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Authors: Dr Virpi Ylänne
        Dr Michelle Aldridge-Waddon
        Dr Tereza Spilioti
        Prof Tom Bartlett

Affiliation (of first author): Cardiff University, UK

Institutional address: Centre for Language and Communication Research, ENCAP
                        Cardiff University
                        John Percival building, Colum Drive
                        Cardiff, CF10 3EU
                        Wales, UK
Email: ylanne@cardiff.ac.uk

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1

Bionotes

Virpi Ylänne is Senior Lecturer in Language and Communication at Cardiff School of English, Communication and Philosophy. Her research interests are in interactional sociolinguistics, discourse analysis, and discourse and identity in the fields of lifespan communication and institutional talk. She has published widely on e.g. relational talk in institutional discourse and media representations of ageing and older people. Address for correspondence: Centre for Language and Communication Research, ENCAP, Colum Drive, Cardiff University, Cardiff, CF10 3EU, Wales, UK. Email: ylanne@cardiff.ac.uk

Michelle Aldridge-Waddon is Reader in the School of English, Communication and Philosophy at Cardiff University. Her research interests are in child language acquisition, communication disorders, forensic linguistics, and psycholinguistics. Her particular focus is on the linguistic experiences of vulnerable people (children, rape victims and people with a disability) and their interactions with professionals especially within the legal system. Address for correspondence: Centre for Language and Communication Research, ENCAP, Colum Drive, Cardiff University, Cardiff, CF10 3EU, Wales, UK. Email: AldridgeM@cardiff.ac.uk

Tereza Spilioti is Reader in Language and Communication at Cardiff School of English, Communication and Philosophy. Her research interests are in discourse and social interaction, with a focus on media and professional communication issues. She has published research related to politeness and relational work, online research ethics, and various aspects of language and digital communication. Address for correspondence: Centre for Language and Communication Research, ENCAP, Colum Drive, Cardiff University, Cardiff, CF10 3EU, Wales, UK. Email: SpiliotiT1@cardiff.ac.uk

2

Tom Bartlett is Professor of Functional and Applied Linguistics at the University of Glasgow and Honorary Professor of Language and Communication Research at Cardiff University. His research interests are in Systemic Functional Linguistics, interactional sociolinguistics, and critical discourse analysis, particularly in the fields of community management and sustainability. Address for correspondence: Department of English Language and Linguistics, Glasgow University, Glasgow, G12 8QH, Scotland, UK. Email: tom.bartlett@glasgow.ac.uk

Managing information, interaction and team building in nurse shift-change handovers: A case study

Virpi Ylänne, (Cardiff University), Michelle Aldridge-Waddon (Cardiff University), Tereza Spilioti (Cardiff University) and Tom Bartlett (University of Glasgow)

Abstract

Whilst there is a wealth of literature on medical handovers, discourse analytic work based on recorded interactional data on these pivotal speech events in health care is less prevalent. This case study of a shift-change nursing handover at a UK hospital Medical Assessment Unit (MAU) takes a microanalytical perspective on nurses' talk and interaction, which enables us to examine its structural and functional complexity at utterance level. Our methodological approach comprises observations, one semi-structured interview with senior nursing staff (and many informal conversations with various staff), and in total twelve audio-recordings of interactions during, and around, the twice-daily shift-change handovers. By adopting 'a multiple goals in discourse' perspective and the framework of activity analysis, we demonstrate the nurses' interactional management of multiple discourse and activity roles and pursuance of goals that transcend the medically and institutionally crucial transmission of information. This shows the nurses' orientation to the handover task as not only a structured institutionally regulated event, but also one that tolerates more spontaneous activities that can potentially contribute to team cohesion and staff well-being.

Keywords: activity roles; discourse roles; interaction; nursing; shift-change handovers; team building

1.   Introduction

Clinical handovers, as pivotal speech events in health care, have received much research attention in terms of their structuring and their communicative challenges (e.g. Grosjean 2004; Manias et al. 2015; Mayor et al. 2012). The present study contributes to existing literature which often emphasises the need for structured handover delivery but less often examines interaction in detail or how its various communicative demands are interactively managed – with the exception of studies such as Eggins and Slade (2015, 2016) or Mayor and Bangerter (2015). Our focus is a case study of a shift-change nursing handover at a UK hospital Medical Assessment Unit (MAU). The unit under study is recognised by the institution for its good practice and has a reputation for successful balancing of patient care with staff welfare. Informal conversations with staff and a semi-structured interview with senior nurses revealed their strong sense of a team in this ward (e.g. '*It's a team thing, you can't do it on your own, everybody adapts into that team spirit*'). We examine how handovers provide nursing staff with the opportunity to meet as a team and engage with one another in multiple institutional and interpersonal roles at the discourse level. We ask how handovers, in addition to their central role in information and care transfer, can also function as community building events, and how this is discursively managed.

Entering the participating ward with little a-priori assumptions about how the handovers were delivered, our initial observations suggested some fluidity of topics and information across different phases of staff interaction around handover events. This prompted us to problematise handovers as clearly bounded events for information transfer. Inspired by Eggins and Slade's (2015: 198) proposition that 'we need to replace the conventional adage that *a short handover is a good handover* with *an interactive handover is a safe handover*', in this paper we explore what opportunities there are for interaction and the fostering of team cohesion in handover discourse. Furthermore, Slade et

al. (2016: 16) call for qualitative analysis of actual handovers and we aim to contribute to this research gap.

We start with a brief literature review on handovers (section 2) as background to our foci. We then introduce the data context, method and analytical frameworks (section 3), followed by data analysis and discussion of staff interactions surrounding one handover as a case study (section 4). Section 5 brings the analysis and findings together as a conclusion.

2.   Literature review: Clinical handover

Clinical handover refers to the 'transfer of professional responsibility and accountability for some or all aspects of care for a patient, or groups of patients, to another person or professional group on a temporary or permanent basis' (British Medical Association (BMA) 2004: 7). Handovers sustain and contribute to the flow of activities within an organisation (cf. Eggins and Slade 2012, 2016; Mehra and Henein 2014; Mayor et al. 2012); they are the 'glue that holds the health care continuum together' (Apker et al. 2010: 161). Like any type of organisational ritual, handover meetings require 'critical communication' (Iedema et al. 2009: 133) in order to achieve (i) the transfer, reporting and recording of information; (ii) responsibility for care across numerous caregivers (personal task commitment); and (iii) accountability (organisational role obligation) through different stages in the patients' trajectory (e.g. from hospital admission to treatment and discharge, cf. Mayor and Bangerter 2015: 130).

Given the justifiable emphasis on patient safety and the need for an efficient and accurate transfer of information, much of the previous literature has identified those areas where such transfer breaks down and the causes behind this. For example, Mehra and Henein (2014: 1) state that a 'clinical handover in hospitals remains one of the most perilous procedures in medicine … a point at which errors in communication, prioritisation and subsequent actions are likely to occur and failure

of handover is a major preventable cause of patient harm'. Similarly, several researchers (e.g. Manias et al. 2015, see also McGregor and Lee 2016) question the extent to which information in handovers is always sufficient (quantity), accurate (quality), organised (structure) and/or supported by appropriate written documentation (means). The lack of training in handover practice is also highlighted (e.g. Iedema et al. 2009; Manser and Foster 2011; Mehra and Henein 2014). In order to address the potential sources of failure, many studies and authorities (e.g. BMA 2004; Sandlin 2007; Ye et al. 2007; Bost et al. 2012) promote using standardised communication protocols (e.g. SBAR, ISBAR[1]) to regulate the amount, type and structure of information in handovers.

Less attention has been paid on interactive elements of talk during handovers (see Kerr 2001; Eggins and Slade 2015). Exceptions include, for example, the study by Bangerter, Mayor and Doehler (2011), who identify both formal transmission of information and informal conversation about non-routine events – often via storytelling – in nurse shift-change handovers. They show how Direct Reported Speech establishes collective sense-making (p. 211), having different functions depending on who is quoted. Whereas self-quotes account for the teller's professional rationality and decision-making, quotes of other colleagues function to legitimate actions by the speaker. Patient quotes typically afford personal assessments of patients in a professionally acceptable way. In terms of turn-taking, Grosjean (2004), drawing on Goffman (1981), provides a detailed analysis of changes in participation frameworks, comparing dilogal and polylogic (spontaneous multi-party) handover interactions and how the latter are triggered, for example, by emotional topics or problem situations.

In addition to the content and turn-taking in handover discourse, the *functions* of nurse handovers have been examined. For example, Kerr's (2001) case studies in two paediatric wards demonstrate informational, social, organisational and educational functions of these events. These refer to patient reports and up-dates; emotional support and socialising between nurses; operational planning about allocation decisions; and student nurses' opportunities for learning, respectively. Liu et al. (2012), on the other hand, using critical ethnography, examine the 'interconnectedness of

7

social, environmental and organisational contexts that impact on handover communication' (p. 942). They link aspects such as the location of the handover (closed-off room or by the bedside) and organisational hierarchies – which result in social and power struggles – with the structuring and delivery of medication information. Promoting opportunities for junior members, such as raising questions during group handover, are recommended.

Mayor and Bangerter (2015) investigate how nurses manage 'perturbations', namely instances 'that can potentially lead to a breakdown of focused talk in the handover' (p. 132), such as phone calls, or third parties interrupting a one-to-one handover. Multimodal analysis uncovers how nurses collaboratively manage these disruptions in order to maximise efficiency, dividing the labour between them both linguistically and non-linguistically (e.g. via gaze or gesture). Such work relies on joint activity, teamwork, and shared understanding, which also form our foci in the analysis to follow.

The above select studies evidence handovers as communicatively complex, where information delivery intersects with organizational and interpersonal functions. While not downplaying the importance of accurate and efficient information delivery, in this paper we take up McGregor and Lee's (2016: 90) claim that 'interpersonal communication processes are [also] an essential part of the management and the transfer of patient information', in order to investigate how one high-performing team is able to attend to a variety of conversational aims while still 'maintaining professional relationships, team building and a crucial way to keep patients safe'. As such work is done in talk-in-interaction, our study develops insights into nurses' management of the tensions between clinical information transfer and interpersonally-focussed aspects of handover discourse. The analysis seeks to answer the following questions:

1. How do nurses manage efficient transfer of information and interpersonal goals in handovers?

2. What interactive roles do nurses take in handover communication?

3. How might the adoption of these roles contribute to nurse team cohesion?

3. Data context, method and analytical frameworks

The data collection comprised audio recordings and observations in total of twelve shift-change handovers in two different wards of a UK hospital. We also interviewed two senior nurses about the nature of handovers and administered a short questionnaire in one ward about nurses' perceptions of handovers. These provided further insights about the ward, the institution, and professional practice (see Spilioti et al. 2019). Ethical clearance was granted by the authors' University research ethics committee and the Health Board's committee responsible for our participating hospital. All nurses who were recorded gave informed written consent. All data examples have been anonymized to protect confidentiality.

This case study of one of the Medical Assessment Unit (MAU) handovers is based on a recording of 32 minutes. As is customary in this unit, the official handover comprised two phases: (i) the core, ritual safety briefing ('Safer Patient Initiative', SPI), which gives a risk assessment of all the patients present; and (ii) the one-to-one (nurse-to-nurse) handover (post-SPI) at the ward bay of a subset of patients (but not by the patients' bedside). However, we also recorded (iii) informal talk before the safety briefing ('pre-SPI' talk) and discovered that aspects of this talk were relevant to subsequent handovers. Hence, we consider handovers as forming a continuum of activities (Bartlett et al. 2020). The pre-SPI and SPI interactions took place in the nurses' office behind a closed door. In these, there were 12 individuals in attendance: two female senior nurses (outgoing and incoming), six nurses (one male, five female), one male agency nurse, and three health support workers (one male, two female).

We adopt a discourse analytic orientation to the talk of nurse handovers, approaching language as social action, interactively managed by participants in their varied roles. As Halvorsen and Sarangi (2015: 2) point out, 'the argument for a…dynamic conceptualisation of role urges us to

9

acknowledge how participant roles…are accomplished situationally and in activity-specific ways, especially in professional settings'. Following Sarangi (2000: 2), who builds on Levinson's (1979) seminal work on 'activity types and language', we orient to nurse shift-change handover as an activity type in which various simultaneous goals and roles are accomplished. This provides us access to the 'work' that task-oriented and interpersonal elements of the handover discourse achieves. Sarangi (2000: 1-2) makes a distinction between *activity type*, 'a means of characterising settings' (such as a nurse shift-change handover here) and *discourse type*, characterising 'the forms of talk' (e.g. the reporting of patient cases or reported speech in our context). Sarangi acknowledges an overlap between activity types and discourse types, constituting 'interactional hybridity' (2000: 2).

Analytically, in accordance with the above-mentioned approach, we differentiate between *activity roles* and *discourse roles*. Roles in the former category, such as leader or participant of a handover, are dependent on the activity type the individual is taking part in and are usually defined in relation to other participants. Discourse roles, on the other hand, are defined at the utterance level, such as presenter/reporter which refer to the relationship between the participant and the message (whether one is producing it, receiving it, transmitting it on behalf of another, etc.) (Goffman 1981; Sarangi 2000, 2010). Discourse roles are relevant to our interest in analysing participant relationships because '[b]y adopting or assigning particular discourse roles, participants implicitly make claims about their role positioning and relationships with co-participants' (Halvorsen and Sarangi 2015: 2). Like Goffman's (1981) participation framework, which extends the roles of speaker and hearer, the focus on discourse roles here affords the extension of the roles of handover giver and receiver.

In terms of conversational/interactional goals, we identify task (or instrumental) goals which are the purpose of the interaction, and non-task goals concerned with self-presentation and the relationship between the participants (e.g. Tracy and Coupland 1990: 5), such as that based on rank or seniority (higher/lower) or familiarity (close/distant). Goals can be further differentiated into those

with interactional outcomes, such as passing on information regarding patient safety or updating colleagues on organisational procedures, down to specific speech act level functions, such as seeking clarification or advising. Our conceptual and analytical framework, thus, identifies activity and discourse role positioning of the participants with the associated local goals in activity types.

4.   Data analysis

The recording (and other sources in the data set) was transcribed and anonymised (see Appendix 1 for transcription conventions). Repeated listening and reading of the data helped us to identify inductively recurrent interactional features, which motivated the analytical framework adopted for more detailed analysis. In the first set of analytical coding, we observed talk that followed an identifiable handover script in line with a prescribed protocol, but also what we have called 'non-scripted talk' (NST, Lloyd et al. forthcoming), such as the inclusion of clinically non-essential information and shifts from the technical medical-institutional voice. We identified features displaying medical, institutional, and relational goals. Safety/risk assessment and organisational/institutional information about the ward configuration are the focus of the safety briefing (SPI). Transfer of medical/clinical information about patients is the central focus in the one-to-one handover. Relational goals are foregrounded in pre-SPI talk.

However, on closer inspection at the second level of coding/analysis, all three phases displayed elements of all types of goal, foregrounded differently and achieved via discourse roles of a varied range (marked in the transcripts to follow). In the SPI, ward-focused information is relayed in a ritualistic, formulaic way, but elaboration of patients' circumstances also takes place. In the one-to-one handover, personalisation of patients, 'downscaled' from a medical case (Bartlett et al. 2020), occurs. In pre-SPI, alongside relational goals fostering team building, shared medical and organisational information allows co-alignment of nurses as professionals. The intertwining of different goals, achieved via a changing range of discourse roles, facilitates both institutionally

11

regulated and spontaneous activities. In the analysis below, in addressing our research questions, we demonstrate how this is managed.

One key function of NST is its contribution to creating an ethos of compassion between the nursing staff (Lloyd et al. forthcoming). Here, our interest is in how the participants orient to each other in ways that promote shared understanding and team cohesion. To do so, we identify the fluctuating activity roles and discourse roles, turn by turn, and analyse the management and delivery of clinically crucial information as well as interpersonally focussed talk. Looking at all three phases enables us to focus on the information-centred safety briefing (SPI), which has residues of the other phases of the interaction as these are brought into temporary focus to attend to immediate interpersonal demands as a sub-motif to the continuing exchange. We then move on to analyse and discuss the nurse-to-nurse bay handover, which again is transactionally-focused but in which the nurses engage in collaborative patient construction, which also happens in the pre-SPI, informal talk phase. The management of this phase is looked at last.

4.1 General ward handover: the safety briefing

The safety briefing (SPI) starts once all expected attendees are inside the staff room and the door is closed. The 12 participants are standing or sitting on desks in very close proximity. The structure and topics of SPI are regulated, and the activity organised around the SPI form (see Appendix 2). This covers the institutionally prescribed transactional goals, clustering around: (i) *recording medical information* related to patients (e.g. patients with pressure ulcers, at risk of falls, etc.); and (ii) *recording organisational information* related to the ward and its patients (e.g. patients sectioned, staffing issues, etc.). In terms of roles, the pre-assigned activity role of the institutional lead is assumed by the outgoing Senior Nurse. The reception format is collective (Grosjean 2004: 33), consisting of the incoming shift. There is collective focusing (Grosjean 2004: 36) on the information given by the leader, with the incoming shift taking notes.

The analysis of SPI talk shows the transfer of clinical information but also the adoption of multiple discourse roles and orientation to concerns that move beyond what the associated form prescribes. In Extract 1, we indicate the respective discourse roles and activity roles of speakers in each turn. The same is subsequently repeated for the nurse-to-nurse (post-SPI) (Extract 2) and the informal talk (pre-SPI) (Extract 3).

Extract 1

			Discourse role	Activity role
1	Emma	Okay (.) evening everybody (2)	greeter	leader
2	Multi	((Laughing))		
3	Emma	We've had no cardiac arrests within the last 12 hours (.) Not For Resus (.) D5 [FNLNM] (1) D6 [FNLNM] (.) C5 [FNLNF] (.) No falls (.) at risk of falls (.) A bay bed 3 and 4 (.) B bay bed 3 and 4 (.) C bay (.) 1 3 and 5 (.) and all of D bay (1) ((clears throat)) trolleys 1 2 3 and 5 (2.5) 7 and 13 (1) urm gentleman on trolley 3 [FNLNM] (.) he's had a POVA (.) initiated (.) urm (.) against his lo:dger (.) his lodger lives with him (.) a:nd takes care of his finances	presenter O presenter P	leader
4	Nurse1	Ah yeh	active listener	participant
5	Emma	Ur::m (.) he's (1) he's an alcoholic on CIWA-Ar	presenter M	leader
6	Nurse1	Who the	elicitor	participant
7	Nurse2	[The patient or the	elicitor	participant
8	Emma	[The patient (.) urm (.) and (.) he was very unkempt this gentleman (.) urm so A and E have initiated (.) a POVA (.) just to look at his ho::me (.) u:m (.) circumstances basically (.) and see (.) you know what else needs to get involved (.) no drug errors clinical incidents patients giving cause for concern (.) trolley 7 [FNLNM] (.) he's on a naloxone infusion	responder evaluator presenter O explainer presenter O	leader
9	Nurse?	Trolley 7	active listener	participant
10	Emma	Trolley 7 (.) he's on half hourly urm (.) obs and GCS (.) GCS is 10 at the moment (3) Trolley 12 [FNLNF] she's being treated for (.) cholangitis and (.) she's on IV anti-biotics there (2) A5 (.) [FNLNF] (.) urm she's been spiking temps throughout the day and she's being treated for urosepsis (1) … D4 (.) [FNLNM] (1) this gentleman is sectioned	responder presenter M	leader
11	Nurse?	Oh yeah	active listener	participant
12	Emma	[He's (.) in [name] Hospital (.) u:rm we have got an RMN there with him 24 hours (1) they're providing that for him (.) he:'s had a Doppler today he's come in with urm left leg swelling he's had a Doppler (.) but hasn't been reviewed so once it's been reviewed and treatment plan (.) he'll be going back (.) trolley 3 [FNLNM] he's the gentleman (.) that I was telling you about the POVA (.) He's on a CIWA-Ar (.) he gets quite agitated and he's very anxious there (1) patients with pressure ulcers (.) D4 [FNLNM] he's got a grade 2 to the sacrum (.) …	presenter O explainer presenter M evaluator presenter O	leader

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                    no patients on COPD bundles
                    no blood transfusion (.)
                    infection isolation (.) trolley 4 [FNLNM] (.) he's in the cubicle
                    there because he's neut- neutrapenic sepsis and we had the: (.)    presenter M
                    cubicle available (2) …                                            explainer
                    pressure ulcer audit done (.) urm (.)                              presenter O
                    a- asked the staff to update the boards (.)
                    no staffing issues (.)
                    we've had 20 admissions (.)
                    49 patients on the ward (.)
                    we've got 5 expected 3 by ambulance (.)
                    s- six patients at risk (.)                                         presenter O
                    all had appropriate response (.)                                    evaluator
                    and one had a diagnosed sepsis (1)                                  presenter M
                    and that's your whole lot
 13  Nurse ?        Thank you (1)                                           responder       participant
 14  Emma           Thank yo::u                                             meeting closer  leader
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Emma, acting as the *chair/leader*, clearly signals the beginning and end of the meeting with devices indicating transitions from one activity to the next, such as the discourse marker 'ok' (turn 1), greeting 'evening everybody' (turn 1), which achieves focused joint activity (Mayor and Bangerter 2015: 133), and politeness formula 'thank you' to close the activity (turn 14). The incoming nurses take on the activity role of *participants.* Despite the large number of members present, their rights to speak are unequal: talk here is largely monologic with the leader holding the floor through *discourse roles* that are associated with the SPI form. Emma repeatedly acts as the *presenter* of information of (i) patient medical conditions (e.g. cardiac arrests, turn 3; pressure ulcers, turn 12), (ii) legal orders (e.g. not for resuscitation patients, turn 3), and (iii) institutional matters (e.g. no staffing issues, number of admissions, etc., turn 12). The other nurses are mainly silent *recipients of the information* (evident in the numerous unfilled pauses occurring in Emma's speech) or offer minimal contributions in the role of *active listeners*.

McGregor and Lee (2016: 81) propose that, to strengthen clinical handover, it is important that the recipients confirm information they are not sure about. The checking and clarification turns are arguably beneficial not only for the speakers themselves but potentially to other team members, too. On the other hand, frequent interruptions can disturb information delivery; as can be seen in Extract 1, questions are kept to a minimum. Team cohesion is aided by a clear demarcation of the

briefing deliverer and recipients. Yet, spontaneous interaction is tolerated. Such interaction is triggered by Emma's elaboration on the patient's circumstances: 'his lodger lives with him (.) a:nd takes care of his finances' (end of turn 3) and 'he's an alcoholic on CIWA-Ar' (The Clinical Institute Withdrawal Assessment for Alcohol Scale, turn 5). The response to the former through back channelling ('ah yeh' turn 4) indicates active listening. The pronoun use in turn 5 is ambiguous, triggering clarification requests (turns 6-7). And in turn 9, an unidentified nurse checks information via repetition ('trolley 7'). The identifying information (bay number and patient name) is suffixed with 'gentleman' in turn 10, having a humanising effect (cf. Lloyd et al. forthcoming), also prompting backchannelling (turn 11). In sum, these brief interpersonal stances promote interaction during a largely monologic and ritualistic briefing and hence arguably contribute to the collective focusing.

Further analysis of Emma's talk reveals more than mere relaying of information. In Extract 1, we have distinguished between different presenter roles, depending on the primary orientation of talk to organisational (O), medical (M) or personal (P) issues.[2] This more nuanced approach enables us to exemplify in more detail the variation in discourse roles. For example, in turns 3-8, Emma's talk is moving beyond what is required by the healthcare institution ('presenter-h'), i.e. the recording of patients under the category 'POVA' (protection of vulnerable adults). She also presents background information related to the patient ('presenter-p') and is an 'evaluator' of the patient's situation and explainer of organisational actions ('presenter –o'). Through these discourse roles, Emma achieves transfer of information but also professional socialisation, involving attention to medical ('presenter-m') as well as personal circumstances, appropriate assessment and course of action taken at different stages of the healthcare continuum. The shift of orientation to professional socialisation is indexed by the change of register from specialised/medicalised to more everyday/colloquial language by vocabulary such as 'unkempt', 'takes care of…', 'to look at'; the use of fillers that appear absent in other parts of SPI talk (e.g. six instances of 'urm', together with 19 pauses, within 38 seconds of

talk); the use of 'you know', a marker/filler that invokes the immediate audience/addressees; and hedging ('just to look'). McGregor and Lee (2106: 86) suggest that 'using vague, non-medical terms during handover' will impede the creation of shared understanding. However, Emma's use of evaluative language such as 'unkempt' (line 10) is likely to help staff form a shared wider understanding of the patient's personal and social circumstances that are relevant for care, alongside his medical profile.

In our interview with the senior nurses, the collective function of the safety briefing was summarised: '*that's what handovers are for, bringing everyone together*' and as an '*important time*' because '*when you're out there, [the ward] there's no kind of interaction*'. Thus, the SPI leaders in this unit frame the group handover as contributing to team cohesion and we have shown some aspects of how this is achieved above. We now move onto the one-to-one nurse handover.

4.2   The nurse-to-nurse handover

Following the safety briefing, the one-to-one mode is the last phase of the handover in this unit, where the outgoing nurse transfers the care of specific patients in a ward bay to the incoming nurse. This part provides patient history and risk assessment (building on the success of the SPI phase) and instructs the incoming nurse on their tasks during their shift (Lamond 2000: 794). An established practice at this stage of a handover is to relay the '5Ps' (Sandlin 2007): Patient history; reason for Patient admission; Patient restrictions, Plan of care and Progress expected in the next shift. Similarly, Grosjean (2004: 31) describes a shift-change session as 'a regular, preplanned encounter' where '[t]he topics discussed are … predictable and closely linked to pathology and the patients' treatment'. However, Grosjean adds that '[r]arely, other themes related to organization, … doctors, or other staff members emerge, but this generally only happens in conversations about patients' treatment.' Lamond (2000: 799) compares verbal shift reports with patient notes and reports that 'global judgements' about a patient's condition, psychological state and personality were more

frequent in the verbal reports. The 'global judgements' assimilate a range of information, thus reducing the cognitive load of the incoming nurse and help the participants share a knowledge schema about concepts that nurses hold about patients (p. 802). Extract 2 shows how this phase is managed in our case study.

Extract 2

			Discourse role	Activity role
1	Vicky	Um (.) her name is [FNLNF] (2) she's a lady that (were) come in (6) ((paper shuffling)) she come i:n earlier o- she originally was in yesterday	presenter_O	handing over, outgoing nurse
2	Gill	Oh right	active listener	co-worker, incoming nurse
3	Vicky	Last night (.) and then sent over to come back for a post (.) take ur:rm [FNLNF] has arranged (.) medical sh- she's had ga- gastric sleeve for (.) urm (.) weight loss (.) but previously over ° the last couple of weeks (there was) increased alcohol° (as in) you know the 70 CL bottles of vodka	presenter_P presenter_M presenter_P	
4	Gill	Oh right yeh	responder	
5	Vicky	She'll drink one of them over three days (1) u::rm (.) so whether or not [there is an element] (.) ye:h there	presenter_P	
6	Gill	[(she must)] [probably (tipped it over)	responder	
7	Vicky	Yeah she had another fall on Monday she said she tripped over the curb (.)	narrator	
8	Gill	Okay	responder	
9	Vicky	U::rm (1) she's got fluids going through now at the minute they probably need reconnecting cause (I) took them down for her to go out for a cigarette	presenter_M instructor, explainer	
10	Gill	Okay	responder	
…				
15	Vicky	45 (2) repeat (.) U and E's (.) ta:ken (3) and with her she's been referred to gastro (.) they were going to talk about (.) urm doing a (.) urm (.) blood transfusion because she had a HB of 8 but they're not doing (4) she's for repeated bloods (.) [obviously to repeat] (1) U and Es (.) dunno (1)	presenter_O presenter_M responder	
16	Gill	[she's got a (?)] okay	elicitor; responder	
17	Vicky	Because it's all to do with this gastric band	presenter_M	
18	Gill	Oh right	active listener	
19	Vicky	Because they don't tend to like (.)[absorb] stuff really do they (.) urm repeat	presenter_M; elicitor	
20	Gill	[absorb]	active listener, co-presenter_M	
…				
26	Gill	So she's still awaiting that then and the ultrasound as well	elicitor; checking	
27	Vicky	[so she's still waiting on- the ultra]sound abdo fluids	responder; confirming	
28	Gill	Yep	active listener	
29	Vicky	…but I did mention to her (.) °because obviously she's suddenly stopped herself drinking on Sunday° (.) I said if you start getting a little bit agitated well she's not on CIWA-Ar and she (.) °doesn't need to be at the minute°	narrator; reporter of interaction; presenter_M	
30	Gill	Okay	active listener	
31	Vicky	So like I said if you start to get anxious (.) anything out of sorts (.) I said just give us a shout	reporter of interaction	
32	Gill	Yeah	active listener	
33	Vicky	And we can get something	reporter	
34	Gill	Yeah	active listener	

In Extract 2, which concerns the first patient handed over, the activity type is achieved in

Vicky's utterances that describe the 5Ps, including the patient's medical history (e.g. turns 3, 9, 15),

reasons for admission (e.g. turns 1, 3), care plan (turns 15, 27), and instruction for care progress (turn

9). The talk pursues institutional goals and forms an intra-professional discourse type via the medical register (e.g. gastric sleeve; fluids going through) and abbreviations (e.g. repeat U and Es; HB of 8). Vicky's discourse roles range from presenter, narrator, reporter to responder, and Gill's from active listener to elicitor and responder.

On closer analysis, we can identify a range of interpersonal and team-building elements in this exchange. There is an active shared construction of the patient taking place (cf. Eggins and Slade 2016). This is achieved via reported but also co-constructed details that extend into the patient's 'lifeworld'. Starting in turn 1, Vicky relays the patient's name, gender and admission information, and the reception of this is acknowledged by Gill. Vicky also then performs relational work in modifying the medical and organisational detail, by adding 'you know 70cl bottles of vodka' (end of turn 3), inviting a response from Gill, which happens. Stories in handovers are 'a means by which nurses create shared understanding' (Bangerter et al. 2011: 184), and what follows is a short and fragmented narrative about the patient. Vicky further specifies the patient's alcohol use (turn 5), which triggers interactive speculation ('whether or not', 'she must', 'probably') about its effect, achieved via overlapping talk and acknowledgment tokens ('yeh'/'yeah'), signalling mutual engagement in the 'small story' (Georgakopoulou 2006), that continues in turn 7. The indirect reported speech in turn 7 ('she said she tripped…') adds an implicit evaluative dimension to the patient characterisation (as the cause for 'falling/tripping over' could be alcohol use) and helps balance professional code of neutrality (cf. Bangerter et al. 2011: 210) and what could be construed as gossip. Again, Gill replies, but her 'okay' (turn 8) is equally ambiguous. This 'gossip', however, has a key role to play in team building as it helps members thrive in their communities through the trust implicit in gossip sharing with another colleague (McAndrew 2008).

Turn 9 moves to presenting medical and care information, and instruction for subsequent care, but continues to incorporate more 'global judgements' (Lamond 2000) of the patient's personal habits (smoking), again acknowledged by Gill. Turns 15 – 28 focus on medical care and care plan

but includes joint construction and shared understanding of these. For example, in turns 19 – 20, Gill anticipates the word 'absorb' and her articulation of it overlaps with Vicky's. Turns 26 – 27 include the echoing of 'so she's still (a)waiting', which signals collaboration.

Vicky's turn 29, 'I did mention to her…I said' (repeated twice in turn 31), constitutes a switching of discourse roles from a reporter of medically/organisationally relevant information to the reporting of interactions between herself and the patient. The direct reported speech can be linked to describing professionally appropriate conduct (Bangerter et al. 2011: 208), and to professional socialisation. Direct reported speech typically elicits recipient response, and acknowledgement / agreement tokens are provided by Gill.

To summarise, the transactional goal of the handover is achieved in that patient history, admission information and care plan and progress are presented. The information exchange continues the themes of the SPI, but much of the interactional work fosters shared understanding and collaborative patient construction, so it differs from the SPI. Vicky's discourse extends towards professional morale and socialisation which needs to be installed and maintained in a high functioning ward. We now look at the talk preceding the safety briefing in terms of its contribution to team building.

4.3 Talk preceding the safety briefing

Extract 3 is from the conversation prior to the safety briefing between staff, who have arrived to start their shift at 7 pm.

Extract 3

			Discourse role	Activity role
1	Nurse 2	I was saying to Rhys is she urm (.) is her HB low (.) °cause she was so pale° (.) she was transparent [it was like four it] wasn't too bad but (.)	narrator, evaluator	co-worker
2	Nurse 1	[what was her name]	elicitor	co-worker
3	Nurse 1	She wasn't here Sunday was she (.) she's new	elicitor	

4	Nurse 2	[no]	responder	
5	Nurse 2	I don't think so no she was new (.) I was saying is her HB low and (.) especially with her dizziness and everything	responder, narrator	
6	Nurse 1	How old was she Helen? (1)	elicitor	
7	Nurse 2 (Helen)	e::r she- she was probably (.) late seventies	responder	
8	Nurse ?	Yeah	responder	
9	Nurse 1	Aa love her	evaluator	
10	Nurse 2	But you know (.) she was rea- she never looked well obviously (.) sh- her HB was (quite) low she was pale she never looked well (.) but when we moved her from the trolley into bed she was (reading something) she was doing her crossword with her husb[and you know] (.) (she was sat there talking)	narrator	
11	Nurse 1	[o:h never]	active listener	
12	Nurse 4	Okay	active listener	co-worker
13	Nurse 1	A:w	evaluator	
14	Nurse 2	And he went home quite happy (.) and you know (.) and then I give her a cup of tea this morning (1) and she said she fel- she like she- yeh (.) she felt like she choked (.) and after that (.) [she was poorly	narrator; mouthpiece	
15	Nurse ?	[she was horrendous	co-narrator	
16	Nurse 2	So she didn't have any £swallowing problems£ there was no reason why (she) couldn't have a cup of tea (1) but she said (.) I know £there must have been something in my tea£	narrator; mouthpiece	
17	M Nurse	It's your tea Helen	teaser	co-worker
18	Helen	Actually you made the tea	responder	
19	Nurse 1	.hh oh she's £trying to (look) at you now£	teaser	
20	M Nurse	[((laughing))	responder	
21	Nurse ?	[((laughing))]	responder	
22	Nurse 2	She said I had my cup of tea and I felt like I'd choked …	narrator; mouthpiece	
23	Nurse 1	Ye::h	assessor	
24	Nurse 2	But I don't think she did choke (.) I think [she just become] short of breath (.)	narrator	
25	Nurse 1	[o:h love her]	evaluator	
26	Nurse 4	[Hiya Jul nice to see you again] ye:h	greeter	
27	Nurse 5	[you oka::y]	greeter	co-worker, incomer
28	Jul	[oh ah:h] …	greeter	
29	Nurse 4	((laughing)) (1) I'm not doing the teas tonight°	joker	
30	Nurse 1	No nor me I'll have no more teas off her	joker	
31	Nurse?	[((laughing)) …		
32	various	((laughing))		
33	Nurse 2	Oh lov- her blood sugar was fine her blood pressure dropped (.) she was tachy (.) and (?) a bit high (.) but that was (.) this morning (.) after a cup of £tea£ …	narrator	
34	Nurse 2	Ah love her (.) ah and she was so scared …	evaluator/ narrator	
35	Nurse 2	I didn't want to leave her …	narrator	
36	Nurse 2	I did feel guilty then about the cup of tea	narrator	

As an activity type, the pre-SPI interaction is a 'gathering' (Goffman 1967: 144). It forms a transitional encounter from off-shift to on-shift, in which colleagues re-establish contact, and so it is expected to consist of phatic communion, small talk (Coupland 2000) and relational talk to fill time as a non-task oriented activity.

In terms of activity roles, the co-present participants align as nurse co-workers, and the participants entering the room as incomers, receiving and returning greetings (turns 27-29). The discourse roles vary as the interaction unfolds. Nurse 2 adopts the discourse role of a narrator of an incident concerning a female patient during the previous night shift. Another Nurse adds to the story (turn 15), becoming a co-narrator. The narrator's discourse role also includes acting as a mouthpiece (Goffman 1981) via reported speech (turns 14, 16, 22). The other staff perform the discourse role of listeners, also eliciting further details (turns 2, 3, 6) provided by the narrator as a responder (turns 4, 5, 7). The listeners display active listener roles with minimal feedback (turns 11, 12), also using the 'discourse type' of teasing and joking (turns 17-19, 29, 30).

The start of the narrative is marked by self-reported speech 'I was saying to Rhys…is her HB low' (turn 1). As we saw in Extract 2, the direct reported speech constructs professionally appropriate conduct, but here it also frames the narrative as centred around the patient's symptoms. Reference to a descriptor of the 'HB' as 'four', qualified as 'low' and '[not] too bad' invokes a medical voice, positioning the hearers as familiar with the abbreviated referents (as in Extract 2 in the one-to-one handover). Nurse 2 refers to the patient's 'dizziness and everything' (turn 5) as 'common knowledge', with 'everything' used as a shorthand reference to other symptoms assumed known to the hearers. Interestingly, Nurse 1's checking the patient's name, date of admission and age (turns 2, 3, 6) covers information typically included in shift change reports (Lamond 2000: 796), which orients to the protagonist as a clinical case and affords the participants' co-alignment as nurses. The point of the narrative stems from the incongruity between her stated medical symptoms,

her actions (reading, doing a crossword and talking, turn 10) and her subsequent reported sudden deterioration.

The narrative, its narration and reception pursue relational goals in various ways. As the story develops, the patient herself is oriented to with a voice of sympathy, such as 'aa love her' (turn 9, repeated later). More notably, the participants orient to each other in ways that foster support: the narrated 'tea incident' is predominantly humorous and the 'culprit' of the tea offered to the patient becomes a contested topic, dealt with through teasing and joint laughter (turns 20-21). There is collaborative storytelling via overlapping talk and joint utterance construction (end of turn 14, turn 15). Furthermore, we see evidence that 'direct reported speech constitutes an important tool in the ongoing social construction of shared culture' and that informal conversations 'can provide collective legitimation of nursing acts by colleagues' (Bangerter et al. 2011: 184, 185). Nurse 2 (Helen) uses strategies to avoid positioning herself as professionally incompetent, thus saving face. In turn 16, she justifies why her actions (giving tea to the patient) were medically appropriate ('she didn't have any swallowing problems there was no reason…'). The direct reported speech of the patient (turns 16 and 22) contrasts with Helen's assessment and implies the patient's inaccurate attribution of her deterioration to Helen's action. The sharing, co-narrating and humorous orientation to the story provides an occasion for colleagues to support Helen in her actions and contributes to team bonding and in-group solidarity. Helen is also acknowledging her professional role responsibility when she says, 'I didn't want to leave her' (turn 35) and 'I did feel guilty then about the cup of tea' (turn 36). This further demonstrates the intertwining of institutional, professional, and relational goals in this activity. The relational bonding in the nurses' transition into their shift is important for team building but also anticipates some of the organisational and medical issues that will be encountered on shift.

5. Conclusion

Our analysis of talk during the shift-change handover continuum highlights the intertwining of medical/task-oriented and interpersonal/relational goals, realised via a range of activity roles and discourse roles. In the safety briefing, shared understanding of the activity is established via collective focusing. During the largely monologic information delivery, questions and checking moves help clarify any ambiguity, whereas the elaboration of patients' circumstances has a humanising effect fostering compassion and shared patient construction. In the one-to-one mode, patient construction is done jointly via collaborative talk, and team cohesion is aided by small stories and reported speech, which also helps the incoming nurse process the information. In the pre-SPI informal talk, collective storytelling fosters team building and professional support, whilst also contributing to socialisation as well as linking to information relevant to subsequent handover. By looking at the three phases as a continuum, we have demonstrated the patterning of effective information delivery with interaction and team-building roles.

'[H]andover is a quintessentially interactive achievement, shaped by the active collaboration of both givers and receivers' (Slade et al. 2016: 20). Furthermore, 'effective teamworking…will help staff cope with stress and feel part of a cohesive and effective work unit' (West 2018), thus contributing to staff well-being. The development of positive professional relationships and connections with others are needed in a team (McGregor and Lee 2016: 78) and this entails the negotiation of informational and interactional dimensions as part of handover activity.

A case study has the obvious limitation of not accounting in detail for any potential variation in the whole dataset. This is outweighed by a close examination of a single case on interactionally important features that are relevant to handovers in general. The lack of video recording precludes detailed multimodal analysis that could usefully complement audio-recordings and observational notes (cf. e.g. Mayor and Bangerter 2015). But as 'the dominant methods used in handover research have been observation and interviews' (Slade et al. 2016: 17), this study has provided data and close analysis of actual handover interaction.

This study contributes to previous research on nurse handovers, especially those with an interactional focus. Our interest was on roles and activity sets, inductively developing categories to account for the data and treating the handover as a continuum across different phases, displaying hybridity as an activity type. The study talks to professional practice and expands our understanding of a core professional activity as one that requires careful balancing of information delivery, interaction, and team building. As a next step, we aim to discuss these findings with nursing staff to promote reflexivity (cf. Iedema 2011).

Appendix 1

Transcription conventions

[overlapping talk begins
] overlapping talk ends
(.) pause, less than half a second
(1) pause in seconds
(?) inaudible talk
wo:: elongation of previous sound
wo-- abruptly ended, cut off sound
(( )) contextual information
… lines of transcript omitted
£ smiley voice
˚talk noticeably quieter˚
FN first name
LN last name
F   female
M male

All names are pseudonyms

Appendix 2

SAFER PATIENT INITIATIVE
work cycle
SAFETY BRIEFING
To record the safety briefing at ward handover on each shift

Date of audit	☐☐ / ☐☐ / ☐☐	**Representation at handover**			
Ward	**MAU**	Trained nursing staff	☐ yes	☐ no	
Shift	☐ Early ☐ Late ☐ Night	Untrained nursing staff	☐ yes	☐ no	

	SAFETY BRIEFING TOPICS	**PLEASE TICK**	**COMMENTS**
1	Cardiac Arrest (within 12 hours)	Yes ☐ No ☐	
2	NFR		
3	Falls		
4	At risk of Falls	Yes ☐ No ☐	
5	POVA/Sectioned Abscond/Self Discharge	Yes ☐ No ☐	
6	Drug Error/Clinical Incident	Yes ☐ No ☐	
7	Patients Giving Concern	Yes ☐ No ☐	
8	Patients with PU Rental air mattresses / Repose cushion	Yes ☐ No ☐	
9	CD check Pt own CD Cardiac arrest drugs	Yes ☐ No ☐	
10	COPD Patients on bundle	Yes ☐ No ☐	

11	Blood Transfusions	Yes ☐ No ☐	
12	Infection/Isolation	Yes ☐ No ☐	
13	Patients needing palliative /oncology service	Yes ☐ No ☐	
14	Check Resus Trolleys (NIGHTS)	Yes ☐ No ☐	Done by: Done by:
15	Hand Hygiene Audit	Yes ☐ Yes ☐	Thursday Night Done by: Sunday Day Done by:
16	PU Audit (DAY Safety crosses	Yes ☐ No ☐	Done by: Done by:
17	Boards Updated	Yes ☐	
18	Calibration bm machines And check/stock boxes	Yes ☐ No ☐	
19	Staffing Issues	Yes ☐ No ☐	
20	Patient returning/ VIP Notes location	Yes ☐ No ☐	
21	Patients referred to outreach	Yes ☐ No ☐	
22	Medication lockers checked for patients own	6 am ☐	

R RAILS Number of admissions		Number of transfers	
Number of patients on ward			
How many patients at risk NEWS 4 +			
How many patients had appropriate response			
How many patients diagnosed with sepsis			

Briefing by   ……………………………………   (Print name)
Signed   ……………………………………

DONT FORGET CANNULA /CATHETER BUNDLES

Notes

[1] SBAR stands for 'Situation, Background, Assessment, Recommendation'

ISBAR stands for 'Identify/Introduce, Situation, Background, Assessment and Recommendation'

[2] We acknowledge that there may be overlap between these categories in individual turns, but we coded the primary orientation in each case.

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