AHRQ Patient Safety Tools and Resources

The Agency for Healthcare Research and Quality (AHRQ) offers tools for health care organizations, providers, policymakers, and patients to improve patient safety in health care settings. The free tools and resources listed here are available online and in print.

Contents

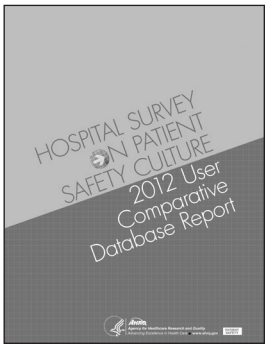
Tools for Health Care Organizations and Providers

Patient Safety Measurement and Reporting Tools

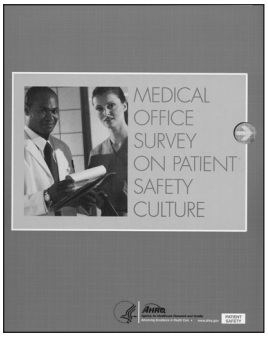
The **Hospital Survey on Patient Safety Culture** examines patient safety culture from a hospital staff perspective and allows hospitals to assess their safety culture and track changes over time. Hospitals that administer the patient safety culture survey can voluntarily submit their data to the Comparative Database, a resource for hospitals wishing to compare their survey results to similar types of hospitals.

Print: AHRQ Publication No. 04-0041
Web: ahrq.gov/qual/patientsafetyculture/hospsurvindex.htm

Hospital Survey on Patient Safety Culture: Comparative Database Reports give benchmark data collected voluntarily from more than 1,000 U.S. hospitals. Survey results from these hospitals are averaged over the entire sample by topical composite or individual survey item. Two appendixes report the average responses, which are broken down by hospital or respondent characteristics.



- 2012 report
  Print: AHRQ Publication No. 12-0017
  Web: ahrq.gov/qual/hospsurvey12
- 2011 report
  Print: AHRQ Publication No. 11-0030
  Web: ahrq.gov/qual/hospsurvey11
- 2010 report
  Print: AHRQ Publication No. 10-0026
  Web: ahrq.gov/qual/hospsurvey10
- 2009 report
  Print: AHRQ Publication No. 09-0030
  Web: ahrq.gov/qual/hospsurvey09
- 2008 report
  Print: AHRQ Publication No. 08-0039
  Web: ahrq.gov/qual/hospsurvey08
- 2007 report
  Print: AHRQ Publication No. 07-0025
  Web: ahrq.gov/qual/hospsurveydb



The **Medical Office Survey on Patient Safety Culture** measures issues relevant to patient safety in the ambulatory medical office setting. Pilot tested in approximately 100 medical offices, the survey lets providers and staff assess their safety culture, identify areas where improvement is needed, track changes in patient safety, and evaluate the effect of interventions. Researchers can also use the survey to assess patient safety culture improvement initiatives.

Print: AHRQ Publication No. 08(09)-0059
Web: ahrq.gov/qual/patientsafetyculture/mosurvindex.htm

The **Medical Office Survey on Patient Safety Culture: 2012 Comparative Database Report** presents data from 23,679 staff within 934 U.S. medical offices that completed the Medical Office Survey on Patient Safety Culture so offices can compare their patient safety culture to other medical offices. The full report contains detailed comparative data for various medical office characteristics (number of providers, specialty, ownership, and region) and staff positions.

Print: AHRQ Publication No. 12-0052
Web: ahrq.gov/professionals/quality-patient-safety/surveys/medical-office/index.html

The **Nursing Home Survey on Patient Safety Culture** uses provider and staff perspectives to assess their nursing home's safety culture, identify areas where improvement is needed, track changes in patient safety, and evaluate the impact of interventions. The survey also lets researchers assess safety culture improvement initiatives in nursing homes.

Print: AHRQ Publication No. 08(09)-0060
Web: ahrq.gov/qual/nhsurvey08/nhguide.htm

The **Nursing Home Survey on Patient Safety Culture: 2011 User Comparative Database Report** is based on data from 226 nursing homes in the United States and provides initial results that nursing homes can use to compare their patient safety culture to other U.S. nursing homes. The report consists of a narrative description of the findings and four appendixes presenting data by nursing home characteristics and respondent characteristics.

Print: AHRQ Publication No. 11-0030
Web: ahrq.gov/qual/nhsurvey11

In response to pharmacies interested in a survey that focuses on patient safety culture in their facilities, AHRQ sponsored the development of the **Pharmacy Survey on Patient Safety Culture**. This new survey is designed specifically for community pharmacy staff and asks for their opinions about the culture of patient safety in their pharmacy.

Print: AHRQ Publication No. 12(13)-0085
Web: ahrq.gov/qual/pharmsurvey/pharmsopsuserguide.pdf

Patient Safety Organizations (PSOs) were created by the Patient Safety and Quality Improvement Act to improve the quality and safety of health care by encouraging clinicians and health care organizations to voluntarily report patient safety events without fear of legal discovery. PSOs offer a secure environment to identify and reduce the risks associated with patient care. As independent, external experts, PSOs collect, analyze, and aggregate patient safety data locally, regionally, and nationally to develop insights into the underlying causes of patient safety events.

Web: pso.ahrq.gov

Patient safety, quality and risk managers, clinicians, and others use **Common Formats** to collect patient safety event information in a standard way, using common language, definitions, technical requirements for electronic implementation, and reporting specifications. Common Formats optimize the opportunity for the public and private sectors to learn more about trends in patient safety with the purpose of improving health care quality. AHRQ has developed Common Formats for hospitals and nursing homes (including skilled nursing facilities) to collect data for all types of adverse events, near misses, and unsafe conditions.

Web: pso.ahrq.gov

Measures of health care quality that make use of readily available hospital administrative data, the **Quality Indicators™** can be used to highlight potential quality concerns, identify areas that need further study and investigation, and track changes over time. AHRQ distributes the Quality Indicators through free software programs that can help hospitals identify quality of care events that might need further study. The current AHRQ Quality Indicators modules represent various aspects of quality:

- **Patient Safety Indicators** reflect quality of care inside hospitals, as well as geographic areas, to focus on potentially avoidable complications and iatrogenic events.
- **Prevention Quality Indicators** identify hospital admissions in geographic areas that evidence suggests may have been avoided through access to high-quality outpatient care.

- **Inpatient Quality Indicators** reflect quality of care inside hospitals, as well as across geographic areas, including inpatient mortality for medical conditions and surgical procedures.
- **Pediatric Quality Indicators** use indicators from the other three modules with adaptations for use among children and neonates to reflect quality of care inside hospitals, as well as geographic areas, and identify potentially avoidable hospitalizations.

Web: qualityindicators.ahrq.gov

A **Toolkit for Hospitals: Improving Performance on the AHRQ Quality Indicators™** helps hospitals understand AHRQ's Quality Indicators that use hospital administrative data to assess the quality of care provided, identify areas of concern in need of further investigation, and monitor progress over time. The toolkit is a general guide to using improvement methods and focuses on the 17 Patient Safety Indicators and the 28 Inpatient Quality Indicators to improve quality and patient safety.

Web: ahrq.gov/qual/qitoolkit

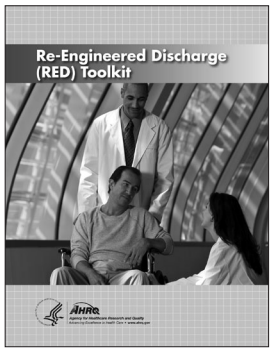
The **Hospital Consumer Assessment of Healthcare Providers and Systems** (HCAHPS) is a survey instrument for measuring patients' perspectives on hospital care. The 27-question survey contains patient perspectives on care and patient rating items that encompass key topics, including communication with doctors and nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, and cleanliness and quietness of the hospital environment. The survey also includes screener questions and demographic items that are used for adjusting the mix of patients across hospitals and for analytical purposes.

Web: hcahpsonline.org

Implementation Guides for Improving Patient Safety

The **Comprehensive Unit-Based Safety Program (CUSP) Toolkit** includes training tools to make care safer by improving the foundation of how physicians, nurses, and other clinical team members work together. It builds the capacity to address safety issues by combining clinical best practices and the science of safety. Created for clinicians by clinicians, the CUSP toolkit is modular and modifiable to meet individual unit needs and was proven effective through a national project that reduced central line-associated blood stream infections by 41 percent. Each module includes teaching tools and resources to support change at the unit level, presented through facilitator notes that take you step-by-step through the module, presentation slides, tools, and videos.

Web: ahrq.gov/cusptoolkit/



A variety of forces are pushing hospitals to improve their discharge processes to reduce preventable readmissions. Researchers at the Boston University Medical Center developed and tested a Re-Engineered Discharge (RED) process, which was effective at reducing readmissions and posthospital emergency department visits. The **Re-Engineered Discharge Toolkit** is designed to assist hospitals, including those that serve diverse populations, in implementing RED.

Print: AHRQ Publication No. 12(13)-0084
Web: ahrq.gov/qual/projectred/toolkit/

Each year, somewhere between 700,000 and 1,000,000 people in the United States fall in the hospital. Research shows that close to one-third of falls can be prevented. **Preventing Falls in Hospitals: A Toolkit for Improving Quality of Care** focuses on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program. The toolkit features an implementation guide for the team that is putting the new prevention strategies into practice and also has links to tools and resources.

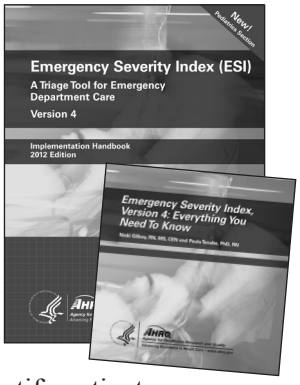
Web: ahrq.gov/research/ltc/fallpxtoolkit/

The **Falls Management Program: A Quality Improvement Initiative for Nursing Facilities** presents an interdisciplinary quality improvement initiative designed to assist nursing facilities in providing individualized, person-centered care and improving their fall care processes and outcomes through educational and quality improvement tools.

Web: ahrq.gov/research/ltc/fallspx/fallspxmanual.htm

Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices is the result of a panel of patient safety experts who assessed the evidence behind 41 patient safety strategies and identified 10 strategies that health systems should adopt now. The strategies can help prevent harmful events such as medication errors, bed sores, and healthcare-associated infections. **Making Health Care Safer II** updates Evidence-based Practice Center report (#43), which was published in 2001 and provided the first systematic assessment of patient safety practices.

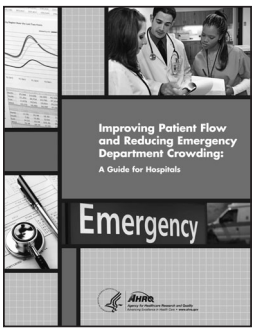
Web: ahrq.gov/research/findings/evidence-based-reports/ptsafetysum.html



The Emergency Severity Index (ESI): A Triage Tool for **Emergency Department Care, Version 4** is a five-level emergency department triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. The ESI helps hospital emergency departments rapidly identify patients in need of immediate attention, better identify patients who could safely and more efficiently be seen in a fast-track or urgent care center rather than the main emergency department, and more accurately determine thresholds for diversion of ambulance patients from the emergency department. The 2012 edition of the Implementation Manual includes a pediatrics section and many other updates.

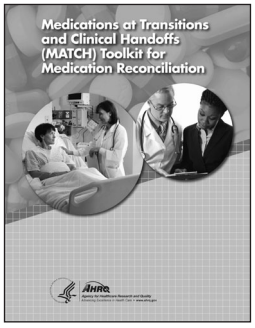
- Implementation Manual
  Print: AHRQ Publication No. 12-0014
  Web: ahrq.gov/research/esi/esi1.htm

- Emergency Severity Index, Version 4: Everything You Need To Know
  DVD: AHRQ Publication No. 05-0046-DVD



Improving Patient Flow and Reducing Emergency Department Crowding: A Guide for Hospitals presents step-by-step instructions for planning and implementing patient flow improvement strategies to alleviate crowded emergency departments. It addresses creating a patient flow team, measuring performance, identifying strategies, preparing to launch, facilitating change, and sharing results.

Print: AHRQ Publication No. 11(12)-0094
Web: ahrq.gov/qual/ptflow/index.html



Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation, based on the MATCH Web site, incorporates the experiences and lessons learned by health care facilities that have implemented MATCH strategies to improve their medication reconciliation processes for patients as they move through health care settings.

Print: AHRQ Publication No. 11(12)-0059
Web: ahrq.gov/qual/match

The **Guide to Patient and Family Engagement in Hospital Quality and Safety** will help hospitals work as partners with patients and families to improve quality and safety. It contains four strategies to help hospitals partner with patients and families, and it has an implementation handbook and tools for patients, families, and clinicians for each strategy. The four strategies are: Helping hospitals recruit and work with patient and family advisors, communicating with patients and families throughout their hospital stay to improve quality, implementing nursing bedside change of shift report, and engaging patients and families in discharge planning.

Print AHRQ 13-0033
Web ahrq.gov/qual/engagingptfam.htm
Available in May 2013

The **Toolkit for Reduction of *Clostridium difficile* Through Antimicrobial Stewardship** assists hospital staff and leadership in developing an effective anti-microbial stewardship program (ASP) with the potential to reduce *Clostridium difficile* infection (*C. difficile*), a serious public health problem that has recently increased in both incidence and severity. An ASP is a systematic approach to developing coordinated interventions to reduce overuse and inappropriate selection of antibiotics, and to achieve optimal outcomes for patients in cost-efficient ways. ASPs targeted to *C. difficile* reduction show promise because increased rates of *C. difficile* are associated with inappropriate antibiotic use.

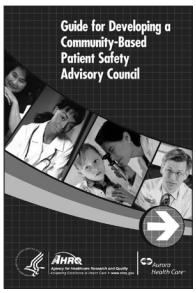
Web: ahrq.gov/qual/cdifftoolkit/cdifftoolkit.pdf

The **Preventing Pressure Ulcers in Hospitals** toolkit assists hospital staff in implementing effective pressure ulcer prevention practices through an interdisciplinary approach to care. The toolkit draws on literature on best practices in pressure ulcer prevention and includes both validated and newly developed tools.

Web: ahrq.gov/research/ltc/pressureulcertoolkit

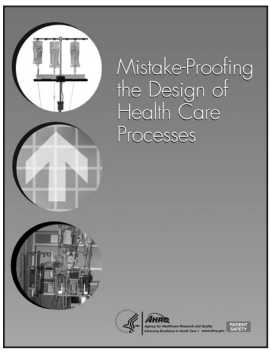
Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement is based on quality improvement initiatives undertaken at the University of California, San Diego Medical Center and Emory University Hospitals in Atlanta. This guide assists quality improvement practitioners in leading an effort to improve prevention of one of the most serious problems facing hospitalized patients: Hospital-acquired venous thromboembolism.

Print: AHRQ Publication No. 08-0075
Web: ahrq.gov/qual/vtguide



Developing a Community-Based Patient Safety Advisory Council provides approaches for hospitals and other health care organizations to use to develop a community-based advisory council that can drive change for patient safety through education, collaboration, and consumer engagement.

Print: AHRQ Publication No. 08-0048
Web: ahrq.gov/qual/advisorycouncil

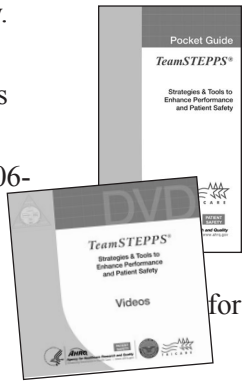


Mistake-Proofing the Design of Health Care Processes is illustrated with numerous examples and explains how to apply the industrial engineering concept of mistake-proofing to processes in hospitals, clinics, and physicians' offices.

Print: AHRQ Publication No. 07-0020
CD: AHRQ Publication No. 07-0020-CD
Web: ahrq.gov/qual/mistakeproof

Patient Safety Training Tools

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) is a set of tools to help train clinicians in teamwork and communication skills to reduce risks to patient safety. TeamSTEPPS tools include—



- The leader's guide that provides materials for leader training.

  Print: AHRQ Publication No. 06-0020-0

- The pocket-sized guide of important team concepts for participants to use in their everyday work.

  Print: AHRQ Publication No. 06-0020-2

Multimedia kit contains training materials including—

- A CD for trainers and leaders that includes reproducible materials for local needs.
- A DVD with video vignettes that illustrate examples of successful and unsuccessful teamwork

  Print: AHRQ Publication No. 06-0020-3

The **TeamSTEPPS Rapid Response Systems Guide** that includes PowerPoint presentations, teaching modules, and video vignettes for training hospital staff who work with Rapid Response Systems, in which hospitals use groups of clinicians to bring critical care expertise to patients requiring immediate treatment.

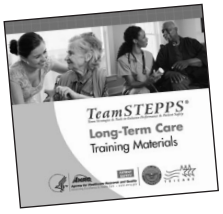
CD: AHRQ Publication No. 08(09)-0074-CD
Web: teamstepps.ahrq.gov

The **TeamSTEPPS® Enhancing Safety for Patients With Limited English Proficiency Module** that helps health care organizations develop and deploy a customized plan to train staff in teamwork skills and lead a medical teamwork improvement initiative for working with applied to patients who have difficulty communicating in English. Comprehensive curricula and instructional guides include short case studies and videos illustrating teamwork opportunities and successes.

Print: AHRQ Publication No. 12(13)-0068-DVD
Web: ahrq.gov/teamsteppstools/lep/

Research suggests that adverse events affect patients with limited English proficiency more frequently, are often caused by communication problems, and are more likely to result in serious harm compared to those that affect English-speaking patients. **Improving Patient Safety Systems for Patients With Limited English Proficiency: A Guide for Hospitals** focuses on how hospitals can better identify, report, monitor, and prevent medical errors in patients with limited English proficiency.

Print: AHRQ Publication No. 12-0041
Web: ahrq.gov/populations/lepguide/

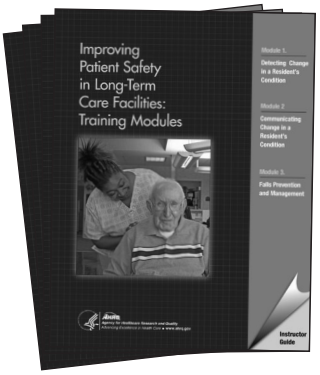


The **TeamSTEPPS® Primary Care Module** that is being tested in primary care practices as part of a project that runs through 2015 and adapts the core concepts of the TeamSTEPPS program to reflect the environment of primary care office-based teams. The module may undergo refinements while it is being tested, but the files are offered as a courtesy to medical offices that wish to apply TeamSTEPPS principles in their practice settings.

Web: ahrq.gov/teamsteppstools/primarycare/

Additionally, the **TeamSTEPPS Long-Term Care Version** adapts the core concepts of the TeamSTEPPS program to reflect the environment of nursing homes and other other long-term care settings such as assisted living and continuing care retirement communities. The examples, discussions, and exercises are tailored to address and improve teamwork in the long-term care environment.

Print: AHRQ Publication No. 12(13)-0004-DVD
Web: ahrq.gov/teamsteppstools/longtermcare/



Detecting and promptly reporting changes in a nursing home resident's condition are critical for ensuring the resident's well-being and safety. Such changes may represent a patient safety problem, and they can be a signal that the resident is at increased risk for falling and other complications. **Improving Patient Safety in Long-Term Care Facilities** is intended for use in training front-line personnel in nursing home and other long-term care facilities. The educational materials are presented in three modules: Module One addresses detecting changes in a resident's condition, Module Two addresses communicating changes in a resident's condition, and Module Three Addresses Falls Prevention and Management. The Instructor Guide comprises all three modules, including suggested slides and pre-and post-tests to gauge the student's knowledge level before and after training. Separate student workbooks are available for each module.

Print:

Instructor Guide, AHRQ Publication No. 12-0001-1
Intructor Set, AHRQ Publication No. 12-0001

Module One: Student Workbook, AHRQ Publication No. 12-0001-2

Module Two: Student Workbook, AHRQ Publication No. 12-0001-3

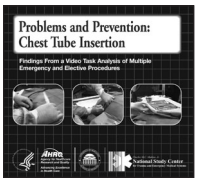
Module Three: Student Workbook, AHRQ Publication No. 12-0001-4

Student Worbook Set (Modules 1-3), AHRQ Publication No. 12-0001-5

Web: ahrq.gov/professionals/systems/long-term-care/ltcmodule0.html

AHRQ Web M&M (Morbidity and Mortality Rounds on the Web) is a free, peer-reviewed online journal and forum on patient safety and health care quality that features expert analysis of medical errors that readers report anonymously, interactive learning modules on patient safety ("Spotlight Cases"), Perspectives on Safety, and interactive learning modules on patient safety ("Spotlight Cases"). Continuing medical education and continuing education unit credits are offered.

Web: WebMM.ahrq.gov



If chest tubes are inserted incorrectly, patients can suffer adverse outcomes and even fatal complications, and clinicians can be exposed to injury or infection. **Problems and Prevention: Chest Tube Insertion** is an 11-minute DVD that uses video excerpts of 50 actual chest tube insertions to illustrate problems that can occur during the procedure.

DVD: AHRQ Publication No. 06-0069-DVD

Resources for Health Care Organizations, Providers, and Policymakers

AHRQ Patient Safety Network (AHRQ PSNet) is a national Web-based resource that features the latest news and essential resources on patient safety. The site offers weekly updates of patient safety literature, news, tools, and meetings ("What's New"); Patient Safety Primers; and a vast set of carefully annotated links to important research and other information on patient safety ("The Collection"). Supported by a robust patient safety taxonomy and Web architecture, AHRQ PSNet provides powerful searching and browsing capability, as well as the ability for diverse users to customize the site around their interests ("My PSNet").

Web: psnet.ahrq.gov

The **Preventing Avoidable Hospital Readmissions Web page** provides links to AHRQ tools for health care teams and consumers to make the hospital discharge process safer and to prevent avoidable readmissions.

Web: ahrq.gov/qual/impptdis.htm

Transforming Hospitals: Designing for Safety and Quality presents the experiences of three model hospitals that incorporated evidence-based design elements into their construction and renovation projects. This DVD shows hospital leaders how evidence-based design can improve the quality and safety of hospital services. It is an especially useful tool for hospitals that are planning capital construction projects or renovations.

DVD: AHRQ Publication No. 07-0076-DVD

Resident Duty Hours: Enhancing Sleep, Supervision, and Safety is an AHRQ-funded study from the Institute of Medicine that confirms that acute and chronically fatigued medical residents are more likely to make mistakes that affect patient care. The Institute of Medicine recommends several changes to the existing 80-hour-per-week limit on resident work hours, including—

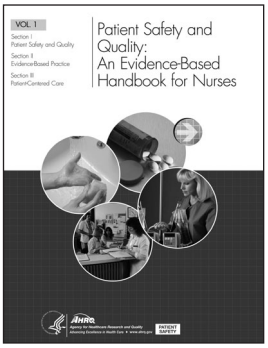
- Residency programs provide opportunities for sleep each day and each week during resident training
- The Accreditation Council for Graduate Medical Education provide better monitoring of duty-hour limits
- Residency review committees set guidelines for residents' patient caseloads

Web: books.nap.edu/openbook.php?record_id=12508&page=R1

Health Care Comes Home: The Human Factors is an AHRQ-funded report from the National Research Council that examines the wide range of people, tasks, technologies, and environments involved in health care in the home to provide an understanding of the most prevalent and serious threats to safety and quality of care. The report makes recommendations for system improvements in the following areas—

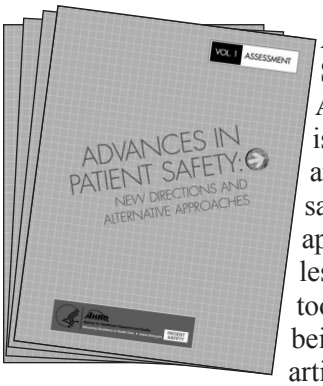
- Health care technologies, including medical devices and health information technologies used in home care settings
- Caregivers and care recipients
- Residential environments for health care
- Research and development needs

Web: nap.edu/catalog.php?record_id=13210



Patient Safety and Quality: An Evidence-Based Handbook for Nurses is a three-volume handbook in which nurses will find peer-reviewed discussions and reviews of issues and literature regarding patient safety and quality health care. Each of the 51 chapters and 3 leadership vignettes presents an examination of the state of the science behind quality and safety concepts and challenges nurses to use evidence to change practices and engage in developing the evidence base to address critical knowledge gaps.

CD: AHRQ Publication No. 08-0043-CD
Web: ahrq.gov/qual/nurseshdbk



Advances in Patient Safety: New Directions and Alternative Approaches is a four-volume set of 115 articles that describe patient safety findings, investigative approaches, process analyses, lessons learned, and practical tools to prevent patients from being harmed. It includes articles by AHRQ-funded patient safety researchers on topics such as reporting systems, risk assessment, safety culture, medical simulation, health information technology, and medication safety.

Print: AHRQ Publication No. 08-0034
CD: 08-0034-CD
Web: ahrq.gov/qual/advances2

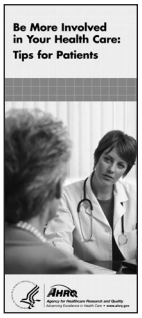
Advances in Patient Safety: From Research to Implementation is a four-volume set of 140 articles that describe accomplishments between 1999 and 2004 by federally funded programs in understanding medical errors and implementing programs to improve patient safety. Included are articles with a research and methodological focus, articles that address implementation issues, and tools to improve patient safety.

CD: AHRQ Publication No. 05-0021-CD
Web: ahrq.gov/qual/advances

Tools for Patients and Families

AHRQ's **Questions are the Answer** initiative is designed to improve communication between patients and clinicians to help make health care safer. It features—

- **Be More Involved in Your Health Care: Tips for Patients**, a brochure that gives patients tips to use before, during, and after a medical appointment to get the best possible care.



  - English
    Print: AHRQ Publication No. 10(11)-0094-A
    Web: ahrq.gov/consumer/beinvolved.htm
  - Spanish
    Print: AHRQ Publication No. 10(11)-0094-B
    Web: ahrq.gov/consumer/beinvolvedsp.htm

- Designed for use in medical office waiting rooms, **My Questions for This Visit** are 50-sheet notepads that let patients list the three questions they want to remember to ask during medical visits.

  - English
    Print: AHRQ Publication No. 10(11)-0094-1
    Web: ahrq.gov/consumer/questionscard.htm
  - Spanish
    Print: AHRQ Publication No. 10(11)-0094-2
    Web: ahrq.gov/consumer/questionscardsp.htm

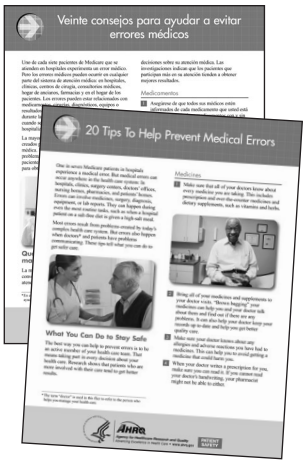
- **Waiting Room Video** – A DVD that features a 7-minute video of patients and clinicians discussing the importance of asking questions and sharing information

  Print: AHRQ Publication No. 10(12)-0094-DVD
  Web: ahrq.gov/patients-consumers/patient-involvement/ask-your-doctor/index.html

Conozca las preguntas (Know the Questions), a Spanish-language companion site to Questions are the Answer, encourages Hispanics to go to the doctor and ask questions to achieve better health outcomes. The Web site features tips on how to talk with doctors and questions to ask when receiving medical care.

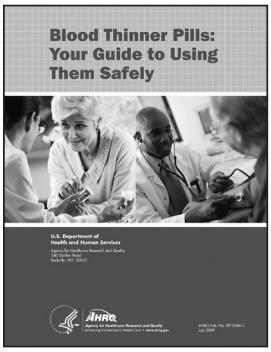
Web: ahrq.gov/preguntas

20 Tips to Help Prevent Medical Errors tells patients what they can do to get safer care and addresses medicines, hospital stays, surgery, medical tests, and more.



- English
  Print: AHRQ Publication No. 11-0089
  Web: ahrq.gov/consumer/20tips.htm

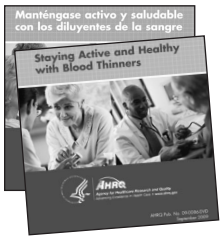
- Spanish
  Print: AHRQ Publication No. 11(12)-0089-B
  Web: ahrq.gov/consumer/20tipssp.htm



Blood Thinner Pills: Your Guide to Using Them Safely explains, in both in English and Spanish, what patients can expect while taking blood thinner medication.

Print: AHRQ Publication No. 09-0086-C
Web: ahrq.gov/consumer/btpills.htm#booklet

Staying Active and Healthy with Blood Thinners is a 10-minute video that features easy-to-understand explanations, in English and Spanish, of how blood thinners work and why it is important to take them correctly. It also introduces BEST, an easy way to remember how to fit blood thinner medication into daily life.



DVD: AHRQ Publication No. 09-0086-DVD
Web – English: healthcare411.ahrq.gov/videocast.aspx?id=555
Web – Spanish: healthcare411.ahrq.gov/videocast.aspx?id=556

Check Your Medicines: Tips for Taking Medicines Safely has questions patients should ask their doctors to help them take the right medicine in the right way at the right time.

Print – English and Spanish: AHRQ Publication No. 10-M052-C
Web – English: ahrq.gov/consumer/checkmeds.htm
Web – Spanish: ahrq.gov/consumer/spcheckmeds.htm

Your Medicine: Be Smart. Be Safe answers common questions about getting and taking medicines and has handy forms that help patients keep track of their medicines.

- English
  Print: AHRQ Publication No. 11-0049-A
  Web: ahrq.gov/consumer/safemeds/yourmeds.htm

- Spanish
  Print: AHRQ Publication No. 11-0049-B
  Web: ahrq.gov/consumer/safemedsp/yourmedssp.htm

Five Steps to Safer Health Care was produced in collaboration with the American Hospital Association and the American Medical Association to explain the questions patients should ask their doctors about medicines, tests, procedures, surgery, and hospitals.

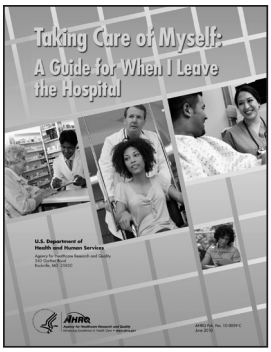
- English
  Print: AHRQ Publication No. 04-M005
  Web: ahrq.gov/consumer/5steps.htm

- Spanish
  Print: AHRQ Publication No. 04-M006
  Web: ahrq.gov/consumer/cincorec.htm

Having Surgery? What You Need to Know lists questions patients should ask to better understand an upcoming surgery.

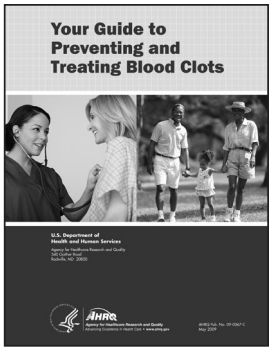
- English
  Web: ahrq.gov/consumer/surgery/surgery.htm

- Spanish
  Web: ahrq.gov/consumer/spsurgery/spsurgery.htm



Taking Care of Myself: A Guide for When I Leave the Hospital is an easy-to-read guide in English and Spanish that helps patients track medication schedules, upcoming medical appointments, and important phone numbers after they leave the hospital. Hospital staff can also complete the information and use the guide to discuss this important information during the discharge process.

Print: AHRQ Publication No 10-0059-C
Web – English: ahrq.gov/qual/goinghomeguide.htm
Web – Spanish: ahrq.gov/qual/goinghomesp.htm



Your Guide to Preventing and Treating Blood Clots discusses ways to prevent, treat, and recognize symptoms of blood clots. It also describes medications used to prevent blood clots and their side effects.

Print: AHRQ Publication No. 09-0067-C
Web – English: ahrq.gov/consumer/bloodclots.htm
Web – Spanish: ahrq.gov/consumer/spblclots.htm

How To Order These Free Resources

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on your mobile device.

AHRQ Pub. No. 13-M004
Replaces AHRQ Pub. No. 12-M008
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