



Patient Safety Action Network

Patient Driven, Patient Led

<https://www.patientsafetyaction.org/>

**PATIENT SAFETY ADVOCATES SUPPORT
A PATIENT-CENTERED, PUBLICLY TRANSPARENT
NATIONAL PATIENT SAFETY BOARD**

March 2023

Our nation is desperately in need of a solution to the unacceptable number of preventable infections, medical errors and harms that kill and injure millions of Americans every year. We are the Patient Safety Action Network, patient driven and patient led advocates working to end medical harm. We strongly support the creation of a National Patient Safety Board (NPSB). Despite multitudes of studies and reports, identified general trends, and focused efforts on encouraging health care facilities and providers to practice known prevention strategies, recent estimates indicate one in four hospital patients are harmed. There is limited information on harm that occurs in other health care settings.

Now is our opportunity to change the secrecy around medical harm. The U.S. needs to move beyond current non-transparent systems like Patient Safety Organizations (PSOs) and the aggregated reports commonly issued by other government agencies. In the development of a NPSB, public transparency and public accountability are critical to progress toward zero patient harm. We strongly recommend that any proposal creating a National Patient Safety Board address the following issues.

1. Public interest: The NPSB should be a public agency created to serve patients and the public. We should be careful to prevent it from functioning as an arm of the health care industry. While wide-ranging advice should always be welcome, no part of the agency's decision-making and oversight should be delegated to private health care entities whose business interests may not parallel the interests of the public.

2. Transparency: The NPSB should be a public resource. The information the agency gathers should be redacted only for patient identifying information and should be open to the public, as is the case with many other government databases. Reports should include names of facilities and names of drugs/devices/products and their manufacturers that are involved in patient harm.

3. Authority: The NPSB should be able to access and hold data from relevant entities both within and outside traditional health care systems. Ideally, the NPSB should maintain a database of its own in addition to accessing selected data for specific projects. A comprehensive historical database is essential to the agency's mission of detecting trends and patterns in patient safety events. To carry out the mission of examining patient safety threats, the agency must be granted authority to undertake studies of patient safety concerns whether invited into a facility or not.

4. Patient Safety Reporting System: Multiple studies document the accuracy and importance of patient and family reports of harm. We strongly support creation of a Patient Safety Reporting System through which patients, health care providers and others can report harm events to the NPSB. These reports of harm events should be integrated into NPSB analyses and studies. They should also be available online

(with only patient identifying information redacted) for the public to view and download, similar to the FDA MedWatch/MAUDE databases.

5. Board Members: NPSB board members should be prohibited from financial relationships or other active relationships with medical facilities, drug and medical product manufacturers, or medical insurance companies. Board members should have a history of working in the public interest with experience in patient safety. Board members should be full-time employees who are adequately paid so their full attention is focused on ending medical harm.

6. Patient and Family Input: All the NPSB's work should be infused with patient and family input. This includes having patient representatives as members of the various agency teams and in official advisory roles.

These are the issues that a NPSB needs to address in order to fulfill its mission.

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