Table 1

Handoff Mnemonics Identified in the English-Language Literature, Including Type of Staff Reported Using the Mnemonic, 1987 to June 2008

Mnemonic	Disciplines or Departments	Description	
AIDET[11]	Perioperative staff, including nurses, anesthesiologists, physicians, and surgical technologists	A	Acknowledge the patient
		I	Introduce yourself
		D	Duration of the procedure
		E	Explanation of process and what happens next
		T	Thank you for choosing our hospital (note: handoff done at bedside)
ANTICipate[12]	Physicians, residents	A	Administrative data
		N	New information (clinical update)
		T	Tasks (what needs to be done)
		I	Illness
		C	Contingency planning/code status
ASHICE[13]	Ambulance/emergency department	A	Age
		S	Sex
		H	History
		I	Injuries
		C	Condition
		E	Expected time of arrival
CUBAN[14,15]	Emergency department nurses, nurses, perioperative staff	C	Confidential
		U	Uninterrupted
		B	Brief
		A	Accurate
		N	Named personnel
DeMIST[16]	Ambulance/emergency department	De	Patient demographics
		M	Mechanism of injury
		I	Injuries sustained
		S	Symptoms and signs
		T	Treatments given
GRRRR[17]	Nurses, physicians	G	Greeting
		R	Respectful listening
		R	Review
		R	Recommend or request more information
		R	Reward
HANDOFFS[18]	Physicians, residents	H	Hospital location: wing, room number
		A	Allergies/adverse reactions/medications
		N	Name (age, gender)/number (medical record)
		D	Do not attempt resuscitation (DNAR)?/diet/deep-vein thrombosis (DVT) prophylaxis
		O	Ongoing medical/surgical problems
		F	Facts about this hospitalization
		F	Follow-up on . . .
		S	Scenarios
I PASS the BATON[19,20]	General nurses, perioperative nurses, physicians	I	Introduction: introduce yourself and your role
		P	Patient: name, identifiers, age, sex, location
		A	Assessment: presenting chief complaint, vital signs, symptoms, diagnosis
		S	Situation: current status and circumstances; including codes status, level of certainty, recent changes, and response to treatment
		S	Safety concerns: critical lab values and reports, socioeconomic factors, allergies, alerts (eg, falls, isolation)
		B	Background: comorbidities, previous episodes, current medications, family history
		A	Actions: which were taken or are required, providing brief rationale
		T	Timing: level of urgency, explicit timing, and prioritization of actions
		O	Ownership: who is responsible (eg, nurse, doctor, team), including patient or family responsibilities
		N	Next: what happens next (eg, any anticipated changes in condition or care, the plan, any contingency plans)

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Table 1 (continued)

Mnemonic	Disciplines or Departments		Description
Just Go NUTS[21,22]	Nurses, physicians, transporters, and other clinical staff	N	Name of patient, diagnosis, room number
		U	Unusual or unique; variances identified on the individual care plan including critical lab values, pain management, etc
		T	Tubes such as IV, NG, catheters, drains, ostomies
		S	Safety concerns such as falls, medication reconciliation
MIST[13,16]	Ambulance/emergency department	M	Mechanism of injury
		I	Injuries sustained or suspected
		S	Signs—vital signs
		T	Treatment initiated (and timing)
PACE[23]	Nurses	P	Patient/problem
		A	Assessment/actions
		C	Continuing/changes
		E	Evaluation
PEDIATRIC[24]	Residents	P	Problem list
		E	Expected tasks to be done
		D	Diagnostic one-liner
		I	If/then
		A	Administrative data/advanced directives
		T	Therapeutics
		R	Results and other important facts
		I	IV access/invasive devices
		C	Custody and current issues
SBAR[14,17,19–22,25–51]	Anesthesiologists, mid-level practitioners, nurse assistants, nurses, nursing students, OR staff, PACU staff, perioperative staff, pharmacists, physical therapists, physicians, transporters, radiologists	S	Situation
		B	Background
		A	Assessment
		R	Recommendation
I-SBAR[19,29]	Nurses, physicians, transporters	I	Introduction
		S	Situation
		B	Background
		A	Assessment
		R	Recommendation
SBARR[38]	Nurses, physicians	S	Situation
		B	Background
		A	Assessment
		R	Recommendation
		R	Response or read back
SBAR-T[36]	Nurses	S	Situation
		B	Background
		A	Assessment
		R	Recommendation
		T	Thank patients for opportunity to work with them (note: handoff done at bedside)
SHARED[34,52]	Emergency department, surgery, PACU, and other nurses; pharmacists, physical therapists, physicians, respiratory therapists, and other staff	S	Situation
		H	History
		A	Assessment
		R	Request
		E	Evaluate
		D	Document
SHARQ[20]	Perioperative nurses	S	Situation: describe the situation
		H	History: medical history, allergies, home medications
		A	Assessment: current medications, intake, output, status
		R	Recommendations: results, discharge planning
		Q	Questions: opportunity to ask questions

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Table 1 (continued)

Mnemonic	Disciplines or Departments		Description
SIGNOUT[43]	Internal medicine residents, medical students	S	Sick or DNR? (highlight sick or unstable patients, identify DNR/DNI patients)
		I	Identifying data (name, age, gender, diagnosis)
		G	General hospital course
		N	New events of the day
		O	Overall health status/clinical condition
		U	Upcoming possibilities with plan, rationale
		T	Tasks to complete overnight with plan, rationale
SOAP[53]	Ambulance/emergency department, neuroscience nurses	S	Subjective information about the patient's concerns, sensations, and/or behavior related to the problem
		O	Objective information related to the problem (eg, level of consciousness, activity tolerance, effect of medication received, postprocedure signs, laboratory values)
		A	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
		P	Plan of what has or should be done for/with the patient
STICC[17,54]	Nurses, physicians, residents	S	Situation
		T	Task
		I	Intent
		C	Concern
		C	Calibrate
4 P's[55]		P	Purpose: Why is the patient here? What priorities does she have?
		P	Picture: What results are we looking for, both short-term and long-term? How can we picture the patient's current condition?
		P	Plan: What did or didn't work?
		P	Part: What part can you play during the next shift?
5P's v.1[20,56]	General nurses, perioperative nurses	P	Patient identity
		P	Plan of care
		P	Purpose of plan: clinical findings supporting plan of care
		P	Problems: abnormal findings, pain scale, vital signs
		P	Precaution: isolation, falls, etc
5P's v.2[20]	Perioperative nurses	P	Patient: identify
		P	Precautions: allergies, isolation, falls, specialty bed
		P	Plan of care: fluids, intake, output, IV access
		P	Problems: assessment, review of systems, pain scale
		P	Purpose: goals to be achieved

IV, intravenous; NG, nasogastric; OR, operating unit; PACU, post-anesthesia care unit; DNR, do not resuscitate; DNI, do not intubate.

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