

# Discussion Points

1. Does your board invest enough time to build board-wide quality literacy?
2. What measures does your board review in its oversight of quality and safety performance and improvement?
3. How does your organization identify the potential for adverse events and errors to occur?
4. How would you describe your board's approach to patient and family engagement?
5. Is time devoted at every board meeting to hear about a quality failure or near miss?
6. Does your board discuss root cause investigations of significant adverse events?
7. What processes are in place for reporting quality concerns and medical errors?
8. When concerns are identified, what steps are taken to correct and improve quality and safety performance?

## *Action Agenda*