BUILDING A CULTURE OF SAFETY

WHAT EVERY CLINICAL TEAM MEMBER SHOULD KNOW

UF College of Medicine
Quality and Patient Safety Initiative
UNIVERSITY of FLORIDA

Safety culture is not a program. It's how we treat each other every day.

THE CULTURE SPECTRUM

Where Does Your Unit Fall?

Punitive Culture

Mistakes are met with blame and punishment

Result:
People hide errors

Just Culture

Holds systems accountable + recognizes individual responsibility

Result:
Psychological safety to report honestly and fairly

Just Culture is the goal — and the foundation for everything else.

Blame-Free Culture

No one is ever held accountable

Result:
Creates its own risks

PSYCHOLOGICAL SAFETY

Why Psychological Safety is Non-Negotiable

Psychological safety means every clinical team member can speak up — about an error, a near miss, a process that isn't working — without fear of punishment or judgment.

It doesn't just ***protect patients***. It makes improvement ***work possible***.

Speak up during a PDSA cycle

Report a concern before it becomes an event

Challenge a process without fear

WHAT JUST CULTURE LOOKS LIKE IN PRACTICE

Not All Errors Are the Same — And the Response Shouldn't Be Either

TYPE	DEFINITION	RESPONSE
Human Error	An unintentional mistake — anyone could make it	Support + learning
At-Risk Behavior	A choice that increases risk, often without full awareness	Coaching + course correction
Reckless Conduct	A conscious disregard for known risk	Accountability

WHAT TO REPORT — AND WHY

Reporting Is a Professional Act of Care

Near Miss: Something almost went wrong — but didn't. These reveal system vulnerabilities before harm occurs.

Latent Error: A hidden weakness already present in a process that hasn't caused harm yet — but will.

Adverse Event: Harm that reached the patient.

Filing a safety report is **not** an admission of failure.

It triggers institutional learning — and it's an expected, non-punitive part of your professional role.

Unsure about next steps after an event? Contact your risk management team.

THE QI CONNECTION

Safety Culture and Improvement Work Are the Same Work

When we ask **"what allowed this to happen?"** instead of **"who did this?"** — we find the systemic causes no individual accountability measure would ever fix.

The honest debrief after a PDSA cycle requires the same courage as reporting a near miss.

A team that can speak up about errors can speak up about processes that aren't working.