the shift-to-shift handover in team building and empowerment.

AUTHOR CONTRIBUTIONS

Anneke Poelen recognized the research question, conducted the interviews, analysed the data and reported the study. Marieke van Kuppenveld analysed the data, read concepts of the paper and improved the article. Anke Persoon responsible for the methodology and directing the study.

ACKNOWLEDGEMENTS

We would like to thank healthcare organization Zorggroep Elde Maasduinen for allowing us to conduct our study in their nursing homes. No funding was obtained for this study.

FUNDING INFORMATION

No funding was received to conduct this study.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available upon request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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How to cite this article: Poelen, A., van Kuppenveld, M., & Persoon, A. (2023). Nurses' perspectives on shift-to-shift handovers in relation to person-centred nursing home care. *Nursing Open*, *00*, 1–9. https://doi.org/10.1002/nop2.1740