

AUDIT REPORT

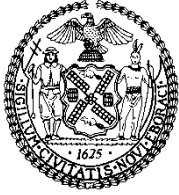


CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
BUREAU OF MANAGEMENT AUDIT
WILLIAM C. THOMPSON, JR., COMPTROLLER

Audit Report on Inventory Controls Over Noncontrolled Drugs at Coney Island Hospital

MG07-111A

June 25, 2009



THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
1 CENTRE STREET
NEW YORK, N.Y. 10007-2341

WILLIAM C. THOMPSON, JR.
COMPTROLLER

To the Citizens of the City of New York

Ladies and Gentlemen:

In accordance with the Comptroller's responsibilities contained in Chapter 5, § 93, of the New York City Charter, my office has examined inventory controls over noncontrolled drugs at Coney Island Hospital in Brooklyn.

Located in Brooklyn, Coney Island Hospital is one of the New York City Health and Hospitals Corporation's (HHC) 11 acute-care hospitals that provide medical, mental health, and substance-abuse services to City residents—regardless of their ability to pay. Audits such as this provide a means of ensuring that City hospitals maintain adequate internal controls over inventory to properly safeguard assets, thereby reducing the risk of misappropriation and theft.

The results of our audit, which are presented in this report, have been discussed with HHC and Coney Island Hospital officials, and their comments have been considered in the preparation of this report. Their complete written response is attached to this report as an addendum.

I trust that this report contains information that is of interest to you. If you have any questions concerning this report, please e-mail my audit bureau at audit@comptroller.nyc.gov or telephone my office at 212-669-3747.

Very truly yours,

A handwritten signature in cursive script that reads "William C. Thompson, Jr.".

William C. Thompson, Jr.
WCT/ec

Report: MG07-111A
Filed: June 25, 2009

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*The City of New York
Office of the Comptroller
Bureau of Management Audit*

**Audit Report on
Inventory Controls over Noncontrolled Drugs at
Coney Island Hospital**

MG07-111A

AUDIT REPORT IN BRIEF

The audit determined whether Coney Island Hospital had adequate internal controls over its pharmacy stockroom inventory of noncontrolled drugs.

As part of the New York City Health and Hospitals Corporation (HHC), Coney Island Hospital purchases, stores, and dispenses noncontrolled drugs. To maintain inventory records, it is responsible for maintaining its perpetual inventory records for noncontrolled drugs kept in its pharmacy stockroom on the HHC computerized OTPS (Other Than Personal Services) procurement management system. During Fiscal Year 2007, Coney Island Hospital spent approximately \$13 million for controlled and noncontrolled drugs and reported the value of its drug inventory as \$883,394 at Fiscal Year-end 2007.

Audit Findings and Conclusions

We determined that Coney Island Hospital had inadequate internal controls over its pharmacy stockroom inventory of noncontrolled drugs in Fiscal Year 2007. As a result, we questioned the disposition of an estimated \$3.75 million of noncontrolled drugs related to inventory “adjustments.” After discussing these findings and newly implemented Hospital procedures with the Hospital and HHC, we conducted additional testing at the end of Fiscal Year 2008 and determined that during that period, the hospital had improved its inventory controls and generally maintained accurate perpetual inventory records.

However, the audit revealed that during Fiscal Year 2007, Coney Island Hospital did not maintain accurate perpetual inventory records, lacked an independent review of transactions entered into OTPS, and did not take corrective actions or document explanations when inventory discrepancies between actual (stockroom) and perpetual (OTPS) inventory were identified. In addition, pharmacy staff made unsubstantiated inventory adjustments on several occasions, totaling an estimated \$3.75 million, to the noncontrolled drug perpetual inventory in OTPS to align it with physical balances at the hospital and yet still had discrepancies in 50 percent of the items at fiscal year-end. The hospital later reported to us that it conducted an analysis of the adjustments and determined that \$2.90 million was related to inventory issuances that had not

been recorded in OTPS. However, we were not provided sufficient information in order to determine the accuracy of that analysis. Inaccurate and incomplete inventory records, along with inventory management problems that we identified, are deficiencies that can create an environment in which theft or misappropriation of items is more likely to occur without detection.

Audit Recommendations

To address these issues, we make four recommendations, including that Coney Island Hospital should ensure that:

- Transactions posted in OTPS are independently reviewed in a timely manner to ensure records are complete and accurate.
- All inventory adjustments posted in OTPS are properly authorized and have supporting written explanations and/or supporting documentation on file.
- Storeroom inventory audits are conducted at least monthly in which all discrepancies are investigated and documented in writing.
- Discrepancies that can not be resolved after investigation are brought to the attention of hospital management in writing to ensure that appropriate corrective actions are taken.

Agency Response

In their response, HHC officials generally agreed with all four recommendations. However, while they agreed with certain findings, they disagreed with the “reported severity of others” in the report. A careful review of HHC’s disagreements found them to be without merit.

INTRODUCTION

Background

The New York City Health and Hospitals Corporation (HHC), the largest municipal hospital and health care system in the country, is a \$5.4 billion public-benefit corporation that serves 1.3 million New Yorkers, nearly 400,000 of whom are uninsured. HHC provides medical, mental health, and substance-abuse services to City residents—regardless of their ability to pay—through its 11 acute-care hospitals, 4 skilled nursing facilities, 6 large diagnostic and treatment centers, and more than 80 community-based clinics.

HHC hospitals require substantial quantities of drugs and must, therefore, ensure that items are in stock when needed. Drugs are classified as either controlled or noncontrolled. Controlled drugs are regulated and audited by the Drug Enforcement Administration (DEA), a federal law-enforcement agency that has strict requirements for storage, record keeping, and dispensing of these drugs. The DEA, however, does not regulate noncontrolled drugs, which are the subject of this audit.

Each of HHC's acute care hospitals purchases, stores, and dispenses noncontrolled drugs. To maintain inventory records, each facility is responsible for maintaining its perpetual inventory records for noncontrolled drugs kept in its pharmacy stockroom on the HHC computerized OTPS (Other Than Personal Services) procurement management system.

At Coney Island Hospital, the facility covered by this audit, noncontrolled drugs are stored in secure areas and are monitored 24 hours a day by security cameras. The noncontrolled drugs for the pharmacy's stockroom are ordered by pharmacy managers. Vendors deliver orders directly to the pharmacy's stockroom, along with invoices, where staff receive and check each shipment for accuracy. Invoices are entered into OTPS to make payments to vendors and to automatically add items received to the hospital's noncontrolled drug perpetual inventory records.

Noncontrolled drugs are issued from the pharmacy stockroom to five pharmacy units¹ within the hospital based upon written requests, called issue sheets. Drugs requested on issue sheets are assembled by stockroom staff. Upon delivery to each unit, issue sheets are reviewed and verified by unit supervisors. Then, these verified issue sheets are entered into OTPS by stockroom staff to update the hospital's perpetual inventory records. Invoices and issue sheets are filed in the pharmacy department.

Each hospital must report the value of its year-end drug inventory through HHC. During Fiscal Year 2007, Coney Island Hospital spent approximately \$13 million for controlled and noncontrolled drugs and reported the value of its drug inventory as \$883,394 at Fiscal Year-end 2007.

¹ Coney Island Hospital has five pharmacy units: Main Pharmacy, Out-patient Pharmacy (OPD), In-patient Satellite Pharmacies on the 6th and 7th floors, and the Re-Pack Department.

Objective

The objective of this audit was to determine whether Coney Island Hospital has adequate internal controls over its pharmacy stockroom inventory of noncontrolled drugs.

Scope and Methodology

The scope of this audit is Fiscal Years 2007 and 2008. To gain an understanding of the inventory controls over noncontrolled drugs at Coney Island Hospital, we reviewed the hospital's policy and procedures related to drug inventory: PHA-119, "Requisitioning Pharmaceuticals and Supplies by the Various Pharmacy Areas from the Main Pharmacy Stockroom"; PHA-160, "Store Room [stockroom] Audit"; PHA-167, "Receiving of Pharmacy Supplies in E-Commerce and OTPS"; PHA-166, "Purchasing Pharmaceuticals and Supplies using the E-Commerce and OTPS System"; and PHA-164, "Adjustments to the OTPS Pharmacy Inventory." We interviewed Coney Island Hospital officials and conducted walk-throughs of the physical space, as well as its processes for the purchase, maintenance, and dispensing of noncontrolled drugs. We reviewed documents related to the pharmacy's drug inventory, including internal audit reports. We used Comptroller's Directive #1, Principals of Internal Control as additional criteria for assessing internal controls.

To assess the data reliability of OTPS, we obtained an OTPS listing of all drugs at Coney Island Hospital and verified its completeness by judgmentally selecting 105 noncontrolled drugs (every tenth drug on the shelf) in the pharmacy storage locations on June 15, 2007 and confirming whether each was in OTPS listing as of a March 1, 2007. We also tested the accuracy of OTPS, when we compared 100% of the noncontrolled drug items on the shelves during the Fiscal Year-end 2007 inventory count to those listed in OTPS.

On June 19, 2007, one week prior to the hospital's Fiscal Year-end 2007 inventory count, we conducted preliminary testing in which we randomly selected a sample of 100 drugs from the 2,058 noncontrolled drugs listed in OTPS as of March 1, 2007. The auditors, along with a Coney Island Hospital pharmacy employee, counted the actual inventory of each drug. We compared the balances on hand to the balances recorded in OTPS that morning, after adjusting balances for invoices and issues not yet recorded. We excluded from our analysis 30 drugs that had no inventory on the shelves and no balance in OTPS, and one drug for which the wrong item was counted. Of the remaining 69 noncontrolled drugs, we determined the number with discrepancies between their actual inventory balances and the balances recorded in OTPS, and estimated the dollar value² of each discrepancy. We subsequently asked pharmacy management for explanations of the discrepancies.

² Coney Island Hospital officials told us that drug prices change often in OTPS when new drug shipments are received, so to value the discrepancies found from each actual inventory count we used the following prices listed in OTPS: For preliminary (6/19/07) and Fiscal Year-end 2007 (6/26-28/07) counts, we used prices as of the morning of 6/30/07; for the October 12, 2007 count, we used prices as of that morning; and for the Fiscal Year-end 2008 (6/25/08) count, we used prices as of the morning of June 25, 2008.

We also followed-up on results of a drug-inventory review conducted by Coney Island Hospital's own internal audit department on January 18, 2007. On June 19, 2007, we conducted a separate count of the seven noncontrolled drugs that had discrepancies in that review to determine whether the discrepancies had been corrected and explained.

On June 26-28, 2007, we accompanied Coney Island Hospital staff members as they conducted their year-end inventory count of all noncontrolled drugs on the stockroom shelves. We independently counted all noncontrolled drugs on the stockroom shelves. We obtained a copy of Coney Island Hospital's count sheets and compared them with our independent count. Then, we compared this Fiscal Year-end 2007 inventory count to the balances recorded in OTPS for all noncontrolled drugs and noted the number, size, and estimated value of gross discrepancies in counts.

In addition, we determined the estimated value of noncontrolled drug inventory adjustments in OTPS for Fiscal Year-end 2006, Fiscal Year 2007 and Fiscal Year 2008³. We also tested whether the adjustments made in OTPS at Fiscal Year-end 2007 corrected the discrepancies found during the year-end count so that balances in OTPS reflected the actual inventory counts.

To determine whether the number of unexplained noncontrolled drug inventory discrepancies had decreased at Coney Island Hospital in Fiscal Year 2008, we conducted three additional tests:

First, we randomly selected the week of September 23-29, 2007 for our tests of documents filed in the pharmacy department. Then, we traced all 892 invoices and issue sheets to OTPS and vouched all 890 entries in OTPS back to the supporting invoices and issue sheets to determine whether Coney Island Hospital is keeping accurate and complete inventory records⁴.

Second, we randomly selected a sample of 200 drugs from 2,164 noncontrolled drugs listed on an OTPS listing as of October 2, 2007. On October 12, 2007, the auditors, along with a Coney Island Hospital pharmacy employee, counted the actual inventory of each drug and compared the balances on hand to the balances recorded in OTPS, after adjusting balances for invoices and issue sheets not yet recorded. We excluded from our analysis 89 drugs that had no inventory on the shelves and no balance in OTPS. Of the remaining 111 noncontrolled drugs, we determined the number with discrepancies between their actual inventory balances and the balances recorded in OTPS, along with the size (number of units) and estimated dollar value of each discrepancy. On October 12, 2007, we also counted the 41 drugs that we found had discrepancies during our June 19, 2007 test to determine whether the inventory records for these items still contained discrepancies.

³ "Adjustments" throughout this report always refer to gross adjustments. We estimated the value of noncontrolled drug inventory adjustments made in OTPS based upon the following prices: adjustments made at Fiscal Year-end 2006 (\$9,469), February 19-March 15, 2007 (\$1,074,228) and at Fiscal Year-end 2007 (\$341,215) are based upon prices listed on June 30, 2007; adjustments made on January 17 and 18, 2007 (\$2,335,635) are based upon prices listed on those days; and adjustments made during Fiscal Year 2008 (\$3,397) are based upon prices listed on June 25, 2008.

⁴ The difference between the tracing (892) and vouching (890) is due to timing differences between the actual transactions and when they were entered in OTPS.

Lastly, on June 25, 2008, we again accompanied Coney Island Hospital staff members as they conducted their year-end inventory count of all noncontrolled drugs on the stockroom shelves. We independently counted all noncontrolled drugs on the stockroom shelves. We obtained a copy of Coney Island Hospital's count sheets and compared them to our independent count. Then, we compared this Fiscal Year-end 2008 inventory count to the balances recorded in OTPS for all noncontrolled drugs and noted the number, size, and estimated value of gross discrepancies in counts.

The results of these tests in conjunction with our review of the existing internal controls provided a reasonable basis to determine whether Coney Island Hospital has adequate inventory controls over its pharmacy stockroom inventory of noncontrolled drugs.

The audit was conducted in accordance with generally accepted government auditing standards (GAGAS) and included tests of records and other auditing procedures considered necessary. This audit was performed in accordance with the City Comptroller's audit responsibilities as set forth in Chapter 5, §93, of the New York City Charter.

Discussion of Audit Results

The matters covered in this report were discussed with HHC and Coney Island Hospital officials during, and at the conclusion of this audit. A preliminary draft report was sent to HHC and Coney Island Hospital officials on February 4, 2009, and was discussed at an exit conference on February 24, 2009. A draft report was submitted to HHC and Coney Island Hospital officials on April 1, 2009, with a request for comments. We received a written response from HHC on April 27, 2009.

In its response, HHC agreed with the audit's recommendations. However, the agency disagreed with the tone of the report. HHC stated: "While we agree with certain findings and disagree with the reported severity of others, we recognize the need for improvement. With respect to the deficiencies cited in your audit regarding pharmacy inventory controls for Fiscal Year 2007, and those identified in CIH's [Coney Island Hospital's] internal review, corrective measures were already being initiated prior to the start of your FY 2007 and FY 2008 audits. In addition, a number of operating procedures and processes were developed to strengthen and enhance internal controls over the facility's noncontrolled drug inventory." A careful review of HHC's disagreements found them to be without merit.

The full text of the HHC response is included as an addendum to this report.

FINDINGS AND RECOMMENDATIONS

We determined that Coney Island Hospital had inadequate internal controls over its pharmacy stockroom inventory of noncontrolled drugs in Fiscal Year 2007. The audit revealed that Coney Island Hospital did not maintain accurate perpetual inventory records, lacked an independent review of transactions entered into OTPS, and did not take corrective actions or document explanations when inventory discrepancies between actual (stockroom) and perpetual (OTPS) inventory are identified. As a result, the risk that items may be misappropriated is increased. After discussing our findings with the Hospital and HHC, however, we conducted additional testing at the end of Fiscal Year 2008 and determined that the hospital had improved its inventory controls and generally maintained accurate perpetual inventory records with respect to that year.

We found that the Hospital had implemented new procedures at the start of our audit, which restricted access to the hospital pharmacy, stockroom, and satellites to specific employees. Cameras were also installed in pharmacy areas to observe activities. Vendors deliver noncontrolled drugs directly to the stockroom, where an employee counts and signs for the number of cases received. Documentation for noncontrolled drugs that are received and issued from the stockroom is maintained in the stockroom files. Therefore, we determined that during the period covered by our audit and the course of our fieldwork the control environment in Coney Island Hospital's Pharmacy had experienced major changes in key personnel, new and updated written procedures for drug handling, and the installation of a new security system.

During Fiscal Year 2007, Coney Island Hospital spent approximately \$13 million for controlled and noncontrolled drugs, while pharmacy staff made unsubstantiated "adjustments" on several occasions to the noncontrolled drug perpetual inventory in OTPS to align it with physical balances at the hospital. The adjustments totaled an estimated \$3.75 million.

HHC Response: "The \$3.75 million in adjustments includes \$110,000 for blood sugar test strips, and intravenous solutions that are improperly included in the non-controlled drug category, which according to the audit scope, should have been excluded."

Auditor Comment: The \$3.75 million in adjustments reported above does not include any blood sugar test strips or intravenous solutions. However, it should be noted that while we reduced the value of total adjustments from \$3.84 million to reflect only noncontrolled drugs, the pharmacy is still responsible for documenting adjustments made in these non-drug items as well.

The hospital later reported to us that it conducted an analysis of the adjustments and determined that \$2.90 million was related to inventory issuances that had not been recorded in OTPS. However, we were not provided sufficient information in order to determine the accuracy of that analysis. The magnitude of the total inadequately documented adjustments of inventory was equal to nearly one-third of the hospital's total spending on drugs for Fiscal Year 2007, and the year-end adjustment alone equals half of the reported value of its year-end drug inventory. Deficiencies such as those we found can create an environment in which theft or misappropriation of items is more likely to occur without detection.

HHC Response: “In November 2008, representatives from HHC’s Office of Internal Audits and the facility met with the audit team to present results of the Pharmacy Department’s analysis. We identified supporting documentation [issue sheets] for \$2.9 million of the \$3.75 million claimed as “unsubstantiated”. Therefore, to continue to represent that the \$3.75 million is “unsubstantiated,” and that the facility did not provide sufficient information to determine the accuracy of the analysis is inaccurate. The statement surrounding the lack of information should be removed from the report, and the \$3.75 million should be modified/reduced to reflect recognition of documentation totaling \$2.9 million, together with the exclusion of an additional \$110,000 of non-pharmaceutical items.

Auditor Comment: We state that \$3.75 million in adjustments were “unsubstantiated” because neither the facility, nor HHC provided the auditors with any documentation until more than a year later, though it was requested from the facility as early as October 2007. Furthermore, we were unable to determine the accuracy of the analysis that finally was provided to us in November 2008. The facility is supposed to keep an explanation or documentation on file for each specific adjustment made in OTPS. We agree that the facility may have since identified documentation, such as unentered issue sheets, to support some of these adjustments. But we could not determine the accuracy of their analysis based upon the issue sheets we obtained. In addition, even with their extensive analysis, the facility still cannot explain some adjustments made during Fiscal Year 2007 that reduced the perpetual inventory levels for noncontrolled drug items in OTPS by approximately \$0.85 million. As stated earlier, all non-pharmaceutical items have already been excluded from the \$3.75 million in unsubstantiated adjustments.

Inaccurate and Incomplete Inventory Records

Physical inventory counts showed that the noncontrolled drug perpetual inventory in OTPS was not accurate nor complete compared to the actual balances of noncontrolled drugs in the pharmacy stockroom at Coney Island Hospital. We found discrepancies in the counts for as many as 59 percent of the noncontrolled drugs reviewed (the error rate), despite millions of dollars in mostly inadequately documented adjustments that hospital officials said had been made in order to align the inventory records with the physical balances at the hospital. The large number and size of discrepancies lead us to conclude that limited reliance can be placed on the hospital’s inventory records. In addition, these discrepancies may have been indicative of a larger problem, such as theft or mismanagement, at the stockroom.

HHC Response: HHC objects to the statement “discrepancies may have been indicative of a larger problem such as theft or mismanagement;” rather HHC “attributes the discrepancies to the following: instances where the new E-Commerce procurement system did not interface appropriately with the Pharmacy Department’s OTPS system; inconsistencies in units of measure for purchases made through the E-Commerce system; insufficient maintenance of pharmacy records by Pharmacy Department personnel; insufficient oversight of pharmacy inventory personnel; and delayed data entry of issues, merchandise received, and adjustments not recorded in the OTPS system.”

Auditor Comment: Throughout the audit, we asked pharmacy officials to explain the discrepancies between the actual inventory counts in its stockrooms and the perpetual

inventory balances in OTPS. So, while we agree that discrepancies in inventory could have been due to some or all of the reasons stated above, it does not change the fact that pharmacy officials could not explain why specific items had specific discrepancies nor could they account for what happened to all of the noncontrolled drugs purchased for Coney Island Hospital in Fiscal Year 2007. Without proper management of its noncontrolled drug inventory, which should include supervisory review of the inventory process to identify and correct errors, we could not rule out the possibility of theft having occurred undetected.

The Coney Island Hospital had two stockroom clerks, who both received and issued noncontrolled drugs. One of these clerks also recorded the transactions in OTPS. Comptroller’s Directive #1 states “Key duties and responsibilities need to be divided or segregated among different staff members to reduce the risk of error or fraud.” However, in cases like the pharmacy stockroom at the hospital, where segregation of duties is difficult, mitigating controls should be implemented. These controls should include supervisory monitoring of work on an ongoing basis, examining related records, and verifying entries. Officials told us that they had no independent review within the Pharmacy to ensure the timeliness or accuracy of entries into OTPS.

To make an initial assessment of the accuracy of the hospital’s inventory records, we conducted a preliminary inventory count of 69 randomly selected noncontrolled drugs on June 19, 2007. Of the 69 items, valued at \$64,137, we found 41 (59%) had gross discrepancies in counts (including shortages and overages) between the perpetual inventory records in OTPS and the actual balances tested in the pharmacy stockroom. We found shortages in 30 items and overages in 11 items. We estimated the gross value of these 41 discrepancies at \$17,398. The results of the preliminary inventory count are shown in Table I, below:

Table I
Shortages and Overages of Noncontrolled Drugs in Pharmacy Stockroom
Preliminary Inventory Count

| | Inventory Records | Shortages | Overages | Total Gross Discrepancies | Error Rate |
|--------------|----------------------|-----------|----------|------------------------------|---------------|
| # of Drugs | 69 | 30 | 11 | 41 | 59% |
| Dollar Value | \$64,137 | \$14,040 | \$3,358 | \$17,398 | 27% |

Prior to our count, hospital officials had not identified any of these discrepancies. After investigating the discrepancies that we identified, hospital officials still could not explain 19 (46%) of them. The hospital was able to provide adequate documentation to resolve the remaining 22 (54%) discrepancies classified as record keeping errors involving incorrect unit of issue, data entry mistakes, and forgetting to enter invoices and issue sheets. An independent and timely review could reduce these errors.

The results of the hospital’s complete Fiscal Year-end 2007 inventory count, one week later, mirrored the results of our preliminary count. Of the 1,276 noncontrolled drugs tested, valued at \$1,055,356, we found 634 (50%) items had gross discrepancies in counts between the perpetual inventory records in OTPS and the actual balances tested in the pharmacy stockroom.

We found shortages in 454 items and overages in 180 items. We estimated the gross value of these 634 discrepancies at \$350,198. The results of the Fiscal Year-end 2007 inventory count are shown in Table II, below:

Table II
Shortages and Overages of Noncontrolled Drugs in Pharmacy Stockroom
Fiscal Year-end 2007 Inventory Count

| | Inventory Records | Shortages | Overages | Total Gross Discrepancies | Error Rate |
|--------------|----------------------|-----------|----------|------------------------------|---------------|
| # of Drugs | 1,276 | 454 | 180 | 634 | 50% |
| Dollar Value | \$1,055,356 | \$250,547 | \$99,651 | \$350,198 | 33% |

During the audit, hospital officials informed us that they had made changes to the inventory process to improve record-keeping since the Fiscal Year 2007 inventory adjustments in OTPS. These changes included replacing and training new stockroom staffers, requiring more timely data entry of invoices and issue sheets, and conducting drug-inventory spot checks. However, officials were unable to adequately explain the reasons for the large number and size of discrepancies identified in the year-end count. These discrepancies are even more disturbing in light of the unsubstantiated inventory gross adjustments totaling \$3.41 million that officials made to OTPS prior to the year-end count. Following the count, the hospital made additional gross adjustments of approximately \$0.34 million, which were also unsubstantiated, for a total of \$3.75 million. (This issue is discussed in more detail in the following section of this report.) Taking this into account, these discrepancies in Fiscal Year 2007 may have been indicative of a larger problem, such as theft or mismanagement, at the stockroom.

We shared the results of our analysis with hospital and HHC officials in November 2007 and January 2008. The hospital pharmacy undertook an extensive analysis of the \$3.75 million in unsubstantiated inventory gross adjustments of noncontrolled drugs, consisting of approximately \$0.16 million in additions and \$3.59 million in reductions, resulting in a net reduction of \$3.43 million. The hospital attempted to account for the shortages in inventory by identifying issue sheets which may not have been entered into OTPS. In November 2008, the hospital reported its findings to us, claiming that based upon its analysis, it had identified about \$2.90 million of inventory that had been issued from the storeroom but had not been entered into OTPS during Fiscal Year 2007. Even with its analysis, the hospital still provided no explanation for approximately \$0.85 million of the inventory adjustments. In addition, the hospital did not provide sufficient information for us to determine the accuracy of its analysis.

Inventory Management Problems

In Fiscal Year 2007, Coney Island Hospital management failed to institute proper controls over its non-controlled drug inventory operations. As a result, it was unable to ensure that waste and mismanagement of inventory are minimized and that inventory is effectively protected against theft.

Hospital officials told us that they became aware of inventory problems in January 2007. The hospital has an Internal Audit Department that reports to its Chief Financial Officer. A hospital internal auditor performed a review of pharmacy inventory of noncontrolled drugs on January 18, 2007. In the report, dated January 31, 2007, it was noted that the inventory level decreased by \$1.08 million, from \$3.23 million to \$2.15 million, on the date of the review. According to the report, a pharmacy official stated that “issues were not entered in the system, but rather inventory levels were adjusted to physical count values.” Our review of OTPS records confirmed that pharmacy staff had “adjusted” inventory levels downwards by \$2.3 million, without adequate explanation and documentation, on January 17 and 18, 2007.

The hospital report warned that there was “no viable method of determining what percentage of the inventory was used for patients or what percentage was lost due to theft.” It recommended that the pharmacy must enter all drug invoices and issue sheets into OTPS on a regular basis, keep documentation to support those OTPS entries, and assign different people to the responsibilities of ordering, receiving, issuing, and recording transactions of drugs.

HHC Response: “The auditors disclosed that no documentation was obtained to support the claim of unsubstantiated adjustments and further, no substantive testing was conducted to validate this audit finding. In fact, we were advised that the auditors’ conclusion was based solely upon an interview conducted with the Assistant Director of Pharmacy.”

Auditor Comment: This conclusion was based upon many discussions with hospital and HHC officials; the hospital’s own internal audit report from January 2007, cited above; and a review of OTPS records. In October 2007, the audit team spoke with both the Director and Assistant Director of the Pharmacy about inventory adjustments having been made without adequate documentation or explanations. In November 2007, the Assistant Director confirmed that they had no documentation for the adjustments. By January 2008, we had identified, and the facility verified, a total of \$3.84 million in inventory adjustments, but the pharmacy did not give the audit team any written documentation supporting these adjustments. In January 2008, we met with HHC officials, who subsequently met with the facility, and determined that the facility needed to do an analysis to explain these adjustments. Finally, in November 2008, HHC officials and the facility met with the audit team to present results of the Pharmacy Department’s analysis related to the inventory adjustments.

In January 2007, the hospital updated existing and issued new written policies for the handling of drugs and drug inventory. In addition, security measures were improved. By March 2007, a new security system including key cards and cameras was installed in the pharmacy areas. However, officials did not put adequate controls in place to ensure that inventory policies were being followed.

The hospital issued a policy requiring monthly drug inventory audits by the pharmacy staff, in which “items to be chosen will be those pharmaceuticals that are either high cost/high volume or high potential for diversion . . . and all discrepancies must be reported and resolved the same day.” We found that during Fiscal Year 2007 these audits were not being conducted monthly, as required.

The policy further states that the assistant director of pharmacy or his designee must also check the invoices and issue sheets entered into OTPS at least once a month. Had the invoices

and issue sheets been reviewed and compared to OTPS entries each month, as required, the unexplained discrepancies, which resulted in millions of dollars in unsubstantiated adjustments of noncontrolled drug inventory in OTPS, might have been identified more quickly and then properly documented and corrected.

In addition, once discrepancies between the perpetual and actual inventory balances are identified, the hospital's policy on "Adjustments to the OTPS Pharmacy Inventory" states: "An investigation to determine the cause of the discrepancy must be investigated within 24 hours or the next business day, to determine the cause of the discrepancy." If there is documentation of the discrepancy, it must be signed by pharmacy officials. All adjustments to OTPS inventory require a brief explanation as to the reason for the adjustment. The purpose of this policy is "to provide an accurate level of inventory control and to prevent the unlawful diversion of medications." Not only did we find extensive discrepancies in the inventory counts in our Fiscal Year 2007 testing, we found no evidence that this policy was being followed.

Following the \$2.34 million in gross adjustments made in January 2007, hospital officials made additional unsubstantiated gross adjustments totaling \$1.07 million in February and March 2007, and \$0.34 million in gross adjustments following the year-end count in June 2007. As stated in the previous section of this report, the gross value of these inadequately documented adjustments totaled \$3.75 million. When asked about the specific adjustments, hospital officials did not provide us with adequate documentation or explanations. Instead, the hospital conducted an extensive analysis to try to account for these adjustments in inventory levels.

HHC Response: "From the date of the entrance conference, CIH officials informed the auditors that the facility had conducted its own internal audit of the pharmacy's internal controls over non-controlled drugs. The facility's audit identified issue sheets (distributions made to units via signed documents that recognize the delivery and receipt of non-controlled drugs) that were not being entered into the OTPS system, and that inventory levels were being adjusted to match physical count values. As a result, the facility started a reconciliation of its FY 2007 issue sheets to adjustments processed in the OTPS system at the time your audit was first being conducted. Although the auditors were alerted to these facts, very little is stated in the current report to recognize the fact that CIH had already taken measures to identify and correct deficiencies."

Auditor Comment: At our entrance conference in February 2007, HHC officials told us that there were no prior, applicable audits or consultant reports on Inventory Controls of Coney Island Hospital over Noncontrolled Drugs. At that time, we were asked to delay our first meeting at the hospital for nearly a month until March 19, 2007 due to the Pharmacy Director's previously planned vacation. In March 2007, when we first met with pharmacy officials at their facility, they mentioned that they were having a problem with one clerk, but they failed to alert the audit team to the existence of the internal audit report, the inventory adjustments, or the security measures, (i.e., the keycards and cameras) that had been implemented since our entrance conference. We later learned that, just ahead of our audit, pharmacy officials had started to review their inventory controls and implement "corrective measures" due to the internal audit report, dated January 31, 2007. Throughout this report, we mention the corrective measures taken,

including: major changes in key personnel; new and updated written procedures for drug handling; and the installation of a new security system. We also learned that during the period of time that Coney Island Hospital requested we delay the audit, between February 15 and March 19, 2007, pharmacy personnel entered \$1.07 million in adjustments.

The January 2007 hospital report had identified specific discrepancies in the inventory counts of seven (35%) of 20 randomly selected items tested on January 18, 2007. On June 19, 2007, five months later, we found that discrepancies still existed for six (86%) of these seven items. If hospital management had implemented the recommendations within the internal report—such as ensuring that the pharmacy enter all drug invoices and issue sheets into OTPS on a regular basis and assigning different people to the responsibilities of ordering, receiving, issuing, and recording transactions—the unexplained inventory discrepancies could have been reduced and inventory records would have been more accurate and complete.

We conclude that during Fiscal Year 2007, Coney Island Hospital did not maintain adequate controls over its noncontrolled drug inventory. The pharmacy staff did not enter noncontrolled drug issues in a timely manner, nor did they document or adequately explain inventory adjustments made in OTPS, as required by the hospital’s own policies. As a result, we are unable to ascertain whether the discrepancies we identified are merely due to poor record keeping or are indicative of more serious problems, such as theft.

The hospital pharmacy has also undergone a number of personnel changes both prior to and during the course of this audit. The former pharmacy director retired in December 2005 and the position remained vacant until a new director was appointed in March 2006, less than a year before the start of our audit. During the audit, by April 2007, the pharmacy clerk responsible for updating the OTPS inventory was transferred and replaced by two new clerks. Finally, the hospital’s Deputy Chief Financial Officer retired in July 2007.

To determine the accuracy of the inventory records during the subsequent fiscal year (2008), we randomly selected a sample of 111 noncontrolled drugs for a stockroom inventory count on October 12, 2007. Of these 111 items, valued at \$75,335, we found 13 (12%) had gross discrepancies in counts between the perpetual inventory records in OTPS and the actual balances tested in the pharmacy stockroom. We found shortages in seven items and overages in six items. We estimated the gross value of these 13 discrepancies at \$2,710. The results of the October 2007 inventory count are shown in Table III, below:

Table III
Shortages and Overages of Noncontrolled Drugs in Pharmacy Stockroom
October 2007 Inventory Count

| | Inventory Records | Shortages | Overages | Total Gross Discrepancies | Error Rate |
|--------------|----------------------|-----------|----------|------------------------------|---------------|
| # of Drugs | 111 | 7 | 6 | 13 | 12% |
| Dollar Value | \$75,335 | \$443 | \$2,267 | \$2,710 | 4% |

Prior to our count, hospital officials had not identified any of these discrepancies. After investigating the discrepancies hospital officials provided documentation to resolve six. Again these discrepancies were due to the same types of record keeping errors found during our preliminary inventory count in June 2007, involving incorrect unit of issue, data entry mistakes, and forgetting to enter invoices and/or issue sheets. However, hospital officials still could not explain seven of the 13 gross discrepancies in counts.

Two additional tests also confirmed improvements in the accuracy of hospital’s inventory records of noncontrolled drug inventory. The first test, in which we traced and vouched all noncontrolled drug invoices and issue sheets for a randomly selected week, found that all (100%) of the transactions were documented and had been accurately and completely entered in OTPS. The second test, in which we followed up and retested all 41 items with discrepancies between the perpetual inventory records in OTPS and the actual balances tested in the pharmacy stockroom on June 19, 2007, found that only two items still had unexplained discrepancies in October 2007.

Of the 41 noncontrolled drugs in this follow-up inventory count on October 12, 2007, valued at \$36,051, we found only two (5%) items had discrepancies between the perpetual inventory records in OTPS and the actual balances tested in the pharmacy stockroom. We found a shortage of one unit in one item and an overage of two units in the other item. We estimated the gross value of the discrepancies for the two items at \$91 compared to a gross value of \$17,398 for the gross discrepancies in counts in these same 41 items in the June 2007 preliminary count detailed earlier in this report in Table I. The results of the October 2007 follow-up inventory count are shown in Table IV, below:

Table IV
Shortages and Overages of Noncontrolled Drugs in Pharmacy Stockroom
Follow-up Inventory Count

| | Inventory Records | Shortages | Overages | Total Gross Discrepancies | Error Rate |
|--------------|----------------------|-----------|----------|------------------------------|---------------|
| # of Drugs | 41 | 1 | 1 | 2 | 5% |
| Dollar Value | \$36,051 | \$59 | \$32 | \$91 | 0.3% |

Based upon the results of these tests, the accuracy of its perpetual inventory records for noncontrolled drugs has improved. However, this improvement in the accuracy of inventory records may be a result of the auditors’ presence along with personnel changes and not due to improvements in management controls over inventory.

HHC Response: “From December 2007 until June 2008, no further contact between the audit team and the facility occurred. Instead of receiving a preliminary draft report which is usually customary after a preliminary exit conference, the auditors returned in June 2008, seven months later, to conduct a 100% review of the Pharmacy Department’s FY 2008 year-end inventory, which effectively changed the audit scope.”

Auditor Comment: We did not hold a “preliminary exit conference” with HHC. In November 2007 we met with Hospital and HHC officials to inform them of our findings. Subsequently, we met with HHC officials in January 2008 and were in contact via phone with HHC and the hospital. Based on the significant findings revealed during our test of the hospital’s Fiscal Year 2007 operations, we expanded the audit’s scope to include Fiscal Year 2008, in order to test whether newly implemented changes in the pharmacy had resulted in improved inventory controls. The audit team returned to the facility for the year-end inventory count in June 2008, in order to ensure that the improvements noted during the limited testing performed in October 2007 had not been temporary adjustments due to our presence at the facility.

We returned to the hospital at Fiscal Year-end 2008 to document whether the accuracy of the hospital’s perpetual inventory records continued to improve. Of the 1,101 noncontrolled drugs tested, valued at \$834,885, we found 9 (0.8%) items had discrepancies between the perpetual inventory records in OTPS and the actual balances tested in the pharmacy stockroom. We found shortages in eight items and an overage in only one item. We estimated the gross value of these nine discrepancies at \$1,857. The results of the Fiscal Year-end 2008 inventory count are shown in Table V, below:

Table V
Shortages and Overages of Noncontrolled Drugs in Pharmacy Stockroom
Fiscal Year-end 2008 Inventory Count

| | Inventory Records | Shortages | Overages | Total Gross Discrepancies | Error Rate |
|--------------|----------------------|-----------|----------|------------------------------|---------------|
| # of Drugs | 1,101 | 8 | 1 | 9 | 0.8% |
| Dollar Value | \$834,885 | \$1,658 | \$199 | \$1,857 | 0.2% |

The results of the hospital’s complete Fiscal Year-end 2008 inventory count showed great improvement over the prior year’s results. The error rate on the number of discrepancies dropped from 50 percent to less than 1 percent, as shown in Table VI, below:

Table VI
Fiscal Year-end Noncontrolled Drug Inventory Count Results
2007 vs. 2008

| | 2007 | 2008 |
|-------------------------------------|-------------|-----------|
| # of Drugs | 1,276 | 1,101 |
| Total Gross discrepancies | 634 | 9 |
| Error Rate | 50% | 0.8% |
| Dollar Value of Drugs | \$1,055,356 | \$834,885 |
| Dollar Value of Gross discrepancies | \$350,198 | \$1,857 |
| Error Rate | 33% | 0.2% |

In addition, during Fiscal Year 2008, the hospital adjusted the balances of 10 noncontrolled drugs with a total dollar value of \$3,397. In view of these reductions in inventory discrepancies and adjustments during Fiscal Year 2008, we are reasonably assured that the problems we identified in Fiscal Year 2007 have been corrected and that the hospital has improved internal controls over its inventory of noncontrolled drugs.

Large differences between the perpetual inventory records in OTPS and the actual inventory balances in the pharmacy stockroom, as well as inadequately documented adjustments to those records, not only interfere with effective inventory management, but also create an environment susceptible to theft and misappropriation. In addition, adequate supervisory review and accurate records would ensure early detection of missing items and would permit timely investigations to identify the source of errors.

Recommendations

Coney Island Hospital should ensure that:

1. Transactions posted in OTPS are independently reviewed in a timely manner to ensure records are complete and accurate.

HHC Response: HHC agreed and stated that as of July 2008, “The pharmacy supervisor conducts weekly tests to monitor the timeliness and accuracy of entries into OTPS”. In addition, as of December 2008, “the hospital’s Internal Auditor conducts a sample audit to verify the accuracy of OTPS entries.”

2. All inventory adjustments posted in OTPS are properly authorized and have supporting written explanations and/or supporting documentation on file.

HHC Response: HHC agreed and stated that as of June 2007, “All inventory adjustments are properly investigated and approved by the Pharmacy Director or his assistant prior to being posted in OTPS. Documentation pertaining to the investigation is maintained in the stockroom files.”

3. Storeroom inventory audits are conducted at least monthly in which all discrepancies are investigated and documented in writing.

HHC Response: HHC agreed and stated that as of August 2008, “On a weekly basis a pharmacy employee (not associated with any purchasing function) conducts a random test count of at least 10, sometimes 20 items and verifies the count to balances in the OTPS system. All items counted are documented on a special audit form. Discrepancies are noted on this form. The form is signed and dated by the employee conducting the audit.” In addition, as of December 2008, “the hospital’s Internal Auditor conducts a test count of stockroom inventory to verify the accuracy of the OTPS perpetual records.”

4. Discrepancies that can not be resolved after investigation are brought to the attention of hospital management in writing to ensure that appropriate corrective actions are taken.

HHC Response: HHC agreed and stated that as of August 2008, “All discrepancies noted and resolved are brought to the attention of both the Assistant Director and Director of Pharmacy. Corrections with explanations are written on the above mentioned audit form. Unresolved discrepancies are reported to the Materials Management Director.”

Alan D. Aviles
President

April 27, 2009

John Graham
Deputy Comptroller
Audits, Accountancy and Contracts
The City of New York
Office of the Comptroller
1 Centre Street
New York, New York 10007-2341

RE: **Draft Audit Report on Inventory Controls Over
Non-Controlled Drugs at Coney Island Hospital MG07-111A**

Dear Mr. Graham:

Thank you for the opportunity to respond to the above referenced audit.

I was pleased to read that after a thorough review and verification of Coney Island Hospital's (CIH) procedures, your audit found adequate internal controls existed over CIH's Fiscal Year 2008 pharmacy inventory. According to your 100% review of the facility's year-end inventory valued at \$834,885, there was a less than one percent (0.8%) error rate noted. Few instances (9 of 1,101 inventory items) were identified where minor discrepancies existed between the perpetual record and physical count. The audit also acknowledged that all noncontrolled drugs are maintained and stored in secured areas within the institution, monitored by security cameras 24 hours a day/7 days a week.

While we agree with certain findings and disagree with the reported severity of others, we recognize the need for improvement. With respect to the deficiencies cited in your audit regarding pharmacy inventory controls for Fiscal Year 2007, and those identified in CIH's internal review, corrective measures were already being initiated prior to the start of your FY 2007 and FY 2008 audits. In addition, a number of operating procedures and processes were developed to strengthen and enhance internal controls over the facility's noncontrolled drug inventory.

Attachment I is the detailed response to the reported audit findings. Attachment II is the Audit Implementation Plan, which addresses all the recommendations cited in the report.

Should you have any questions concerning this response, please contact Mr. Walter Otero, Assistant Vice President, Internal Audits at (646) 458-5603.

Sincerely,



Alan D. Aviles

- c. F.J. Cirillo, Senior Vice President, Operations
- R. Raju, M.D., Executive Vice President/Chief Medical Officer, Medical & Professional Affairs
- A. Wagner, Senior Vice President (Acting), South Brooklyn Health Care Network
- A. Marengo, Senior Assistant Vice President, Communications & Marketing
- J. Schick, Chief of Staff, President's Office
- P. Pandolfini, Chief Financial Officer, Coney Island Hospital
- K. Fehily, Associate Executive Director, Materials Management
- W. Lakoff, Director of Pharmacy, Coney Island Hospital
- W. Otero, Assistant Vice President, Office of Internal Audits
- A. Pistone, Director, Office of Internal Audits

New York City Office of the Comptroller Audit Report on Inventory Controls Over Non-Controlled Drugs at Coney Island Hospital MG07-111A

Attachment I

The report states (page 1):

“...pharmacy staff made unsubstantiated inventory adjustments on several occasions, totaling an estimated \$3.75 million, to the noncontrolled drug perpetual inventory in OTPS to align it with physical balances at the hospital...”

The report also states (pages 1-2):

“The hospital later reported to us that it conducted an analysis of the adjustments and determined that \$2.90 million was related to inventory issuances that had not been recorded in OTPS. However, we were not provided sufficient information in order to determine the accuracy of that analysis.” We disagree with the above statements for the following reasons:

First, the \$3.75 million in adjustments incorrectly includes \$110,000 for blood sugar test strips, and intravenous solutions that are improperly included in the non-controlled drug category, which according to the audit scope, should have been excluded. This was pointed out to the auditors at the exit conference, and again in an earlier correspondence.

Second, from the date of the entrance conference, CIH officials informed the auditors that the facility had conducted its own internal audit of the pharmacy’s internal controls over non-controlled drugs. The facility’s audit identified issue sheets (distributions made to the units via signed documents that recognize the delivery and receipt of non-controlled drugs) that were not being entered into the OTPS system, and that inventory levels were being adjusted to match physical count values. As a result, the facility started a reconciliation of its FY 2007 issue sheets to adjustments processed in the OTPS system at the time your audit was first being conducted. Although the auditors were alerted to these facts, very little is stated in the current report to recognize the fact that CIH had already taken measures to identify and correct deficiencies.

Further, on November 17, 2007, at the conclusion of the audit fieldwork, the auditors held their preliminary exit conference at the facility eleven months after the start of this engagement. During the preliminary exit conference, there was never any disclosure that the audit findings would include reference to unsubstantiated inventory adjustments to the OTPS system approximating \$3.75 million.

In December 2007, the audit team met with Office of Internal Audits (OIA) staff to inform that the additional finding was being included in the draft report. OIA staff advised the audit manager that any additional findings must be presented to the facility before any draft report is issued to ensure the accuracy of the findings, and to provide the facility with an opportunity to refute and/or mitigate the auditors’ claim. Therefore, if effective audit practices had been followed as recommended by our staff, a meeting would have been held with the facility’s Pharmacy Department in December 2007, and the necessary documentation would have been provided to mitigate/resolve the issue of “unsubstantiated adjustments” more than fifteen months ago.

At the exit conference held on February 24, 2009, the auditors disclosed that no documentation was obtained to support the claim of unsubstantiated adjustments and further, no substantive testing was conducted to validate this audit finding. In fact, we were advised that the auditors' conclusion was based solely upon an interview conducted with the Assistant Director of Pharmacy.

During the early stages of audit fieldwork, the auditors were advised that the issue sheets (i.e., the supporting documentation to the adjustments) were unavailable because the department was conducting a reconciliation of the issue sheets to adjustments in the OTPS system. Despite what is stated in your draft report, we maintain that the issue sheets were always available for your review. The Pharmacy Director maintains that had the field auditors made an additional inquiry at the time of fieldwork, this issue may have been clarified earlier. Had the auditors returned to validate their initial finding that there was no documentation to support the adjustments in the OTPS system, they would have arrived at a much different conclusion.

From December 2007 until June 2008, no further contact between the audit team and the facility occurred. Instead of receiving a preliminary draft report which is usually customary after a preliminary exit conference, the auditors returned in June 2008, seven months later, to conduct a 100% review of the Pharmacy Department's FY 2008 year-end inventory, which effectively changed the audit scope. In addition, in August 2008 the audit team obtained copies of all FY 2007 issue sheets and are a part of your work papers. Therefore, these documents have been available for your review.

As you may recall in November 2008, representatives from HHC's Office of Internal Audits and the facility met with the audit team to present results of the Pharmacy Department's analysis. We identified supporting documentation [issue sheets] for \$2.9 million of the \$3.75 million claimed as "unsubstantiated adjustments". Therefore, to continue to represent that the \$3.75 million is "unsubstantiated," and that the facility did not provide sufficient information to determine the accuracy of the analysis is inaccurate. The statement surrounding the lack of information should be removed from the report, and the \$3.75 million should be modified/reduced to reflect recognition of documentation totaling \$2.9 million, together with the exclusion of an additional \$110,000 of non-pharmaceutical items.

The report makes several statements that discrepancies may have been indicative of a larger problem such as theft or mismanagement. We do not agree with your assessment. Rather, we attribute the remaining discrepancies to the following:

- Instances where the new E-Commerce procurement system did not interface appropriately with the Pharmacy Department's OTPS system;
- Inconsistencies in units of measure for purchases made through the E-Commerce system;
- Insufficient maintenance of pharmacy records by Pharmacy Department personnel;
- Insufficient oversight of pharmacy inventory personnel; and
- Delayed data entry of issues, merchandise received, and adjustments not recorded in the OTPS system.

All of these issues have been addressed, as evidenced by your FY 2008 inventory review results.

MAYOR'S OFFICE OF OPERATIONS

ATTACHMENT I

AUDIT COORDINATION AND REVIEW
 AUDIT IMPLEMENTATION PLAN
 PART A

Audit Title: Audit Report on Inventory Controls Over Non-Controlled Drugs at Coney Island Hospital
 Audit Agency: The City of New York Office of the Comptroller

Date: April 27, 2009

Agency: NYCHCC (OIA # 07-42)

Audit Date: April 1, 2009

Audit No: MG07-111A

OMB Control No:

| RECOMMENDATION WITH WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT | METHODS/PROCEDURES | IMPLEMENTATION TARGET DATE |
|---|--|---------------------------------------|
| <p>Recommendation # 1</p> <p>Coney Island Hospital should ensure that transactions posted in OTPS are independently reviewed in a timely manner to ensure records are complete and accurate. (Page 14)</p> | <p>The Pharmacy supervisor conducts weekly tests to monitor the timeliness and accuracy of entries into OTPS.</p> <p>The hospital's Internal Auditor conducts a sample audit to verify the accuracy of OTPS entries.</p> | <p>July 2008</p> <p>December 2008</p> |
| <p>Recommendation # 2</p> <p>Coney Island Hospital should ensure that all inventory adjustments posted in OTPS are properly authorized and have supporting written explanations and/or supporting documentation on file. (Page 14)</p> | <p>All inventory adjustments are properly investigated and approved by the Pharmacy Director or his assistant prior to being posted in OTPS. Documentation pertaining to the investigation is maintained in the stockroom files.</p> | <p>June 2007</p> |
| <p>Recommendation # 3</p> <p>Coney Island Hospital should ensure that storeroom inventory audits are conducted at least monthly in which all discrepancies are investigated and documented in writing. (Page 14)</p> | <p>On a weekly basis a pharmacy employee (not associated with any purchasing function) conducts a random test count of at least 10, sometimes 20 items and verifies the count to balances in the OTPS system. All items counted are documented on a special audit form. Discrepancies are noted on this form. The form is signed and dated by the employee conducting the audit.</p> | <p>August 2008</p> |

**AUDIT COORDINATION AND REVIEW
AUDIT IMPLEMENTATION PLAN
PART A**

Audit Title: Audit Report on Inventory Controls Over Non-Controlled Drugs at Coney Island Hospital
 Audit Agency: The City of New York Office of the Comptroller

Date: April 27, 2009

Agency: NYCHCC (OIA # 07-42)

Audit Date: April 1, 2009

Audit No: MG07-111A

OMB Control No: _____

| RECOMMENDATION WITH WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT | METHODS/PROCEDURES | IMPLEMENTATION TARGET DATE |
|---|--|---|
| <p>Recommendation # 4</p> <p>Coney Island Hospital should ensure that discrepancies that can not be resolved after investigation are brought to the attention of hospital management in writing to ensure that appropriate corrective actions are taken. (Page 14)</p> | <p>The hospital's Internal Auditor conducts a test count of stockroom inventory to verify the accuracy of the OTPS perpetual records.</p> <p>All discrepancies noted and resolved are brought to the attention of both the Assistant Director and Director of Pharmacy. Corrections with explanations are written on the above mentioned audit form. Unresolved discrepancies are reported to the Materials Management Director.</p> | <p>December 2008</p> <p>August 2008</p> |

MAYOR'S OFFICE OF OPERATIONS

AUDIT COORDINATION AND REVIEW
AUDIT IMPLEMENTATION PLAN
PART B

ATTACHMENT I

Audit Title: Audit Report on Inventory Controls Over Non-Controlled Drugs at Coney Island Hospital
Audit Agency: The City of New York Office of the Comptroller

Date: April 1, 2009

Agency: NYCHHC (OIA # 07-42)

Audit Date: April 1, 2009

Audit No: MG07-111A

OMB Control No: _____

| RECOMMENDATIONS WITH WHICH THE AGENCY AGREES BUT IS UNABLE TO IMPLEMENT | REASONS FOR INABILITY TO IMPLEMENT | WHAT IS NEEDED TO ALLOW FOR IMPLEMENTATION (RESOURCES, PERSONNEL, LEGISLATION, LEGAL OPINION, ETC.) |
|---|------------------------------------|---|
| | | |
| | | |

MAYOR'S OFFICE OF OPERATIONS
 AUDIT COORDINATION AND REVIEW
 AUDIT IMPLEMENTATION PLAN
 PART C

ATTACHMENT I

Audit Title: Audit Report on Inventory Controls Over Non-Controlled Drugs at Coney Island Hospital
 Audit Agency: The City of New York Office of the Comptroller

Date: April 1, 2009

Agency: NYCHHC (OIA # 07-42)

Audit Date: April 1, 2009

Audit No: MG07-111A

OMB Control No: _____

| RECOMMENDATIONS WITH WHICH THE AGENCY DISAGREES AND DOES NOT INTEND TO IMPLEMENT | REASONS FOR DISAGREEMENT AND REFUSAL TO IMPLEMENT |
|--|---|
| | |
| | |