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Audit as a hospital management tool: a qualitative analysis

Auditoria como ferramenta de gestão hospitalar: uma análise qualitativa

La auditoría como herramienta de gestión hospitalaria: un análisis cualitativo

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ABSTRACT

Objective: To analyze, from the managers perspective, the factors that favor and hinder the use of auditing as a management tool in hospitals.

Method: A qualitative, descriptive study, based on the Critical Incident Technique, conducted in a general hospital in the interior of São Paulo, Brazil. Semi-structured interviews were

conducted with managers (March–June/2023). The incidents were organized into situation-behavior-consequence and subjected to content analysis, with thematic categorization.
Results: A total of 34 critical incidents were identified, highlighting 41% (n=14) of aspects that favor and 59% (n=20) that hinder the use of auditing in hospital management. The incidents were grouped into thematic categories: Supporting documentation, Audit activities, and Electronic medical records. The results show that managers recognize auditing as a strategic tool for healthcare and financial management, particularly in monitoring document compliance, preventing claim denials, standardizing care flows, and strengthening patient safety. By focusing on processes such as clinical records, prescriptions, billing, and indicator control, auditing objectively contributes to improving the quality of care and institutional sustainability. However, the results also indicate that the use of digital health records remains a significant challenge for managers and healthcare professionals.
Final considerations: The use of auditing as a management tool in hospitals is favored by adequate supporting documentation and the possibility of reviewing both operational and care processes, but hindered by weaknesses in medical records that reveal noncompliance with institutional protocols and in the technical-operational structuring of the audit, particularly regarding the insufficient definition of monitoring indicators, unclear delimitation of work scope, low standardization of evaluation instruments, assignment of responsibilities, as well as lack of team training and contractual deficiencies with health insurance plans.
Descriptors: Health administration; Hospital administration; Electronic health records; Financial audit; Quality of care.

RESUMO

Objetivo: Analisar, sob a visão dos gestores, os fatores que favorecem e dificultam o uso da auditoria como uma ferramenta de gestão nos hospitais.
Método: Estudo qualitativo, descritivo, baseado na Técnica do Incidente Crítico, realizado em hospital geral no interior de São Paulo, Brasil. Foram realizadas entrevistas semiestruturadas com 10 gestores (março–junho/2023). Os incidentes foram organizados em situação–comportamento–consequência e submetidos à análise de conteúdo, com categorização temática.
Resultados: Foram identificados 34 incidentes críticos que permitiram evidenciar 41% (n=14) de aspectos que favorecem e 59% (n=20) que dificultam o uso da auditoria na gestão hospitalar. Os incidentes foram agrupados nas categorias temáticas: Documentação comprobatória, Atuação da auditoria e Prontuário digital. Os resultados evidenciam que os gestores reconhecem a auditoria como instrumento estratégico para a gestão assistencial e financeira, particularmente no monitoramento da conformidade documental, na prevenção de glosas, na padronização de fluxos assistenciais e no fortalecimento da segurança do paciente. Ao incidir sobre os processos como registro clínico, prescrição, faturamento e controle de indicadores, a auditoria contribui objetivamente para a qualificação da assistência e para a sustentabilidade institucional. No entanto, os resultados também indicam que o uso de prontuários digitais ainda é um desafio expressivo para os gestores e profissionais de saúde.
Considerações finais: O uso da auditoria como uma ferramenta de gestão nos hospitais é favorecida pela adequada documentação comprobatória e pela possibilidade de revisão de processos operacionais e assistenciais, sendo dificultada quando se relacionam as fragilidades de registros em prontuários que revelam não conformidades com protocolos institucionais e com a estruturação técnico-operacional da auditoria, particularmente no que se refere à definição insuficiente de indicadores de monitoramento, delimitação pouco clara de escopo de trabalho, baixa padronização dos instrumentos de avaliação, atribuição de responsabilidades, bem como falta de treinamento da equipe e deficiências contratuais com planos de saúde.

Descritores: Administração em saúde; Administração Hospitalar; Registros Eletrônicos de Saúde; Auditoria Financeira; Qualidade da Assistência.

RESUMEN

Objetivo: Analizar desde la perspectiva de los gestores, los factores que favorecen y dificultan el uso de la auditoría como herramienta de gestión en hospitales.

Método: Estudio cualitativo y descriptivo, basado en la Técnica de Incidentes Críticos, realizado en un hospital general del interior de São Paulo, Brasil. Se realizaron entrevistas semiestructuradas a gestores (marzo-junio de 2023). Los incidentes se organizaron en situación-comportamiento-consecuencia y se sometieron a análisis de contenido, con categorización temática.

Resultados: Se identificaron 34 incidentes críticos, destacando el 41% (n=14) de los aspectos que favorecen y el 59% (n=20) de los que dificultan el uso de la auditoría en la gestión hospitalaria. Los incidentes se agruparon en categorías temáticas: Documentación de soporte, Desempeño de la auditoría e Historia clínica digital. Los resultados muestran que los gestores reconocen la auditoría como una herramienta estratégica para la gestión sanitaria y financiera, especialmente para supervisar el cumplimiento de la documentación, prevenir la denegación de reclamaciones, estandarizar los flujos de atención y fortalecer la seguridad del paciente. Al centrarse en procesos como la historia clínica, las recetas, la facturación y el control de indicadores, la auditoría contribuye objetivamente a mejorar la calidad de la atención y la sostenibilidad institucional. Sin embargo, los resultados también indican que el uso de la historia clínica digital sigue siendo un desafío importante para los gestores y profesionales sanitarios.

Consideraciones finales: El uso de la auditoría como herramienta de gestión en hospitales se ve favorecido por la adecuada documentación de soporte y la posibilidad de revisar los procesos operativos y asistenciales, y se ve obstaculizado por las debilidades en las historias clínicas que revelan incumplimientos de los protocolos institucionales y en la estructuración técnico-operativa de la auditoría, en particular en lo que respecta a la definición insuficiente de los indicadores de seguimiento, la delimitación poco clara del alcance del trabajo, la baja estandarización de los instrumentos de evaluación, la asignación de responsabilidades, así como la falta de formación del equipo y las deficiencias contractuales con los planes de salud.

Descriptores: Administración sanitaria; Administración hospitalaria; Registros Médicos Electrónicos; Auditoría Financiera; Calidad de Atención.

INTRODUCTION

Health auditing can be understood as a systematic process of evaluating records, care practices, and institutional processes, with the objective of verifying compliance, quality, and the proper use of resources. It constitutes an important tool for hospital management, providing relevant contributions to the establishment of goals, plans, procedures, rules, standards, and regulations, as well as being grounded on the relevance of the adequacy, integrity, and reliability of information and records[1].

In addition to determining/monitoring the achievement of desirable and planned outcomes, auditing recognizes the mechanisms involved in the audited process, enabling internal improvements[1].

Auditing favors the improvement of aspects related to the qualification of services and the organization of care and management processes, the optimization of financial management, and support for the planning, execution, and evaluation of standards in health services, both in qualitative and quantitative dimensions. Auditing contributes significantly to improving the quality of care and strengthening patient safety in health services[2]. Moreover, health auditing allows for in-depth analysis of different institutional processes through the monitoring of indicators, whether through document verification and/or on-site analyses, proving essential in the examination of processes so that failures can be identified and corrected[1].

Audits are increasingly used in healthcare institutions to ensure that interventions and their respective records/documentation comply with established standards, supporting the promotion of practices that ensure continuity of care and the integrity of records. However, it is necessary to recognize the need to improve professional training and the development of skills related to the use of electronic medical records to enhance hospital auditing practices[3].

Investment in hospital auditing has expanded, becoming consolidated as a strategy to improve the adequacy of reimbursement for services provided, support deliberations and decision-making processes, ensure greater transparency in recorded information, and simultaneously improve processes, correct inconsistencies, and enhance the quality of care provided[4]. Auditing goes beyond mere inspection, becoming an indispensable tool to improve management efficiency and raise the quality of services, providing relevant information on items and interventions to be considered in the establishment of contracts between healthcare providers and funding institutions[4].

Auditing plays an essential role by providing comprehensive support to managers, contributing to strategic decision-making, the identification of opportunities for improvement, the correction of failures, and the promotion of process transparency. In this context, it operates in the monitoring of care activities and in the analysis of service documentation, seeking to identify nonconformities or inconsistencies that require adjustments, while also supporting the development of managerial and care indicators. Thus, auditing encompasses both aspects related to reimbursement and those focused on care delivery, adopting specific approaches for each dimension. Furthermore, the adequate allocation of resources in the healthcare sector directly influences the assurance of quality and continuity of care provided[4].

There are different audit approaches, and it is not possible to determine an ideal type, since the auditing modality employed is contextual. In this sense, a classification based on the

timing of the audit should be highlighted. Prospective auditing is carried out prior to the execution of procedures, examinations or consultations, and has a preventive character, which aims to analyze the technical relevance and conformity of the request before its execution, contributing to the quality and safety of care provided[5]. Concurrent auditing occurs simultaneously with the provision of care, during hospital admission, as well as in home care; its objective is to monitor the adequacy of the supplies used, the conformity of the records and the quality of the services provided[5]. Retrospective auditing is conducted after patient discharge and consists of the technical-administrative analysis of hospital bills, with the purpose of validating the charges for services performed and identifying inconsistencies subject to denial; it includes document verification and assumes a strategic role, especially in nursing auditing, by articulating quality of care and financial compliance[5,6].

Auditing plays a leading role in hospital organizations, especially when presenting data and results that favor economic and financial balance, the quality of services provided to the patient, as well as the pursuit of improving professional practice to ensure qualified care[7]. From this perspective, the daily practice of auditing includes providing feedback to the care delivery team, highlighting its relevance as an evaluative method for nursing practices and the healthcare team, as well as promoting fair billing for the care provided.

Considering the above, this study is justified due to the importance of auditing in the context of the dynamism of hospital organizations, with care, financial, and management implications. Despite its relevance to hospital management, studies exploring, from the perspective of managers, the factors that favor or hinder the use of auditing as a management tool are still limited[8-9]. Thus, the present study assumes an innovative character by focusing on managers' perspectives regarding auditing in a hospital setting, in order to explore how this tool can positively influence hospital organization, ensure qualified care and the management of care-related risks, the results bring relevant contributions to fill a knowledge gap.

Therefore, the study aims to analyze, from the managers' perspective, the factors that favor and hinder the use of auditing as a management tool in hospitals.

METHOD

This is a descriptive study with a qualitative approach which complied with the recommendations of the international protocol Consolidated Criteria for Reporting Qualitative Research (COREQ), which comprise consolidated criteria for reporting qualitative research based on a checklist of 32 items[10].

The study was conducted in a general hospital, located in the interior of São Paulo and a regional reference center for approximately 300,000 inhabitants, serving users of the Unified Health System (*Sistema Único de Saúde* - SUS), supplementary health (health insurance plans) and private patients. It has a Neonatal ICU with eight beds and a pediatric ICU with two beds, a Neonatal Intermediate Care Unit (NICU) with eight beds, an Adult Intensive Care Unit (ICU) with 25 beds, a Hemodialysis and Hemodynamics Service, Oncology and a Surgical Center, including an obstetrics room, totaling 151 beds[11].

The institution systematically performs retrospective auditing for all care services linked to partnered health insurance providers. In the auditing process, the clerks of the inpatient units are initially responsible for verifying the order in which documents are presented and identifying possible absences or nonconformities. Subsequently, the medical records are forwarded to the internal auditing department, whose team is composed of auditing analysts and a nurse auditor, who perform quantitative and qualitative analyses of care and administrative records. Once this stage is completed and the necessary adjustments are made, the documents are sent to the billing department, which is responsible for presenting the services provided to the payer source for reimbursement purposes. Auditing and billing operate in a systematized manner. In cases involving hospitalization through SUS, the medical record is sent directly for billing without passing through the auditing department, which finalizes the service process.

To achieve the research objective, the steps proposed[12] for the Critical Incident Technique (CIT) were followed, including: 1- Determination of the objectives of the activity to be performed; 2- Development of the questions to be asked to the people who will provide the critical incidents of the activity to be analyzed; 3- Definition of the population and sample; 4- Collection of critical incidents; 5- Content analysis of the collected incidents, as well as highlighting the behaviors expressed; 6- Grouping and categorization of critical behaviors; 7- Survey of the frequencies of positive and negative critical behaviors.

Step 1 of the Critical Incident Technique was presented previously and refers to the objective of this investigation; Step 2 of the CIT was represented by the script that guided the semi-structured interview, designed to allow for the professional characterization of the participants and to support the questions that provided the critical incidents of the activity to be analyzed. Step 3, which concerns the definition of participants, considering the characteristics and objective of the research, selected participants by convenience, according to their role and the relationship of their position to auditing. Inclusion criteria were: working in the administrative and care management area for at least two years, a period justified by the

need for relevant knowledge regarding organizational processes; working at different levels of the decision-making process in the administrative, billing, and healthcare management areas; not having any involvement, either direct or indirect, with this study, in order to minimize the bias of the participants' perception regarding auditing in the institution analyzed. There was a total of 10 potential participants.

Step 4, which refers to the collection of critical incidents, used a semi-structured interview script, composed of three items, in order to meet the recommendations of CIT[12,13], namely: participant characterization (age, sex, year of admission to the institution, education, and sector of activity); and two open-ended questions with similar wording, one aimed at retrieving an incident with a positive reference and the other from a negative perspective, considering situations experienced or observed, from the managers' perspective, regarding auditing.

The script underwent face validation by three expert judges in scientific methodology and in the subject, who considered the script adequate; subsequently, a pre-test was conducted with professionals performing a function similar to the participants, but who were not part of the final study sample. It should be noted that adjustments were made to the form and not to the content for the final version of the script.

Regarding the data collection procedure, it is also worth highlighting that the interviews were conducted by the main researcher (a master's student in nursing, specialist in auditing, and auditing nurse at the hospital under analysis) between March and June 2023. They were conducted individually and in person, in a private setting within the study hospital, and after obtaining the participants' consent. The interviews were recorded on two digital devices and lasted approximately 35 minutes. They were fully transcribed by the researcher and checked by another researcher and subsequently stored in an institutional e-mail account of the research center, creating a database. The transcribed transcripts were represented by the letter "I" for "interview," followed by a number (1, 2, 3... up to 10) in the order in which they were conducted: I1, I2, I3, [...] I10, representing each participant. The full interview transcripts were not sent to the participants; instead excerpts categorized by theme, were shared for corrections and comments.

For step 5 regarding content analysis of the collected incidents, it is important to highlight that, considering the audit as a dynamic tool, developed in stages and by many hands, there was no intention to emphasize the professional background of each participant. Each interview had its respective content organized and systematized by the principal researcher, extracting the triads that compose the situation-behavior-consequence CIs, which

were classified by participants as positive or negative[13], corresponding to the strengths and limitations according to the managers' perspective on auditing as a hospital management tool.

Steps 6 and 7 of the CIT, referring respectively, to the grouping and categorization of critical behaviors and the survey of the frequencies of positive and negative critical behaviors, occurred concomitantly. To present the frequencies of positive and negative CIs, descriptive statistics of the data were used, and the set of interviews underwent content analysis, which is widely used in studies employing the CIT[12].

In the present study, it was adopted Bardin's framework[14], encompassing the stages of pre-analysis, material exploration, and interpretation of results. In the pre-analysis phase, a floating reading of the interviews was performed to make a broad approximation to the content of the CIs; the material was also prepared, including grammatical corrections and the exclusion of language flaws, interferences, and external noise, with the objective of preserving the original meaning of the accounts and facilitating reader comprehension; in the material exploration phase, the accounts of each CI were identified and grouped by similarity of content, resulting in the construction of three analytical categories: Supporting Documentation, Audit Activities, Electronic Medical Record; in the analysis phase, these categories were interpreted in the light of the adopted theoretical framework and in accordance with the study object. After categorization, the participants were consulted and expressed agreement and convergence between what was stated and what was presented in the interviews and systematized data.

Regarding ethical aspects, the Research Ethics Committee of the Ribeirão Preto School of Nursing, *Universidade de São Paulo*, evaluated and approved the study, according to opinion number 0270/2021 and CAAE number 50840521.7.0000.5393, in compliance with the determinations of Resolution No. 466/2012 of the National Health Council. Before the interviews began, all participants signed the Informed Consent Form.

RESULTS

Ten professionals participated in the study, eight of whom were female (80%), with the age range between 40 and 59 years (60%), 80% in coordination positions and 20% in management positions. In terms of length of service, 50% of the participants had been working at the institution for more than 20 years. Regarding educational background, 40% were administrators, another 40% were nurses, and only 20% had other qualifications also related to the healthcare sector.

From the analysis of the reports, 34 critical incidents (CI) originated, of which 14 (41%) of the references point to positive aspects and 20 (59%) to negative aspects. The CIs were grouped into three thematic categories, as shown in the table below.

Table 1 – Situations extracted from critical incidents regarding managers' perspectives on auditing as a hospital management tool, reported by professionals from the studied hospital. Matão, SP, 2023

Critical Incident Category	**Positive**		**Negative**		**Total**	
	nº	**%**	**nº**	**%**	**nº**	**%**
Supporting documentation	5	29%	12	71%	17	50%
Audit activities	7	58%	5	42%	12	35%
Electronic medical record	2	40%	3	60%	5	15%
Total	14	41%	20	59%	34	100%

Supporting Documentation

This category encompasses incidents related to the proper documentation of records in medical charts, adequate verification of materials used, the checking of administered medications, and also includes how the procedures performed by the healthcare team were described, the complete nursing record, and the correction of documentary inconsistencies that were not properly verified during hospitalization.

The following transcripts correspond to the negative incidents reported regarding the audit process.

> *[...] the physician performed the tubal ligation according to the nursing record but did not describe the procedure in the general surgical report*. (I1)

> *[...] we encountered a lack of documentation of procedures performed, such as performing a blood glucose test [...]* (I1)

> *[...] doing documents or adding information that was missing because it had not been completed by the team, even though it had been performed on the patient* (I3).

The regularization of medical records, including the correction of inconsistencies, the proper recording of supporting information, and the insertion of billing items after patient

discharge, may occur. However, it is recognized that this type of rework negatively compromises operational dynamics and the efficiency of institutional processes. In contrast, the positive references in this category, which were predominant, are evidenced in the following statements:

> *[...] requesting a post-surgical X-ray to verify the material that was used and receive payment for the OPME after confirmation of its use [...]* (I1)

> *With the supporting documentation properly completed/recorded in the medical record, we are able to charge room fees, dressing fees, or any other contracted procedure, in addition to receiving payment for what was performed.* (I1)

> *[...] we had the idea of hiring a nurse or a nursing technician who could correct inconsistencies, such as checking medications and documenting unidentified materials directly within the auditing department, adjusting everything that is missing in order to streamline the process [...] (*I9)

> *The fact is that we forget that the medical record is not just a piece of paper, that lacks a stamp, or a check, or a request, a description of procedures, it is a legal document that ensures all care provided and guarantees payment for the service delivered.* (I10)

The audit process involves the previous analysis of hospital bills for subsequent presentation to health insurance plans, at which time medical records are carefully examined in order to identify the care effectively provided. This verification includes information regarding hospitalizations, surgical procedures, use of materials and medication administration, ensuring that the billing is in accordance with the established contractual terms[6].

Audit Activities

This category comprises incidents related to the audit activity, the work methodology adopted by the institution, the structuring of functions and work stages. It encompasses everything from the registration of billing items and training on billing criteria to the presentation of different payment models according to current contracts. It also includes the preparation of external manuals and the verification of the adequacy of medical records, ensuring that they are properly filled out, organized in a pre-established order, and updated so that the hospital bill can be closed and submitted to the health insurance plan operators, ensuring proper payment for services rendered. This is the category with the highest number of incidents, corresponding to 58% positive references and 42% negative references.

Incidents with positive references:

> *[...] the billing sector depends on the audit activities and their technical basis...* (I4)

> *The establishment of contracts with health insurance providers must be aligned with the entire healthcare team, including physicians, physical therapists, speech therapists, and nutritionists; this should be carried out by the auditing department and then communicated to everyone involved, including reception staff...* (I10)

> *[...] We created a manual among the auditing teams containing all items that must be verified, from materials and medications to fees and items to be excluded, in order to facilitate the records, with this document, the actions become more aligned [...]* (I10)

The statements demonstrate that the operationalization of audit activities encompasses strategic issues, such as participation in contract formulation, in addition to issues of professional training, monitoring the delivery of medical records, and the readjustment of records. However, incidents with negative references were also evidenced, as presented below:

> *We didn't have a structured audit, so we didn't know what it required, it took time for the roles to be defined [...]* (I1)

> *[...] when we set up the audit department, nobody came in and said: "from now on it will be like this, let's train," the work happened and people were trained* (I2)

> *The fact is that the audit is only used to collect accounts, mainly on closing dates, and not to fulfill its role.* (I5)

> *[...] we had a situation where there was a failure in signing a contract with a health insurance plan, a specific table was negotiated to pay teams and diets, this table pulled lower values than those practiced, and the audit only found out later, as it did not participate in the negotiations ...* (I10)

The negative references highlight elements related to the organization of audit activities, their responsibilities, team training, and possible deficiencies in the establishment of contractual documents with health insurance providers. These factors demonstrate that auditing, as a management tool, requires investment, institutional support, and an active role within the service. The educational dimension of auditing is essential to raise awareness

among healthcare teams regarding its relevance, enabling more effective use of the process in identifying weaknesses and proposing improvements.

The training of healthcare professionals is complex, involving many challenges and opportunities, and is the subject of frequent studies and debates related to the intense social transformations experienced by society[15,16].

Electronic Medical Record

This category groups incidents related to the creation and use of computerized resources. It was found that these deficiencies are associated both with professional training and qualification and with the lack of investment in organizational information structures, such as the adoption of functionalities for the operationalization of electronic medical records, digitized records within electronic medical records, and the use of electronic verification systems. The incidents were considered negative by 60% of participants and positive by 40% of them. Incidents with negative references are presented below:

> *[...] hybrid medical record, this middle ground, I am facing a lot of difficulty. Some sectors like the ICU and inpatient care for health insurance plans are electronic, while other sectors work with handwritten records.* (I3)
>
> *The institution is undergoing a long-term transformation toward paperless medical records; currently, it remains hybrid, generating a great deal of divergence.* (I3)
>
> *Correcting the electronic medical record check has become more difficult, it takes longer to release the record. It was easier with paper.* (I8)
>
> *The medical record is completely printed for presentation and archiving in the SAME in physical form. This hybrid medical record generates a lot of rework, that's what this partially implemented technological innovation has generated.* (I9)
>
> *The audit is resistant to this implementation of electronic medical records, claiming that it is not legally recommended to present a hybrid document.* (I10)

Nevertheless, excerpts exemplifying positive incidents were also identified:

> *[...] we implemented the electronic medical record, with electronic verification through electronic prescription administration (EPA), during the pandemic, and we were able to complete this implementation, improving documentation...* (I7)
>
> *The electronic medical record is excellent, but there is still a long way to go for its implementation. We only have diagnostic services, such as imaging*

> *exams and laboratory tests in the system, while the others are not yet included*. (I10)

The categories “supporting documentation” and “electronic medical record” concentrate incidents with a large number of negative references, which weaken the use of auditing; the audit activities category encompasses a significant number of incidents with positive references, which favor the use of auditing.

DISCUSSION

Regarding the development of auditing, aspects involved in each category may overlap, however, the discussion is presented by highlighting elements from each of the categories.

In the Supporting Documentation category, which focuses on the relevance of supporting documentation for care, negative incidents predominated, especially those related to inconsistencies in records and difficulties in adapting electronic medical records.

The medical record is part of the documents used to prove and support the performance of care, management, research, financial recording and legality of actions[17].

The occurrence of errors or discrepancies in the documentation and recording of professional activities is relatively common, a fact that can compromise patient safety, the quality of care and, ultimately, the billing for the work performed. It is observed that discrepancies in the formulation of the medical record are associated both with professional training and qualification, and with a lack of investment in information structures, which are essential for the more efficient conduct of data recording and processing[15].

Therefore, the quality of clinical records is a central element for patient safety and the effectiveness of health audits, since documentary inconsistencies can compromise the evaluation of care processes and institutional decision-making[2].

It should be emphasized that the process of systematizing supporting documentation is a structuring component of health auditing, enabling traceability and the analysis of the reliability of the evidence supporting the care provided, in addition to allowing qualified professionals to understand the nature, scope, and technical basis of the work performed. In this sense, complete and standardized records allow verification of compliance with regulatory and contractual standards and guidelines, support evidence-based decision-making processes, and strengthen clinical governance[18 - 19].

Despite the great relevance of records, the data presented indicate evidence of failures in documentation, revealing nonconformities related to institutional protocols, care provided,

and the use of guiding procedures. These documentary discrepancies also include the absence of patient and professional identification, insufficient information related to medication prescriptions, care prescriptions and interventions, lack of details regarding patient complaints, inappropriate use of abbreviations, and illegible handwriting.

Deficiencies in supporting documentation can lead to negative impacts, such as an increased incidence of adverse events, difficulties in communication, reduced continuity of care, and even fragmentation of the care provided[15]. The detection of discrepancies in medical record documentation throughout the auditing process generates inconsistencies in billing, points to possible failures in processes, violates the ethical and legal principles that guide professional practice, and indicates potential problems in care procedures[20]. The occurrence of inconsistencies, the absence or inadequate recording of information generates significant impacts on services, resulting in discontinuity of care, ethical and legal compromise of professionals, and has financial repercussions for the health sector[21]. It should also be noted that, although recording and documenting care in medical records is an essential responsibility of professionals, lapses and inadequacies often occur on the part of their supervisors.

Recent evidence from international literature reinforces that systematic audits associated with the use of quality indicators contribute to guiding changes in care practices and strengthening the culture of safety in healthcare institutions[28]. Thus, auditing has the potential to promote continuous improvements, providing support for training and planning aimed at optimizing processes that need improvement within health institutions[20,22].

Making adequate records, in a clear, objective, complete and simplified manner, demonstrates organization, understanding and continuity of care provided, in addition to greater control of the procedures performed and the assurance of the correct form of reimbursement[21].

In this sense, some strategies can be developed to optimize the audit activities, such as mapping actions to identify and correct any failures[3], as well as establishing evaluation goals, carrying out data collection and analysis, and implementing changes in institutional processes[23].

Regarding the Audit Activities category, there was a predominance of positive references, especially when relating auditing to quality control and patient safety, showing that the way auditing activities are developed, from macro aspects, such as participation in contract preparation, to professional training, account monitoring, and record adjustments, are recognized by managers as positive for management.

Health auditing can provide improvements by contributing to the development of action plans in processes of readjustment and redirection of institutional strategies, in addition to favoring the institution's financial sustainability[22]. Based on the analysis of the compatibility between the amounts charged as reimbursement and the procedures contractually established between the service provider and health insurance companies, considering all the supplies used, the daily rates, usage and gas fees, medical fees, and everything that comprises a hospital bill, auditing becomes vital in the quality improvement process[24].

From this perspective, auditing emerges as an investigative tool aimed at continuous quality improvement and clinical governance, being used primarily to bring practice back to established minimum standards. This approach limits the potential of auditing as a strategy for promoting the quality of nursing care and disregards relevant contributions from the nursing professionals themselves regarding the analyzed context[24,23].

Regarding hospital billing, auditing plays a leading role in reviewing accounts and evaluating costs, with the objective of controlling and ensuring the organization's accounting balance, contributing to efficiency and effectiveness in hospital management[3,7-8]. Understanding auditing practices may optimize the use of material resources, promote development, improve planning and work execution, and positively impact the financial sustainability of services[3].

The operationalization of auditing activities comprises sequential and articulated steps, aimed at evaluating the conformity of care processes, the efficiency of resource use, and the quality of care offered. These steps include planning to identify critical aspects of the care and administrative process; establishing criteria, indicators, and documentary sources. The execution includes the analysis of medical records, compliance, opportunities to optimize the process and propose adjustments; finalization with the development of reports to support and strengthen governance, institutional transparency and the enhancement of strategies to improve safe care[2 e 25].

Regarding the Electronic Medical Records category, which had a predominance of negative references, it is important to understand that we are experiencing a context of transition between types of medical records, a situation that requires investments to expand its use, including educational actions to desensitize professionals who may be resistant to its adoption. It is observed that, over the last decade, the health sector has undergone a significant process of transformation and technological innovation. In this context, technology

assumes an essential role in supporting the prevention, promotion and monitoring of health, as well as in optimizing processes within the hospital environment[26].

There is an educational gap, both in undergraduate education and continuing education, regarding ensuring the development of competencies necessary not only for direct patient care but also for indirect activities, such as completing medical records[27].

In this perspective, criticism has emerged regarding the use of electronic medical records, since they require time for the use of computer equipment during patient care and divide the professional's attention between the patient and the device, potentially causing harm to dialogue, interaction, and patient-centered care[26].

It becomes evident, according to the professionals' perception, that inadequate completion of medical records, as well as nonconformities occurring during healthcare delivery, may alter the deadlines for appeals, affect care performance, and compromise financial purposes. Healthcare organizations should consider strengthening auditing and implementation processes within nursing, given their direct effects on the quality of patient care and on the psychological well-being of nursing professionals[23]. Such practices provide relevant support for evaluating work processes, contributing to improvements in quality of care and to the reduction of claim denials, which represent negative financial impacts for the institution[6].

The electronic medical record presents numerous advantages, highlighting the improved accessibility to the patient's clinical history, the possibility of simultaneous use by several professionals during care, the flexibility in organization and the presentation of data that ensures legible and easily interpreted information. Furthermore, it favors integration with other systems, eliminates redundancies and minimizes the risk of document loss. This model provides an organized and accurate document structure, clearly reflecting the care provided by the entire healthcare team[27].

To ensure efficient and transparent healthcare service delivery, auditing supports managers by enabling the entire process involving patient care, payments, and healthcare service providers within the hospital setting to be appropriate and fairly remunerated. With an emphasis on efficient cost management, it is possible not only to promote significant improvements in service quality but also to improve other aspects related to infrastructure, patient safety measures, and the development of training programs. This demonstrates that auditing is not limited to verifying compliance with rules and regulations but also acts in identifying opportunities to improve efficiency and optimize the use of resources[9].

When completing electronic medical records, if documentation is incomplete, health insurance plans may apply payment reductions, known as claim denials, which may affect several items and significantly impact the institution's billing. Therefore, this tool is also used as a financial record by healthcare organizations for reimbursement purposes[26,27]. Furthermore, it is important to remember that, regarding legal validity, the medical record is a fundamental document for both the patient and the medical and nursing staff, encompassing the entire healthcare team. It must contain records of all care provided to the patient while receiving health care. Each professional responsible for a note, record, or progress entry is accountable for the information documented therein, and it is not appropriate to redo or make subsequent adjustments to such information[17].

Although health audit programs are associated with significant benefits, their implementation faces significant challenges, especially resistance to change at individual and organizational levels. This resistance is manifested through professional insecurity, fear of punitive approaches, attachment to consolidated practices, and a limited understanding of auditing as an educational and continuous improvement tool, which can compromise its consolidation as a clinical governance strategy and quality of care improvement[28,29].

As study limitations, it should be noted that the analysis is restricted to one healthcare service and the perception of the hospital organization managers, as those responsible for the decision-making process, without analyzing the other actors involved in and benefit from audit activities. These limitations do not disqualify the findings, they indicate the need for development of future research aimed at analysis that bring together healthcare professionals, as well as users of hospital organizations, in order to provide a broader overview of the potential of auditing in health management and care delivery.

FINAL CONSIDERATIONS

Regarding aspects that favor the use of auditing in hospital management, the following stand out: adequate supporting documentation of interventions and procedures performed, both in physical and electronic medical records, which benefits not only the audit itself, but also care, management, teaching, research, financial recording , and legal support aspects of health organizations; and the possibility of reviewing operational and care processes, strategies, and actions, when the way the audit is developed encompasses broader aspects such as participation in contract preparation, as well as professional training, account monitoring, and record adjustments.

The following factors hinder the use of auditing in hospital management: weaknesses in medical records that reveal nonconformities with institutional protocols and professional guidelines; failures in the organization of auditing activities, assignment of responsibilities and functions, as well as lack of team training and contractual deficiencies with health insurance plans.

In this sense, far beyond the compliance with protocols and for billing purposes, the use of auditing as a strategic hospital management tool requires that managers and audit teams seek to integrate technological solutions and training practices to enhance aspects that favor the use of auditing.

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Data and material availability

Access to the dataset is available upon request from the corresponding author.

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