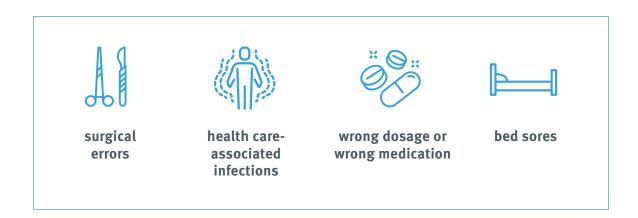


A National Patient Safety Board: What America Needs to Ensure Patient Safety

A doctor's office or hospital is supposed to be a place where someone can heal and get well. But for many across the country, access to their healthiest lives is hindered by the quality of care they receive, including preventable mistakes. One in four people experience harm from the U.S. health care system. The harm is driven by medical error and patient safety events impacting over 250,000 people each year, costing billions of dollars in excess health care spending.¹ These events are now the third leading cause of preventable death in the U.S.



September 2024 Fact Sheet



In the fast-paced world of health care, mistakes can happen despite the best intentions. But when the system itself does not prioritize safety, mistakes can turn into life threatening situations in mere seconds.

As a dedicated nurse, Rachel\* has always been committed to the safety and well-being of her patients. One day, when a patient was seized with a life-threatening arrhythmia, she received a verbal order to administer amiodarone, a medication crucial for stabilizing the patient's heart rhythm. Time was of the essence, and as she quickly prepared the medication, she reached into the cabinet where the amiodarone was stored. Unbeknownst to her, right beside it in nearly identical packaging was nicardipine, a drug with a completely different purpose — one that would lower the patient's blood pressure.

In the rush to help, Rachel inadvertently grabbed the wrong medication. Moments later, the patient's blood pressure plummeted, sending shockwaves of concern through the team. The sudden drop left everyone scrambling to understand what had gone wrong, leading to more invasive care to save the patient's life.

This near tragedy wasn't just a result of human error; it was a systemic failure. The environment in which healthcare professionals work can often set them up for mistakes. Had there been clearer labeling, better separation of medications, or a double-check system in place, this simple yet dangerous mix-up might have been avoided.

System-focused solutions that consider the real-world environment of health care can prevent errors like these. With a National Patient Safety Board comes the opportunity to build more reliable systems that achieve better patient safety standards. By improving medication storage practices, enhancing safety protocols, and ensuring that every aspect of patient care is designed with human factors in mind, we can protect both patients and the health care workers who care so deeply for them.

To join us in advocating for the National Patient Safety Board visit <a href="https://npsb.org/get-on-board/">https://npsb.org/get-on-board/</a> today.

\*Name has been changed

## Congress has the power to end unnecessary harm to patients.

Current efforts to address patient safety are fragmented across the health care system, split amongst different state and federal agencies, and payors.<sup>2</sup> But now a growing coalition of consumers, advocates, providers, and payors are asking Congress to establish a National Patient Safety Board.<sup>3</sup>

The National Patient Safety Board Act (H.R. 7591), introduced by U.S. Representatives Nanette Barragán (CA-44) and Dr. Michael Burgess (TX-26), provides the necessary solutions to ensure patients are getting the safe, effective care that they need. The bill will help cut down on harmful, preventable medical errors that cost patients with their lives, and businesses and taxpayers with their pocketbooks.<sup>4</sup>

## THE NATIONAL PATIENT SAFETY BOARD (NPSB)

The National Patient Safety Board (NPSB, or the Board) would have the sole mission of improving patient safety and would give this issue a home at the federal level.

As an independent board within the Department of Health and Human Services, the NPSB would aggregate and analyze existing patient safety data to:5



Identify and anticipate harm that happens in the health care system;



Study the precursors, contextual factors, and causes of harm to better understand patterns and trends in patient safety events;



**Develop and deploy solutions**to prevent harm in the first place.

The legislation would also establish a new patient reporting portal so that people, as well as family members, caretakers, health care providers, and others can bring their experiences forward directly. And a public-private partnership team of representatives from various federal agencies, organized labor, patients, caregivers, providers, and more would bring their varied perspectives to the Board's work. Central to solving the problem of poor patient safety is ensuring that the people directly impacted are heard and their experiences are represented in both analysis and solutions.

Families USA and consumers across America call on Congress to pass this legislation to end unnecessary harm patients.

## **Endnotes**

- ¹ National Patient Safety Board Advocacy Coalition, <a href="https://npsb.org">https://npsb.org</a>; James G. Anderson, and Kathleen Abrahamson, "Your Health Care May Kill You: Medical Errors," Studies in Health Technology and Informatics, 2017, <a href="https://pubmed.ncbi.nlm.nih.gov/28186008/">https://pubmed.ncbi.nlm.nih.gov/28186008/</a>; Van Den Bos J., Rustagi K., Gray T., et al, "The \$17.1 billion problem: the annual cost of measurable medical errors," Health Affairs, April 20, 2011, <a href="https://psnet.ahrq.gov/issue/171-billion-problem-annual-cost-measurable-medical-errors#:~:text=This%20actuarial%20study%20used%20a,associated%20infections%2C%20and%20pressure%20ulcers.">https://psnet.ahrq.gov/issue/171-billion-problem-annual-cost-measurable-medical-errors#:~:text=This%20actuarial%20study%20used%20a,associated%20infections%2C%20and%20pressure%20ulcers.
- <sup>2</sup> President's Council of Advisors on Science and Technology, "Report to the President: A Transformational Effort on Patient Safety," Executive Office of the President, September 2023, chrome-extension:// efaidnbmnnnibpcajpcglclefindmkaj/https://www.whitehouse.gov/wp-content/uploads/2023/09/PCAST\_Patient-Safety-Report\_Sept2023.pdf
- <sup>3</sup> "Home," National Patient Safety Board Advocacy Coalition, Home National Patient Safety Board (npsb.org)
- <sup>4</sup> H.R. 7591 118th Congress (2023-2024), https://www.congress.gov/bill/118th-congress/house-bill/7591
- <sup>5</sup> H.R. 7591 118th Congress (2023-2024), <a href="https://www.congress.gov/bill/118th-congress/house-bill/7591">https://www.congress.gov/bill/118th-congress/house-bill/7591</a>; National Patient Safety Board Advocacy Coalition, <a href="https://npsb.org/">https://npsb.org/</a>

For more information, please contact:

Jane Sheehan, Deputy Senior Director of Government Relations, Families USA: <a href="mailto:jsheehan@familiesusa.org">jsheehan@familiesusa.org</a>

Hazel Law, Policy Analyst, Families USA: <a href="mailto:hlaw@familiesusa.org">hlaw@familiesusa.org</a>

The following Families USA staff contributed to the preparation of this material (listed alphabetically):

Ben Anderson, Deputy Senior Director, Health Policy
Nichole Edralin, Associate Director, Design and Publications
Cheryl Fish-Parcham, Director, Private Coverage
Lauren Rubenstein, Communications Associate
Lisa Shapiro, Senior Advisor for Strategy and Children's Policy
Jane Sheehan, Deputy Senior Director, Federal Relations
Jen Taylor, Senior Director, Federal Relations

