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PATIENT SAFETY: CHALLENGES AND ACHIEVEMENTS OF THE MULTIDISCIPLINARY TEAM IN IMPROVING HEALTHCARE QUALITY

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ABSTRACT: Patient safety has established itself as an essential dimension of care quality and as one of the main indicators of organizational maturity in health systems. In a scenario marked by clinical complexity, the growing use of technologies, the fragmentation of care pathways, and the interdependence among multiple professional categories, it is insufficient to analyze the occurrence of preventable harm solely from the perspective of individual error. This article aims to discuss, in light of scientific literature and national and international regulatory frameworks, the main challenges and achievements of the multidisciplinary team in promoting patient safety. This is a narrative review of a theoretical-reflective nature, based on documents from the World Health Organization, the Pan American Health Organization, the Ministry of Health, the National Health Surveillance Agency, and indexed studies addressing safety culture, interprofessional communication, continuing education, patient participation, and incident reporting. The analysis shows that challenges persist in areas such as ineffective communication, a punitive culture, underreporting of adverse events, work overload, discontinuity of care, and weak interprofes-

sional integration. On the other hand, the field has also seen significant advances, such as the institutionalization of patient safety in public policies, the creation of Patient Safety Centers, the dissemination of basic protocols, the strengthening of a culture of organizational learning, and the growing emphasis on patient and family participation in care. It is concluded that patient safety depends on the integration of technical competencies, interprofessional collaboration, institutional leadership, continuing education, and an ethical commitment to the prevention of avoidable harm.

KEYWORDS: patient safety; multidisciplinary team; safety culture; quality of healthcare; teamwork.

INTRODUCTION

In recent decades, patient safety has become one of the most relevant expressions of quality in healthcare, not only because it refers to the prevention of avoidable harm, but because it reveals the degree of organization, responsibility, and institutional maturity of healthcare services. The contemporary understanding of the

topic goes beyond the simplistic view that links care failures exclusively to the individual performance of professionals and now recognizes that risk arises from complex processes, interdependent decisions, fragile organizational barriers, and work models that are not always capable of anticipating and mitigating errors. The World Health Organization defines patient safety as a set of organized activities that produce cultures, processes, procedures, behaviors, technologies, and environments designed to reduce risks, make errors less likely, and lessen the impact of harm when it occurs. At the same time, the WHO maintains that the elimination of preventable harm requires coordinated action among policy formulation, institutional management, and point-of-care practices, which broadens the debate beyond the isolated clinical act and places it within the realm of health systems governance (WORLD HEALTH ORGANIZATION, 2021, 2023, 2024).

This approach takes on particular importance in increasingly complex healthcare settings. Contemporary care is characterized by hospitalizations involving greater technological complexity, increased life expectancy, the coexistence of chronic conditions, the simultaneous use of multiple therapies, the need for transitions between different levels of care, and the intense flow of information among professionals, departments, and institutions. In this reality, risks are not limited to highly complex procedures but also extend to seemingly routine steps, such as communication among teams, accurate patient identification, medication use, shift handoffs, continuity of care, and shared decision-making. The first WHO Global Patient Safety Report, published in 2024, confirms that the implementation of policies,

learning systems, patient engagement, and the strengthening of professional competencies still progresses unevenly among countries, which demonstrates the relevance and urgency of the issue (WORLD HEALTH ORGANIZATION, 2024).

In Brazil, the consolidation of patient safety as a public agenda gained regulatory expression through Ordinance No. 529, dated April 1, 2013, which established the National Patient Safety Program with the objective of contributing to the improvement of care in all healthcare facilities nationwide. Subsequently, ANVISA's RDC No. 36/2013 established specific measures for patient safety in health services, and the program's reference document outlined guidelines focused on safety culture, risk management, incident reporting, and the implementation of basic protocols. More recently, the Ministry of Health and Anvisa have reiterated, on their institutional websites and in their campaigns, that patient safety requires organized care, early detection of risks, integration of healthcare networks, and the continuous use of improvement strategies (BRAZIL, 2013a, 2013b, 2014, 2025a, 2025b).

In this context, the multidisciplinary team plays a central role. The Pan American Health Organization defines interprofessional teams as groups composed of different health professionals and workers who share a team identity and act in an integrated and interdependent manner to solve complex problems and provide health services. This concept shifts the focus from individual performance to the coordination of knowledge, responsibilities, and practices—a factor particularly relevant to patient safety, as the delivery of safe care depends on the quality of the interfaces between medicine, nursing,

pharmacy, physical therapy, nutrition, psychology, social work, and other fields involved in care. It is precisely at these interfaces that risks can be amplified or mitigated (PAN AMERICAN HEALTH ORGANIZATION, 2025a, 2025b).

In light of this, this article aims to discuss the challenges and achievements of the multidisciplinary team in promoting patient safety, emphasizing the organizational, cultural, communicational, and educational factors that influence the creation of safer care environments. The relevance of this discussion lies in the fact that patient safety is not based solely on standards and protocols, but on how professionals interact, learn, communicate, and assume shared responsibility for care.

METHODOLOGY

This is a narrative review, qualitative in nature and of a theoretical-reflective character. The literature review was conducted in April 2026, consulting official documents from the World Health Organization, the Pan American Health Organization, the Ministry of Health, and the National Health Surveillance Agency, as well as studies indexed in databases such as PubMed, SciELO, and LILACS. Priority was given to texts addressing patient safety, teamwork, safety culture, interprofessional communication, continuing education, incident reporting, and patient participation in care.

A narrative review was chosen because this is a topic that requires the articulation of conceptual, normative, and empirical frameworks, with an emphasis on the critical interpretation of institutional and care processes. The aim was not to conduct an exhaustive synthesis of evidence, as in system-

atic reviews, but to construct an analysis grounded in and consistent with current literature and existing regulatory frameworks. Documents and studies considered relevant to understanding both the persistent challenges and the advances already achieved in the field of patient safety were included, especially from the perspective of multidisciplinary practice.

RESULTS AND DISCUSSION

Patient Safety as an Ethical, Systemic, and Organizational Imperative

One of the main theoretical gains in the field of patient safety has been the transition from a moralizing interpretation of error to a systemic interpretation of risk. This shift does not imply denying professional responsibility, but rather recognizing that the occurrence of preventable harm, in most cases, results from the convergence of multiple factors: poorly designed processes, deficient communication, leadership that is not sufficiently inclusive, insufficient resources, work overload, inadequate supervision, and an institutional culture that is not open to learning. The international literature consistently supports this understanding. The meta-analysis by Panagioti et al. (2019), by examining the prevalence, severity, and nature of preventable harm in different care settings, reinforces that such harm remains relevant and that its prevention requires intervention on systems and not just on individuals. Similarly, the WHO states that patient safety should be treated as an organized set of actions, rather than as a spontaneous attribute of clinical practice (PANAGIOTI et al., 2019; WORLD HEALTH ORGANIZATION, 2021, 2023).

This understanding has profound ethical implications. When a service holds the professional who “made a mistake” solely responsible, without examining the context in which the failure occurred, it preserves the conditions that foster new incidents. In contrast, when an institution analyzes the error as a sign of system vulnerability, it creates space for reviewing workflows, strengthening safety barriers, refining processes, and fostering organizational learning. Patient safety, therefore, is not merely a technical issue; it is also an ethical commitment to institutional honesty, transparency, and the refusal to normalize harm that could have been prevented. This perspective has been reaffirmed in both international documents and Brazilian regulations that guide the structuring of the PNSP, Patient Safety Centers, and reporting systems (BRAZIL, 2013a, 2013b, 2014; WORLD HEALTH ORGANIZATION, 2021).

The Multidisciplinary Team and the Centrality of Interprofessional Collaboration

Patient safety becomes fragile when healthcare work is conducted in a parallel, compartmentalized, and hierarchically rigid manner. Conversely, it tends to strengthen when different professionals recognize the interdependence of their actions and operate with shared objectives. PAHO has emphasized that interprofessional and cross-y teams are fundamental for addressing complex care challenges and providing person-centered care. This understanding is consistent with what Peduzzi et al. (2020) discuss regarding teamwork in the health field: more than a mere gathering of professionals, it is a process in which distinct centers of expertise must engage in dialogue without

losing their specificity, but also without reproducing technical isolation or inequalities that hinder cooperation. Interprofessional work, in this sense, is not an organizational embellishment; it is a prerequisite for quality and safety (PEDUZZI et al., 2020; PAN AMERICAN HEALTH ORGANIZATION, 2025a, 2025b).

Rosen et al. (2018), in synthesizing the accumulated evidence on healthcare teams and work, show that elements such as leadership, psychological safety, coordination, communication, clarity of roles, and learning from mistakes have a direct impact on the quality of care. These findings are particularly relevant because they help explain why the mere coexistence of multiple professions within the same care setting does not guarantee patient safety. Multidisciplinary only yields benefits when it translates into concrete collaboration—that is, when there is openness to speaking, listening, questioning, reviewing practices, and sharing responsibility. Where opaque hierarchies, fear of taking a stand, and incomplete information exchange prevail, risks accumulate in the transition zones between people and processes (ROSEN et al., 2018).

From this perspective, the multidisciplinary team should be understood as one of the primary safety barriers available in healthcare services. Physicians, nurses, pharmacists, physical therapists, dietitians, psychologists, social workers, and other professionals observe the patient from distinct angles, which expands the capacity to identify risk signals, therapeutic inconsistencies, and neglected needs. When these perspectives come together in an organized manner, care becomes more robust; when they remain disconnected, gaps multiply. Patient safety depends, therefore, less on the sum of

individual competencies and more on the quality of the professional relationships that link these competencies.

Persistent Challenges: Communication, Punitive Culture, and Fragmentation of Care

Among the most recurring challenges to patient safety is ineffective communication. This problem spans different care settings and takes multiple forms: incomplete shift handoffs, inaccurate records, ambiguous language, misunderstood verbal orders, clinical information that does not reach all those involved, and low- or no-patient involvement in understanding the treatment plan. Nogueira and Rodrigues (2015) argue that effective communication is a central requirement for teamwork and patient safety, highlighting that training, simulations, and standardized strategies for presenting information are measures capable of reducing communication barriers. Along the same lines, the qualitative systematic review by Gleeson et al. (2023) shows that interprofessional communication in hospital settings remains marked by obstacles such as hierarchy, fragmentation of information, and structural limitations that compromise care coordination (NOGUEIRA; RODRIGUES, 2015; GLEESON et al., 2023).

The persistence of punitive cultures constitutes another major obstacle. In institutions where errors are still predominantly treated as individual fault, professionals tend to conceal incidents, avoid reporting them, and limit frank discussion of failures. This undermines the primary function of safety systems: learning from what happened to prevent recurrences. Rosen et al. (2018) show that psychological safety within teams is essential for professionals to feel comforta-

ble reporting problems and questioning decisions. The WHO, in turn, emphasizes that reporting and learning systems should be focused on improving care, rather than on a purely punitive approach. Without a just culture, there is no sustainable institutional learning (ROSEN et al., 2018; WORLD HEALTH ORGANIZATION, 2021).

Work overload and pressure to increase productivity also compromise safety. In understaffed care settings characterized by a heavy workload and a fast pace, essential verification and monitoring practices tend to be cut short or performed under high cognitive load. This problem is particularly critical when it comes to medication safety. The systematic review and meta-analysis by Hodkinson et al. (2020) demonstrated that preventable medication-related harm remains significant across various care settings, most frequently occurring during the prescribing and monitoring stages. This reinforces the need for closer coordination among professionals, particularly between medicine, nursing, and pharmacy, since failures at any of these interfaces can directly impact patient outcomes (HODKINSON et al., 2020).

Within the context of primary care and care networks, the fragmentation of care poses additional challenges. Patients move between different points in the network and often bear the responsibility of reconstructing their own medical history for teams that do not always have complete and integrated information. In 2025, the Ministry of Health even highlighted the need to strengthen the National Primary Care Program (PNSP) at all levels of care and to expand the integration of Health Care Networks as a strategy for holistic and safe care. This point is crucial because patient safety

is not limited to the hospital: it depends on continuity of care, information interoperability, and shared accountability throughout the therapeutic journey (BRASIL, 2025c).

Brazilian studies on safety culture reveal that these problems are not merely theoretical. Raimondi, Bernal, and Matsuda (2019), in investigating safety culture in primary care, highlighted differences among teams and professional categories, suggesting that the perception of safety is not homogeneous within services. Notaro et al. (2019), meanwhile, when analyzing multidisciplinary teams in neonatal intensive care units at public hospitals, identified significant weaknesses in the consolidation of safety culture. In both cases, it is noteworthy that safety does not depend solely on the existence of protocols, but on how professionals perceive, experience, and incorporate patient protection into their routines (RAIMONDI; BERNAL; MATSUDA, 2019; NOTARO et al., 2019).

Continuing education, interprofessional training, and learning from errors

Recent literature has indicated that patient safety is not achieved solely through regulation and monitoring; it requires continued investment in the training and continuing education of teams. The WHO had already pointed in this direction by publishing the *Patient Safety Curriculum Guide: Multi-professional Edition*, designed to support the teaching of patient safety in medicine, nursing, dentistry, pharmacy, obstetrics, and other health professions. The guide is relevant because it makes clear that safety training should not be limited to technical content but should include systems understanding, risk management,

teamwork, communication, learning from errors, and the engagement of patients and caregivers (WORLD HEALTH ORGANIZATION, 2011).

This guideline remains current. Jiang et al. (2024), in a scoping review of interprofessional educational interventions focused on patient safety, identified a wide variety of strategies, with an emphasis on simulation-based learning and collaborative in-person activities. The authors show that the field increasingly recognizes that safety-related incidents are often associated with failures in communication and collaboration, which justifies strengthening educational processes that develop interprofessional competencies in the real-world workplace. This is especially important because continuing education, when organized in a critical, inter , and contextualized manner, not only conveys information but also reshapes team culture and enhances the ability to anticipate risks (JIANG et al., 2024).

Similarly, Alsabri et al. (2022), in reviewing training interventions on communication and teamwork in emergency departments, concluded that such strategies improve safety culture and can positively impact patient care. This finding is important because it shows that safety is not achieved solely through increased oversight, but also through the creation of pedagogical and relational conditions that enable professionals to learn to work together. Team training, when combined with inclusive leadership, clear protocols, and space for feedback, fosters environments where errors are more likely to be detected early, unsafe decisions are questioned, and processes are reviewed with less blame and a greater commitment to continuous improvement (ALSABRI et al., 2022; ROSEN et al., 2018).

Learning from mistakes, however, is not an intuitive act. It depends on an organizational culture that legitimizes the critical analysis of incidents and converts adverse events, near misses, and process failures into inputs for change. In Brazil, Anvisa maintains specific pages on patient safety, notifications, Patient Safety Centers, and safety culture assessment, recognizing the need to diagnose and monitor institutional commitment to safe practices. This development is significant because it demonstrates that the country has moved from an exclusively regulatory phase to a phase of monitoring and evaluation, even though significant inequalities persist between services and regions (BRASIL, 2025b, 2025d).

Cumulative achievements: policies, safety centers, protocols, and patient participation

Despite the weaknesses that still exist, the field of patient safety has also achieved substantial progress. The first of these is the institutionalization of the issue itself. The creation of the National Patient Safety Program, its regulation by RDC No. 36/2013, and the publication of the PNSP reference document represented an important milestone by introducing, into the Brazilian health agenda, the idea that safe care must be planned, measured, and managed. By establishing objectives, responsibilities, and strategies, these instruments facilitated the progressive integration of patient safety into the clinical, administrative, and training processes of health services (BRASIL, 2013a, 2013b, 2014).

Another significant achievement was the establishment of Patient Safety Centers. These centers began to function as coordinating structures linking surveillance, care,

continuing education, and risk management. Their role is strategic because it enables the transformation of patient safety into a continuous organizational practice, rather than limiting it to one-off campaigns or reactive responses to serious events. At the same time, the Ministry of Health's dissemination of basic patient safety protocols—with an emphasis on patient identification, hand hygiene, fall prevention, pressure ulcer prevention, communication, and safety in the prescription and administration of medications — has helped to establish a common language and minimum care priorities throughout the system (BRASIL, 2021, 2025e).

Progress is also evident in the growing emphasis on safety culture as an object of assessment and intervention. Anvisa's initiative to conduct a national assessment of safety culture in Brazilian hospitals demonstrates that it is no longer sufficient to have formally established protocols; it has become necessary to measure the extent to which professionals perceive institutional support, openness to dialogue, capacity for reporting, and a genuine commitment to learning. This shift is important because it moves safety from the exclusively normative realm to the realm of lived practice. In other words, the contemporary concern is not merely whether the service “has” a safety policy, but whether that policy is expressed in work relationships, information flows, and everyday decisions (BRAZIL, 2025d).

An additional achievement, still in the process of maturing, concerns patient and family participation in care. The WHO dedicated World Patient Safety Day 2023 to the theme “Engaging patients for patient safety,” recognizing that patients, family members, and caregivers play a crucial role

in the safety of care. Reviews such as that by Vaismoradi, Jordan, and Kangasniemi (2015) show that patients can participate in safety initiatives and contribute to identifying risks, reporting signs of clinical deterioration, questioning inconsistencies, and strengthening treatment adherence. The incorporation of this principle is particularly transformative because it dismantles the image of the patient as a passive recipient of care and reposition them as a legitimate partner in the prevention of avoidable harm (VAISMORADI; JORDAN; KANGASNIEMI, 2015; WORLD HEALTH ORGANIZATION, 2023b, 2023c).

It must be acknowledged, however, that these achievements are not distributed evenly. In many settings, adherence to protocols is inconsistent, units operate with limited resources, reporting remains incomplete, and patient participation faces cultural resistance. Even so, the progress already achieved is significant: patient safety has ceased to be a peripheral issue and has become part of institutional vocabulary, professional training, and quality assessment. This shift, in and of itself, already represents an important achievement for the multidisciplinary team and public health policies.

Strategic Perspectives for Strengthening the Multidisciplinary Team

If patient safety depends on genuine cooperation among professionals, it is necessary to invest in strategies that concretely strengthen interprofessional practice. This involves improving clinical meetings, structuring safer shift handoffs, standardizing communication tools, reviewing care transition workflows, expanding the role of clinical pharmacy, supporting leaders capable

of fostering psychological safety within teams, and including the patient as a participant in the treatment plan. The literature demonstrates that improved communication and team training can have a positive impact on safety culture, while studies on interprofessional collaboration show that integration among professional categories is associated with improved care quality and a better patient experience (GLEESON et al., 2023; ALSABRI et al., 2022; ROSEN et al., 2018).

Furthermore, strengthening the interprofessional team requires addressing material constraints in the workplace. There is no solid safety culture in environments marked by precarious conditions, chronic exhaustion, limited time, and structures that hinder communication. Recognizing this reality is essential to avoid a purely moralistic approach to the issue, in which professionals are expected to be flawless even when operating within unsafe systems. In this sense, patient safety is also a matter of work management, service organization, and political commitment to adequate care conditions.

Finally, the consolidation of a multidisciplinary safety culture requires continuity. Isolated protocols, occasional training sessions, and annual campaigns have value, but they do not replace ongoing processes of monitoring, education, evaluation, and feedback to teams. Patient safety is strengthened when the institution learns, when professionals feel empowered to speak up, when patients are heard, and when errors cease to be taboo and become a source of transformation. It is in this direction that the greatest challenges of the present and the most promising possibilities of the future lie.

FINAL CONSIDERATIONS

The analysis conducted suggests that patient safety is a historical, ethical, organizational, and clinical construct that has gained normative and scientific substance, but still faces significant barriers to its full implementation in the day-to-day operations of healthcare services. Among the most significant challenges are ineffective communication, a punitive culture, underreporting of incidents, fragmented care, work overload, and the difficulty of consolidating truly interprofessional practices. These elements demonstrate that preventable harm cannot be understood merely as an isolated failure, but as a sign of systemic vulnerabilities that require a coordinated institutional response.

At the same time, the field has achieved significant and irreversible progress. The institutionalization of patient safety on national and international agendas, the creation of the National Patient Safety Program (PNSP), the work of Anvisa, the establishment of Patient Safety Centers, the dissemination of protocols, and the growing emphasis on a culture of safety indicate that there has been significant maturation in how care is conceived and organized. Added to this is the gradual strengthening of the interprofessional perspective and the recognition of the patient as a legitimate stakeholder in healthcare safety.

It can therefore be concluded that the multidisciplinary team occupies a strategic position in transforming patient safety into effective practice. The prevention of avoidable harm depends less on individual heroic acts and more on the collective capacity to communicate, cooperate, learn, and sustain shared responsibility for care. In practical terms, this means that investing in patient

safety is investing in higher-quality working relationships, continuing education, committed leadership, living protocols, and institutions willing to learn from their own limitations.

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