# National Patient Safety Board (NPSB)

The proposed National Patient Safety Board (NPSB) would be focused on creating solutions to prevent injury/harm in healthcare settings by:

- identifying and anticipating significant injury/harm;
- studying the pre-cursors of and causes of injury/harm; and
- developing solutions to prevent injury/harm from occurring.

When designing the proposed NPSB as a data-driven, non-punitive, independent, and collaborative R&D body, the NPSB Policy & Advocacy Coalition took lessons from the National Transportation Safety Board (NTSB) and the public-private Commercial Aviation Safety Team (CAST).[1] The Coalition also designed the NPSB to complement the existing patient safety programs in the public and private sectors and address the gaps in the current patient safety ecosystem across the U.S.

As a result, 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 analyze this data to identify and anticipate the major sources of harm with available technologies, such as AI, ML, and autonomous surveillance systems. This addresses the *current gap* in the system where there are a lot of "silos of data collection," where data is being submitted but not being acted on in a timely manner to create national solutions. The NPSB would aggregate this data, provide analyses and insights, and *offer solutions*.

*Instead of* conducting investigations, 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 most healthcare settings do not have the resources available to access systems experts, such as human factors engineers, to understand why errors are occurring and create solutions.

The NPSB *would not* have 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 adopt with urgency in order 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 of creating national solutions.

The NPSB would deepen our understanding of the conditions that precede significant harm, how to prevent harm before it occurs, and how to make this prevention function as autonomous and fail-safe as possible.

[1] The NTSB is an independent federal agency that investigates accidents and issues recommendations to prevent future accidents. CAST is an industry-government partnership team that proactively identifies emerging safety risks based on shared data and gains consensus on safety enhancements to voluntary implement before the event occurs.