National Patient Safety Board

What it is and isn't

We haven't solved the problem of patient safety at the national level—the estimates of deaths caused by medical errors have increased since the *To Err is Human* report. The OIG report with 2018 Medicare data indicates 25% of patients experienced harm in hospitals, and the NEJM perspective by CMS and CDC indicated there was an even further "substantial deterioration" in patient safety measures during COVID-19. This is connected to COVID-19's impact on healthcare workforce shortages and burnout. The manual solutions haven't worked, and we can't ask providers to do more in this environment – we need to create autonomous solutions and use human factors engineering principles to build providers a better work environment with better equipment to achieve safe, optimal care.

The National Patient Safety Board (NPSB) would be focused on creating solutions to prevent "patient safety events." The NPSB Coalition has defined "patient safety events" as follows across the continuum of health care settings:

- an action or inaction that led to patient injury or harm in a healthcare setting,
- an action or inaction that could lead to patient injury or harm as pre-cursors to potential harm in a healthcare setting, or
- a near-miss that could have harmed the patient but did not cause harm in healthcare settings as a result of chance, prevention, or mitigation.

The NPSB Coalition took lessons from both the National Transportation Safety Board (NTSB) and the public-private Commercial Aviation Safety Team (CAST), and then designed the NPSB to complement the existing patient safety programs in both the public and private sectors and address the gaps.

- As such, the NPSB would not collect additional data. Instead, the NPSB's public-private Healthcare Safety Team would identify the existing data sources for a prioritized set of measures, with a focus on the major sources of harm/injury in health care. The NPSB would view this aggregated data to identify and anticipate the major sources of harm. The focus will be on discovery, on "solutions," including solutions that incorporate available technologies, such as AI, ML, and autonomous surveillance systems.
    - This addresses the current gap in the system where there are lots of "silos of data collection," but this data is not timely, aggregated or analyzed to create national

solutions. The NPSB would aggregate this data across the solutions, provide analyses and insights, AND offer solutions.
    - *Note:* While the NPSB's specs include an "NPSB Patient Safety Reporting System," this is not meant to be a major focus or to compete with any existing reporting systems. It was added in case the other existing data sources miss any significant patient safety events.

- Recognizing that some organizations already investigate incidents or conduct root cause analyzes, the NPSB would not have the authority to enter healthcare organizations to investigate. Instead, the NPSB would offer a multidisciplinary team of experts, including clinically-informed human factors engineers, to healthcare settings experiencing unusual patterns of major sources of harm to help them understand the causes and inform national solutions.
    - This addresses the current gap in the system where not all health care settings have the resources available to access systems experts, such as human factors engineers, to understand why errors are occurring and to create solutions. The NPSB would increase access to these types of resources.

- The NPSB would not have any authority to publicly report data or to certify, accredit, regulate, or license healthcare organizations, recognizing there are already existing organizations and agencies that carry out these functions. Instead, the NPSB would focus on creating and adopting solutions. Based on the causes, contextual factors, and precursors to the major sources of harm/injury, the NPSB's public-private Healthcare Safety Team would gain consensus on solutions, including autonomous technologies, to voluntarily adopt with urgency to prevent the major sources of harm from occurring.
    - This addresses the current gap in the system, where there is no single entity that is able to identify patterns and causes of errors that are happening in healthcare settings across the US, with the sole purpose to create national solutions.

Learn more at npsb.org