Analysis of The Content of Nursing Developments in a University Hospital

Análise do Conteúdo das Evoluções de Enfermagem em um Hospital Universitário
Análisis del Contenido de los Desarrollos de Enfermería en un Hospital Universitario

RESUMO
Objetivo: Analisar o conteúdo das evoluções de enfermagem em um hospital universitário. **Método:** Estudo qualitativo, desenvolvido em um hospital universitário em Salvador, Bahia, Brasil, em dezembro/2023, mediante coleta das evoluções de enfermagem das últimas 24 horas de pacientes internados há pelo menos um dia, processadas pelo software Iramuteq. Projeto aprovado pelo comitê de ética em pesquisa, CAAE-71498723.7.0000.0049. **Resultados:** Analisou-se 180 evoluções que geraram quatro classes por similaridade de conteúdo. A primeira classe descreve as queixas, sono, eliminações fisiológicas, uso de dispositivos invasivos; a segunda registra dados identificatórios do paciente, diagnóstico médico; a terceira descreve o exame-físico destacando a inspeção e palpação; a quarta relata evolução das últimas 24 horas do paciente: estado geral, sinais, sintomas, padrão hemodinâmico. **Conclusão:** Nota-se ênfase em aspectos médicos, predomínio da escrita descritiva frente a avaliativa e sub-registros de informações indispensáveis à assistência. Sugere-se ações institucionais para qualificar o conteúdo das evoluções de enfermagem conforme legislação**.**
DESCRITORES: Registros de enfermagem; Processo de enfermagem; Educação permanente; Enfermagem.

ABSTRACT
Objective: To analyze the content of nursing evolution reports in a university hospital. **Method:** Qualitative study, developed in a university hospital in Salvador, Bahia, Brazil, in December/2023, through the collection of nursing evolution reports from the last 24 hours of patients hospitalized for at least one day, processed by the Iramuteq software. Project approved by the research ethics committee, CAAE-71498723.7.0000.0049. **Results:** 180 evolution reports were analyzed, generating four classes by content similarity. The first class describes complaints, sleep, physiological eliminations, use of invasive devices; the second records patient identification data, medical diagnosis; the third describes the physical examination, highlighting inspection and palpation; the fourth reports the patient's evolution in the last 24 hours: general condition, signs, symptoms, hemodynamic pattern. **Conclusion:** There is an emphasis on medical aspects, a predominance of descriptive writing over evaluative writing, and under-recording of information essential to care. Institutional actions are suggested to qualify the content of nursing development reports in accordance with legislation.
DESCRIPTORS: Nursing records; Nursing process; Continuing education; Nursing.

RESUMEN
Objetivo: Analizar el contenido de los informes de evolución de enfermería en un hospital universitario. **Método:** Estudio cualitativo, desarrollado en un hospital universitario en Salvador, Bahía, Brasil, en diciembre/2023, a través de la recopilación de informes de evolución de enfermería de las últimas 24 horas de pacientes hospitalizados durante al menos un día, procesados por el software Iramuteq. Proyecto aprobado por el comité de ética en investigación, CAAE-71498723.7.0000.0049. **Resultados:** Se analizaron 180 informes de evolución, generando cuatro clases por similitud de contenido. La primera clase describe quejas, sueño, eliminaciones fisiológicas, uso de dispositivos invasivos; la segunda registra datos de identificación del paciente, diagnóstico médico; la tercera describe el examen físico, destacando la inspección y la palpación; la cuarta informa la evolución del paciente en las últimas 24 horas: estado general, signos, síntomas, patrón hemodinámico. **Conclusión:** Hay un énfasis en los aspectos médicos, un predominio de la escritura descriptiva sobre la escritura evaluativa y un subregistro de información esencial para el cuidado. Se sugieren acciones institucionales para cualificar el contenido de los informes de desarrollo de enfermería, de acuerdo con la legislación vigente.
DESCRIPTORES: Registros de enfermería; Proceso de enfermería; Educación continua; Enfermería.

Aliane da Silva Andrade
Nursing student at the Federal University of Bahia (UFBA). Salvador/Bahia, Brazil
ORCID: https://orcid.org/0009-0001-9298-0864

Valdenir Almeida da Silva
Nurse and member of the Continuing Education in Nursing Committee (CEPE) of the Professor Edgard Santos University Hospital (HUPES/UFBA). Adjunct Professor at the Federal University of Bahia (UFBA)/Salvador (BA), Brazil. Doctor from the Postgraduate Program in Nursing and Health at UFBA.
ORCID: https://orcid.org/0000-0003-1947-468X

Andreia Santos Mendes
Nurse and coordinator of the Continuing Education in Nursing Committee (CEPE) at the Professor Edgard Santos University Hospital (HUPES/UFBA). Master's degree and doctoral candidate in the Postgraduate Program in Nursing and Health at UFBA.
ORCID: https://orcid.org/0000-0002-6929-3951

Rosana Santos Mota
Nurse and Head of the Nursing Division at Professor Edgard Santos University Hospital (HUPES/UFBA). PhD from the Postgraduate Program in Nursing and Health at UFBA.
ORCID: https://orcid.org/0000-0002-3193-9972

Alessandra de Jesus Salomão
Radiology Technician at Fortes Technical Training in Health. Salvador/Bahia, Brazil. Nursing student at the Federal University of Bahia (UFBA).
ORCID: https://orcid.org/0009-0000-0449-2805

Received: 07/14/2025
Approved: 30/07/2025

DOI: https://doi.org/10.36489/nursing.2025v29i325p10976-10989

INTRODUCTION

Medical records gather essential information about patients' journeys in healthcare facilities through various records of the multidisciplinary team. Nursing records, among their purposes, include providing evidence of the application of the Nursing Process (NP). Chronological records in medical records allow for the identification of the care provided to patients. Furthermore, they facilitate communication within the multidisciplinary team, serve as a basis for scientific research, and provide legal support for potential questions regarding the care provided. Therefore, their quality is essential to ensuring patient and professional safety, assuming legitimate, clear, and consistent information. [1,2]

The international panel establishes that nursing documentation should reflect the NP consistently, clearly, and factually, with critical reasoning expressed in the recording of the patient's physical, psychological, and spiritual state. This avoids the adoption of generalizations, biases, and subjective labels that could compromise the assessment of the care provided. [3]

The nursing care methodology is systematized in five crucial and interrelated stages, namely: Nursing Assessment, Nursing Diagnosis, Nursing Planning, Nursing Implementation and the fifth stage, Nursing Evolution. (4) Nursing progress reports, assigned as a function exclusively to nurses, should be written in an impersonal and objective manner, focusing on the periodic assessment of the patient's general condition. This record is based on identified care needs, the patient's responses to the care provided, and a review of the NP stages, supported by scientific literature. [1,5] Such record must express a relationship with the EP and its basic standards, including standardized, clear, concise and reliable language; be free of erasures, personal abbreviations and unfamiliar language; and follow the chronology of the assistance performed in the last 24 hours. [1]

The nursing progress record is an intrinsic factor in the care provided, as it attributes responsibility to the person who wrote it and confirms the competence and safety of the care provided, in accordance with established legal standards. [3] Like other records in medical records, the evolution is also used in audits and legal proceedings to determine what care was provided to the patient and to define the time frame of the analyzed event, to identify the professionals involved and to resolve conflicts in statements. [3,6]

International literature shows a close correlation between inaccurate, incomplete and untimely nursing records and the quality of care, which tend to reflect the same weaknesses.[6] Incompetence in documenting information is directly related to the distance from standards of excellence in professional practice, which can be harmful to the nurse-patient relationship. [7]

Thus, developing a nursing progress report, understanding it as an expression of the NP, requires nurses to possess critical thinking and scientifically grounded clinical reasoning skills that guide care. However, although mastery of writing parameters is crucial, and there are guidelines proposed by the Federal Council of Nursing (COFEN) for writing nursing progress reports, there is no consensus in the literature regarding their content or writing format.

Several publications derived from medical record audit research address the quality of nursing records regarding compliance with related legislation and the inclusion of essential items for documenting patient care. Furthermore, no current articles have been found in the national or international literature analyzing the content of nursing progress reports. What should be recorded is known, but not what is actually practiced by professionals.

Thus, this article aims to shed light on this point and prompt a discussion on the need for a progress record practice based on nursing standards that demonstrates the scientific basis for care provided through the NP methodology. Given the above, this article aims to analyze the content of nursing progress reports in a university hospital.

METHOD

This research is a qualitative study based on the analysis of the dynamics and structure of a given reality, based on a work environment comprised of meanings, values, experiences, and intentions. To understand attitudes and minimize the disconnect between theory and practice, it was possible to examine textual elements. [8] It was conducted at a University Hospital (UH) located in Salvador, Bahia, Brazil, which provides medium- and high-complexity care and has 277 full-time inpatient beds. The choice of the research site was based on the idea that it should follow ethical principles, set an example in the care provided, and train new professionals.

Data collection was conducted on a single day in December 2023. All nursing progress reports from the last 24 hours recorded in electronic medical records of patients hospitalized for more than one day were collected, regardless of the specific focus of care in the wards. Eleven units for adult patients and three pediatric units at all levels of complexity participated in the research, such as intensive care units (ICU), clinical, surgical and psychiatric wards.

The collected developments that constituted the corpus of analysis were grouped into a single document in LibreOffice software, coded according to the numerical order of collection. They were then standardized in terms of language and grammatical norms,

DOI: https://doi.org/10.36489/nursing.2025v29i325p10976-10989

formatted, and exported according to the standards of the Iramuteq (R Interface for Multidimensional Analysis of Texts and Questionnaires) software, chosen for processing the textual corpus.

Iramuteq is a free and open-source software, licensed under the GNU General Public License (GPL) (v2), developed by Pierre Ratinaud in 2009. It is widely used in qualitative research for statistical analysis of large volumes of textual data that share a common theme. It facilitates the presentation of an overview of a large textual corpus within a short period of time, thus enabling the researcher to understand the content derived from the research. Through objective analysis, it helps reduce results that confirm the researcher's prior assumptions about the corpus. [9]

For this research, we used Descending Hierarchical Classification (DHC). This approach aims to hierarchically group the text corpus into text segment (TS) classes. The software organizes the TS based on textual similarity, grouping common content. The most similar and recurring topics form classes and generate a tree diagram, called a dendrogram. [9]

To interpret the information, it was based on content analysis, which corresponds to a group of communication analysis techniques through systematic and objective procedures for describing the content of messages with the aim of obtaining indicators that favor the inference of knowledge from the content of the messages. [10]

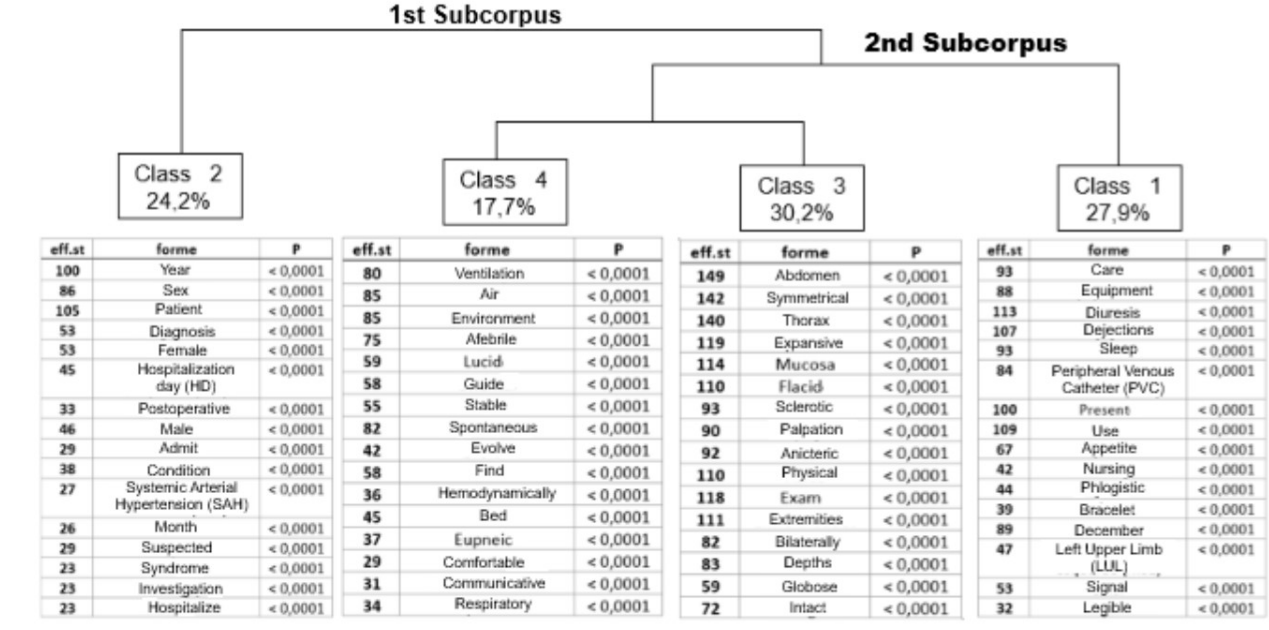
The main project was approved by a Research Ethics Committee (CEP) according to Resolution 466/12 of the National Health Council and received a favorable opinion through CAAE 71498723.7.0000.0049. The focus was maintained only on the content of the developments, on the generation of knowledge about the quality of nursing development records and on improving professional practice.

RESULTS

The research corpus consisted of 180 nursing development reports. After text preparation and export to Iramuteq software for processing, the textual retention rate was 84.59%, demonstrating a good level of similarity and homogeneity in the content of the analyzed development reports. The literature indicates that good retention in the software should be above 75%. [9]

The text corpus, automatically classified according to the similarity of its contents, generated a dendrogram illustrating the four classes obtained (Figure 1). Initial processing divided the corpus into two main subcorpuses, each with opposing similarity in terms of text content. The first subcorpus gave rise to class 2, while the second subcorpus formed class 1 and branched into two other classes, forming classes 3 and 4 (Figure 1).

Figure 1. Dendrogram of the Descending Hierarchical Classification of the research corpus using the Iramuteq software, with illustration of the most frequent words (Forme), number of text segments containing the word in the class (eff.stt), and the value of association with the classes (P). Salvador, BA, Brazil, 2024



eff.st	forme	P
100	Year	< 0,0001
86	Sex	< 0,0001
105	Patient	< 0,0001
53	Diagnosis	< 0,0001
53	Female	< 0,0001
45	Hospitalization day (HD)	< 0,0001
33	Postoperative	< 0,0001
46	Male	< 0,0001
29	Admit	< 0,0001
38	Condition	< 0,0001
27	Systemic Arterial Hypertension (SAH)	< 0,0001
26	Month	< 0,0001
29	Suspected	< 0,0001
23	Syndrome	< 0,0001
23	Investigation	< 0,0001
23	Hospitalize	< 0,0001

eff.st	forme	P
80	Ventilation	< 0,0001
85	Air	< 0,0001
85	Environment	< 0,0001
75	Afebrile	< 0,0001
59	Lucid	< 0,0001
58	Guide	< 0,0001
55	Stable	< 0,0001
82	Spontaneous	< 0,0001
42	Evolve	< 0,0001
58	Find	< 0,0001
36	Hemodynamically	< 0,0001
45	Bed	< 0,0001
37	Eupneic	< 0,0001
29	Comfortable	< 0,0001
31	Communicative	< 0,0001
34	Respiratory	< 0,0001

eff.st	forme	P
149	Abdomen	< 0,0001
142	Symmetrical	< 0,0001
140	Thorax	< 0,0001
119	Expansive	< 0,0001
114	Mucosa	< 0,0001
110	Flacid	< 0,0001
93	Sclerotic	< 0,0001
90	Palpation	< 0,0001
92	Anicteric	< 0,0001
110	Physical	< 0,0001
118	Exam	< 0,0001
111	Extremities	< 0,0001
82	Bilaterally	< 0,0001
83	Depths	< 0,0001
59	Globose	< 0,0001
72	Intact	< 0,0001

eff.st	forme	P
93	Care	< 0,0001
88	Equipment	< 0,0001
113	Diuresis	< 0,0001
107	Dejections	< 0,0001
93	Sleep	< 0,0001
84	Peripheral Venous Catheter (PVC)	< 0,0001
100	Present	< 0,0001
109	Use	< 0,0001
67	Appetite	< 0,0001
42	Nursing	< 0,0001
44	Phlogistic	< 0,0001
39	Bracelet	< 0,0001
89	December	< 0,0001
47	Left Upper Limb (LUL)	< 0,0001
53	Signal	< 0,0001
32	Legible	< 0,0001

DOI: https://doi.org/10.36489/nursing.2025v29i325p10976-10989

By reading the most frequently used words in the research corpus, highlighted by the dendrogram (Figure 1), and inserting them into text segments (TS), it was possible to analyze the content of the nursing progress reports, classified into four classes.

Class one comprised 27.9% of the corpus, with 225 text segments analyzed. This class predominantly describes sleep and appetite status, complaints, aspects of nursing care, and patient monitoring regarding diet acceptance, feeding routes (oral, gastrostomy, enteral, or parenteral), physiological eliminations; use of identification bracelets, tubes, and catheters (central, peripheral, and device type); and phlogistic signs observed at the insertion site; and completed or upcoming exams.

> [...] reports spontaneous diuresis in the parrot, stools present in the diaper, good oral diet acceptance, maintained sleep pattern, has been using a peripheral venous catheter (CVP) in the right upper limb (upper limb) since December 8th, with no inflammatory signs or hydrolyzed fluid. He reports no complaints at this time and is under the care of the team. (Evolution number 127)
>
> [...] A nuclear magnetic resonance imaging scan is scheduled today starting at 1:00 PM. He has been fasting since 5:00 AM and is under the care of the team. (Evolution number 131)

Class two represents 24.2% of the content classified by the software, with 195 text segments. The content of this class relates to the nurses' description of the patients' age, expressed in both years and months for pediatric patients; biological sex; the diagnosis and medical investigations, with a repetition of the clinical picture that led to admission, including a record of the progression of signs and symptoms since their onset. Furthermore, the respective medication, clinical, or surgical treatments are described. It was uncommon to find records of the day of admission or postoperative period in the follow-up reports.

Class two represents 24.2% of the content classified by the software, with 195 text segments. The content of this class relates to the nurses' description of the patients' age, expressed in both years and months for pediatric patients; biological sex; the diagnosis and medical investigations, with a repetition of the clinical picture that led to admission, including a record of the progression of signs and symptoms since their onset. Furthermore, the respective drug, clinical, or surgical treatments are described. It was uncommon to find records of the day of admission or postoperative period in the follow-up reports.

> [...] female patient, 51 years old, diagnosed with rheumatic heart disease, mitral valve repair in 1992, biological valve in 2007, biological valve in 2008, post-endocarditis and mechanical valve replacement in 2015, in addition to mitral valve stenosis and dysfunction, and severe pulmonary hypertension. (Evolution number 30)
>
> [...] 11-month-old female infant weighing 5.758 kg; December 4th with prolonged hospitalization in this unit due to bronchopulmonary dysplasia and late postoperative tracheostomy on September 27th and gastrostomy on August 31st. (Evolution number 155)

Class three contains 244 text segments, comprising 30.2% of the research corpus. The content of this class concerns the description of the physical examination, predominantly focused on inspection and palpation of the respiratory and abdominal systems. Only in the ICU is thoracic and abdominal auscultation mentioned. The propaedeutic step of percussion is rarely described. It is possible to identify in some evaluations the description of the patient's neurological status, including an assessment of their ability to interact with the team.

> [...] physical examination reveals normal-colored, sclerotic, and anicteric ocular mucosa; bilateral facial hyperchromia; bilaterally symmetrical and expansive chest; soft, round abdomen, painless to palpation; warm, perfused extremities, and no edema. (Evolution number 33)
>
> [...] symmetrical, expansive chest; diffuse crackles on respiratory auscultation; decreased vesicular murmurs on the right; soft, round abdomen; bowel sounds present; gastrostomy orifice with a slight yellowish secretion on a dressing; intact genitalia. (Evolution number 156)

The physical examination described in this class, regarding inspection, presents the patient's general condition, including trophism, skin color, and the presence of lesions; the mobility of body segments; the appearance of the scalp and oral cavity, and the respective assessment of the dentition; the ocular mucous membranes, regarding color; the condition of the pupils; the auricle; chest inspection, highlighting symmetry and expansion; the condition of the abdomen, regarding shape, distension, pain, and the presence of lesions and ostomies; a description of whether or not the genitalia were assessed; the condition of the back for lesions; and the condition of the extremities regarding temperature, perfusion, edema, cyanosis, and mobility. Regarding skin assessment, nurses describe the presence of lesions and injuries, evaluating the type of tissue, products used in dressings, and the condition of the dressings.

Class four accounts for 17.7% of the textual corpus, with 143 text segments. It describes the beginning of the process of assessing patient progress over the

DOI: https://doi.org/10.36489/nursing.2025v29i325p10976-10989

24-hour period considered for the study. Thus, nurses begin by describing how they found the patients in bed, including their position and the presence or absence of companions; reporting complaints and the evolution of signs and symptoms over the last 24 hours; level of consciousness and ability to interact and communicate with the team. Next, they describe the assessment of the respiratory pattern, the use or not of oxygen support; and the hemodynamic pattern, including assessment of vital signs and blood glucose levels over the period considered.

> [...] he is nonverbal, bedridden, and responding with difficulty to commands. He has been hemodynamically stable over the past 24 hours, hypertensive, and has a good respiratory pattern on room air. At the time of the visit, he presented spontaneous eye opening. He is aphasic; he is expelling spontaneous greenish secretions from his mouth. (Evolution number 48)
>
> [...] he was found calm, with his mother, breathing spontaneously on room air, with a comfortable respiratory pattern; afebrile. His mother reports continued episodes of short seizures, 9 episodes in the past 24 hours, with no hemodynamic repercussions. (Evolution number 172)

It was common to identify key expressions with a vague and non-evaluative meaning, which were repeated in nursing developments, such as: "symmetrical and expandable chest"; "flat and flaccid abdomen"; "good respiratory pattern"; "perfused and warm extremities"; "preserved appetite"; "present defecations"; "preserved sleep and appetite"; "continues under the care of the team"; "continues without complaints".

DISCUSSION

The interpretation of the results revealed that all progress reports begin with Class 2, identifying the patient's age, sex, length of hospital stay, reason for admission, diagnosis, and medical therapy adopted. Next, the patient's evaluation is described over the 24-hour period, identified in Class 4. Subsequently, a description of the physical examination is provided, classified in Class 3. Finally, the progress record concludes with information from Class 1, focusing on sleep patterns; feeding; elimination; and use, location, and condition of intravenous access.

The information obtained from the analysis of nursing progress reports demonstrates the centrality of content in the description of medical diagnoses, clinical findings, examinations, and diagnostic investigation. The persistence of the biomedical model in clinical nursing practice likely influenced the way these records were recorded. This influence manifests itself, for example, in the prioritization of descriptions focused on medical aspects, to the detriment of interventions performed by the nurse themselves. This conclusion, although already pointed out in the literature, [11] is reinforced by other authors [12] when they show that the biomedical model continues to impact the professional autonomy of nurses and, consequently, generates the fragmentation of care. The fact that studies published more than a decade ago point to similar issues reveals the persistence of deep-rooted actions, suggesting the urgent need to review the paradigms that guide the recording of nursing developments.

The progress reports contained repeated information, such as the patient's age and sex. This information is already part of the header automatically generated by the electronic medical record system and, therefore, there is no need to repeat it, just as there is no relevance in stating that a given patient "is under the care of the nursing team." Under the law, nurses are prohibited from recording partial information about the care provided 13), therefore, the expression becomes unnecessary when it fails to record the care measures implemented to justify this statement.

Regarding the description of the head-to-toe physical examination, it was observed that the progress recorded in the ICUs was more evaluative, with more detailed information about the patients' clinical status, compared to other care units. In the wards, incomplete physical examination records predominate, often limited to a descriptive rather than evaluative nature, lacking relevant information and sometimes marked by subjectivity, as exemplified by the expression: "Good ventilation pattern."

This practice diverges from recommendations in the literature, which advises against the use of subjective information in records, given that it compromises objectivity, clinical safety, and interprofessional communication, as it influences misinterpretations and individualized judgments by other professionals. [3,6] Therefore, the low use of scientific parameters for writing can lead to significant losses for care management, and harm to the measurement of the technical-scientific quality of the nurse. [14]

Furthermore, the greater emphasis on physical examination of specific regions, such as the mucosa, sclera, extremities, and the respiratory and gastrointestinal systems, is noteworthy, to the detriment of other equally important body systems. This selective approach to the physical examination suggests a standardization that does not necessarily reflect the individual clinical reality of patients, especially when there are wards with multiple specialties, as is the case in the field of this analysis. Current legislation requires the cephalopodal physical examination to be performed according to the patient's needs [1] therefore, the completeness and relevance of the physical examination in light of the specific needs of each patient are questionable.

DOI: https://doi.org/10.36489/nursing.2025v29i325p10976-10989

The results of a cross-sectional study conducted at a public hospital in the Northeast reinforce this selective view by revealing a lack of documentation in the description of the physical examination, highlighting the greater frequency of recording cardiovascular and digestive exams compared to other exams. [14]

International literature links the absence of certain information in nursing records to the conclusion that the action was not taken. [6] Given this assumption, there is also minimal description in the progress notes of nursing interventions related to the identified signs and symptoms, and a predominance of a limited association between the patients' psychosocial responses and nursing diagnoses and interventions from the previous 24 hours. This may indicate a gap between the stages of the Nursing Process or the underreporting of this information.

The overlap of psychobiological needs with psychosocial and psychospiritual needs is also evident. This supremacy, which reveals a care practice focused on pathophysiological aspects, is supported by previous studies, which also identified a greater emphasis on biological problems compared to other dimensions of the human being, and consequently, greater interventions in order of greater prevalence. [16] The literature reinforces this trend regarding the influence of the biomedical model in directing clinical reasoning and decision-making, even though academic training in nursing is currently based on a multidimensional view of the human being. [16]

The data from this study highlight significant gaps in the development of progress reports. Although records are present, the use of clinical reasoning based on scientific literature has been neglected, compromising their validity. The lack of a critical eye in the development of progress reports raises questions about the causes of the unsatisfactory results. Authors [15,17] point to work overload, insufficient staffing, and a lack of theoretical knowledge about the NP and physical examination as challenges faced by the nursing team in clinical practice, impacting the content of medical records.

Besides the weaknesses presented, the analysis also noted important positive aspects. The recorded content plays a crucial role in care because, although it lacks standardized analytical and evaluative language, it demonstrates attention to the patient's condition by reporting key findings in a timely manner. Recording progress not only confirms the patient's progress but also legally legitimizes the nurse's work. These factors offer valuable insights for audits, multidisciplinary applications, and research that support analyses, such as this one. [18]

The hospital, where the research was conducted, did not have a standardized model for recording progress until the time of data collection, which favored individualized reporting. National and international literature emphasizes that progress should be recorded over a specific period of time and should be evaluative. [1,3] However, no publications were found that establish a standard format for preparing the text, as exists for procedure records. This lack of standardization favors subjective individualization in records and, often, a greater emphasis on medical information.

The study's main limitation was the ad hoc collection, conducted on a single day, without a sequential and prolonged evaluation of the same patients. To minimize this limitation, we chose to expand the sample density (number > 100) and temporal diversity (morning and evening) to ensure robustness of the findings. Furthermore, we triangulated the results with national and international literature. This facilitated the identification of a documentary standard and the establishment of a uniform overview of the content of records prepared by different professionals, thus providing tools for improving the writing of nursing progress reports.

CONCLUSION

The study revealed the repetition of unnecessary data and the possibility of underreporting essential information in the nursing progress reports analyzed, such as a strong emphasis on medical diagnoses rather than nursing diagnoses, and a lack of correlation between patient responses to diagnoses and priority nursing interventions. The writing style is notable for its predominance of descriptive rather than evaluative writing.

The lack of a standard model for recording nursing progress reports is also noteworthy, favoring individual writing. Progress reports should follow a logical structure with a beginning, middle, and end, but should be written analytically. The nurse is responsible for recognizing and analyzing the patients' primary needs, and unsatisfactory recording highlights gaps that could potentially hinder continuity of care and communication within the multidisciplinary team.

Future research with expanded longitudinal methodology is suggested to capture greater variability in the content of nursing progress reports, and to conduct further studies on nurses' perspectives on writing nursing progress reports to elucidate potential unanswered questions. This study is expected to support immediate institutional initiatives, such as reviewing recording protocols, structuring standardized records, and providing training both in the research field and in other healthcare institutions.

In summary, it is essential to expand understanding of nursing progress reports, recognizing their value in improving care and as a legal framework. Furthermore, it is the responsibility of professionals to assume their role as team leaders and improve assessments and records, ensuring that care is interconnected with the NP stages in accordance with legislation.

DOI: https://doi.org/10.36489/nursing.2025v29i325p10976-10989

References

1. **Conselho Federal de Enfermagem (BR). Resolução n° 514, de 5 de maio de 2016. Guia de Recomendações para os registros de enfermagem no prontuário do paciente e outros documentos de enfermagem. Brasília: Conselho Federal de Enfermagem; 2016. Disponível a partir de: https://www.cofen.gov.br/wp-content/uploads/2016/06/RESOLU%C3%87%C3%83O-COFEN-N%C2%BA-0514-2016-GUIA-DE-RECOMENDA%C3%87%C3%95ES-vers%C3%A3o-web.pdf.**

2. **Oliveira NB, Peres HHC. Quality of the documentation of the nursing process in clinical decision support system. Rev Latino-Am Enfermagem. 2021;29:e3426. Doi: 10.1590/1518-8345.4510.3426.**

3. **College Of Refistered Nurses of Saskatchewan (CA). Documentação Diretriz. Saskatchewan: College Of Refistered Nurses of Saskatchewan; 2021. Disponível a partir de: https://www.srna.org/wp-content/uploads/2021/02/Documentation-Guideline.pdf.**

4. **Conselho Federal de Enfermagem (BR). Resolução n° 736, de 17 de janeiro de 2024. Dispõe sobre a implementação do Processo de Enfermagem em todo contexto socioambiental onde ocorre o cuidado de enfermagem. Brasília: Conselho Federal de Enfermagem, 2024. Disponível a partir de: https://www.cofen.gov.br/resolucao-cofen-no-736-de-17-de-janeiro-de-2024/.**

5. **Hinkle JL, Cheever KH, Overbaugh KJ. Brunner & Suddarth. Tratado de Enfermagem Médico-Cirúrgica. 14a ed. Rio de Janeiro: Guanabara Koogan; 2020.**

6. **British Columbia College Of Nurses And Midwives (CA). Documentation. Vancouver (BC): British Columbia College Of Nurses And Midwives; 2023. Disponível a partir de: https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN_PS_Documentation.pdf.**

7. **Ledesma D, Meza N, Vergara V, Villalba G, Medina O. Calidad de los registros electrónicos de enfermería de un hospital de alta complejidad de la ciudad de Corrientes. Notas de Enfermería. 2023;24(42):26-33. Doi: 10.59843/2618-3692.v24.n42.42639.**

8. **Minayo MCS, Deslandes SF, Gomes R. Pesquisa social: teoria, método e criatividade. Petrópolis: Vozes, 2024**

9. **Salviati, ME. Manual do Aplicativo Iramuteq (versão 0.7 Alpha 2 e R versão 3.2.3). Planaltina (DF);2017. Disponível a partir de: http://www.iramuteq.org/documentation/fichiers/anexo-manual-do-aplicativo-iramuteq-par-maria-elisabeth-salviati.**

10. **Sousa JR, Santos SC. Análise de conteúdo em pesquisa qualitativa: modo de pensar e de fazer. PDE. 2020;10(2):1396-41. Doi: 10.34019/2237-9444.2020.v10.31559.**

11. **Franco MTG, Akemi EN, D'Inocento M. Avaliação dos registros de enfermeiros em prontuários de pacientes internados em unidade de clínica médica. Acta Paul Enferm. 2012;25(2):163-70. Doi: 10.1590/S0103-21002012000200002.**

12. **Possmoser Wm, Makita Las, Ohta Aa, Kuvabara Lf, Góes Hlf. A Perspectiva Do Enfermeiro No Acolhimento: Uma Revisão Integrativa Sobre os Desafios para a Humanização do Cuidado. 2025;29(145):40-1. Doi: 10.69849/revistaft/cl10202504251140.**

13. **Conselho Federal de Enfermagem (BR). Resolução n° 564, de 06 de junho de 2017. Aprova o novo Código de Ética dos Profissionais de Enfermagem. Brasília. Conselho Federal de Enfermagem; 2017. Disponível a partir de: https://www.cofen.gov.br/resolucao-cofen-no-5642017/**

14. **Ferreira LL, Chiavone FBT, Bezerril MS, Alves KYA, Salvador PTCO, Santos VEP. Analysis of records by nursing technicians and nurses in medical records. Rev Bras Enferm. 2020;73(2):e20180542. Doi: 10.1590/0034-7167-2018-0542.**

15. **Silva AGI, Dias BRL, Leite MR. A elaboração de evoluções de enfermagem e possíveis dificuldades: percepção do enfermeiro. Nursing. 2019;22(254):3039-40. Doi: 10.36489/nursing.2019v22i254p3039-3040.**

16. **Paula AS. Cuidados de Enfermagem para Pessoa Idosa Hospitalizada com Covid-19 Alicerçados nas Necessidades Humanas Básicas[Dissertação]. Curitiba: Universidade Federal do Paraná; 2021. Disponível a partir de: https://acervodigital.ufpr.br/xmlui/handle/1884/80938?show=full.**

17. **Moraes AM, Vasconcelos DV, Imbiriba TCO. Os desafios da anamnese e exame físico na sistematização da assistência de enfermagem -sae: revisão integrativa de literatura. REASE.2021;7(10):3262-81. Doi: 10.51891/rease.v7i10.3036.**

18. **Silva VA, Mota RS, Oliveira LS, Jesus N, Carvalho CM, Magalhães LGS. Auditoria da qualidade dos registros de enfermagem em prontuários em um hospital universitário. Enferm Foco 2019;10(3):28-33. Doi:10.21675/2357-707X.2019.v10.n3.2064.**

CONFLICTS OF INTEREST

I, Aliane da Silva Andrade, certify that I have no conflicts of interest related to this article.

FUNDING

This project was funded with a research initiation grant from the Office of the Vice President for Affirmative Action and Student Assistance (PROAE) of the Federal University of Bahia, under PROAE Call for Proposals 09/2023 – Permanecer 2023 Program.