Assessment of Care Quality in the SUS Through Nursing Audits in an Accredited Cardiology Hospital

Avaliação da Qualidade Assistencial no SUS por Auditoria de Enfermagem em Hospital Cardiológico Acreditado

Evaluación de la Calidad Asistencial en el SUS Mediante Auditoría de Enfermería en Hospital Cardiológico Acreditado

RESUMO

Objetivo: Desenvolver e validar um guia educativo para auditoria interna dos registros de enfermagem no contexto do SUS. **Métodos:** Estudo metodológico baseado nos modelos de Phaneuf e Kurcgant, com foco nas sete funções da enfermagem como padrões de qualidade. A construção do guia seguiu os referenciais de Echer, incluindo revisão bibliográfica, estruturação técnica e validação prática. **Resultados:** O guia contribuiu para a padronização das anotações, rastreabilidade das intervenções e fortalecimento da cultura organizacional voltada à segurança e qualidade. Sua estrutura permite avaliação qualitativa e quantitativa dos registros, com potencial para reduzir glosas e aprimorar a comunicação interprofissional. **Conclusão:** A auditoria proposta tem caráter educativo e atua como ferramenta de apoio à gestão, formação profissional e melhoria contínua dos processos assistenciais. Recomenda-se sua implementação sistemática e a realização de estudos futuros para avaliar seu impacto em diferentes contextos hospitalares.

DESCRITORES: Auditoria em enfermagem; Segurança do paciente; Gestão da qualidade total; Educação continuada em enfermagem.

ABSTRACT

Objective: To develop and validate an educational guide for internal auditing of nursing records within the SUS context. **Methods:** Methodological study based on the models of Phaneuf (1972) and Kurcgant (2016), focusing on the seven nursing functions as quality standards. The guide was constructed following Echer's (2005) framework, including literature review, technical structuring, and practical validation. **Results:** The guide contributed to the standardization of notes, traceability of interventions, and strengthening of an organizational culture focused on safety and quality. Its structure allows for both qualitative and quantitative evaluation of records, with potential to reduce billing denials and improve interprofessional communication. **Conclusion:** The proposed audit has an educational character and serves as a support tool for management, professional training, and continuous improvement of care processes. Systematic implementation and further studies are recommended to assess its impact in different hospital settings.

DESCRIPTORS: Nursing audit; Patient safety; Total quality management; Continuing education in nursing.

RESUMEN

Objetivo: Desarrollar y validar una guía educativa para la auditoría interna de los registros de enfermería en el contexto del SUS. **Métodos:** Estudio metodológico basado en los modelos de Phaneuf (1972) y Kurcgant (2016), con enfoque en las siete funciones de la enfermería como estándares de calidad. La construcción de la guía siguió los lineamientos de Echer (2005), incluyendo revisión bibliográfica, estructuración técnica y validación práctica. **Resultados:** La guía contribuyó a la estandarización de las anotaciones, la trazabilidad de las intervenciones y el fortalecimiento de una cultura organizacional centrada en la seguridad y la calidad. Su estructura permite una evaluación cualitativa y cuantitativa de los registros, con potencial para reducir glosas y mejorar la comunicación interprofesional**. Conclusión:** La auditoría propuesta tiene un carácter educativo y actúa como herramienta de apoyo a la gestión, formación profesional y mejora continua de los procesos asistenciales. Se recomienda su implementación sistemática y la realización de estudios futuros para evaluar su impacto en distintos contextos hospitalarios.

DESCRIPTORES: Auditoría de enfermería; Seguridad del paciente; Gestión de calidad total; Educación continua en enfermería

DOI: 10.36489/saudecoletiva.2025v16i100p17192-17201

RECEIVED: 08/07/2025 **APPROVED:** 08/23/2025

How to cite this artilce: Souza VF, Oliveira DVR, Ferreira JML, Oliveira JS, Sousa LP, Gentil SR. Assessment of Care Quality in the SUS Through Nursing Audits in an Accredited Cardiology Hospital. Saúde Coletiva (Edição Brasileira) [Internet]. 2025 [acesso ano mês dia];16(100):17192-17201. Disponível em: DOI: 10.36489/saudecoletiva.2025v16i100p17192-17201

Vitória Fagian de Souza
Resident nurse at the Dante Pazzanese Institute of Cardiology.
ORCID:https://orcid.org/0000-0001-6762-3091

Denise Viana Rodrigues de Oliveira
Nurse with a Master's Degree in Health Sciences, Dante Pazzanese Institute of Cardiology.
ORCID: https://orcid.org/0000-0002-7869-9486

Jhienniffer Mikelle de Lima Ferreira
Nurse specializing in Cardiovascular Health, Dante Pazzanese Institute of Cardiology.
Orcid: https://orcid.org/0000-0002-7189-5038.

Juliana Dos Santos Oliveira
Nurse, Dante Pazzanese Institute of Cardiology.
ORCID: https://orcid.org/0009-0000-5589-2446

Luana Pereira de Sousa
Nurse, Dante Pazzanese Institute of Cardiology.
ORCID: https://orcid.org/0009-0005-2675-9087

Selma Rossi Gentil
Nurse Master of Health Sciences, Dante Pazzanese Institute of Cardiology.
ORCID: https://orcid.org/0009-0000-5589-2446

INTRODUCTION

Auditing, which emerged as an administrative control mechanism, has evolved into a strategic tool in the health field, with its application in medical practice in 1918[1] and in nursing in 1955[2]. Currently, it is considered fundamental for quality management[3] and acts as a pedagogical and transformative instrument that fosters critical reflection and process improvement[4]. Its relevance lies in its ability to transcend mere supervision, becoming a pillar for the continuous improvement of care and management practices, directly impacting the safety and effectiveness of health services.

In Brazil, auditing was incorporated into the SUS in 1990[5]. The effectiveness of the system depends on professional qualifications and standardization of processes, aspects in which nursing plays a central role[6]. The need for improvements in the completeness of clinical records, especially nursing records, is a point of attention highlighted in technical bulletins[7], as accurate documentation is vital for traceability and institutional defense. The lack of detailed records can compromise continuity of care, hinder the evaluation of outcomes, and expose institutions to legal and financial risks.

Hospital accreditation, promoted by ONA[8], is a relevant strategy for the qualification of services, with nursing being crucial for the compliance of clinical records[9]. Health education, with a focus on auditing, is essential for qualifying practices and strengthening the commitment to patient safety[10], in addition to influencing curricular changes[11]. Through continuing education programs, professionals are trained to understand the importance of auditing as a cyclical process of evaluation and improvement, integrating it into their daily professional lives.

Patient safety is the central principle of nursing auditing[12], and COFEN Resolution No. 429/2012 reinforces record-keeping as an essential element for comprehensive care and institutional support[13]. Given the gaps in professional training, this study proposes the creation of a guide for internal auditing of nursing care, with the aim of developing and validating an educational resource that assists in the auditing of records, promoting the standardization of practices and a culture of safety and quality in health services. This initiative aims to meet a pressing need, enabling nurses to act as agents of change in the quality of documentation and, consequently, in the safety and effectiveness of the care provided.

METHOD

This is a methodological study, whose main objective was to develop a retrospective and periodic audit instrument applied to the verification of the quality of nursing care. Based on the analysis of electronic medical records and on-site verification, the instrument assesses the compliance of records with quality of care standards. Designed for internal use in nursing, it aligns with the criteria of the National Accreditation Organization, aiming to improve care processes, reinforce patient safety, and standardize practices. The research was conducted in a tertiary cardiovascular hospital in São Paulo, beginning in July 2025.

The variables analyzed include compliance of records with healthcare quality standards, such as signature, stamp, description of procedures, clinical evolution, medication administration, use

DOI: 10.36489/saudecoletiva.2025v16i100p17192-17201

of OPME and DMI, dressings, venous accesses, and catheters. The instrument was structured via Google Forms, based on institutional protocols. The audit was based on the models of Kurcgant[14], Phaneuf[2], and Anderson and Lesnick[1]. The guide was constructed according to the methodological assumptions of Echer[15] and Polit and Beck[12]. As it is an educational guide without patient identification or sensitive data, there was no need to submit it to the Research Ethics Committee, in accordance with Resolution No. 510/2016 of the National Health Council[16].

RESULTS

This guide highlights that complete, accurate, and technically consistent nursing records are fundamental to the quality of healthcare. Complete and accurate nursing records are essential to the quality of healthcare. Proper documentation improves communication among the multidisciplinary team, promotes patient safety, and contributes to the legitimacy of billing, mitigating hospital disallowances.

Uniformity in documentation promotes cost rationalization, optimizing the use of resources and eliminating redundancies. Systematized records also reveal gaps in work processes, serving as indicators for professional improvement and continuing education. Clinical documentation is a pillar of patient safety, ensuring the traceability of interventions and supporting clinical decisions. Nursing audits are a strategic component in ensuring the quality of care, promoting trust and safety.

In the context of financial audits or legal proceedings, unambiguous time records validate procedures and strengthen institutional defense. This practice not only reinforces patient safety and continuity of care, but also improves resource allocation and decision-making, contributing to more effective hospital management.

Table 1: Essential Audit Items for Nursing Technicians, São Paulo, São Paulo, Brazil, 2025.

Audit Item	Detailed Description of Required Note (with time)
Admission - Standard Note	Complete record of patient admission, including identification data, general conditions upon arrival (level of consciousness, mobility, presence of devices), initial signs and symptoms, and the exact time of entry into the unit/sector.
Referral for Exams/ Sectors	Note the time of departure and return of the patient for referral to exams or procedures in other sectors (outpatient clinic, hemodialysis, etc.), recording the mode of transport and the patient's condition during the trip.
Bathing and oral hygiene	Record the time of bathing, type of bathing (in bed, sponge bath, shower), water temperature, body area cleaned, use of specific products, and patient response (comfort, complications).
Discharge	Note the time of hospital discharge, the patient's clinical condition at the time of discharge (general condition, ambulation, use of devices), detailed instructions provided to the patient/family member (medications, dressings, return visit), and the patient's destination.
Medication Administration	Record the exact time of administration of each medication, including the full name of the drug, dose, route of administration, and observations on adverse reactions or complications.
Diet	Note the time the diet was offered and the patient's acceptance (total, partial, refusal), with observations on complications (e.g., nausea, vomiting, difficulty swallowing) and volume ingested, if applicable.
Complications	Detailed record with the exact time of any adverse event, acute change in the patient's health status, unexpected complaints, or other relevant complications, describing the immediate actions taken.
Vital Signs	Recording of temperature, pulse, respiration, blood pressure, and oxygen saturation values, with the exact time of measurement and observations on significant changes or trends.
Diaper Change	Record the time of the diaper change and Uripen type of soiling (urine, feces), estimated volume (if applicable), skin conditions in the area (presence of lesions, diaper rash), application of protective and intimate hygiene products.
Dressing	Note the time the dressing was applied, location of the lesion, type of dressing applied (cleaning, debridement, dressing change), materials used, appearance of the lesion (size, exudate, odor, and tissue characteristics), and patient response (symptoms).
Capillary blood glucose	Record the time the capillary blood glucose was taken, the value obtained, and the actions taken (e.g., insulin administration, carbohydrate intake) with the corresponding time.
Hydration	Note the time and type of hydration provided (oral, intravenous), volume administered, patient acceptance, and observations regarding signs of dehydration or fluid overload. Note and respect fluid restrictions as prescribed by a physician.
Bed Mobilization	Record the time of patient mobilization in bed (change of position according to the position change clock), position adopted, use of support devices (pillows, cushions), and skin conditions in pressure areas.
Peripheral and Central Venous Devices	Note the time of insertion or replacement of the catheter/dressings, insertion site, catheter number, appearance of the site (signs of inflammation, leakage, and catheter permeability), and date of next replacement. Replacement of the valve connector.
Bladder Catheter	Record the time of insertion or replacement of the catheter, type of catheter, volume and appearance of urine output, and observations on complications (e.g., hematuria, pain, obstruction). Perform replacement and fixation.
Nasogastric/ Nasoenteral Tube	Record the time of insertion or replacement of the tube, type of tube, confirmation of location, volume and appearance of output, observations on complications (e.g., nausea, vomiting, nasal irritation), and note the completion of the bundle after checking all items.

DOI: 10.36489/saudecoletiva.2025v16i100p17192-17201

Drains	Record the time of drain inspection, location, volume and appearance of discharge, observations on complications (e.g., leakage, obstruction, pain), and water seal and dressing changes.
Pressure Injury	Note the time of the injury assessment, location, stage, size, appearance (tissue, exudate, odor), and interventions performed (cleaning, dressing, pressure relief).
Mechanical Restraint	Note the time of application of the restraint, type of restraint, reason for application, time of removal, and observations about the patient's behavior during restraint. (upon medical prescription and prior assessment by the nurse)
Body Preparation	Record the time and date of death, post-mortem body preparation, including hygiene, closure of ostia, and identification of the body. They are sent to the morgue. Verify the correct identification of the patient with the bracelet and identification tags.
Microorganism Precautions	Record the type of precaution the patient is under (contact, aerosols) and whether PPE was kept near the patient's bed, respecting the precautions according to the type of precaution.

Table 2: Essential Audit Items for Nurses, São Paulo, São Paulo, Brazil, 2025.

Audit Item	Detailed Description of Nurse's Record (with time)
PICC Assessment	Record the time of the Peripherally Inserted Central Catheter (PICC) assessment, including the date of insertion, conditions at the insertion site (presence of pain, hyperemia, exudate), lumen patency, external segment measurement, and signs of complications (phlebitis, infection, obstruction).
SBAR (Situation, Background, Assessment, Recommendation)	Record the time of communication using the SBAR methodology, with a concise record of the current clinical situation, relevant background, assessment of the patient's condition, and recommendations for the care plan, as well as the name of the professional with whom you communicated.
Admission to the ER/ICU/Hemodynamics	Detailed record with the time of admission of the patient to the Emergency Room (ER), Intensive Care Unit (ICU), or Hemodynamics, including the nurse's complete initial assessment (history, physical exam, care plan), identified risks, and care goals.
Patient Transfer	Record of the time of intra-hospital transfer, reason for transfer, patient's current clinical condition (hemodynamic stability, level of consciousness, use of ventilatory support), and crucial information for the destination unit team, including devices in use.
Hospital Discharge	Record the time of hospital discharge, the patient's final clinical condition, complex guidelines for home care (wound management, medications, warning signs), post-discharge follow-up planning, confirmation of patient/family understanding, and delivery of the post-discharge care plan and note in the electronic system.
Medication Administration	Record the time each medication was administered, the dose, route, dilution (if applicable), and the name of the professional who administered it.
Fluid Balance	Record the time of the fluid balance, including the volume of fluids administered (oral, parenteral) and eliminated (urine, drainage, insensible losses).
Prescription Check	Record the time of the medical prescription check, including confirmation of the dose, route, time, and name of the professional who performed the check.
Nursing Process	Apply all stages of the nursing process according to the patient's current complaint and make changes to the patient's clinical deterioration.
Nursing Progress	Record the time of the nursing progress, including the patient's assessment, interventions performed, and care plan.
Shift Handover	Record the time of the shift handover, including a summary of the patient's clinical condition, pending issues, and care plan.
Therapeutic Plan.	Structure the therapeutic plan, verify the evolution of results together with the evolution and discussion of the multidisciplinary team.

DISCUSSION

The quality of nursing documentation has been widely recognized as an essential component for patient safety, continuity of care, and efficiency in health service management. Studies reinforce that complete and standardized records favor communication among members of the multidisciplinary team, in addition to contributing to the traceability of actions and the ethical and legal accountability of the professionals involved[17,18]. The audit tool presented in this study was developed based on the main documentary inconsistencies identified in the literature, especially regarding the absence of schedules, incomplete descriptions of procedures, and inconsistencies between records and billed services[19,3]. Such gaps compromise not only the quality of care, but also the

DOI: 10.36489/saudecoletiva.2025v16i100p17192-17201

financial sustainability of institutions, making it difficult to prove the care provided. Kurcgant points out that accurate and ethical documentation is a direct reflection of organizational culture and the value placed on professional care[9]. In this sense, the proposed instrument seeks not only to standardize records, but also to foster a culture of responsibility and transparency, aligned with the principles of continuing education and continuous improvement[10].

When used for training purposes, nursing audits can be a powerful tool for identifying weaknesses in work processes and guiding educational interventions. The absence of a scoring system in the instrument does not compromise its applicability, since its structure allows for qualitative analysis and identification of non-compliance patterns. This approach is consistent with the literature that advocates audits focused on organizational learning rather than individual punishment[11,4].

CONCLUSION

The developed instrument improves nursing documentation practices by offering a systematic methodological structure to qualify care. Standardization and accurate recording strengthen patient safety and the traceability of interventions.

With an educational and managerial character, the proposed audit identifies opportunities for improvement and promotes critical reflection, reinforcing a culture of excellence and shared responsibility. The instrument supports quality management, valuing nursing care and technical autonomy. Its systematic incorporation into institutional routines is recommended. The main limitation is the lack of empirical validation in other hospital contexts. Its institutional adoption can represent a significant advance in the quality of care, contributing to the sustainability and humanization of health services.

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ACKNOWLEDGMENTS, FINANCIAL OR TECHNICAL SUPPORT, DECLARATION OF FINANCIAL CONFLICT OF INTEREST AND/OR AFFILIATIONS:

The authors declare that they did not receive institutional, public, or private financial assistance to conduct this research. The study was developed with the authors' own resources and is not linked to any funding announcement.