‘General Care’ is a state-owned hospital in the capital of the Republic of Angelistan. The hospital has a certain level of autonomy, but works with a budget through a service level agreement with the Ministry of Health. The Ministry of Health also has two seats on the Board of the hospital.

General Care has been struggling hard to attract specialist doctors to its hospital. These specialists can earn more money in a private hospital or abroad. However, the specialists who joined General Care since last year are allowed to have a small private practice besides their hospital work. They are not allowed to work for another hospital.

In order to be able to compete with private hospitals, the Board of General Care recently decided to apply for the JCI accreditation. This decision to go for a quality label was widely published by the government last month. Last year a big scandal occurred, when scissors were ‘forgotten’ inside the body of a patient after a surgery.

The limited government budget does not allow General Care to make huge investments. The hospital would like to purchase an additional MRI, as currently patients have to wait up to six months for an MRI scan.

Most treatments and surgeries are covered by the state social security system. However, certain treatments are considered by the Ministry of Health as luxury treatments and are not covered by social security. Only a very limited number of patients have a private insurance. According to the service level agreement, General Care does not have the right to refuse patients.

Normal hospital rooms are for two or four patients. When a patient insists on having a single, private room, the doctors have the right to ask for a higher fee. The extra cost for a private room is not covered by the social security. Patients are also expected to use lockers for their personal belongings. Valuables sometimes disappear and people are very fast to point a finger towards the hospital staff.

The doctors are very often fighting with the hospital management. The doctors claim that management gives too much priority to bureaucratic measures rather than the health of the patients.

General Care has been quite often in the press. Given this public exposure, internal audit decided to incorporate some processes and challenges in its 2017 internal audit plan.

ADDITIONAL INFORMATION:

Many medical services providers, public and private ones, are on the market with an over-supply of the medical services. The number and capacity of the medical service providers are too high compared to the population structure, which is diminishing due to emigration because of the poor economic situation of the country. On the market there are many private laboratories which are working and collecting the analysis from entire country. Also there are many diagnosis services providers such as MRT, computer tomography, etc

General Care is a small state hospital and it is not far from State Emergency hospital. A State Emergency hospital exists and it is of the very big capacities.

General care has the following structure of the budget:

* 90% from the total budget are from founds from State social insurance company and
* 9 % from private insurance and
* 1 % from extra cost for a private room.

Medical treated cases (patients) produced by the sections:

80 % of the patients - the surgical sections.

1. % for therapeutically sections, which are only 2: hematology and therapy.

The main procurement are for drugs and blood, also for food.

The organizational structure - see in the attachment 1.

The staff statistic is in the attachment 2.

The information on the blood statistics in in the attachment 3.

Two years ago the Medical care bought one new very expensive equipment: **computed tomography** scan (CT scan), but it is unused jet.

**Secret information:**

The computed tomography*scan* – it is still not in use because there are no specialized doctors and engineers to use this **computed tomography** scan. This info can be seen in the staff info (attachment).

The doctors are not happy with the public procurement process and they are complaining on the deficit of the blood. You can see this easily in the attachment nr.2.

The doctors always complain on pharmacy. There are many drugs there, but not the ones which are really effective (evidence based). This because procurement unit is economy oriented and select the cheapest drugs.

In the pharmacy there are the drugs which were bought 1 year ago but were not used. These specific drugs are 20 % of the total of the annual drugs’ use.

Attachment 1

***Attachment 2: Planned and hired staff***

|  |  |  |
| --- | --- | --- |
| ***Staff*** |  |  |
|  | ***Planned staff*** | ***Hired staff*** |
| **DIRECTOR** | **1** | **1** |
| **Deputy director nr.1** | **1** | **1** |
| **Deputy director nr.2** | **1** | **1** |
| **Administrative Department****Including** |  |  |
| * Head
 | 1 | 1 |
| * Accounting
 | 3 | 3 |
| * public procurement
 | 2 | 1 |
| * human resources
 | 2 | 2 |
| **Logistic Department, including** |  |  |
| * head
 | 1 | 1 |
| * canteen
 | 5 | 5 |
| * warehouse
 | 3 | 3 |
| * garage
 | 4 | 4 |
| * general and medical engineering
 | 4 | 2 |
| **Medical units, including** |  |  |
| * laboratory
 | 1 | 3 |
| * image
 | 2 | 1 |
| * surgery
 | 1 | 1 |
| * haematology
 | 1 | 1 |
| * orthopaedics
 | 1 | 1 |
| * gynaecology
 | 2 | 2 |
| * therapy
 | 3 | 3 |
| * reanimation
 | 1 | 1 |
| * pharmacy
 | 1 | 1 |

**BLOOD PRODUCTS**

|  |  |  |  |
| --- | --- | --- | --- |
| N/o | Product name | **2016** | **2017** |
| **Ordered(requested)** | **recieved** | **Ordered(requested)** | **recieved** |
|  | Red Cell Concentrate | 550 | 189,885 | 250 | 218,927 |
|  | Degraded red blood cell concentrate | 400 | 311,7 | 400 | 393,14 |
|  | Platelet concentrate | 100 | 8,6 | 10 | 8,5 |
|  | Freshly frozen plasma | 400 | 129,655 | 200 | 88,325 |
|  | Cryopreciptat | 50 | 0 | 50 | 24 |
|  | Albumin solution 10% - 200 ml | 250 | 113 | 250 | 33,2(166) |
|  | Human normal immunoglobulin | 250 | 140 | 280 | 280 |

**Proposals from Tashkent:**

**Audit objectives by consultants**

**1.**To assess the current level of commitment to quality.

**2.**To assure that the doctors behave in line with their contractual agreement.

----------------------------------------------------------------

*Personal Comment:* ***Thinking out of the box.*** *Your country system is not the best. Always when you asses think to the best system. Is possible to have a system in compliance with your legal framework but not properly working.*

|  |  |  |  |
| --- | --- | --- | --- |
| ***Objectives*** | ***Criteria*** | ***Observations*** | ***Solutions*** |
| 1. Evaluation of the financing process for hospital
 | * State Budget law;
* other financing possibilities for hospitals law;
* the existing procedures framework in this fields at the level on hospital
* The country legal framework in the field on internal control
 | *The legal framework has to provide the minimum requirements/conditions in each field. Based on this framework the entity (hospital) has to develop internal procedures, regulations for each activity**If the legal framework has deficiencies Internal Auditor has to propose improvements/modifications etc*  | *If at the level of the hospital there are not procedures developed we as Internal Auditors have 3 solutions:** *If we know another hospital with procedures we recommend to contact them for best practice*
* *If they have sufficient funds they will use external consultant to develop procedure*
* *An advisory mission from your side in order to help them to develop procedures*
 |
| 1. Assessment of the security system for hospital (the patient’s goods /different others/visits days for patients/access control in hospital/web surveillance/etc
 | * The legal framework in the field
* The procedures in the field existing at the level of hospital
* The country legal framework in the field on internal control
 |
| 1. Assessment of the existing administrative procedures at the level of the hospital
 | * Internal rules and regulations/procedures/law
* The country legal framework in the field on internal control
 |
| 1. Evaluation of the existing procedures for private rooms
 | * Internal procedures/price/criteria for private rooms
* The country legal framework in the field on internal control
 |
| 1. Assessment of the HR system for recruitment in hospital
 | * Legal framework in the field/internal procedures/internal regulations
* The country legal framework in the field on internal control
 |
| 1. Assessment the external communication system of hospital/ relation with patients/media/public relations
 | * Internal procedure external communication/ethic code/confidentiality requirements
* The country legal framework in the field on internal control
 |

**Working group’ s proposals for audit objective:** Give assurance to the ministry of health regarding the functionality of the system in the Hospital ….X

**Working group’ s proposals for audit the audit Scope:** Evaluation of the hospital activity in last 2 years.

**Audit Team:** S -Livia. team leader -coordination/supervision activity

 Auditor 1 - George. senior auditor

 Auditor 2 - Alice. junior auditor

 Auditor 3 – Ana senior auditor

**Audit Steps:**

*Assumptions = we start from the idea the in our internal/specific audit methodology are mentioned the documents for each activity carry on by the auditors/ tasks, the documents circuit and the responsibility to be elaborated, etc. In the specific methodology we have the possibility to eliminate some documents which are to birocratique.*

**Proposals from Brussels: WORK PROGRAMME FOR AUDIT FIELDWORK**

| **Nr** | **Process** | **Inherent Risk (before controls)** | **Risk rating** | **Mitigating Controls/Attributes****(Expected)** | **Tests of design** | **Control Adequacy** | **Tests of implementation** | **X-Ref****Control effectiveness** | **Conclusion** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |
| 12 | Identification and filling of staffing needsContract with doctors | Staffing needs are incorrectly identified from a quantitative and/or qualitative point of view (i.e., too many or not enough resources are identified in a particular unit, department etc).Hospital compensation package is not competitiveDoctors may direct the patients to their private practice.Doctors also work for other (competing) hospitals. | HighHighHighHigh | *- existence of an HR strategy;**- existence of a written staff recruitment procedure;**- existence of criteria used for identification of staffing needs in terms of:** *quantity: benchmarks with other hospitals are performed once a year;*
* *quality: competency registers exist in each unit; job descriptions exist for all staff and they include skills required for the respective job;*

*- existence of approvals for identified staffing needs;**- benchmark with other hospitals are performed once a year;**- a strategy on services rendered by contracted doctors outside our hospital;**- a proper and open communication with the contracted doctors on the implementation of the strategy;**- a yearly declaration of ‘no conflict of interest’ by the contracted doctors;**- a yearly collection of the tax declarations of the contracted doctors;* | Verification of existence of:* an HR strategy;
* a written recruitment procedure;
* approval for identified staffing needs;
* documentation of the benchmark performance method.

Review of the existing HR strategy and assessment whether it is in line with the organization’s strategy.Review of the existing written recruitment procedure and assessment whether it is in line with the organization’s procedures and whether it contains all necessary elements to guide its users through an effective recruitment process.Review of the criteria used to identify staffing needs (e.g. benchmarking) and assessment for reasonableness compared to the HR strategy and taking into account the unit’s specific needs;Review of the criteria used to determine staff compensation schemes (e.g. benchmarking) and assessment for reasonableness compared to the HR strategy and the specific qualifications of the unit concerned.Review of the hospital strategy on services rendered by contracted doctors outside the hospital.Assess whether the restrictions are clearly communicated to and acknowledged by the doctors.Review of the periodical declaration (conflict of interest, tax) process. |  | - for a sample of selected open and filled positions review the criteria used to identify staffing needs in terms of quantity, quality, timeliness and category; ensure that this was in line with the existing guidelines (i.e., trace the search process to the request made by the hiring unit and assess both the requests made and the recruitment efforts);- for a sample of selected recruitment requests check that the appropriate approval was in place (i.e., the proposal to the Senior Management);- assess whether the compensation benchmark has been performed on a regular basis; assess whether senior management was informed about significant variances; assess whether management has taken action on the variances identified;- assess for a sample of closed but unsuccessful recruitment transactions whether compensation has been a major issue to decline the job offer;- assess for a sample of doctors the acknowledgment of the rules with regard to services rendered outside the hospital;- assess how management is following up on missing declarations;- assess management actions on perceived irregularities in the declarations; - review on the various websites of other hospitals whether our doctors’ names appear; search on Google for a sample of specialist doctors; |  |  |

**Proposals from Brussels: Risk and controls**

**Risk**

Unacceptable waiting time for patients.

**Expected Control**

Procedure in place for forming a waiting list (emergency or not, age and how priorities are established). How frequent the patients need to use MRI (based on the patient type). Onboard patients or externally served. How waiting list is prepared in practice. Is there a software for the waiting list forming. Is there a complaint mechanism and awareness of the patients on the possibility to make compliant.

Allocation of sufficient time for patient service as per the medical standards established. Allocation of the time for emergency. Allocation of time for onboard patients.

The possibility to register on-line, via phone, other means.

IN case of epidemy the procedure and schedule (?) for the doctors to visit patients at home.

Procedure for establishing back up of doctors who can join if there is outbreak.

Is there a support staff to provide a support to doctors allocated. The registration to be done not directly by doctors, but by the support staff.

Procedure for calculation a standard consultation time.

Planning doctors and nurses availability for the busy season/high demand hours.

Time recording of the staff working hours (electronic building or office access controls).

Is there anti-corruption/integrity management procedure in place, e.g. Code of Ethics, or say cameras recording.

Threshold for acceptable waiting time. Is the double shifts procedure in place?

Is there an electronic health management system in place, so to identify the patient, and ease not only access management, but also tracking the patients full medical history.

**Testing**

* Determine sample based on the last year patients list. If the criteria for prioritizing of patients was followed. Manual or application control to make it impossible to place patients on the top of the waiting list bypassing procedure.
* Review the sample of complaint filed.
* Reconcile the actuals with the plan. Actual service turnaround time.
* Conduct survey of patients on the satisfaction level including turnaround time.
* Observation of the process, and confidential testing of the process through acting as a patient.
* Check the electronic time match records.
* Review the complaint file.
* Automatic scheduling and rescheduling system, reminder procedure, and cancellation of the appointments by the patients (or the doctor).
* Procedure to move to the next patient if the patient is late.
* The utilization rate/time of MRI (say working 20+ hours a day with 2-3 shifts), if that is the bottleneck.

**Risk**

Privacy of the information. Risk is high

**Expected Control**

Procedure to reflect the data protection legislation requirements. Procedure on validating the patient and providing access to personal data to the patient who owns this info.

Code of Ethics, procedure of privacy of the printed documents. Procedure for the access rights to the electronic databases. Password policy. Security of the information databases. Procedure to inform the patients on the data security, and notice to the patient on the information security applied in the hospital.

**Testing**

Are the procedures followed in practice? Sample basis check the application controls to the sensitive data. Observe the data protection procedure application. Review the logs to identify unauthorized access to the patient’s data.

**Risk**

Shortage of blood – high risk.

**Expected Control**

Sound Inventory control system to identify expected shortage in blood reserves and expiration dates to effectively manage the blood reserves. Blood quality inspection procedure in place. Plan for public awareness activities to have regular blood donors supply. A procedure to quality check of the blood taken. Establish a database and keep in contact with donors when the blood is needed.

Regular assessment of daily needs for the blood.

Organize procurement process, and have a committee to predict the need for the blood.

Monitor the usage of the blood.

Reciprocal agreements with other hospitals on the blood supply.

**Testing**

If we pay on time to donors.

Check the logs of the blood standard usage and actually used – efficiency of the blood usage by doctors.

Check the procurement process, including procurement committee members and their qualification.

Check the contracts with blood supplier to meet the projected demand for the blood.

**Identification and assessment of control**