Handoff Mnemonics Resource Table

Created for the Multi-Center Handoff Collaborative

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First Author Last Name	Year Published	Mnemonic	Write out Mnemonic	Anesthesia yes/no	Participants	Full Reference of Source
Abela-Dimech	2018	SBAR	Situation, Background, Assessment, Recommendation	No	Psychiatry, Nurse	Abela-Dimech F, Vuksic O. Improving the practice of handover for psychiatric inpatient nursing staff. Arch Psychiatr Nurs. 2018;32(5):729-736. doi:10.1016/j.apnu.2018.04.004
Allen	2014	iCATCH	Identify, Chief Complaint, Active Problem List, Therapies and Interventions, Clinical Trajectory and Condition, Help Me	Yes	Multispecialty Interns	Allen S, Caton C, Cluver J, et al. Targeting improvements in patient safety at a large academic center: an institutional handoff curriculum for graduate medical education. Acad Med. 2014;89(10):1366–1369.
Andreoli	2010	SBAR	Situation, Background, Assessment, Recommendation	No	Clinical and Non-Clinical Staff of Geriatric and Musculoskeletal Rehabilitation Units	Andreoli A, Fancott C, Velji K, et al.. Using SBAR to communicate falls risk and management in inter-professional rehabilitation teams. Healthc Q 2010;13(Spec No):94–101.
Arora	2006	PEDIATRIC	Problem list, Expected tasks to be done, Diagnostic one-liner If/then, Administrative	No	Internal Medicine Resident	Arora V, Johnson J. A model for building a standardized hand-off protocol. Jt Comm J Qual Patient Saf. 2006;32(11):646-655. doi:10.1016/s1553-7250(06)32084-3

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			data/advanced directives, Therapeutics, Results and other important facts, IV access/invasive devices, Custody and current issues			
Avallone	2015	SBAR	Situation, Background, Assessment, Recommendation	No	Nursing Student	Avallone MA, Weideman Y. Evaluation of a nursing handoff educational bundle to improve nursing student handoff communications: A pilot study. J Nurs Educ Practice. 2015;5(8):65-75. doi:10.5430/jnep.v5n8p65.
Bass	2013	IDEAL	Identify, Diagnose, Events, Anticipated, Leave	No	Internal Medicine Residents	Information, data entry, and reporting requirements for a resident handoff of Care Support Tool. 2013 IEEE International Conference on Systems, Man, and Cybernetics. 2013. doi:10.1109/smc.2013.120.
Bigham	2014	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	Yes	Pediatrics Clinicians (e.g. ICU Attending, Nurse)	Bigham MT, Logsdon TR, Manicone PE, Landrigan CP, Hayes LW, Randall KH, Grover P, Collins SB, Ramirez DE, O'Guin CD, Williams CI, Warnick RJ, and Sharek PJ. Decreasing handoff-related care failures in Children's Hospitals. Pediatrics 2014;134:e572-e579.
Bonds	2018	SBAR	Situation, Background, Assessment, Recommendation	Yes	Anesthesiologists, CRNAs, ICU Residents, SICU Nurses	Bonds RL. SBAR tool implementation to advance communication, teamwork, and the perception of patient safety culture. Creat Nurs. 2018;24(2):116-123.
Budd	2007	MIST	Mechanism of injury, Injuries sustained or suspected, Signs—vital signs, Treatment initiated (and timing)	No	Emergency Department Staff	Budd HR, Almond LM, Porter K. A survey of trauma alert criteria and handover practice in England and Wales. Emerg Med J. 2007;24(4):302-304. doi:10.1136/emj.2006.038323
Bump	2012	SIGNOUT	Sick or Not Sick, Do Not Resuscitate Order, Identification Data, General Hospital Course, New Events of the Day, Overall Health Status, Upcoming possibilities with a plan, rationale, Tasks to complete overnight	No	Post Graduate Year 1, Internal Medicine Resident	Bump GM, Bost JE, Buranosky R, Elnicki M. Faculty member review and feedback using a sign-out checklist: improving intern written sign-out. Acad Med. 2012;87(8):1125–1131.
Bump	2012	SIGNOUT	Sick or Not Sick, Do Not Resuscitate Order, Identification Data, General Hospital Course, New Events of the Day, Overall Health Status, Upcoming possibilities	No	Post Graduate Year 1, Internal Medicine Resident	Bump GM, Jacob J, Abisse SS, et al. Implementing faculty evaluation of written sign-out. Teach Learn Med. 2012;24(3):231–237.

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			with a plan, rationale, Tasks to complete overnight			
Calaman	2016	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Not Implemented	Calaman S, Hepps JH, Bismilla Z, Carraccio C, Englander R, Feraco A, Landrigan CP, Lopreiato JO, Sectish TC, Starmer AJ, Yu CE, Spector ND, West DC; I-PASS Study Education Executive Committee. The creation of standard-setting videos to support faculty observations of learner performance and entrustment decisions. Acad Med. 2016;91(2):204-9. doi: 10.1097/ACM.0000000000000853. PMID: 26266461.
Calaman	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for Pediatric Residents but not implemented	Calaman S, Spector ND, Starmer AJ, O'Toole JK, Allen AD, Tse LL, Bale JF, Bismilla Z, Coffey M, Cole FS, Destino L, Everhart J, Hepps J, Kahana M, McGregor RS, Patel SJ, Rosenbluth G, Srivastava R, Stevenson A, West DC, Sectish TC, Landrigan CP, Yu CE, Lopreiato JO. I-PASS handoff curriculum: computer module. MedEdPORTAL; 2013.Full text available from: https://www.mededportal.org/publication/9337
Calaman	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for Pediatric Residents but not implemented	Calaman S (co-first), Hepps JH (co-first), Spector ND, Sectish TC, Landrigan CP, Srivastava R, Starmer AJ, Yu CE (co-last), Lopreiato JO (co-last), and the I-PASS Education Executive Committee. I-PASS handoff curriculum: handoff simulation exercises. MedEdPORTAL 2013. Available from: www.mededportal.org/publication/9402
Canale	2018	PATIENT	Patient and Positioning, Airway, Antibiotics, Allergies, and Type of Anesthetic, Temperature, Intravenous and Intake/Output, End-Tidal CO2, Narcotics, Twitches	Yes	CRNAs	Canale ML. Implementation of a standardized handoff of anesthetized patients. AANA J. 2018;86:137–145.
Caruso	2017	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	Yes	PICU Physicians, Nurses, Respiratory Technicians, Anesthesiologists	Caruso TJ, Marquez JLS, Gipp MS, et al. Standardized ICU to OR handoff increases communication without delaying surgery. Int J Health Care Qual Assur. 2017;30:304–311
Chaboyer	2010	SBAR	Situation, Background, Assessment, Recommendation	No	Surgical, Medical Surgical, and Rehabilitation Nurses	Chaboyer W, McMurray A, Wallis M. Bedside nursing handover: a case study. Int J Nurs Pract. 2010;16(1):27-34.
Chapman	2009	SBAR	Situation, Background, Assessment, Recommendation	No	Medical Surgical Telemetry Staff (Nurses, Pharmacists, Case managers, Physicians, Clinical	Chapman KB. Improving communication among nurses, patients, and physicians. Am J Nurs. 2009;109(11):21-25.

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					Coordinators, Educators, Supervisors)	
Christie	2009	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses	Christie P, Robinson H. Using a communication framework at handover to boost patient outcomes. Nurs Times. 2009;105:13-15.
Compton	2012	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses and Physicians	Compton J, Copeland K, Flanders S, Cassity C, Spetman M, Xiao Y, Kennerly D. Implementing SBAR across a large multihospital health system. Jt Comm J Patient Saf. 2012;38(6):261–8.
Currie	2002	CUBAN	Confidential, Uninterrupted, Brief, Accurate, Named personnel	No	Emergency Department Nurses, Nurses, Perioperative staff	Currie J. Improving the efficiency of patient handover. Emerg Nurse. 2002;10(3):24-27. doi:10.7748/en2002.06.10.3.24.c1064
De Meester	2013	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses and Physicians	De Meester K, Verspuy M, Monsieurs KG, et al.. SBAR improves nurse–physician communication and reduces unexpected death: a pre and post intervention study. Resuscitation 2013;84:1192–6.
Dewar	2019	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Family Medicine, Resident	Dewar ZE, Yurkonis T, Attia M. Hand-off bundle implementation associated with decreased medical errors and preventable adverse events on an academic family medicine in-patient unit: A pre-post study. Medicine (Baltimore). 2019;98(40):e17459.
Devereaux	2016	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses	Devereaux T, Devereaux T, Marchetti G, et al.. Condition-specific sbar effect on transfers, hospitalizations, and 30-day readmissions from long-term care to acute-care. J Am Med Dir Assoc 2016;17:B25 10.1016/j.jamda.2015.12.078
Dojmi	2014	ISBAR	Introductions, Situations, Background, Assessment, Recommendation	No	Pre-Hospital Providers and Emergency Department Staff	Dojmi Di Delupis F, Pisanelli F, Di Luccio G, et al. Communication during handover in the pre-hospital/hospital interface in Italy: from evaluation to implementation of multidisciplinary training through high-fidelity simulation. Int Emerg Med 2014;9:575–82.
Downey	2013	IPASS the BATON	Introduction, Patient Name, Assessment, Situation, Background, Actions, Timing, Ownership, Next	No	Emergency Medicine Physicians	Downey LV, Zun L, Burke T. What constitutes a good hand offs in the emergency department: a patient's perspective. Int J Health Care Qual Assur. 2013;26:760-767.
Ebben	2015	DeMIST	Demographics, Mechanism of Injury/Illness, Signs, Treatment Given	No	ED Nurses and ED Physicians	Ebben RH, van Grunsven PM, Moors ML, Aldenhoven P, de Vaan J, van Hout R, van Achterberg T, Vloet LC. A tailored elearning program to improve handover in the chain of emergency care: a pre-test post-test study. Scand J Trauma Resusc Emerg Med. 2015;23:33. doi:10.1186/s13049-015-0113-3.
Ellis	2007	5P's v.1	Patient identity, Plan of care, Purpose of plan: clinical findings supporting plan of	No	General nurses, Perioperative nurses	Ellis D, Mullenhoff P, Ong F. Back to the bedside: patient safety and handoff report, 2007 NACNS national conference abstracts: February 28-March 3, 2007, Phoenix, Arizona. Clin Nurse Spec. 2007;21:109.

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			care, Problems: abnormal findings, pain scale, vital signs, Precaution: isolation, falls, etc			
Evans	2010	MIST	Mechanism of injury/illness, Injuries (sustained or suspected), Signs, Treatment given	No	Paramedics and Trauma Team	Evans SM, Murray A, Patrick I, et al. Clinical handover in the trauma setting: a qualitative study of paramedics and trauma team members. Qual Saf Health Care 2010a;19:e57.
Fabila	2016	SBAR	Situation, Background, Assessment, Recommendation	Yes	Anesthetic Unit Nurse and PICU Nurse	Fabila TS, Hee HI, Sultana R, Assam PN, Kiew A, Chan YH. Improving postoperative handover from anaesthetists to non-anaesthetists in a children's intensive care unit: the receiver's perception. Singap Med J. 2016;57(5):242.
Federwisch	2007	SBAR-T	Situation, Background, Assessment, Recommendation, Thank patients for opportunity to work with them (note: handoff done at bedside)	No	Nurse	Federwisch A. Passing the baton: Bedside shift report ensures quality handoff. NurseWeek California 2007;20(21):14
Feraco	2016	SIGNOUT	Sick or DNR, Identifying data, General hospital course, New events of day, Overall health status, Upcoming possibilities, Tasks to complete, Any questions?	No	Pediatrics Resident	Feraco AM, Starmer AJ, Sectish TC, Spector ND, West DC, Landrigan CP. Reliability of verbal handoff assessment and handoff quality before and after implementation of a resident handoff bundle. Acad Pediatr. 2016;16(6):524-531.
Field	2011	SBAR	Situation, Background, Assessment, Recommendation	No	Physicians and Nurses in Nursing Homes	Field TS, Tjia J, Mazor KM, et al.. Randomized trial of a warfarin communication protocol for nursing homes: an SBAR-based approach. Am J Med 2011;124:179.e1–7.
Finnigan	2010	ISBAR	Identify, Situation, Background, Assessment, Request	No	All Clinical Staff at Level 2 Hospital	Finnigan MA, Marshall SD, Flanagan BT (2010) ISBAR for clear communication: one hospital's experience spreading the message. Aust Health Rev Publ Aust Hosp Assoc. 2010;34(4):400–404.
Freitag	2011	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses and Patient Care Technicians in Telemetry Unit	Freitag M, Carroll SV. Handoff communication: using failure modes and effects analysis to improve the transition in care process. Qual Manag Health Care. 2011;20:103-109.
Friesen	2013	ISHAPED	Introduce, Story, History, Assessment, Plan, Error Prevention, Dialogue	No	Obstetric, Pediatric, and Medical Nurses	Friesen M, Herbst A, Turner J, Speroni K, Robinson J. Developing a patient-centered ISHAPED handoff with patient/family and parent advisory councils. J Nurs Care Qual. 2013;28(3):208-216.
Fryman	2017	I-PASS	Illness Severity, Patient Summary, Action List,	No	Internal Medicine Resident	Fryman C, Hamo C, Raghavan S, Goolsarran N. A quality improvement approach to standardization and sustainability of the hand-off process.

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			Situation Awareness with Contingency Planning, Synthesis by Receiver			BMJ Qual Improv Rep. 2017;6(1):u222156.w8291. doi:10.1136/bmjquality.u222156.w8291
Funk	2016	ISBARQ	Introduction, Situation, Background, Assessment, Recommendation, Questions	No	Pediatrics attendings, nurses, fellows, residents, medical students	Funk E, Taicher B, Thompson J, Iannello K, Morgan B, Hawks S. Structured handover in the Pediatric postanesthesia care unit. J Perianesth Nurs. 2016;31(1):63-72. doi:10.1016/j.jopan.2014.07.015
Gakhar	2010	SIGNOUT	Sick or Not Sick, Do Not Resuscitate Order, Identification Data, General Hospital Course, New Events of the Day, Overall Health Status, Upcoming possibilities with a plan, rationale, Tasks to complete overnight	No	Internal Medicine Resident, Emergency Medicine Resident	Gakhar B, Spencer AL. Using direct observation, formal evaluation, and an interactive curriculum to improve the sign-out practices of internal medicine interns. Acad Med. 2010;85(7):1182-1188.
Garcia Roig	2020	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Pediatrics Physician	García Roig C, Viard MV, García Elorrio E, Suárez Anzorena I, Jorro Barón F; Colaboradoras. Implementation of a structured patient handoff between health care providers at a private facility in the Autonomous City of Buenos Aires. Arch Argent Pediatr. 2020;118(3):e234-e240. doi:10.5546/aap.2020.eng.e234
Gopwani	2015	SOUND	Synthesis, Objective Data, Upcoming Tasks, Nursing Input, Double Check	No	Pediatric Emergency medicine Physicians, Nurses, Fellows, and Trainees	Gopwani PR, Brown KM, Quinn MJ, et al. Sound: a structured handoff tool improves patient handoffs in a pediatric emergency department. Pediatr Emerg Care. 2015;31:83–87.
Groah	2007	SBAR	Situation, Background, Assessment, Recommendation	Yes	Anesthesiology, OR nurse and Physicians	Groah L. Tips for introducing SBAR in the OR. OR Manager. 2006;22(4):12.
Guise	2006	SBAR	Situation, Background, Assessment, Recommendation	No	Nurse and Physicians	Guise JM, Lowe NK. Do you speak SBAR? J Obstet Gynecol Neonatal Nurs 2006;35(3):313-314
Haig	2006	SBAR	Situation, Background, Assessment, Recommendation	No	ICU/PICU Staffs, multiple discipline unit staffs	Haig KM, Sutton S, Whittington J. SBAR: A shared mental model for improving communication between clinicians. Jt Comm J Qual Patient Saf 2006;32(3):167-175.
Hamilton	2006	SBAR	Situation, Background, Assessment, Recommendation	No	Nursing Student, Labor and Delivery Nurse	Hamilton P, Gemeinhardt G, Mancuso P, Sahlin CL, Ivy L. SBAR and nurse-physician communication: Pilot testing an educational intervention. Nurs Adm Q 2006;30(3):295-299.
Hansten	2003	4 P's	Purpose: Why is the patient here? What priorities does she have? Picture: What results are we looking for, both short-term and long-term? How can	No	Nurse	Hansten R. Streamline change-of-shift report. Nurs Manage. 2003;34:58-59.

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			we picture the patient's current condition? Plan: What did or didn't work? Part: What part can you play during the next shift?			
Higgins Joyce	2016	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Medical Student	Higgins Joyce A. Team-Based simulation for medical student handoff education. MedEdPORTAL. 2016;12:10486. doi:10.15766/mep_2374-8265.10486
Hill	2017	PASSON	Patient Information, Active Hospital Course, Status (code status, sick or not sick), Supporting Data, Overnight to do (including contingency plan), Nursing (pin plan, diet status, procedures), Summary by Received	No	Internal Medicine Resident	Hill E, Cartabuke RH, Mehta N, et al. Resident-led handoffs training for interns: online versus live instruction with subsequent skills assessment. Am J Med. 2017;130(10):1225-1230.e6. doi:10.1016/j.amjmed.2017.06.003
Hindmarsh	2012	SBAR	Situation, Background, Assessment, Recommendation	No	Acute Medical Unit Staff	Hindmarsh D, Lees L. Improving the safety of patient transfer from AMU using a written checklist. Acute Med 2012;11:13–17.
Hohenhaus	2006	SBAR	Situation, Background, Assessment, Recommendation	No	Nurse	Hohenhaus S, Powell S, Hohenhaus JT. Enhancing patient safety during the hands-off: Standardized communication and teamwork using the 'SBAR' method. Am J Nurs 2006;106(8):72A-72C.
Horwitz	2007	SIGNOUT	Sick or DNR? (highlight sick or unstable patients, identify DNR/DNI patients), Identifying data (name, age, gender, diagnosis), General hospital course, New events of the day, Overall health status/clinical condition, Upcoming possibilities with plan, rationale, Tasks to complete overnight with plan, rationale	No	Internal medicine residents, medical students	Horwitz LI, Moin T, Green ML. Development and implementation of an oral sign-out skills curriculum. J Gen Intern Med 2007;22(10):1470-1474.

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Horwitz	2012	SIGNOUT	Sick or DNR? (highlight sick or unstable patients, identify DNR/DNI patients), Identifying data (name, age, gender, diagnosis), General hospital course, New events of the day, Overall health status/clinical condition, Upcoming possibilities with plan, rationale, Tasks to complete overnight with plan, rationale	No	Physicians from all Specialties	Horwitz LI, Schuster KM, Thung SF, Hersh DC, Fisher RL, Shah N, et al. An institution-wide handoff task force to standardize and improve physician handoffs. BMJ Qual Saf. 2012;21(10):863–871.
Huth	2016	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Resident	Huth K, Hart F, Moreau K, et al. Real-world implementation of a standardized handover program (I-PASS) on a pediatric clinical teaching unit. Acad
Iedema	2012	IMIST-AMBO	Identification of the Patient, Mechanism/Medical Complaint, Injuries/Information Relative to Complaint, Signs, Vitals, Treatment, Allergies, Medications, Background History, Other	No	ED Clinicians and Paramedics	Iedema R, Ball C, Daly B, et al. Design and trial of a new ambulance to-emergency department handover protocol: 'IMIST-AMBO'. BMJ Qual Saf 2012;21:627–33.
Jarboe	2015	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses	Jarboe DE. The effect of evaluating a quality improvement initiative on reducing hospital transfers of nursing home residents. Minneapolis: Walden University, 2015.
Johnson	2012	ICCCO	Identification of the Patient, Clinical History/Presentation, Clinical Status, Care Plan, Outcomes/Goals of Care	No	Nurses	Johnson, M., Jefferies, D., Nicholls, D. (2012). Exploring the structure and organization of information within nursing clinical handovers. International Journal of Nursing Practice, 18(5) 462–470. h
Johnson	2015	I-PASS SIGNOUT	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Resident and Student, Medical Resident	Johnson DP, Zimmerman K, Staples B, McGann KA, Frush K, Turner DA. Multicenter development, implementation, and patient safety impacts of a simulation-based module to teach handovers to pediatric residents. Hosp Pediatr. 2015;5(3):154-159. doi:10.1542/hpeds.2014-0050

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			Sick or Not Sick, Do Not Resuscitate Order, Identification Data, General Hospital Course, New Events of the Day, Overall Health Status, Upcoming possibilities with a plan, rationale, Tasks to complete overnight			
Johnson	2016	ICCCO	Identification of the Patient, Clinical History/Presentation, Clinical Status, Care Plan, Outcomes/Goals of Care	No	Nurses	Johnson, M., Sanchez, P., & Zheng, C. (2016). Reducing patient clinical management errors using structured content and electronic nursing handover. J Nurs Care Qual. 31(3), 245–253.
Kesten	2011	SBAR	Situation, Background, Assessment, Recommendation	No	Nursing Student	Kesten KS. Role-play using SBAR technique to improve observed communication skills in senior nursing students. J Nurs Educ. 2011;50(2):79-87. doi:10.3928/01484834-20101230-02.
Kilpack	1987	SOAP	Subjective information about the patient's concerns, sensations, and/or behavior related to the problem, Objective information related to the problem (eg, level of consciousness, activity tolerance, effect of medication received, postprocedure signs, laboratory values), Assessment of the patient's condition as substantiated with the data from S (subjective) and O (objective) and an indication of the direction of change in the patient's condition, Plan of what has or should be done for/with the patient	No	Ambulance/emergency department, neuroscience nurses	Kilpack V, Dobson-Brassard S. Intershift report: oral communication using the nursing process. J Neurosci Nurs. 1987;19:266-270.
Kitney	2018	ISBAR	Introduction/Identification, Situation, Background, Assessment, Request/Recommendation	Yes	Anesthesiology Physicians, PACU Nurse	Kitney, P. Perioperative handover using ISBAR at two sites: A quality improvement project. J Perioper Nurs. 2018;31(4):17-25. doi:10.26550/2209-1092.1031

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Knapp	2006	SBAR	Situation, Background, Assessment, Recommendation	No	Patient care staffs, Physicians in all discipline	Knapp C. Bronson Methodist Hospital: Journey to excellence in quality and safety. Jt Comm J Qual Saf 2006;32(10):556-563.
Krowl	2018	DOCFISH	Daily Events, Overnight Events, Code Status, Follow-up Tasks, If/then Statements, Sick/Stable, History of presenting illness	No	Internal Medicine Resident	Krowl L, Gudlavalleti A, Patel A, Panebianco L, Kosters M, Dhamoon AS. A pilot study to standardize and peer-review shift handoffs in an academic internal medicine residency program: The DOCFISH method. Medicine. 2018;97(41):e12798.
Kwok	2019	ED-VITALS	Entity, Diagnosis, Vitals, Investigations, Treatments, Actions, Logistics, Services	No	Emergency Medicine Resident & Physician	Kwok ESH, Clapham G, White S, Austin M, Calder LA. Development and implementation of a standardised emergency department intershift handover tool to improve physician communication. BMJ Open Qual. 2020;9(1):e000780. doi:10.1136/bmjoq-2019-000780
Lautz	2018	ABC-SBAR	Assessment of Airway, Breathing, Circulation—Situation, Background, Assessment, Recommendation	No	Pediatrics Resident	Lautz AJ, Martin KC, Nishisaki A, et al. Focused training for the handover of critical patient information during simulated pediatric emergencies. Hosp Pediatr. 2018;8(4):227-231. doi:10.1542/hpeds.2017-0173
Lee	2016	SIGNOUT	Sick or not sick, identifying data, general hospital course, new events of the day, overall health status/clinical condition, upcoming possibilities with plan rationale, tasks to complete with plan and rationale	No	Nursing Student	Lee J, Mast M, Humbert J, Bagnardi M, Richards S. Teaching handoff communication to nursing students: a teaching intervention and lessons learned. Nurse Educ. 2016;41(4):189-193. doi:10.1097/NNE.0000000000000249
Lee	2017	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Internal Medicine Resident	Lee SH, Terndrup C, Phan PH, et al. A randomized cohort controlled trial to compare intern sign-out training interventions. J Hosp Med. 2017;12(12):979-983. doi:10.12788/jhm.2843
Leonard	2004	SBAR	Situation, Background, Assessment, Recommendation	No	Nurse	Leonard M, Graham S, Bonacum D. The human factor: The critical importance of effective teamwork and communication in providing safe care. Qual Saf Health Care 2004;13(Supp 1):i85-i90.
Lescinskas	2018	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Internal Medicine Resident	Lescinskas E, Stewart D, Shah C. Improving handoffs: implementing a training program for incoming internal medicine residents. J Grad Med Educ. 2018;10(6):698-701. doi:10.4300/JGME-D-18-00244.1

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Lo	2016	SBAR	Situation, Background, Assessment, Recommendation	No	Pediatrics Physician	Lo HY, Mullan PC, Lye C, Gordon M, Patel B, Vachani J. A QI initiative: implementing a patient handoff checklist for pediatric hospitalist attendings. BMJ Qual Improv Rep. 2016;5:1-5. doi:10.1136/bmjquality.u212920.w5661.
Loftin	2019	SBAR	Situation, Background, Assessment, Recommendation	No	Emergency Department Nurse, Medical/Surgical Nurse	Loftin E, Andrews D, Mikitarian G, LaManna J. Zero harm during transition in care from the emergency department to medical/surgical units. J Nurs Care Qual. 2020;35(2):153-157. doi:10.1097/NCQ.0000000000000427.
Manning	2006	SBAR	Situation, Background, Assessment, Recommendation	No	Nurse	Manning ML. Improving clinical communication through structured conversation. Nurs Econ 2006;24(5):268-271.
Mannix	2017	ISBAR	Identify, Situation, Background, Assessment, Recommendation	No	Pediatrics Nurse	Mannix T, Parry Y, Roderick A. Improving clinical handover in a paediatric ward: implications for nursing management. J Nurs Manag. 2017;25(3):215-222. doi:10.1111/jonm.12462
Matern	2018	SBAR	Situation, Background, Assessment, Recommendation	No	Post Graduate Year 1 Resident	Matern LH, Farnan JM, Hirsch KW, Cappaert M, Byrne ES, Arora VM. A standardized handoff simulation promotes recovery from auditory distractions in resident physicians. Simul Healthc. 2018;13(4):233-238. doi:10.1097/SIH.0000000000000322.
Mathias	2006	SHARED	Situation, History, Assessment, Request, Evaluate, Document	No	Emergency department, surgery, PACU, and other nurses; pharmacists, physical therapists, physicians, respiratory therapists, and other staff	Mathias JM. A SHARED tool strengthens handoffs. OR Manager 2006;22(4):15-16.
McAllen	2018	ISBARQ	Introduction, Situation, Background, Assessment, Recommendation, Questions	No	Medical/Surgical Nurse	McAllen ER, Stephens K, Swanson-Biearman B, Kerr K, Whiteman K. Moving shift report to the bedside: an evidence-based quality improvement project OJIN. 2018;23(2). doi:10.3912/OJIN.Vol23No02PPT22
McCrory	2012	ABC-SBAR	Airway, Breathing, Circulation—Situation, Background, Assessment, Recommendation	No	Pediatrics Resident	McCrory MC, Aboumatar H, Custer JW, et al. ‘‘ABCSBAR’’ training improves simulated critical patient hand-off by pediatric interns. Pediatr Emerg Care. 2012;28(6):538–543.
McQuillan	2014	SBAR	Situation, Background, Assessment, Recommendation	No	Junior Physicians and Nurses	McQuillan A, Carthey J, Catchpole K, McCulloch P, Ridout DA, Goldman AP. Creating a safe, reliable hospital at night handover: a case study in implementation science. BMJ Qual Saf. 2014;23:465-473
Mikos	2007	SBAR	Situation, Background, Assessment, Recommendation	No	Nurse	Monitoring handoffs for standardization. Nurs Manage 2007;38(12):16-20.
Murphy	2017	SIGNOUT	Sick or do not resuscitate, Identifying data, General hospital course, New events of	No	Pediatrics Resident, Post Graduate Year 1 Resident	Murphy HJ, Karpinski AC, Messer A, Gallois J, Mims M, Farge A, Hernandez L, Steinhardt M, Sandlin C. Resident workshop standardizes patient handoff and improves quality, confidence, and knowledge.

First Author Last Name	Year Published	Mnemonic	Write out Mnemonic	Anesthesia yes/no	Participants	Full Reference of Source
			the day, Overall health status/clinical condition, Upcoming possibilities with plan, rationale, Tasks to complete overnight with plan, rationale			South Med J. 2017;110(9):571-577. doi:10.14423/SMJ.0000000000000698.
Nelson	2010	SBAR	Situation, Background, Assessment, Recommendation	No	GI Surgical Oncology Nurses	Nelson BA, Massey R. Implementing an electronic change-of-shift report using transforming care at the bedside processes and methods. J Nurs Adm. 2010;40(4):162-168.
O'Toole	2014	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatric Residents	O'Toole JK, West DC, Starmer AJ, Yu CF, Calaman S, Rosenbluth G, Hepps JH, Lopreiato JO, Landrigan CP, Sectish TC, Spector ND and the I-PASS Education Executive Committee. Placing faculty development "front and center" in a multi-site educational initiative: experiences and lessons learned from the I-PASS Handoff Study Group. Academic Pediatrics 2014;14:221–224.
O'Toole	2014	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for Medical Students but not implemented	O'Toole J, Calaman S, Everhart J, Bismilla Z, Good B, Guiot A, Johnstone N, Nilforoshan V, Noble E, Rosenbluth G, Schwartz S, Solan L, Tse L, West D, Weiser J, Landrigan C, Sectish T, Srivastava R, Starmer A, Spector N. I-PASS handoff curriculum: medical student workshop. MedEdPORTAL; 2014. Available from: www.mededportal.org/publication/9854
O'Toole	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Medical Students on Pediatric Clerkships and Pediatric Residents, Not Implemented	O'Toole JK (co-first), Stevenson AT (co-first), Good BP, Guiot AB, Solan LG, Tse LL, Landrigan CP, Sectish TC, Srivastava R, Starmer AJ (co-last), Spector ND (co-last), and the I-PASS Study Group. Closing the Gap: A Needs Assessment of Medical Students and Handoff Training. J Peds AMSPDC Pages 2013;162(5):887-888. PMID: 23617969.
O'Toole	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for faculty to teach handoffs to residents, but not implemented	O'Toole JK, Sectish TC, Starmer AJ, Rosenbluth G, West DC, Landrigan CP, Allen AD, Noble EL, Srivastava R, Tse LL, Hepps J, Lopreiato JO, Calaman S, Yu CE, Spector ND, and the I-PASS Educational Executive Committee. I-PASS handoff curriculum: faculty development resources. MedEdPORTAL; 2013. Available from: https://www.mededportal.org/publication/9540
Panesar	2016	SBAR	Situation, Background, Assessment, Recommendation	No	PICU Nurses and Physicians	Panesar RS, Albert B, Messina C, Parker M. The effect of an electronic SBAR communication tool on documentation of acute events in the pediatric intensive care unit. Am J Med Qual. 2016;31(1):64–8.
Parent	2018	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S	Yes	Anesthesiologists, Nurses, Advanced Practice Providers,	Parent B, LaGrone LN, Albirair MT, et al. Effect of standardized handoff curriculum on improved clinician preparedness in the intensive

First Author Last Name	Year Published	Mnemonic	Write out Mnemonic	Anesthesia yes/no	Participants	Full Reference of Source
			= Situation awareness and contingency planning; S = Synthesis by receiver		Intensivist, Surgeons, Allied Healthcare Providers	care unit: a stepped-wedge cluster randomized clinical trial. JAMA Surg. 2018;153(5):464-470.
Parent	2018	UW-IPASS	(UW = adapted at University of Washington); I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Resident, Advanced Practice Provider (Nurse Practitioners, Physician Assistants), Fellow, Physician	Parent B, LaGrone LN, Albirair MT, Serina PT, Keller JM, Cuschieri J, Addison EJ, Choe L, Delossantos GB, Gaskill CE, Moon SD, MacDonald JT, Stolzberg MJ, Van Eaton EG, Zech JM, Kritek PA. Effect of standardized handoff curriculum on improved clinician preparedness in the intensive care unit: a stepped-wedge cluster randomized clinical trial. JAMA Surg. 2018;153(5):464-470. doi:10.1001/jamasurg.2017.5440.
Pearce	2014	CHAT	Communicate/Clear, History, Assessment/Actions, Treatment Plan/Thank You	No	Emergency Department Nurses	Pearce IS, McCarry N. Let's chat: bedside reporting in the ED. Nursing. 2014;44(8):15-17.
Pesanka	2009	SBAR	Situation, Background, Assessment, Recommendation	No	Transport Staff and Emergency Department Nurses	Pesanka DA, Greenhouse PK, Rack LL, et al. Ticket to ride: reducing handoff risk during hospital patient transport. J Nurs Care Qual 2009;24:109–15.
Pineda	2015	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses	Pineda RO. Improving patient outcomes and nurse satisfaction through nurse-to-nurse communication. Chester: Widener University, 2015.
Pope	2008	SBAR	Situation, Background, Assessment, Recommendation	No	Physicians, Nurse	Pope BB, Rodzen L, Spross G. Raising the SBAR: How better communication improves patient outcomes. Nursing 2008;38(3)41-43.
Porteous	2009	iSoBAR	Identify, Situation, Observations, Background, Agreed plan, Read back	No	Clinical Staff, Nurse, Physicians	Porteous JM, Stewart-Wynne EG, Connolly M, Crommelin PF. iSoBAR—a concept and handover checklist: The national clinical handover initiative. Med J Aust 2009;190(11 Suppl):S152-S156.
Powell	2007	SBAR	Situation, Background, Assessment, Recommendation	No	Emergency Department Nurse and Physicians	Powell SK. SBAR–it's not just another communication tool. Prof Case Manag 2007;12(4):195-196
Radtke	2013	ISBAR	Introduction, Situation, Background, Assessment, Recommendation	No	Medical Surgical Nurses	Radtke K. Improving patient satisfaction with nursing communication using bedside shift report. Clin Nurse Spec. 2013;27(1):19-25.
Randmaa	2014	SBAR	Situation, Background, Assessment, Recommendation	Yes	Anesthesiologists and Nurses in the Perioperative Setting	Randmaa M, Mårtensson G, Leo Swenne C, et al.. SBAR improves communication and safety climate and decreases incident reports due to communication errors in an anaesthetic clinic: a prospective intervention study. *BMJ Open* 2014;4:e004268
Reinbeck	2013	SBAR	Situation, Background, Assessment, Recommendation	No	Direct Care Nurses	Reinbeck DM, Fitzsimons V. Improving the patient experience through bedside shift report. Nurs Manage. 2013;44(2):16-17
Renz	2013	SBAR	Situation, Background, Assessment, Recommendation	No	Nursing Home RN and LPN	Renz SM, Boltz MP, Wagner LM, Capezuti EA, Lawrence TE. Examining the feasibility and utility of an SBAR protocol in long-term care. Geriatr Nurs. 2013;34(4):295 –301.

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Riley	2017	I-5	I know what is wrong, I know what to do, I know what to worry about, I know when to escalate, I see what you see	Yes	Pediatric Cardiac ICU Staff (Nurses, Respiratory Therapists, Anesthesiologists, Surgeons, Intensivists, Trainees)	Riley C, Merritt A, Mize J, Schuette J, Berger J. Assuring Sustainable Gains in Interdisciplinary Performance Improvement. Pediatr. Crit. Care Med. 2017;18(9):863-868. doi:10.1097/pcc.0000000000001231
Rosenbluth	2015	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Residents, Hospitalists, and Medical Students	Rosenbluth G, Bale JF, Starmer AJ, Spector ND, Srivastava R, West DC, Sectish TC, Landrigan CP, and the I-PASS Study Education Executive Committee. Variation in printed handoff documents: results and recommendations from a multicenter needs assessment. Journal of Hospital Medicine 2015; PMID 26014471.
Rosenbluth	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for Residents but not implemented	Rosenbluth G, Patel SJ, Destino LA, Everhart JL, O'Toole JK, Stevenson AT, Yu CE, Calaman S, Allen AD, Starmer AJ, Srivastava R, Spector ND, Landrigan CP and Sectish TC. I-PASS Handoff curriculum: campaign toolkit. MedEdPORTAL 2013. Available from: www.mededportal.org/publication/9397
Rudiger-Sturchler	2010	dINAMO	Doctor, remember! Identity, Needs of the Patient, Analysis, Medical Management, Organization	No	Emergency Medicine Physicians	Rudiger-Sturchler M, Keller DI, Bingisser R. Emergency physician intershift handover - can a dINAMO checklist speed it up and improve quality? Swiss Med Wkly. 2010;140:w13085. doi: 10.4414/smw.2010.13085.
Rush	2012	SBART	Situation, Background, Assessment, Recommendation, Thanks	No	Nurses	Rush SK. Bedside reporting: dynamic dialogue. Nurs Manage. 2012;43(1):40-41.
Sandlin	2007	5P's v.2	Patient: identify, Precautions: allergies, isolation, falls, specialty bed, Plan of care: fluids, intake, output, IV access, Problems: assessment, review of systems, pain scale, Purpose: goals to be achieved	No	Perioperative nurses	Sandlin D. Improving patient safety by implementing a standardized and consistent approach to hand-off communication. J Perianesth Nurs 2007;22(4):289-292.
Sawatsky	2013	SIGNOUT	Sick/not sick or code status, identifying data, general hospital course, new events of the day, overall health status, upcoming possibilities with plan and rationale, tasks to complete with plan and (?) time for questions	Yes	Post Graduate Year 2 – 4 Anesthesiology Resident	Sawatsky AP, Mikhael JR, Punatar AD, Nassar AA, Agrwal N. The effects of deliberate practice and feedback to teach standardized handoff communication on the knowledge, attitudes, and practices of first-year residents. Teach Learn Med. 2013;25(4):279-84. doi:10.1080/10401334.2013.827970.

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Schroeder	2006	PACE	Patient/Problem, Assessment/Actions, Continuing/Change, Evaluation	No	Nurse	Schroeder SJ. Picking up the PACE: a new template for shift report. Nursing. 2006;36:22-23.
Sectish	2010	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Residents, not implemented	Sectish TC, Starmer AJ, Landrigan CP, Spector ND, and the I-PASS Study Group. Establishing a multisite education and research project requires leadership, expertise, collaboration, and an important aim. Pediatrics 2010;126(4):619-622. PMID: 20876168.
Shahian	2017	I-PASS	Illness Severity, Patient Summary, Action List, Situational Awareness and Contingency Plan, Synthesis by Receiver	No	Physicians and Nurses	Shahian D, McEachern K, Rossi L, Chisari R, Mort E. Large-scale implementation of the I-PASS handover system at an academic medical centre. BMJ Qual Saf. 2017;26(9):760-770. doi:10.1136/bmjqs-2016-006195
Shaughnessy	2015	SAFETIPS	Stats, Assessment, Focused Plan, Exam, To Do, If/then, Pointers/pitfalls, Sick o-meter, Repeat Back	No	Pediatrics and Medical Resident	Shaughnessy EE, Ginsbach K, Groeschl N, Bragg D, Weisgerber M. Brief educational intervention improves content of intern handovers. J Grad Med Educ. 2013;5(1):150-153. doi:10.4300/JGME-D-12-00139.1.
Sheen	2017	SWIFT	Subject, Why? Issues, Fetus, Tasks	No	Post Graduate Year 1 – 4 Obstetrics and Gynecology Resident	Sheen JJ, Reimers L, Govindappagari S, Ngai IM, Garretto D, Donepudi R, Tropper P, Goffman D, Dayal AK, Bernstein PS. A SWIFT method for handing off obstetrical patients on the labor floor. J Patient Saf. 2017 Jul 6. doi:10.1097/PTS.0000000000000377.
Sheth	2016	IPASS the BATON	Introduction, Patient Name, Assessment, Situation, Background, Actions, Timing, Ownership, Next	No	CVICU Residents, Fellows, Advance Practitioners, Hospitalists	Sheth S, McCarthy E, Kipps AK, et al. Changes in efficiency and safety culture after integration of an I-PASS– supported handoff process. Pediatrics. 2016;137(2):1-9.
Sibbald	2007	SBAR	Situation, Background, Assessment, Recommendation	No	Wound Care Physicians and Nurse	Sibbald RG, Ayello EA. From the experts. SBAR for wound care communication: 20-second enablers for practice. Adv Skin Wound Care 2007;20(3):135-136.
Simon	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatric Hospitalists	Simon TD, Starmer AJ, Conway P, Landrigan CP, Shah SS, Shen MW, Sectish TC, Spector ND, Tieder JS, Srivastava R, Willis LE, Wilson K on behalf of Pediatric Research in Inpatient Settings Network (PRIS). Quality improvement in pediatric health care. Academic Pediatrics. 2013;13(6S):S54-S60.
Smith	2015	SAIF-IR	Summary, Active Issues, If-then contingency planning, Follow-up tasks, Interactive questions, Readback	No	Medical Student Year 4	Smith C, Peterson G, Dallaghan G. Handoff training for medical students: attitudes, knowledge, and sustainability of skills. Educ Med J. 2015;7(2):15-6. doi:10.5959/eimj.v7i2.360

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Spector	2012		I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for Residents but not implemented	Spector ND (co-first), Starmer AJ (co-first), Yu CE, O'Toole JK, Allen AD, Tse LL, Bale JF, Bismilla Z, Calaman S, Coffey M, Cole FS, Destino LA, Everhart JL, Hepps JH, Kahana M, Lopreiato JO, McGregor RS, Patel SJ, Rosenbluth G, Srivastava R, Stevenson AT, West DC, Landrigan CP (co-last), Sectish TC (co-last). I-PASS handoff curriculum: core resident workshop. MedEdPORTAL 2012. Available from: www.mededportal.org/publication/9311
Starmer	2017	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Pediatrics Nurse	Starmer AJ, Schnock KO, Lyons A, et al. Effects of the I-PASS nursing handoff bundle on communication quality and workflow. BMJ Qual Saf. 2017;26(12):949-957. doi:10.1136/bmjqs-2016-006224.
Starmer	2015	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Residents	Starmer AJ, Destino LA, MD2, Yoon CS, Landrigan CP. Intern and resident workflow patterns on pediatric inpatient units: a multi-center time motion study. JAMA Pediatrics 2015;169(12).
Starmer	2014	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Pediatrics Resident	Starmer AJ, Spector ND, Srivastava R, et al.; I-PASS Study Group. Changes in medical errors after implementation of a handoff program. N Engl J Med. 2014;371(19):1803-12. doi:10.1056/NEJMsa1405556.
Starmer	2014	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Residents but not implemented	Starmer AJ, O'Toole JK, Rosenbluth G, Calaman S, Balmer D, West DC, Bale JF, Yu CE, Noble EL, Tse LL, Srivastava R, Landrigan CP, Sectish TC, Spector NS, and members of the I-PASS Study Group. Development, implementation, and dissemination of the I-PASS handoff curriculum: a multisite educational intervention to improve patient handoffs. Academic Medicine 2014;89(6):876-884.
Starmer	2013	SIGNOUT	Sick or do not resuscitate, Identifying data, General hospital course, New events of the day, Overall health status/clinical condition, Upcoming possibilities with plan, rationale, Tasks to complete overnight with plan, rationale	No	Post Graduate Year 1 – 3 Pediatrics Resident	Starmer AJ, Sectish TC, Simon DW, Keohane C, McSweeney ME, Chung EY, Yoon CS, Lipsitz SR, Wassner AJ, Harper MB, Landrigan CP. Rates of medical errors and preventable adverse events among hospitalized children following implementation of a resident handoff bundle. JAMA. 2013;310(21):2262-70. doi:10.1001/jama.2013.281961.

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Starmer	2013	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Created for Residents but not implemented	Starmer AJ, Landrigan CP, Srivastava R, Wilson K, Allen AD, Mahant S, Blank J, Sectish TC, Spector ND, West DC. I-PASS handoff curriculum: faculty observation tools. MedEdPORTAL; 2013. Available from: www.mededportal.org/publication/9570
Starmer	2012	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Pediatrics Residents, not implemented	Starmer AJ, Spector ND, Srivastava R, Landrigan CP, Sectish TC. I-PASS, a mnemonic to stardardize verbal handoffs. Pediatrics 2012;192(2):201-204. PMID:22232313
Stojan	2016	SIGNOUT	Sick or do not resuscitate, Identifying data, General hospital course, New events of the day, Overall health status/clinical condition, Upcoming possibilities with plan, rationale, Tasks to complete overnight with plan, rationale	No	Medical Student Year 4	Stojan J, Mullan P, Fitzgerald J, Lypson M, Christner J, Haftel H, Schiller J. Handover education improves skill and confidence. Clin Teach. 2016;13(6):422-426. doi:10.1111/tct.12461
Street	2011	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses	Street M, Eustace P, Livingston PM, Craike MJ, Kent B, Patterson D. Communication at the bedside to enhance patient care: a survey of nurses' experience and perspective of handover. Int J Nurs Pract. 2011;17(2):133-140
Sutcliffe	2004	STICC	Situation, Task, Intent, Concern, Calibrate	No	Nurses, Physicians, Residents	Sutcliffe KM, Lewton E, Rosenthal MM. Communication failures: an insidious contributor to medical mishaps. Acad Med. 2004;79:186-194.
Sutker	2008	SBAR	Situation, Background, Assessment, Recommendation	No	Physicians and Nurse	Sutker WL. The physician's role in patient safety: What's in it for me? Baylor Univ Med Cent Proc 2008;21(1):9-14.
Talbot	2007	MIST	Mechanism of injury, Injuries sustained or suspected, Signs—vital signs, Treatment initiated (and timing)	No	Emergency Department Staff	Talbot R, Bleetman A. Retention of information by emergency department staff at ambulance handover: do standardized approaches work? Emerg Med J. 2007;24:539-542.
Tam	2018	SIGNOUT?	Sick or do not resuscitate, Identifying data, General hospital course, New events of the day, overall health status, Upcoming possibilities with plan, Tasks to complete, Questions	No	Internal Medicine Resident	Tam P, Nijjar AP, Fok M, Little C, Shingina A, Bittman J, Raghavan R, Khan NA. Structured patient handoff on an internal medicine ward: A cluster randomized control trial. PLoS One. 2018;13(4):e0195216. doi:10.1371/journal.pone.0195216.

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Telem	2011	SBAR	Situation, Background, Assessment, Recommendation	No	General Surgery Residents	Telem DA, Buch KE, Ellis S, Coakley B, Divino CM. Integration of a formalized handoff system into the surgical curriculum: resident perspectives and early results. Arch Surg. 2011;146:89-93.
Thomas	2012	I PASS the BATON	Introduction, Patient, Assessment, Situation, Safety Concerns, Background, Actions, Timing, Ownership, Next	No	Nurses	Thomas L, Donohue-Porter P. Blending evidence and innovation: improving intershift handoffs in a multihospital setting. J Nurs Care Qual. 2012;27(2): 116-124.
Thompson	2011	ISBAR	Identity of Patient, Situation, Background, Assessment, Recommendation	No	Interns, Residents, and Medical Registrars	Thompson JE, Collett LW, Langbart MJ, et al. Using the ISBAR handover tool in junior medical officer handover: a study in an Australian tertiary hospital. Postgrad Med J 2011;87:340–4.
Ting	2017	SBAR	Situation, Background, Assessment, Recommendation	No	Labor and Delivery Nurses	Ting, W. H., Peng, F. S., Lin, H. H., & Hsiao, S. M. (2017). The impact of situation-background-assessment-recommendation (SBAR) on safety attitudes in the obstetrics department. Taiwanese Journal of Obstetrics and Gynecology, 56(2), 171–174.
Townsend-Gervis	2014	SBAR	Situation, Background, Assessment, Recommendation	No	Medical Surgical Nurses	Townsend-Gervis M, Cornell P, Vardaman JM. Interdisciplinary rounds and structured communication reduce re-admissions and improve some patient outcomes. West J Nurs Res. 2014;36(7):917–28
Tufts	2020	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Post Graduate Year 1 Pediatrics Resident	Tufts LM, Damron CL, Flesher SL. Addition of CORES to the I-PASS handoff: a resident-led quality improvement study. Pediatr Qual Saf. 2020;5(1):e251. doi:10.1097/pq9.0000000000000251
Uhm	2017	SBAR	Situation, Background, Assessment, Recommendation	No	Pediatrics Nurse	Uhm JY, Lim EY, Hyeong J. The impact of a standardized inter-department handover on nurses' perceptions and performance in Republic of Korea. J Nurs Manag. 2018;26(8):933-944. doi:10.1111/jonm.12608.
Usher	2018	SBAR (T)	Situation, Background, Assessment, Recommendation, Thank	No	Nurse	Usher R, Cronin SN, York NL. Evaluating the influence of a standardized bedside handoff process in a medical-surgical unit. J Contin Educ Nurs. 2018;49(4):157-163. doi:10.3928/00220124-20180320-05.
Vardaman	2012	SBAR	Situation, Background, Assessment, Recommendation	No	Nurses, Nurse Managers, and Physicians	Vardaman JM, Cornell P, Gondo MB, Amis JM, Townsend-Gervis M, Thetford C. Beyond communication: the role of standardized protocols in a changing health care environment. Health Care Manag Rev. 2012;37(1):88 –97.
Vidyarthi	2006	ANTICipate	Administrative data, New information (clinical update), Tasks (what needs to be done),	No	Physicians and Nurse	Vidyarthi AR, Arora V, Schnipper JL, Wall SD, Wachter RM. Managing discontinuity in academic medical centers: strategies for a safe and effective resident sign-out. J Hosp Med. 2006;1:257-266.

First Author Last Name	Year Published	Mnemonic	Write out Mnemonic	Anesthesia yes/no	Participants	Full Reference of Source
			Illness, Contingency planning/code status			
Walia	2016	I-PASS	Illness Severity, Patient Summary, Action List, Situation Awareness with Contingency Planning, Synthesis by Receiver	No	Post Graduate Year 1 – 3 Pediatrics Resident	Walia J, Qayumi Z, Khawar N, Dygulska B, Bialik I, Salafia C, Narula P. Physician transition of care: benefits of I-PASS and an electronic handoff system in a community pediatric residency program. Acad Pediatr. 2016;16(6):519-23. doi:10.1016/j.acap.2016.04.001.
Walton	2015	SBAR	Situation, Background, Assessment, Recommendation	No	Physicians and Nurses	Walton H, Munro W. Improving the quality of handover by addressing handover culture and introducing a new, multi-disciplinary, team-based handover meeting. BMJ Qual Improv Rep. 2015;4.
Weinger	2015	SBAR	Situation, Background, Assessment, Recommendation	Yes	PACU Nurses and AP-RNs	Weinger M, Slagle J, Kuntz A et al. A Multimodal Intervention Improves Postanesthesia Care Unit Handovers. Anesth. Analg. 2015;121(4):957-971. doi:10.1213/ane.0000000000000670
Wentworth	2012	SBAR	Situation, Background, Assessment, Recommendation	No	PCU Nurses	Wentworth L, Diggins J, Bartel D, et al. SBAR: electronic handoff tool for noncomplicated procedural patients. J Nurs Care Qual 2012;27:125–31.
White-Trevino	2018	SBAR SBAR-T	Situation, Background, Assessment, Recommendation Set Aside Assumptions, Be Attentive, Ask Questions, Respond, Thank the Reporting Nurse and Patient	No	Emergency Medicine Nurse	White-Trevino K, Dearmon V. Transitioning nurse handoff to the bedside: engaging staff and patients. Nurs Adm Q. 2018;42(3):261-268. doi:10.1097/NAQ.0000000000000298.
Wilson	2011	P-VITAL	Present, Vital Signs, Input and Output, Treatment and Diagnosis, Admission or Discharge, Legal Issues	No	Emergency Medicine Clinical Staff	Wilson R. Improving clinical handover in emergency departments. Emerg Nurse. 2011;19:22-26.
Wollenhaup	2017	SBAR	Situation, Background, Assessment, Recommendation	No	Obstetrics and Gynecology Nurse	Wollenhaup CA, Stevenson EL, Thompson J, Gordon HA, Nunn G. Implementation of a modified bedside handoff for a postpartum unit. J Nurs Adm. 2017;47(6):320-326. doi:10.1097/NNA.0000000000000487.
Wong	2017	SBAR	Situation, Background, Assessment, Recommendation	No	Internal Medicine Nurses and Physicians	Wong HJ, Bierbrier R, Ma P, Quan S, Lai S, Wu RC. An analysis of messages sent between nurses and physicians in deteriorating internal medicine patients to help identify issues in failures to rescue. Int J Med Inform. 2017; 100:9 –15
Wright	2013	PATIENT	Patient and Positioning, Airway, Antibiotics, Allergies, and Type of Anesthetic, Temperature, Intravenous and	Yes	CRNAs	Wright SM. Examining transfer of care processes in nurse anesthesia practice: introducing the PATIENT protocol. AANA J. 2013;81:225–232.

First Author Last Name	Year Published	Mnemonic	Write out Mnemonic	Anesthesia yes/no	Participants	Full Reference of Source
			Intake/Output, End-Tidal CO2, Narcotics, Twitches			
Yee	2009	HAND ME AN ISOBAR	Hey, it's handover time!, Allocate staff for continuity of patient care, Nominate participants, time and venue, Document on written sheets and patient notes, Make sure all participants have arrived, Elect a leader, Alerts, attention and safety, Notice, Identification of patient, Situation and status, Observations of patient and call to MET, Background and history, Action, agreed plan and accountability, Responsibility and risk management	Yes	General medicine, general surgery and emergency medicine Physicians and Nurse	Yee KC, Wong MC, Turner P. "HAND ME AN ISOBAR": A pilot study of an evidence-based approach to improving shift-to-shift clinical handover. Med J Aust 2009;190(11 Suppl):S121-S124.
Yu	2017	SBAR	Situation, Background, Assessment, Recommendation	No	Nursing Student	Yu M, Kang KJ. Effectiveness of a role-play simulation program involving the SBAR technique: A quasi-experimental study. Nurse Educ Today. 2017;53:41-47. doi:10.1016/j.nedt.2017.04.002.
Zavodnick	2019	I-PASS	I = Illness severity; P = Patient summary; A = Action items; S = Situation awareness and contingency planning; S = Synthesis by receiver	No	Post Graduate Year 1 Resident (multiple specialties)	Zavodnick J, Jaffe R, Altshuler M, Cowan S, Wickersham A, Diemer G. Leveraging structural changes in an electronic health record tool to standardize written handoff. Am J Med Qual. 2019;34(4):354-359. doi:10.1177/1062860618808018.
Zipursky	2016	I-CATCH	Identify Patient, Characterize Situation, Action-what was done Overnight, To do for the Team in the Morning, Confirm the Handoff	No	Internal Medicine Resident	Zipursky JS, Dhhar G, Weinerman A, Stroud L, Wong BM. I-CATCH: A novel bundle to improve postcall morning handoffs. J Grad Med Educ. 2018;10(6):702-706. doi:10.4300/JGME-D-18-00178.1.