FINAL AUDIT REPORT

A Report to the Audit Committee

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Audit Recommendations Follow-up – Audit of Nashville General Hospital Pharmacy Operations

March 23, 2021

Metropolitan Nashville Office of Internal Audit

EXECUTIVE SUMMARY
March 23, 2021

Audit Recommendations Follow-Up - Audit of the Nashville General Hospital Pharmacy Operations

Why We Did This Audit

To evaluate management's implementation of previous audit recommendations as of March 1, 2021.

What We Recommend

Management should continue efforts to implement the remaining three recommendations issued.

BACKGROUND

On December 20, 2019, the Metropolitan Nashville Office of Internal Audit issued an audit report on pharmacy operations at Nashville General Hospital between May 1, 2017, and April 30, 2019. The audit report included 17 recommendations, all of which were accepted by management for implementation. Office of Internal Audit guidelines require monitoring and follow-up to ensure that the recommendations assessed as high or medium risk are appropriately considered, effectively implemented, and yield intended results.

OBJECTIVES AND SCOPE

The objectives of this follow-up audit were to determine if the recommended action or an acceptable alternative was implemented.

The scope of the follow-up audit included all 17 accepted recommendations that management reported as implemented.

WHAT WE FOUND

Of the initial 17 recommendations made, Nashville General Hospital has implemented 14 recommendations. The three recommendations not implemented include the reconciliation of cash receipts collected by the Community Pharmacy by an individual outside of the pharmacy to ensure cash receipts are complete and accurate, developing an inventory methodology for the purpose of identifying inventory shrinkage, and monitoring badge access for the pharmacy to ensure only authorized individuals can access the pharmacy areas.

AUDIT FOLLOW-UP RESULTS

The initial audit report encompassed the pharmacy operations of Nashville General Hospital between May 1, 2017, and April 30, 2019. The audit report included 17 recommendations all of which were accepted by management for implementation.

The Office of Internal Audit will close a recommendation only for one of the following reasons:

- The recommendation was effectively implemented.
- An alternative action was taken that achieved the intended results.
- Circumstances have so changed that the recommendation is no longer valid.
- The recommendation was not implemented despite the use of all feasible strategies or due to lack of resources. When a recommendation is closed for these reasons, a judgment is made on whether the objectives are significant enough to be pursued later in another assignment.

The scope of the follow-up audit included all 17 accepted recommendations that management reported as implemented. Of the 17 accepted recommendations, 7 recommendations were fully implemented, and 3 were not implemented. Implementation actions were evaluated, as well as progress being made on any open recommendations. Details of the implementation status and updated implementation dates can be seen in Appendix A.

METHODOLOGY

To achieve the audit objectives, auditors performed the following steps:

- Reviewed policies and procedures for the 340B Pricing Program, Covered Entity, and Community Pharmacy cash collections.
- Reviewed the meeting minutes for the 340B Oversight Committee and Medical Diversion Prevention Committee.
- Obtained deposit documentation for the Community Pharmacy to ensure controls over cash collections were implemented.
- Obtained and reviewed the cost-benefit analysis for the implementation of an inventory management system for the Nashville General Hospital.
- Verified pharmacy cameras are operational.
- Ensured the Nashville General Formulary was updated after every Pharmaceutical and Therapeutics Meeting.
- Detail-testing of drug invoices to verify procurement verification controls

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our observations and conclusions based on our audit objectives.

AUDIT TEAM

Seth Hatfield, CPA, CIA, CFE, In-Charge Auditor

Lauren Riley, CPA, CIA, ACDA, CMFO, Metropolitan Auditor

APPENDIX A – PRIOR RECOMMENDATIONS AND IMPLEMENTATION STATUS

The following table shows the guidelines followed to determine the status of implementation.

Table 1

Recommendation Implementation Status	
Implemented	The department or agency provided sufficient and appropriate evidence to support the implementation of all elements of the recommendation and the recommendation's implementation caused or significantly influenced the benefits achieved.
Partially Implemented	The department or agency provided some evidence to support implementation progress but not of all elements of the recommendation were implemented.
Not Implemented	The department or agency did not implement a recommendation because: a) of lack of resources; b) an alternative action was taken that achieved the intended results; c) circumstances have so changed that the recommendation is no longer valid.

The following are the audit recommendations made in our original audit report dated December 20, 2019, and the current implementation status of each recommendation based on our review of information and documents provided by Nashville General Hospital.

Recommendation	Implementation Actions	Outstanding Issues	Implementation Status
A.1 Develop policies and procedures for the 340B Drug Discount Program within the Nashville General Hospital. **Assessed Risk Level: High**	The Nashville General Hospital developed policies and procedures for the 340B Drug Pricing Program and Covered Entity Program.	None	**Fully Implemented/ Closed**
A.2 Develop an internal compliance program for the 340B Drug Discount Program. The compliance program should include periodically reviewing policies and procedures, reviewing 340B drug transactions for compliance, and maintain auditable records. **Assessed Risk Level: High**	The Nashville General Hospital received an Audit Checkup by Macro Helix, a third party 340B management service, in 2020. Policies and procedures were developed for the 340B program as well as a charter for the 340B Oversight Committee. A review of the 340B Oversight Committee minutes showed that the Nashville General Hospital is actively monitoring and reviewing the 340B program.	None	**Fully Implemented/ Closed**

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B.1 Develop policies and procedures for the collection of cash receipts in the Community Pharmacy. **Assessed Risk Level**: **High**	The Nashville General Hospital developed a policy and procedure for the collection of cash in the Community Pharmacy.	None	**Fully Implemented/ Closed**
B.2 Develop a retention schedule for deposit documentation in the Community Pharmacy and maintain the documentation for the specified time frame. **Assessed Risk Level**: **High**	The Community Pharmacy Cash Collections Policy and Procedure specifies a retention policy of two years.	None	**Fully Implemented/ Closed**
B.3 Require both the pharmacist and the pharmacy technician to sign off on the accuracy of the Community Pharmacy cash deposit. **Assessed Risk Level: High**	The Nashville General Hospital Community Pharmacy is using two-person integrity when preparing cash deposits. A review of cash deposits in December 2020 was performed to verify the implementation.	None	**Fully Implemented/ Closed**
B.4 Develop a process in which an employee outside of the Community Pharmacy reconciles the Community Pharmacy cash deposits to the WinRx point-of-sale close out reports. **Assessed Risk Level: High**	A reconciliation was not being performed by an individual outside of the community pharmacy. A deposit slip is delivered to the accounting department, but no verification is done to ensure the deposit is complete or accurate.	Management of the Community Pharmacy has communicated that moving forward the WinRx point-of-sale closing report will be emailed to the accounting department daily so a reconciliation can be performed between the deposit slip and the point-of-sale closing report. **Note:** Implementation occurred during the reporting phase of the audit (3/1/2021) and did not have sufficient implementation time for testing.	**Not Implemented/ Open**
B.5 Maintain a log in the Community Pharmacy to document the transfer of cash from the Community Pharmacy to the courier. Require the courier to sign for the deposit before transferring it to the bank. **Assessed Risk Level: High**	A log was developed and being used in the Community Pharmacy to document the transfer of custody between the Community Pharmacy and the courier.	None	**Fully Implemented/ Closed**

APPENDIX A – PRIOR RECOMMENDATIONS AND IMPLEMENTATION STATUS

B.6 Ensure that cash receipts are deposited in the bank within one business day of collection. **Assessed Risk Level**: **High**	The Nashville General Hospital Community Pharmacy is depositing cash collections within one business day of collection. A review of cash collections from December 2020 was performed to verify the implementation.	None	**Fully Implemented/ Closed**
B.7 Develop a methodology for reconciling the third-party reimbursement checks from insurance carriers to claims processed in the WinRx Pharmacy Management Software to ensure accuracy and completeness. **Assessed Risk Level**: **High**	The Nashville General Hospital developed a policy and procedure for reconciling reimbursement checks from insurance carriers.	None	**Fully Implemented/ Closed**
C.1 Perform a cost-benefit analysis for the implementation of a drug inventory management system in the inpatient pharmacy. **Assessed Risk Level: High**	Pricing was obtained from three vendors for a drug inventory management system and a cost benefit analysis was performed on 2/24/2020. Due to budget constraints, Nashville General Hospital decided against the implementation of a drug inventory management system.	None	**Fully Implemented/ Closed**
C.2 Establish a physical inventory methodology as part of the inventory management process within the Nashville General Hospital inpatient and Community Pharmacy. Inventory shrinkage over a specified percentage should be investigated. For example, cycle counting could be used for medications with a high cost. **Assessed Risk Level: High**	An inventory was conducted in June 2020 for the purpose of an inventory valuation for the Nashville General Hospital financial statements. However, A physical inventory methodology was not developed for the purpose of identifying shrinkage.	Without the use of an inventory management system, periodic cycle counts would be manual making the counts time consuming and cumbersome. However, since no inventory detection controls are in place for the misappropriation on noncontrolled drugs, the Nashville General Hospital should explore ways to perform inventory checks in some capacity. **Revised Date: 12/31/2021**	**Not Implemented/ Open**

APPENDIX A – PRIOR RECOMMENDATIONS AND IMPLEMENTATION STATUS

D.1 Ensure the pharmacy badge access is removed for terminated employees in a timely manner and employees that do not have pharmacy related duties. The director of pharmaceutical services should be periodically provided with the listing to ensure that only authorized employees can enter the pharmacies. **Assessed Risk Level**: **High**	The Pharmacy Director reviewed a report that showed who accessed the pharmacy areas during the month, but no documentation was retained to show the review was done. Additionally, no periodic review was done for the report that listed which employees had access to the pharmacy areas. An audit procedure was performed to reconcile a listing of individuals who have access to the pharmacy areas to an active employee listing. This found that individuals had access to pharmacy storage areas that were not current hospital employees.	Management of the inpatient pharmacy has stated that moving forward the Director of Pharmaceutical Services will perform a monthly review of the badge access report that shows which employees entered the pharmacy and a report that lists the employees that have access to the pharmacy. Documentation of this review will be maintained. **Note:** Implementation occurred during the reporting phase of the audit (3/15/2021) and did not have sufficient implementation time for testing.	**Not Implemented/ Open**
D.2 Ensure that all cameras in the inpatient pharmacy and the Community Pharmacy are operational and that footage is periodically reviewed. **Assessed Risk Level**: **High**	The cameras were verified to be working on January 29, 2021.	None	**Fully Implemented/ Closed**
E.1 Formally document the process for investigating possible drug diversion events identified in RxAuditor reports and reporting the conclusions of the investigations in a formal policy and procedure. **Assessed Risk Level: High**	The Medical Diversion Prevention Committee was formed and met 6 times in 2020. A review of the meeting minutes was performed.	None	**Fully Implemented/ Closed**

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F.1 Ensure the Nashville General Hospital Formulary is updated after each Pharmacy and Therapeutics meeting. **Assessed Risk Level: Medium**	The Nashville General Hospital Formulary was updated after every Pharmacy and Therapeutics Meeting in 2020.	None	**Fully Implemented/ Closed**
G.1 Ensure the Tennessee sales tax exemption is communicated to McKesson to prevent sales tax from being paid on over-the-counter medication and medical supplies. **Assessed Risk Level: Medium**	A review of invoices found that sales tax is not being charged on over-the-counter medication and medical supplies.	None	**Fully Implemented/ Closed**
G.2 Ensure that drug orders are placed and received by different employees or the drug orders are received using two-person verification. Receipt Verification should be documented and maintained in the pharmacy. **Assessed Risk Level**: **Medium**	A review of invoices found that two-person integrity is being used to verify the receipt of drugs orders.	None	**Fully Implemented/ Closed**