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Documentation of Family Nurse Assessment and Intervention in the Structural Dimension: A Retrospective Study

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Abstract

Introduction
Documenting the Nursing Process contributes to the quality and safety of care, both for individuals and for families as care recipients. The structural assessment of the family is the starting point for understanding its composition and its internal and external resources. Therefore, documenting the structural dimension is essential to ensuring care continuity for the family as a unit of care.

Objective
To develop documentation within the SClínico-CSP® nursing information system encompassing assessment, intervention, and family health gains related to the structural dimension.

Methods
This quantitative, descriptive, and retrospective study included two evaluation time points. The study population consisted of 669 families registered with a Functional Unit. The first sample consisted of 24 families; and the second comprised 71 families. Data were presented using charts and tables.

Results
The highest assessment rates were observed for housing type, family type, and residential building condition. The highest prevalence was associated with inadequate water supply. The most significant health gains were found in family income and safety precautions.

Conclusion
The study objective was achieved, as evidenced by increased documentation rates in the SClínico-CSP® nursing information system. Improvements in the quality of nursing care for families within the structural dimension were reflected in higher assessment, prevalence, and outcome indicators. However, these results must continue to improve over time. To support this progress, the contractual inclusion of indicators that acknowledge the family as a unit of nursing care may be essential.

Keywords
Family Health; Dynamic Family Assessment and Intervention Model; Family Nursing; Continuous Quality Improvement; Quality; Nursing Process; Health Information Systems.

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Introduction

Assessing a family's structure makes it possible to identify its characteristics, along with potential strengths and internal and external resources such as social class, biological environment, extended family, and broader systems that may support the management of health and illness, two areas formally included in the contractual goals of Functional Units (FUs). To this end, documenting assessments and interventions related to these characteristics, which make up the structural dimension of the family as a unit of care, is essential.[1]

Documenting the entire Nursing Process (NP) contributes to care quality and safety.[2] It enables the transfer of relevant information to other healthcare professionals, particularly in identifying the client's care needs and specifying the interventions to be implemented, that is, demonstrating the customization of the care plan to the client's needs.[3,4] Furthermore, documentation protects nurses against negligence claims, preserves retrievable data for research and quality improvement purposes, and supports the evaluation of care outcomes.[4]

In addition to these functions, proper documentation improves the quality of nursing care itself, enhances professional satisfaction, increases the visibility of nurses' work, reinforces the value of their actions, promotes autonomy and efficiency, and strengthens the scientific basis of the profession.[5]

To monitor improvements in care quality based on the NP, it is necessary to use documentation indicators that can be shared[5]. However, for these indicators to be meaningful, the information about nursing care provided must be properly recorded[6]. In this regard, Duclos-Miller[4] states that the quality of nursing care delivered to clients can only be measured by the quality of nursing documentation—namely, the documentation of the client's care plan, the evaluation of care effectiveness, and the communication between the client and other healthcare professionals.

Nursing Information Systems (NIS) enable the documentation of care using standardized language, thereby contributing to improved care quality, greater professional visibility, and better performance assessment.[6] The NIS used in Primary Health Care (*Cuidados de Saúde Primário*s - CSP) is SClínico-CSP®. This system allows for the documentation of care provided to individuals and families using standardized terminology such as the International Classification for Nursing Practice (ICNP®).[7] Through individual and family assessments, SClínico-CSP® supports the standardized recording of data related to the structural dimension of the family, including housing characteristics, social class, and family type.

Nurses' decision-making in this area is guided by theoretical models such as the Calgary Family Assessment Model (CFAM) and the Calgary Family Intervention Model (CFIM),[8] and, more specifically, by the Dynamic Family Assessment and Intervention Model (MDAIF),[1] which serves not only as a theoretical framework but also as a practical tool for clinical application.[9,10]

The Regulation of Specific Competencies for the Family Health Nurse Specialist (FHNS)[11] states that nurses must care for the family as a unit, as well as for each of its members individually, and must document the care process by integrating health, family, and environment. However, documenting care with the family as the client is not yet a widespread practice among nurses who provide care to families. This fact was confirmed by Melo et al.[12] in a study that aimed to identify, through health information systems in northern Portugal, the nursing foci resulting from assessments and interventions involving the family as the unit of care. The findings showed that attention areas within the structural dimension - specifically, family income, residential building condition, and water supply - had documentation rates as low as 0.002%.

Several studies also identify barriers to documenting care, such as a lack of continuing education, excessive workload, limited time, insufficient resources, and the perception of documentation as a bureaucratic task[5,13–16].

A study involving more than 500 Portuguese – nurses without postgraduate training in family health nursing showed that their self-perceived competence in the stages of the NP declined as the process advanced.[17] The same study also found that the areas of focus with the lowest average levels of self-perceived competence were family income, residential building condition, water supply, and pet care, all of which are components of the family's structural dimension.

All the characteristics that comprise the structural dimension can be observed, assessed, and documented, particularly when there is continuity of care for families and their individual members. It is therefore important to more effectively integrate NP documentation related to family assessment and intervention, specifically within the structural dimension. This integration may increase documentation rates, contributing to improved quality of care for families and their members, as well as greater visibility of this care.

This study aimed to develop documentation within the SClínico-CSP® nursing information system encompassing assessment, intervention, and family health gains related to the structural dimension.

Methods

This descriptive, retrospective study included two distinct evaluation periods. We conducted the first assessment on March 22, 2023, prior to the implementation of the project activities, allowing for comparison with the results of the second assessment, carried out on June 1, 2023, after the project had been implemented. The study population consisted of families registered with the FU, totaling 669 families as of February 2023.

We defined the inclusion criterion as families whose members had a nursing consultation (individual, subsystem-based, or whole-family) either at the FU or at home. Families whose members were not permanently registered with the FU were excluded.

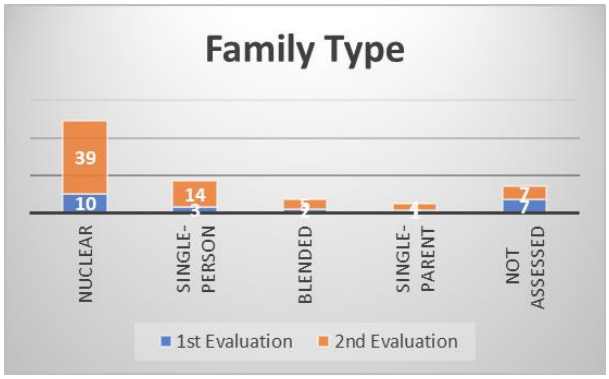
The sample for the first assessment comprised all families whose family records included some form of assessment and documentation related to the structural dimension, totaling 24 families. This information was retrieved using

the data extraction tools available in the SClínico-CSP® nursing information system.
In the second evaluation (June 2023), using the same data extraction process and documentation in Microsoft Excel®, 71 families were identified.
The team responsible for implementation was composed of the UF nursing team.
During data collection, the anonymity of family members was maintained, with all identifying information withheld.
To conduct the evaluation, we used indicators for family assessment and intervention within the family's structural dimension based on the indicator mapping from the Dynamic Family Assessment and Intervention Model (MDAIF).[18] These included assessment rates, prevalence rates, and outcome indicators.
The Relvas classification[19] was applied to evaluate the life cycle stage of nuclear families. This classification considers the age of the oldest child and encompasses the following stages: Stage 1 (couple formation); Stage 2 (family with young children); Stage 3 (family with school-age children); Stage 4 (family with adolescent children); and Stage 5 (family with adult children).
The Adapted Graffar Scale[1] was used to evaluate housing type and social class. This tool assesses the family's socioeconomic conditions based on five criteria: occupation, education level, sources of family income, comfort and housing, and characteristics of the neighborhood. These criteria are scored on a 5-point scale. For the evaluation, the classification of the partner with the highest score was considered.
The activities carried out by the UF nursing team for families whose members had a nursing appointment (individual, subsystem-based, or whole-family), either at the UF or at home, included:
- Evaluation of the type of family (nuclear, blended, single-parent, extended, one-person, cohabiting, communal, institutional, or other) and corresponding documentation in the SClínico-CSP® nursing information system;
- Evaluation of the life cycle stage of nuclear families (Stage 1: couple formation; Stage 2: family with young children; Stage 3: family with school-age children; Stage 4: family with adolescent children; Stage 5: family with adult children) and corresponding documentation in the SClínico-CSP® nursing information system;
- Evaluation of housing type (grades 1–5 of the Adapted Graffar Scale) and social class (classes I–V of the Adapted Graffar Scale) and corresponding documentation in the SClínico-CSP® nursing information system;
- Evaluation of the structural dimension areas of attention based on the Dynamic Family Assessment and Intervention Model (MDAIF), including family income, residential building condition, safety precautions, water supply, and pet care, and corresponding documentation in the SClínico-CSP® nursing information system;
- Formulation of nursing diagnoses related to the structural dimension and their documentation in the SClínico-CSP® nursing information system; Implementation of nursing interventions within the structural dimension and their documentation in the SClínico-CSP® nursing information system;
- Evaluation of health outcomes/gains within the structural dimension and their documentation in the SClínico-CSP® nursing information system;
- Extraction of data from the SClínico-CSP® nursing information system into Microsoft Excel® software;
- Analysis of the collected data, including the evaluation of assessment rates, prevalence rates, and outcome indicators within the structural dimension (ESEP/CINTESIS, 2013).
The data were documented in the SClínico-CSP® nursing information system and quantitatively recorded in tables using Microsoft Excel® software.

Results

The results of both evaluations are presented in the form of charts and tables, along with explanatory notes. In the first evaluation, 24 families (3.59%) out of a total of 669 had at least one family-related nursing assessment documented in their records.
Regarding family type (Chart 1), 17 out of the 24 families had their typology assessed: 10 (41.7%) were classified as nuclear families, 3 (12.5%) as single-person families, 2 (8.3%) as blended families, 1 (4.2%) as single-parent families, and 1 (4.2%) as extended families. Seven families (29.2%) did not have their typology assessed.
In the second evaluation, an increase in assessments was observed: 71 families (10.6%) out of the same total of 669 had at least one family-related nursing assessment recorded. As for family type, an assessment of 64 out of 71 families revealed: 39 nuclear families (55%), 14 single-person families (24%), 5 blended families (7%), 2 single-parent families (2.8%), and 4 extended families (5.6%). Seven families (9.9%) did not have their typology assessed.

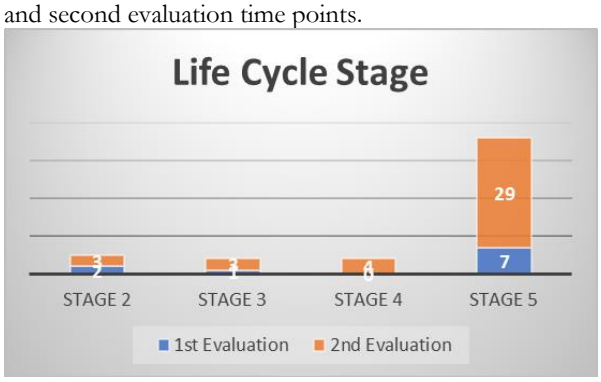
Chart 1 – Family type at the first and second evaluation time points.



According to Relvas' (2000) family life cycle stages (Chart 2), the first evaluation of the 10 nuclear families revealed: 2 families (20%) at stage 2 (young children), 1 (10%) at stage 3 (school-age children), and 7 (70%) at stage 5 (adult children).

The second evaluation of 39 nuclear families revealed the following distribution across family life cycle stages: 7.7% (n = 3) at Stage 2, another 7.7% (n = 3) at Stage 3, 10.2% (n = 4) at Stage 4 (families with teenage children), and 74.3% (n = 29) at Stage 5.

Chart 2 – Life cycle stages of nuclear families at the first and second evaluation time points.



Regarding housing conditions (Chart 3), the first evaluation showed that 14 of the 24 families (58.3%) resided in Grade 3 homes according to the Adapted Graffar Scale[1]. These homes had a bathroom, kitchen, living room, and bedrooms. They were well maintained and had essential appliances, running water, sanitation, electricity, good ventilation, and natural light. Four families (16.7%) lived in Grade 4 housing, which had limited space, was in poor condition, lacked essential appliances, and had little ventilation, no running water, sanitation, or electricity, and limited natural light. Six families (25%) had no documented housing assessment.

Regarding social class, also based on the Adapted Graffar Scale, 1 family (4.2%) was classified as Class II (upper-middle), 11 (45.9%) as Class III (middle), 3 (12.5%) as Class IV (lower-middle), and 9 families (37.5%) had no classification documented (Chart 3).

Of the 71 families assessed in the second evaluation, 3 (4.2%) lived in Grade 2 homes—spacious and well maintained, with central heating, appliances beyond the essentials, running water, sanitation, electricity, good ventilation, and natural light. Forty families (56.3%) resided in Grade 3 homes, 19 (26.8%) in Grade 4 homes, and 9 (12.7%) had no housing classification.

As for social class, 5 families (7%) were categorized as Class II (upper-middle), 34 (48%) as Class III (middle), 21 (30%) as Class IV (lower-middle), and 11 families (15.5%) had no social class classification.

Chart 3 – Housing type and social class of families in the first and second evaluation.

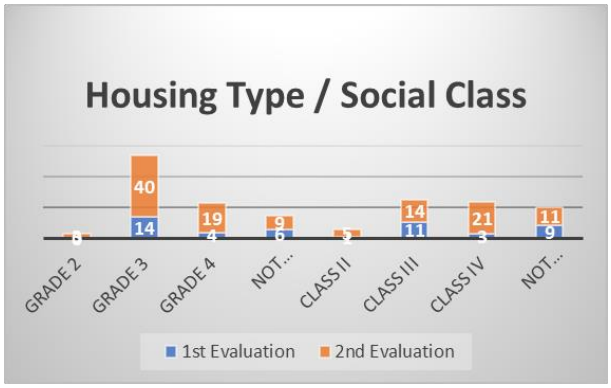


Table 1 presents the results related to assessment rates in the first and second evaluations. An overall increase was observed from the first to the second evaluation. The highest rate in both the first (3.6%) and second (10.6%) evaluations was related to documentation in the Family Health Program, with a 7% increase between the two time points. The lowest assessment rate in both the first (1.6%) and second (3.3%) evaluations corresponded to Pet Care (PC).

The category showing the greatest increase from the first to the second evaluation was Residential Building (RB), with a 7.2% rise. This was followed by: Family Health Program (7%), Housing Type (6.6%), Social Class and Family Income (FI) (6.5%), Family Type (6%), Safety Precautions (SP) (5.7%), Water Supply (WS) (3.3%), and finally Pet Care (PC) (1.7%).

Table 1. Indicators – Assessment rates in the first and second evaluation

Assessment rates	Assessment	
	1st	2nd
Number of families enrolled in the Family Health Program / Total number of families registered at the FU × 100	3.6% (n=24)	10.6% (n=71)
Number of families assessed for Social Class / Total number of families registered at the FU × 100	2.4% (n=16)	8.9% (n=60)
Number of families assessed for Family Type / Total number of families registered at the FU × 100	2.7% (n=18)	9.3% (n=62)
Number of families assessed for Housing Type / Total number of families registered at the FU × 100	3% (n=20)	9.3% (n=62)
Number of families assessed for Residential Building Condition / Total number of families registered at the FU × 100	2.1% (n=14)	9.3% (n=62)
Number of families assessed for Family Income / Total number of families registered at the FU × 100	2% (n=13)	8.5% (n=57)
Number of families assessed for Safety Precautions / Total number of families registered at the FU × 100	2.2% (n=15)	7.9% (n=53)
Number of families assessed for Water Supply / Total number of families registered at the FU × 100	2.1% (n=14)	5.4% (n=36)
Number of families assessed for Pet Care / Total number of families registered at the FU × 100	1.6% (n=11)	3.3% (n=22)

As for prevalence rates (Table 2), in the first evaluation, the most frequent diagnoses were: Inadequate Water Supply (IWS) (42.9%), Undemonstrated Safety Precautions (USP) (20%), Neglected Pet Care (NPC) (18.2%), and Insufficient Family Income (IFI) (7.7%).

In the second evaluation, the most prevalent diagnoses were: IWS (47.2%), NPC (27.3%), and Unsafe Residential Building (URB) (17.7%). These were followed by: USP (9.4%), IFI (7%), and Neglected Residential Building (NRB) (3.2%).

Table 2. Indicators – Prevalence rates of nursing diagnoses in the first and second evaluation

Prevalence rates	Assessment	
	1st	2nd
Number of families with Unsafe Residential Building (URB) / Total number of families assessed for Residential Building (RB) × 100	0% (n=0)	17.7% (n=11)
Number of families with Neglected Residential Building (NRB) / Total number of families assessed for Residential Building (RB) × 100	0% (n=0)	3.2% (n=2)
Number of families with Insufficient Family Income (IFI) / Total number of families assessed for Family Income (FI) × 100	7.7% (n=1)	7.0% (n=4)
Number of families with Undemonstrated Safety Precautions (USP) / Total number of families assessed for Safety Precautions (SP) × 100	20% (n=3)	9.4% (n=3)
Number of families with Inadequate Water Supply (IWS) / Total number of families assessed for Water Supply (WS) × 100	42.9% (n=6)	47.2% (n=17)
Number of families with Neglected Pet Care (NPC) / Total number of families assessed for Pet Care (PC) × 100	18.2% (n=2)	27.3% (n=6)

As for the outcome indicators (Table 3), the first evaluation revealed no health gains related to the structural dimension. In the second evaluation, however, there was an increase in both documented outcomes and recorded nursing interventions, which resulted in health gains within this dimension. The only exception to this trend was PC, which remained at 0% in the second evaluation.

The areas of focus with the highest percentages of positive outcomes in the second evaluation were RB, FI, and SP. Half of the families (50%) with RB-related diagnoses experienced health gains following nursing interventions aimed at improving household hygiene and sanitary conditions. Approximately 75% of the families diagnosed with IFI achieved resolution of this issue through increased knowledge of family income management. SP improved in 60% of the cases in which it had previously been compromised. WS also improved in the second evaluation,

with a positive outcome of around 10%, as did URB, with a 9.1% improvement.

Table 3. Indicators – Outcome/Health gains in the first and second evaluation

Outcome/Health gains indicators	Assessment	
	1st	2nd
Number of families with a resolved diagnosis of Unsafe Residential Building (URB) / Total number of families diagnosed with URB × 100	0% (n=0)	9.1% (n=1)
Number of families with a resolved diagnosis of Neglected Residential Building (NRB) / Total number of families diagnosed with NRB × 100	0% (n=0)	50% (n=1)
Number of families with a resolved diagnosis of Insufficient Family Income (IFI) / Total number of families diagnosed with IFI × 100	0% (n=0)	75% (n=2)
Number of families with a resolved diagnosis of Undemonstrated Safety Precautions (USP) / Total number of families diagnosed with USP × 100	0% (n=0)	60% (n=2)
Number of families with a resolved diagnosis of Inadequate Water Supply (IWS) / Total number of families diagnosed with IWS × 100	0% (n=0)	9.9% (n=2)
Number of families with a resolved diagnosis of Neglected Pet Care (NPC) / Total number of families diagnosed with NPC × 100	0% (n=0)	0% (n=0)

Discussion

The results from the first evaluation revealed generally low documentation rates regarding the assessment of the family's structural dimension. This finding is consistent with previous studies,[12,17] which also report low documentation rates in this area and attribute this issue to various factors, including a lack of training.[5,13–16]

As for the prevalence rates, we found that most diagnoses showed an increase between the first and second evaluations, except for two (FI and SP). However, this does not necessarily indicate an actual increase in the prevalence of diagnoses such as URB, NRB, IWS, and NPC. Rather, the increase in prevalence rates is primarily related to the substantial rise in assessment rates between the first and second evaluations, which consequently led to more diagnoses being recorded.

Notably, the prevalence rate of IWS accounted for nearly half of all families whose water supply was assessed in both evaluation periods. This result is closely associated with the context in which these families live. Located in a predominantly rural area, water is often supplied by private systems, as a comprehensive public water supply network has yet to be established in this community. According to official data, in Portugal, approximately 96% of households were served by public water supply systems in 2020, and 85% were connected to public wastewater systems.[20] Therefore, some families may live in areas not covered by public water services, with 4% of homes still relying on private sources. In this particular region, the most recent data available from 2019 indicate that only about 47% of households were connected to public water supply systems and 48% to public wastewater systems.[20]

Another important point is that IWS often reflects a lack of knowledge about the risks of water contamination and/or a family's inability to properly manage the care required for this type of water supply[1], particularly in light of the guidelines issued by the Water and Waste Services Regulatory Authority (ERSAR) for maintaining the quality of drinking water.[21]

These guidelines recommend not using unregulated water for human consumption, including drinking, cooking, and hygiene, and call for regular quality testing of drinking water—annually or whenever necessary.

Regarding health gains, we found that, in the first evaluation, there were no improvements in health outcomes related to the structural dimension. There was a declining trend in the documentation of nursing care for families, which ran counter to the progression of the NP. As such, evaluation rates were significantly higher than outcome indicators. We believe this can be explained by the fact that family nursing care is delivered from a co-evolutionary and longitudinal perspective.[1] It is also important to note that the number of family nursing consultations available to nurses to care for the family as a unit is often lower than desired, which delays the progression of the NP stages.

This inverse trend throughout the stages of the NP was also identified in a previous study,[17] which analyzed nurses' self-perception of their graduate-level competencies in the field of family health nursing. Conducted with over 500 Portuguese nurses who had not undergone specialized training, the study revealed that nurses' perceived competence decreased as the NP progressed.

In contrast, the second evaluation showed a rise in outcome indicators, reflecting health gains in most diagnoses. These findings reinforce the relevance of systematic assessment, intervention, and proper documentation in securing and measuring health improvements for families. As Nascimento et al.[6] state, quality assessment indicators cannot be generated without comprehensive documentation of the NP. This absence of documentation not only limits public recognition of the nursing profession's contributions but also hinders transparency in the quality improvement process.

Thus, documenting family health nursing care is fundamental to increasing the visibility of FHNS specific competencies and ensuring the ongoing enhancement of care quality. As highlighted by Fernandes and Tareco,[22]

specialized training significantly influences adherence to documentation practices in NIS, as well as professionals' engagement in change processes. Figueiredo et al.[17] also underscore the need for graduate-level training in family health nursing as a means of improving nurses' self-perceived competence in applying the NP to systemic family care alongside individualized care for each family member.

Conclusion

Considering that the quality of care is also reflected in the quality of documentation, an improvement in the quality of nursing care for families was achieved in the context of the structural dimension, as evidenced by increased evaluation, prevalence, and outcome indicators.

Regarding the assessment data, the indicators with the highest evaluation rates were housing type, family type, and residential building condition. Water supply was the area of focus requiring the most intervention, as it showed the highest prevalence rate. However, the most significant health gains were observed in family income and safety precautions.

The results obtained from this project demonstrate the importance of documenting family assessment and intervention activities to improve the quality of care provided to families, as well as to enhance the visibility of FHNS roles.

The internal and external contracting process does not include any outcome indicators related to the family as a client. All indicators contracted for Family Health Units (USF) and Personalized Health Care Units (UCSP) relate solely to individuals. Consequently, it becomes more difficult for FHNSs to place appropriate emphasis on family assessment and intervention, since this area of knowledge is not part of the officially defined objectives of the health units, nor is it integrated into their action plans.

However, we recognize that understanding the family and the individual from a systemic perspective is essential to achieving both individual and family health gains. Therefore, it is important that political and institutional decision-makers become aware of the relevance of family assessment and intervention and propose indicators related to the family as a client to be adopted by family health teams.

Study limitations

One limitation of this study was the short interval between the first and second evaluations, as well as the absence of a third evaluation time point, which could have enhanced the findings, particularly by reflecting a greater increase in health gains.

Authorship and Contributions

LS: Conception and design of the study; Data collection; Analysis and interpretation of data; Writing of the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

VG: Conception and design of the study; Data collection; Analysis and interpretation of data; Writing of the manuscript; Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

HF: Critical review of the manuscript; Approval of the final version of the manuscript and assumption of responsibility for it.

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The authors declare no conflict of interest.

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References

1.Figueiredo M. Modelo dinâmico de avaliação e intervenção familiar: uma abordagem colaborativa em enfermagem de família. 1ª ed. Loures: Lusociência; 2012. 224p.

2.Oliveira N, Peres H. Qualidade da documentação do processo de enfermagem em sistemas de apoio à decisão clínica. Rev Latino-Am Enferm [Internet]. 2021 [cited 2024 Jul 3];29:e3426. Available from: https://doi.org/10.1590/1518-8345.4510.3426

3.Ávila GS, Cavalcante RB, Gontijo TL, Carbogim FC, Brito MJM. Prontuário eletrônico na gestão do cuidado em equipes de saúde da família. Cogitare Enferm [Internet]. 2022 [cited 2025 Feb 21]; 27. Available from: https://doi.org/10.5380/ce.v27i0.79641

4. Duclos-Miller P. Improving nursing documentation and reducing risk. Chicago: HCpro Inc; 2016. 140p.

5. Azevedo O, Guedes E, Araújo S, Maia M, Cruz D. Documentation of the nursing process in public health institutions. Rev Esc Enferm USP [Internet]. 2019 [cited 2024 Jul 3]; 53:e03471. Available from: http://dx.doi.org/10.1590/S1980-220X2018003703471

6.Nascimento T, Frade I, Miguel S, Presado M, Cardoso M. Os desafios dos sistemas de informação em enfermagem: Uma revisão narrativa da literatura. Ciênc Saúde Colet [Internet]. 2021[cited 2024 Jul 3];26(02):505-510. Available from: https://doi.org/10.1590/1413-81232021262.40802020

7.Serviços Partilhados do Ministério da Saúde, EPE. SClínico: Processo de enfermagem, manual de utilizador. Versão 1.0. Lisboa: SPMS; 2017.

8.Wright L, Leahey M. Enfermeiras e famílias: Guia para avaliação e intervenção na família. 5ª Ed. S. Paulo: ROCA; 2012. 392p.

9.Ferreira M, Pereira C, Rodrigues MJ, Paiva M, Arrojado V, Figueiredo MH. Ganhos em saúde familiar sensíveis ao modelo dinâmico de avaliação/intervenção familiar. Rev Invest Inov [Internet]. 2020 [cited 2025 Feb 21];3(2):7-20. Available from: https://doi.org/10.37914/riis.v3i2.84

10. Souza SSAL, Batista ABM, Silva EP, Santos VGN. A repercussão que o modelo Calgary de avaliação familiar na assistência em saúde: Revisão integrativa. In: CIPCEn-2023: 4º Congresso Internacional de Produção Científica em Enfermagem. Instituto Enfservic [Internet.]. 2023[cited 2025 Feb 21];4(4):33. Available from: https://revistaremecs.com.br/index.php/remecs/article/view/1447/1467

11.Portugal. Ordem dos Enfermeiros. Regulamento nº 428/2018. Regulamento de competências específicas do enfermeiro especialista em enfermagem comunitária na área de enfermagem de saúde comunitária e de saúde pública e na área de enfermagem de saúde familiar [Internet]. Lisboa: DRE; 2018 [cited 2024 Jul 3]. Available https://dre.pt/dre/detalhe/regulamento/428-2018-115698616

12.Melo P, Bastos J, Figueiredo MH, Rodrigues J, Pinto D. Vigilância epidemiológica dos diagnósticos de enfermagem na família: Um estudo no ACES do Grande Porto. In: Livro de resumos do I Congresso Internacional de Enfermagem de Saúde Familiar [Internet]. Arcos de Valdevez: Sociedade Portuguesa Enfermagem Saúde Familiar; 2019 [cited 2025 Feb 21]; p112-113. Available from: http://hdl.handle.net/10400.14/27192

13.Júnior WL, Braga CG, Freire BSM, Costa ACB, Andrade MBT, Chini LT, et al. Documentação do processo de enfermagem: desafios e potencialidades. Contrib Cienc Sociales [Internet]. 2023 [cited 2025 Feb 21]; 6(8):9416-9441. Available from: https://ojs.revistacontribuciones.com/ojs/index.php/clcs/article/view/1282

14. Santos AKO, Sousa MS, Silva AF, Estrela FM, Lima NS, David RAR, et al. Implantação da sistematização da assistência por enfermeiras na atenção básica: facilidades e dificuldades. J. Nurs. Health [Internet]. 2021 [cited 2025 Feb 21];11(2):e2111220246. Available from: https://doi.org/10.15210/jonah.v11i2.20246

15.Dias T, Coelho KR, Menezes AC, Andrade SN, Oliveira F. Sistematização da assistência e processo de enfermagem na saúde da família: Percepção de enfermeiros. J Nurs Health [Internet]. 2022 [cited 2025 Feb 21];12(1):e2212120794. Available from: https://doi.org/10.15210/jonah.v12i1.2246

16. Macedo ER, Basílio ACM, Silva BJR, Santos BDV, Andrade CR, Souza G, et al. Fatores que dificultam a aplicação do processo de enfermagem pelos enfermeiros da atenção primária à saúde. REAS [Internet]. 2022 [cited 2025 Feb 21]; 15(2):e9584. Available from: https://doi.org/10.25248/reas.e9584.2022

17. Figueiredo MH, Ferreira MM, Silva ML, Guedes VS. Self-perception of nurses' competence in family assessment and intervention. Invest Educ Enferm [Internet]. 2021 [cited 2024 July 3];39(3):e13. Available from: https://doi.org/10.17533/udea.iee.v39n3e13

18.ESEP/CINTESIS. Projeto: Modelo dinâmico de avaliação e intervenção familiar: Uma acção transformativa em cuidados de saúde primários [Internet]. Porto: ESEP; 2013 [cited 2024 July 3]. Available from: https://i-d.esenf.pt/mdaif/

19. Relvas A. O ciclo vital da família: Perspetiva sistémica. 2ª Ed. Porto: Edições Afrontamento; 2000.236p

20.PORDATA. Portal estatístico da Fundação Francisco Manuel dos Santos [Internet]. Lisboa: Fundação Francisco Manuel dos Santos; 2024 [cited 2024 Jul 3]. Available from: https://www.pordata.pt

21.Entidade Reguladora dos Serviços de Águas e Resíduos (ERSAR). Utilização de captações particulares de água para consumo humano. Cadernos Sensibilização [Internet]. 2017 [cited 2024 July 3];Serie 1. Available from: https://www.ersar.pt/_layouts/mpp/file-download.aspx?fileId=1264466

22.Fernandes S, Tareco E. Sistemas de informação como indicadores de qualidade na saúde: Uma revisão de níveis de abordagem. RISTI [Internet]. 2016 [cited 2024 Jul 3];19: 34-35. Available from: https://doi.org/10.17013/risti.19.32-45