IMPACTO CIENTÍFICO EDITORA

THE ROLE OF THE NURSE IN MEDICAL RECORD ANALYSIS: MAIN CHALLENGES ENCOUNTERED

FUNÇÃO DO ENFERMEIRO DIANTE DA ANÁLISE DE PRONTUÁRIOS: PRINCIPAIS DIFICULDADES ENFRENTADAS

EL PAPEL DE LA ENFERMERA EN EL ANÁLISIS DE HISTORIAS CLÍNICAS: PRINCIPALES RETOS AFRONTADOS

https://doi.org/10.56238/edimpacto2025.087-013

Katiulcy Carvalho Oliveira[1], Bruna Angelica Pereira[2], Denis Lay Neves Damião[3]

ABSTRACT

This study aims to highlight the importance of the nurse's role in the analysis of medical records, emphasizing the main challenges encountered in this process. The analysis of medical records is a fundamental practice to ensure the quality, continuity, and safety of healthcare, as it allows monitoring of clinical interventions and evaluation of the effectiveness of nursing care. In this context, nurses play a crucial role in verifying the completeness, accuracy, and coherence of recorded information, ensuring that documentation accurately reflects the care provided to patients. Nevertheless, several barriers are identified, including incomplete or inconsistent records, limited time for detailed reviews, lack of institutional standardization, and insufficient training in health information systems. These factors may compromise the reliability of documentation and, consequently, patient safety. Therefore, continuous professional education, the implementation of standardized documentation protocols, and the strengthening of communication within multidisciplinary teams are essential strategies to improve documentation practices and promote safer, higher-quality nursing care.

Keywords: Nursing. Medical Records. Documentation. Professional Practice. Patient Safety.

RESUMO

Este trabalho tem a finalidade de mostrar a importância da atuação do enfermeiro na análise de prontuários, destacando as principais dificuldades enfrentadas nesse processo. A análise de prontuários é uma prática essencial para garantir a qualidade, a continuidade e a segurança da assistência em saúde, pois possibilita o acompanhamento das ações realizadas e a avaliação da efetividade dos cuidados prestados. O enfermeiro, nesse contexto, desempenha papel fundamental ao verificar a completude e a coerência das informações registradas, assegurando que os dados reflitam fielmente o cuidado oferecido

[1] Master's degree in Health Care. E-mail: katiulcy@gmail.com
Lattes: http://lattes.cnpq.br/7091135674888973
[2] Undergraduate student in Nursing. Faculdade de Princípios Militares.
E-mail: brunaangelicapereira@gmail.com Lattes: https://lattes.cnpq.br/1040031107057319
[3] Undergraduate student in Nursing. Faculdade de Princípios Militares. E-mail: Tec.denislay@gmail.com
Lattes: https://lattes.cnpq.br/443186747786814

ao paciente. No entanto, diversos desafios são observados, como o preenchimento inadequado dos registros, a falta de tempo para análises detalhadas, a ausência de padronização institucional e a carência de capacitação específica para o uso de sistemas de informação em saúde. Esses fatores podem comprometer a qualidade dos registros e, consequentemente, a segurança do paciente. Assim, reforça-se a necessidade de investir em educação permanente, padronização dos processos de registro e fortalecimento da comunicação entre as equipes multiprofissionais, a fim de aprimorar a prática documental e garantir uma assistência de enfermagem mais segura e eficiente.

Palavras-chave: Enfermagem. Prontuário do Paciente. Documentação. Prática Profissional. Segurança do Paciente.

RESUMEN

Este trabajo tiene como objetivo demostrar la importancia del rol de la enfermera en el análisis de historias clínicas, destacando las principales dificultades que enfrenta en este proceso. El análisis de historias clínicas es una práctica esencial para garantizar la calidad, la continuidad y la seguridad de la atención sanitaria, ya que permite el seguimiento de las acciones realizadas y la evaluación de la efectividad de los cuidados brindados. En este contexto, la enfermera desempeña un papel fundamental en la verificación de la integridad y la coherencia de la información registrada, asegurando que los datos reflejen fielmente la atención ofrecida al paciente. Sin embargo, se observan diversos desafíos, como el llenado inadecuado de las historias clínicas, la falta de tiempo para un análisis detallado, la ausencia de estandarización institucional y la falta de capacitación específica en el uso de sistemas de información sanitaria. Estos factores pueden comprometer la calidad de las historias clínicas y, por consiguiente, la seguridad del paciente. Por lo tanto, se refuerza la necesidad de invertir en la formación continua, la estandarización de los procesos de registro y el fortalecimiento de la comunicación entre equipos multidisciplinarios, con el fin de mejorar las prácticas de documentación y garantizar una atención de enfermería más segura y eficiente.

Palabras clave: Enfermería. Historia Clínica. Documentación. Práctica Profesional. Seguridad del Paciente.

1 INTRODUCTION

This study seeks to explore the importance of the audit of medical records performed by nurses, an essential professional to ensure the quality and safety of health care. Auditing, in the context of health services, is a crucial process to ensure compliance with institutional standards, the quality of care provided and efficiency in the use of available resources. Thus, nursing auditing stands out as a strategic tool for quality control, allowing a systematic evaluation of the effectiveness and efficiency of care.

This study is justified by the need to understand the challenges faced by nurses in the auditing process. Despite its relevance, this practice still generates impasses, mainly due to conflicts between the auditor and the auditee when failures are identified. One of the major obstacles refers to the absence or inadequacy of nursing records, which compromises both the continuity of care and professional safety.

Researchers point out that the lack of identification of the professional, the incorrect use of abbreviations, writing errors and incomplete records are factors that directly hinder the audit. In addition, such failures are associated with a higher risk of adverse events, impairing the analysis of the patient's clinical evolution and compromising the reliability of the medical records.

In view of this scenario, the general objective of this study is to describe the functions of nurses and the main difficulties encountered in the analysis of medical records. As specific objectives, we seek to characterize the role of the clinical nurse and the auditor, identify the main challenges faced, evaluate the impacts of these difficulties on professional practice and propose measures capable of minimizing them.

Our research was guided by the following guiding question: "What is the importance of the nurse auditor and the main difficulties encountered in the analysis of medical records?"

2 OBJECTIVES

2.1 GENERAL OBJECTIVE

To describe the nurses' functions and the main difficulties encountered when analyzing medical records.

2.2 SPECIFIC OBJECTIVES

Describe the role of the nurse and the nurse auditor;

Identify the main difficulties faced by the nurse auditor.

3 LITERATURE REVIEW

3.1 NURSING AND ITS HISTORICAL CONTEXT

Nursing has a significant historical trajectory, starting empirically, when care was provided by family members, community members, priests and healers. In the Middle Ages, this practice began to have a strong link with the Catholic Church, being performed mainly by monks and nuns in monasteries, evidencing the religious influence in the care of the sick [1,2].

Nursing underwent a significant transformation in the nineteenth century with the work of Florence Nightingale, recognized as the founder of modern nursing. During the Crimean War, its hygiene measures and hospital reorganization significantly reduced mortality among wounded soldiers. Later, in 1860, she created the first professional nursing school at St. Thomas' Hospital in London, consolidating the foundations for the systematized training of nurses [3, 4].

In Brazil, the organization of nursing began in the colonial period, with the foundation of the first Santa Casa de Misericórdia, in Santos, in 1543, inspired by the Portuguese model. Over the centuries, the profession has undergone significant advances, driven by the legal regulation of the practice and, more recently, by the creation of the Unified Health System (SUS), which expanded and consolidated the role of nurses in public health care [5, 6].

3.2 AUDITING OF HEALTH SYSTEMS

According to the National Audit System (SNA), auditing health systems is an essential process to ensure the quality of the services provided, compliance with regulatory standards, and efficiency in the management of resources. It can be carried out at different levels, including hospitals, clinics, health plan operators, and public agencies [7].

The work carried out by the auditors will be formally reported, including examinations, opinions and recommendations intended by the entities, so that they make the necessary adjustments [8].

There are several types of auditing in the health area, such as verifying that internal processes are working well and that the services offered are of good quality; analyze expenses to ensure that the money is being used correctly; analyzing the adequacy of the procedures performed, verifying whether they are aligned with protocols and good health practices, is also responsible for supervising the application of public resources in the Unified Health System (SUS) [7].

3.3 LEGISLATION

The National Audit System (SNA) was created on June 27, 1993, article 6 of Law 8.689 and regulated on September 28, 1995 by Decree 1651. It operates at the three levels of SUS management – Federal, State and Municipal [7].

Health auditing in Brazil is regulated by several laws, standards, and decrees that guarantee the transparency and quality of the services provided. Some of the main laws and decrees include: Law No. 8,080/1990 - establishes the conditions for the promotion, protection and recovery of health, in addition to defining the organization and operation of the corresponding services; Law No. 8,689/1993: establishes the National Audit System (SNA) within the scope of the Unified Health System (SUS), regulated by Decree No. 1,651/1995; Complementary Law No. 141/2012: defines the minimum values to be applied annually by the Union, States and Municipalities in public health actions and services; Ordinance GM/MS No. 4,644/2022: provides for the preparation and approval of the Annual Internal Audit Plan (PAA) and the Annual Internal Audit Report (RAA) in the Unified Health System (SUS); COFEN Resolution No. 720/2023: Regulates the performance of nurses in nursing auditing, ensuring that services are performed by qualified professionals [7].

3.4 FUNCTIONS OF THE CLINICAL NURSE AND THE AUDITOR NURSE

The clinical nurse plays a fundamental role in providing direct care to patients, being responsible for activities such as medication administration, monitoring of vital signs, preparation of personalized care plans and emotional support. In addition, it works in the coordination of the nursing team, in the education of patients and family members about preventive health practices, and in the maintenance of accurate clinical records, contributing to the continuity and quality of the care provided [9].

The clinical nurse plays an essential role in the provision of direct care to the patient, being responsible for actions that involve welcoming, active listening and humanization, elements that favor the construction of therapeutic bonds and positively impact clinical outcomes. They face the challenge of balancing organizational and care tasks, being responsible for planning, executing and evaluating care [10].

While the clinical nurse works directly in the provision of patient care, such as medication administration, clinical monitoring and emotional support, the auditor nurse focuses on analyzing the quality of these services, evaluating records, compliance with protocols and efficiency of care processes. This distinction highlights the technical-operational character of the assistentialist and the analytical-managerial profile of the auditor [11].

The nurse auditor is responsible for reviewing medical records and clinical records in order to assess the quality of the care provided, proposing improvements that directly impact patient safety and the efficiency of health services [12].

The performance of the nurse auditor contributes to the administrative improvement of hospital institutions, by identifying losses and gains in care processes and proposing strategies for organizational restructuring [13].

The nurse auditor must have a holistic view of the care process, integrating clinical, economic and ethical aspects, in addition to issuing technical opinions that support managerial decisions [12].

Nursing auditing is an essential tool for controlling the quality of the services provided, allowing a systematic analysis of the efficiency and effectiveness of health care [14].

The performance of the nurse auditor is regulated by resolutions of the Federal Council of Nursing, which define their exclusive competencies and the ethical principles that should guide their practice [14].

The clinical nurse needs to master clinical and relational skills to deal with patients in real time, while the nurse auditor requires administrative skills, knowledge of health legislation and mastery of billing systems and procedure tables. The care experience is considered a differential for the auditor, as it allows a more accurate analysis of the audited processes [15].

3.5 ROLE OF THE NURSE IN THE ANALYSIS OF MEDICAL RECORDS

The Systematization of Nursing Care (NCS), as defined by the Federal Council of Nursing, is composed of interdependent stages that include evaluation, carried out through continuous data collection via interview and physical examination; nursing diagnosis, which identifies signs, symptoms and conditions of vulnerability of the patient; planning, which establishes a care plan with therapeutic measures; implementation, that it performs the planned actions; and evolution, which records the results obtained throughout the care [16, 17].

Nursing records should be clear, objective and concise about the care provided to hospitalized patients, functioning as a link between nurse evolution and nursing prescription. In addition to serving as a means of effective communication between the professionals involved in the care that ensures the continuity of services with quality. The information recorded in the medical record should reflect positively on the care, being carried out in an ethical, respectful and cordial manner [18,19].

Based on the analysis performed, the nurse auditor is able to identify critical areas that require greater attention, as well as training and continuing education needs of the

professionals involved in the care process, contributing to the continuous improvement of the quality of care [20, 21].

3.6 MEDICAL RECORD ANALYSIS

Medical record analysis is a systematic process of reviewing and evaluating patient care records. Its main objective is to ensure the accuracy, integrity and compliance of documents with regulatory standards and best care practices [22].

It allows healthcare professionals to thoroughly examine medical records, including progress notes, lab reports, test results, prescriptions, and doctor's orders. In this way, it is possible to identify discrepancies, errors, omissions, or inadequacies in documentation that may compromise the quality of patient care [22].

In addition, the audit of medical records helps to ensure that the services provided by the multiprofessional team are being provided properly, contributing to the improvement of the quality of care and to the reduction of costs through more efficient management [22].

3.7 DIFFICULTIES FACED BY NURSE AUDITORS

Incomplete records are directly associated with the increase in adverse events, and with the role of the nurse auditor in the review of medical records, playing a strategic role in ensuring the quality of care, in the efficiency of billing and maintaining patient safety during the care process. At the same time, this activity faces multiple challenges that can compromise its effectiveness and generate professional exhaustion [23].

Poorly filled out medical records compromise the evaluation of the patient's clinical evolution, that the absence of clear information can lead to errors in the administration of medications, duplication of procedures or omission of essential care, taking into account that the lack of accurate data makes it difficult to plan interventions and communicate between shifts and multidisciplinary teams [24].

The quality of the record directly influences the assertiveness of nursing decisions**,** without adequate access to reliable information, nurses can make decisions based on assumptions, increasing the risk of inappropriate care conducts and making it impossible to later analyze the medical record in relation to care [25].

Nursing records are legal and technical instruments that support professional practice and quality management, poorly structured medical records make it difficult to measure performance indicators and identify failures in care processes, such as nursing records.

3.8 METHODS THAT HELP IN THE ANALYSIS OF MEDICAL RECORDS

The analysis of a medical record by the nurse auditor, when based on scientific and normative references, follows a structured process that combines technical, legal and quality of care criteria. It is not just "reading what is written", but verifying that the record complies with standards that guarantee security, continuity of care and legal support [27, 28, 29].

According to COFEN resolutions (such as No. 514/2016) and current legislation guide what should be included in the records, completeness, legibility, chronology, use of technical language, absence of erasures and coherence between evolution, prescription and procedures performed, methods that help in the analysis and quality of a nursing record that helps to define indicators and checklists [29].

The medical records must include the correct identification of the patient, the verification of personal and administrative data, the verification of records of signs, symptoms, nursing diagnoses, interventions and patient responses, as well as the verification that all documents are complete, dated, signed and compatible with the clinical evolution [29, 30, 31].

The use of validated checklists allows measuring compliance with institutional protocols and clinical guidelines, in addition to comparing practice with standards described in the literature, ensuring objective and measurable records that contribute to the reduction of errors and hospital disallowances [32, 33].

3.9 MAIN DIFFICULTIES FACED BY THE NURSE AUDITOR

The [21] audit in nursing consists of a careful and organized evaluation of the quality of care provided to patients. With this, the medical records are analyzed and the compatibility between the procedures performed and the items included in the hospital bill is verified. This process ensures that the charge is adequate and that the payment is made fairly.

It has been observed in some studies that the absence of professional identification, the inappropriate use of abbreviations, writing errors and the lack of nursing records hinder the audit process, and it is worth noting that these records are of paramount importance for the safety of the professional. Thus, the lack of information makes us reflect on what the clinical nurse understands about the NCS and about their daily responsibilities [21].

According to the Code of Ethics for Nursing Professionals - Art. 41 - it establishes that it is the professional's duty to provide complete and reliable verbal and written information, thus ensuring the continuity of care [34].

Another aspect identified in the readings was the lack of communication between professionals, marked by constant conflicts. Auditing is an essential tool for management and

quality. However, when pointing out errors and failures, many professionals do not recognize them, which generates conflicts between the auditee and the auditor [21].

The recurrent failures in nursing records reinforce the need for continuing education to ensure adequate notes [35].

3.10 IMPACT THAT THESE DIFFICULTIES CAN HAVE ON THE NURSES' PERFORMANCE DURING THE ANALYSIS OF MEDICAL RECORDS

During the analysis of medical records, the nurse auditor is often faced with incomplete or missing records, which compromises the evaluation of the quality of care and hinders the traceability of the actions performed. This document gap directly impacts patient safety and the measurement of results [21].

Another recurring challenge is the difficulty of communication and integration between the different sectors and professionals involved in care, which can generate inconsistencies in the information recorded and impair the continuity of care [36].

In addition, the overload of functions and the low institutional recognition of nursing auditing can limit the time and resources available for an in-depth analysis, affecting the effectiveness of the process and the implementation of improvements [36].

3.11 METHODS FOR ASSESSING AND MINIMIZING THESE DIFFICULTIES

In view of the studies and experience, it is perceived that there is a significant difficulty for the nursing team to report the procedures performed, thus, it is up to the nurse to develop and act in skills development processes to minimize the difficulties faced [37].

According to COFEN Resolution No. 514/2016, the systematic evaluation of records must be carried out through periodic audits and application of standardized instruments, such as checklists based on its guidelines. These instruments make it possible to measure the compliance of records with legal standards, identify the main document failures and establish correction plans. The use of quality indicators, such as the completeness rate and compliance of records, is also an efficient tool for monitoring practice and directing training [28].

Permanent Education in Health (EPS) enables critical reflection on practice, promotes the exchange of knowledge among professionals and stimulates the development of technical, ethical and communicative skills, and should be implemented in the routine of the units. The central point of continuing education is the professional's ability to analyze their own practice and transform it based on the reality experienced [38].

The care aspects involve valuing the nursing record as part of the care process. A complete and ethical record reflects the continuity of care, guarantees legal support and

strengthens communication between the members of the multiprofessional team. Thus, it is essential that nurses encourage safe practices and promote the standardization of records, ensuring the traceability of actions and the quality of care provided [34].

The pedagogical and technical-scientific aspects refer to continuous training and access to normative and scientific updates. Investment in courses, workshops and training on nursing auditing and documentation strengthens the critical and technical performance of nurses and nurse auditors, in addition to promoting professional autonomy. On the other hand, the political and organizational aspects are linked to the creation of institutional policies to value nursing auditing and records, ensuring adequate working conditions and recognition of the importance of this process in quality management [21].

Therefore, the combination of evaluation methods, continuing education, technical strengthening and institutional incentive constitutes the basis for overcoming the difficulties faced by the nurse auditor in the analysis of medical records. These actions favor a safer, more transparent practice that is committed to excellence in health care.

4 METHOD

4.1 TYPE OF STUDY

The present study is a Final Paper of an undergraduate course in Nursing at the Faculty of Military Principles and addresses an integrative systematic bibliographic review of scientific articles that address as the main subject the theme "Nurse's role in the analysis of medical records".

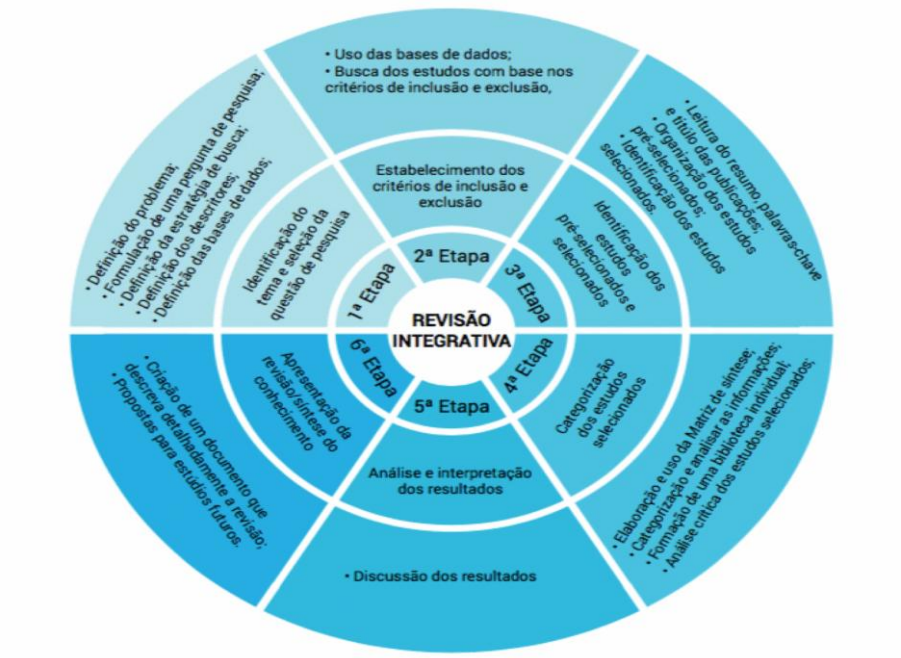
Integrative review is a type of research method that seeks to summarize the existing literature on a particular subject, both empirical and theoretical, with the goal of providing a more complete understanding of the phenomenon in question. The main objective of this approach is to analyze the existing knowledge in previous research on the subject, allowing the synthesis of multiple studies and the generation of new knowledge based on the results presented by previous studies.

The concept of "integrative" comes from the combination of opinions, concepts, or ideas originating from research using methodologies, including experimental and non-experimental approaches.

The literature review study is an integrative evaluation analysis that is carried out in six stages, namely: identification of the theme and selection of the research question; establishment of inclusion and exclusion criteria; definition of pre-selected and selected studies; categorization of the selected studies; analysis and interpretation of results; presentation of the review/synthesis of knowledge (BOTELHO, CUNHA, MACEDO, 2011).

Figure 1

Stages of the integrative review



Source: BOTELHO; WEDGE; MACEDO, 2011.

The integrative review gets its name because it provides details about certain problems that are in the literature various scientific opinions and formalized studies, in this way, the researcher who does the integrative review can offer a wide variety of useful views that improve the idea, evaluate the concept or evaluate the research method in a specific article (ERCOLE et al., 2014).

To define the research question that will guide the entire following study, we used the PICO strategy, which consists of an acronym for Patient, Intervention, Comparison and "Outcomes", thinking about these four strands, we formulated our guiding question: "What is the importance of the nurse auditor in the analysis of medical records?"

From the formulation of the guiding question, the writing of the objectives of this study began, in which it was defined "What is the importance of the nurse auditor and the main difficulties encountered in the analysis of medical records?"

Thus, the inclusion and exclusion criteria emerged, as an inclusion criterion we used articles ≥ 2015; integrative reviews; systematic reviews; studies in the area of nursing; articles written in English and Portuguese; as exclusion criteria we used articles that did not address the topic in full, studies dated less than 2015 (except in descriptive contexts the laws, ordinance and manuals). We used studies available between January 2015 and October 2025.

A search was carried out in the online databases of international and national literature. The results of the present study were obtained from the following databases: SCIELO (Scientific Electronic Library Online); VHL (Virtual Health Library), and Google Scholar.

In all three databases, the following descriptors were used: "health audit", "nurse auditor", "medical record analysis", "difficulties faced", "continuing education", "audit laws".

The search returned the following results 76 SCIELO (Scientific Electronic Library Online), after applying the inclusion, exclusion and evaluation criteria according to the guiding question, the result of this database was given by 10 studies. In the VHL (Virtual Health Library) database, 61 were located, which in the sequence, after using the criteria of inclusion, exclusion and fit to our objective given through the guiding research, resulted in 25 studies, finally in Google Scholar we obtained 81 results and after applying the criteria, the result was 43 studies.

In all, we obtained 78 studies as bibliographic return, and only 59 of them were used, for the next phase, in which the titles, abstracts and studies in full were carefully read, and only 38 articles were selected for this study.

5 INCLUSION AND EXCLUSION CRITERIA

5.1 INCLUSION CRITERIA

The inclusion criteria were: all types of articles that addressed the theme, articles ≥ 2015, studies in the area of nursing; Articles written in English, Spanish and Portuguese. Studies available between January 2015 and October 2025 were used. We selected 59 articles for reading in full, in which 38 articles were used to compose this work.

5.2 EXCLUSION CRITERIA

The exclusion criteria were defined articles that did not address the topic in full and studies dated less than 2015 (except in descriptive contexts the laws, ordinances and manuals).

5.3 VENUE AND PARTICIPANTS

The study was carried out in Goiânia, Goiás, Brazil, by students of the 10th period of the nursing course at the Faculty of Military Principles: Bruna Angelica Pereira and Denis Lay Neves Damião under the guidance of Professor Katiulcy Carvalho Oliveira.

5.4 ETHICAL ASPECTS

All ethical and legal aspects that guide integrative systematic review research will be followed. Attesting to the elaboration of the articles studied in this work, with citations and references of the authors following the norms of the Brazilian Association of Technical Standards (ABNT).

6 DATA ANALYSIS

All types of articles that addressed the theme Role of nurses in the analysis of medical records were analyzed. Articles referring to the years 2015 to 2025 were selected.

A total of 59 articles were selected for reading, in which 38 articles were used for the composition of this work.

Articles that did not address the topic in full and studies dated less than 2015 (except in descriptive contexts such as laws, ordinances and manuals) were not analyzed, except for 38 articles, according to exclusion criteria.

7 FINAL CONSIDERATIONS

In view of this theme, which is the complexity inherent to document analysis and the challenges in the quality of the record in medical records, we used the research method of Systematic Integrative Review, seeking a better understanding of the subject.

We observed that some professionals, including nursing, do not have in-depth knowledge about the guidelines and legal implications of the correct analysis and recording in the medical record. We found few articles that specifically mention the difficulties of nursing in this activity. And in analyzing the articles found, we saw that there is a greater scope on the importance of electronic medical records and patient safety in general.

With this work, we want to emphasize the importance of careful analysis of the medical record, as knowledge about its regulations and quality of completion is scarce, and to show that this procedure can guarantee the safety of the patient and the professional. Since in most situations the failure in communication or registration would lead to assistance errors, in addition to benefiting the professional defense in any ethical and judicial proceedings.

It is understood that there is a lack of awareness of the team about the entire careful process, laws, resolutions and regulations that govern the completion and storage of the medical record, generating inconsistencies, omissions and difficulty in the traceability of information.

Taking into account that the medical record is a legal, confidential document that reflects the totality of the care provided to the patient. And for this analysis to be effective, a

deep investigation is needed on the content (clinical data, evolution and exams), the form (readability, organization) and compliance with current regulations.

Nursing is referenced for its technical knowledge, care management capacity and holistic view of the patient. Thus, the importance of the nurse is highlighted, as he is inserted in the patient's entire trajectory and acts in the leadership of the team, being able to bring great knowledge and clarification of doubts about the importance and difficulties faced in maintaining the quality of the records in the medical record, an element that is so crucial for safe and legal care.

REFERENCES

1. Portal Enfermagem. (s.d.). A história da enfermagem: Um panorama aprofundado. https://portalenfermagem.com.br/a-historia-da-enfermagem/

2. Universidade do Oeste Paulista. (2024). Pesquisa científica do curso de enfermagem. https://www.unoeste.br/graduacao/faculdade-de-enfermagem/pesquisa-cientifica

3. Campos, L. V. (s.d.). Florence Nightingale. https://brasilescola.uol.com.br/biografia/florence-nightingale.htm

4. Y7rik. (2024, 20 de fevereiro). Florence Nightingale: Biografia, teoria e contribuições. https://maestrovirtuale.com/florence-nightingale-biografia-teoria-e-contribuicoes/

5. Associação Educacional Dom Bosco. (2021). História da enfermagem no Brasil. https://www.aedb.br./

6. Conselho Regional de Enfermagem de São Paulo. (2017). História da enfermagem: Da Santa Casa ao SUS. https://portal.coren-sp.gov.br

7. Brasil. Ministério da Saúde. (2023). Tipos de auditoria na saúde. https://www.gov.br/saude/pt-br

8. Oliveira, B., Fialho Barbosa, M., Medeiros Rosa, M., Felicio Batista Filho, A., Aparecida Bayonetta de Souza, J., & Lacerda de Almeida Junior, A. (2020). Auditoria: Conceitos, características e especificidades. Revista Mythos, 13(1), 33–39. https://periodicos.unis.edu.br/mythos/article/view/376

9. Excelente Care. (2024, 7 de outubro). Funções cruciais do enfermeiro assistencial. https://cuidador.excelentecare.com.br/blog/categorias/artigos/funcoes-cruciais-do-enfermeiro-assistencial

10. Cavalcante, D. A. L., & Silva, M. L. (2025). Protagonismo do enfermeiro frente à gestão da atenção básica: Revisão integrativa. Revista Interdisciplinar de Saúde, 12, 1750–1760. https://www.exemplo.com.br/artigo

11. Silva, S. R. (2018). Auditoria em enfermagem: O enfermeiro auditor e a assistência prestada à saúde [Internet]. https://www.exemplo.com.br/artigo

12. Machado, R. S. (2025). Competências técnicas do enfermeiro auditor no contexto da auditoria em saúde. Revista FT, 29(149). https://revistaft.com.br/

13. Tibúrcio, A. P. N., Sousa, L. A. A., & Santos, R. F. (2019). A importância do enfermeiro auditor nas instituições hospitalares. Psicodebate, 5(1). https://psicodebate.dpgpsifpm.com.br/

14. Hospital Universitário Júlio Bandeira de Mello. (2023). Manual de auditoria de enfermagem. https://www.exemplo.com.br/manual-hujb

15. Conselho Regional de Enfermagem da Bahia. (2017). Parecer COREN–BA nº 010/2017. https://www.coren-ba.gov.br/pareceres/

16. Conselho Federal de Enfermagem. (2024). Resolução n.º 736/2024: Atualiza a implementação do Processo de Enfermagem (PE). https://www.cofen.gov.br/cofen-atualiza-resolucao-sobre-implementacao-do-processo-de-enfermagem/

17. Barbosa, A. A., Rosa, S. C., & Brasileiro, M. S. E. (2018). Implantação da Sistematização da Assistência de Enfermagem – SAE, no serviço de enfermagem: Revisão integrativa. Revista Científica Multidisciplinar Núcleo do Conhecimento, 3(3), 102–109. https://www.nucleodoconhecimento.com.br/saude/sistematizacao-da-assistencia-de-enfermagem

18. Conselho Regional de Enfermagem de São Paulo. (2022). Anotação de Enfermagem. https://portal.coren-sp.gov.br/wp-content/uploads/2022/09/anotacao-de-enfermagem.pdf

19. Silva, M. A., & Oliveira, R. C. (2018). Importância das anotações de enfermagem para a qualidade da assistência. Revista de Enfermagem Contemporânea, 7(1), 45–52. https://www5.bahiana.edu.br/index.php/enfermagem/article/view/1880

20. Almeida, T. S., Miura, C. R., Azzolin, G. M. C., & Oliveira, N. A. (2021). A atuação do enfermeiro auditor na qualidade da assistência à saúde: Revisão bibliográfica integrativa. Revista de Administração em Saúde, 21(85). https://cqh.org.br/ojs-2.4.8/index.php/ras/article/view/303/447

21. Morais, A. M., Silva, K. C. O., Lemos, T. A. B., Sousa, M. M., Silva, M. F. N., & Rodrigues, I. D. C. V. (2019, junho–agosto). Obstáculos enfrentados pelo enfermeiro auditor no serviço de saúde: Revisão bibliográfica. Brazilian Journal of Surgery and Clinical Research, 27(1), 121–125. https://www.mastereditora.com.br/periodico/20190607_200700.pdf

22. Caldas, E., Ferreira, M. V., Marcelino, E. da C., Caixeta, F. de C., Ribeiro, A. T. M. C., & Rosa, S. A. (2023, julho–agosto). Auditoria em saúde aplicada pela enfermagem: Uma ferramenta de gestão. Brazilian Journal of Health Review, 6(4), 16946–16961. https://ojs.brazilianjournals.com.br/ojs/index.php/BJHR/article/view/62010/44654/

23. Souza, T. M., et al. (2019). Impacto dos registros incompletos na assistência de enfermagem. Revista Saúde Foco. https://www.exemplo.com.br/artigo

24. Mendes, M. A., & Silva, R. A. (2020). A importância do registro de enfermagem na continuidade do cuidado. Revista de Enfermagem Atual. https://www.exemplo.com.br/artigo

25. Oliveira, J. S., et al. (2018). Qualidade dos registros de enfermagem e sua relação com a segurança do paciente. Revista Brasileira de Enfermagem. https://www.exemplo.com.br/artigo

26. Agência Nacional de Vigilância Sanitária. (2013). Manual de notificação de eventos adversos. https://www.gov.br/anvisa/pt-br/assuntos/medicamentos/eventos-adversos

27. Camilo, M. S., & Mota, E. A. (2018). A importância do enfermeiro auditor na análise dos registros e anotações de enfermagem: Uma revisão integrativa. Brazilian Journal of Surgery and Clinical Research, 24(3), 66–71. https://www.exemplo.com.br/artigo

28. Carvalho Junior, A. S., et al. (2023). A relevância do registro de enfermagem no processo de auditoria. Revista de Saúde UNIFAN, 3(1), 49–57. https://www.exemplo.com.br/artigo

29. Conselho Federal de Enfermagem. (2016). Resolução nº 514, de 5 de maio de 2016: Guia de recomendações para registro de enfermagem no prontuário do paciente e outros documentos de enfermagem. https://biblioteca.cofen.gov.br/guia-de-recomendacoes-para-registro-de-enfermagem-no-prontuario-do-paciente-e-outros-documentos-de-enfermagem/

30. Hemesath, M. P., et al. (2015, dezembro). Estratégias educativas para melhorar a adesão à identificação do paciente. Revista Gaúcha de Enfermagem, 36(4), 55–61. http://www.seer.ufrgs.br/rgenf/article/view/52530

31. Brasil. (2013, 23 de outubro). Lei nº 12.871, de 22 de outubro de 2013: Institui o Programa Mais Médicos, altera as Leis nº 8.080, de 19 de setembro de 1990, e nº 8.142, de 28 de dezembro de 1990, e dá outras providências. Diário Oficial da União: Seção 1. http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2013/lei/l12871.htm

32. Silva, G. L., et al. (2021). Ações de enfermagem que promovem a segurança do paciente no âmbito hospitalar. Research, Society and Development, 10(5), Article e44110515202. https://rsdjournal.org/index.php/rsd/article/view/15202/13601

33. Boeckmann, L. M. M., & Rodrigues, M. C. S. (2018). Adaptação e validação de checklist de segurança cirúrgica na cesárea. Texto & Contexto Enfermagem, 27(3), Article e2780017. https://www.scielo.br/j/tce/a/bgRN5yG79j654M4prxr8vyr?lang=pt

34. Conselho Federal de Enfermagem. (2017). Código de Ética dos Profissionais de Enfermagem. Resolução COFEN nº 564/2017. https://www.cofen.gov.br/

35. Lopes Lima, O. J., & Lima, Â. R. A. (2017). Realização da evolução de enfermagem em âmbito hospitalar: Uma revisão sistemática. Revista Journal of Nursing and Health. https://periodicos.ufpel.edu.br/index.php/enfermagem/article/view/9076/

36. Almeida, H. M. F., & Fonteles, H. M. A. (2025). Auditoria em serviços de saúde: Desafios e resultados da atuação da enfermagem. Revista FT, 29(147). https://revistaft.com.br/auditoria-em-servicos-de-saude-desafios-e-resultados-da-atuacao-da-enfermagem/

37. Siqueira, A., et al. (2017). Erros de enfermagem: Análise crítica sobre a liderança do enfermeiro. Disciplinarum Scientia Série: Ciências da Saúde, 17(2), 181–189. https://periodicos.ufn.edu.br/index.php/disciplinarumS/article/view/2028

38. Freire, P. (2011). Pedagogia da autonomia: Saberes necessários à prática educativa (43ª ed.). Paz e Terra. https://nepegeo.paginas.ufsc.br/files/2018/11/Pedagogia-da-Autonomia-Paulo-Freire.pdf