Discussion Points

1. How strongly would you rate your organization's leadership engagement in ensuring the delivery of high-quality care and patient safety?

2. Of the seven critical components that help to define a safe culture, which are the "weak links" for your organization? (The seven components were commitment of leadership, open communication, engaged patients, reporting, informed action, teamwork, focus on improving systems and not blaming individuals)

3. What actions should the board take to strengthen these "weak links"?

4. Is there board and administrative recognition that patient safety errors occur in your organization? Is there agreement that the current error rate is unacceptable?

5. Is there a culture of fixing the system to prevent errors?

6. Are physicians engaged and active partners in achieving quality aims?

7. Are the medical staff and employees held accountable for following safe practices?

8. Is the CEO's compensation linked to quality and safety results at the same degree it is linked to financial success?

9. Does the board allocate resources for quality improvement and error prevention?

Action Agenda