Blood Consultative Committee Meeting

05 February 2019

Medicines & Healthcare products Regulatory Agency

Agenda

13:00 – 13:05	Introduction and apologies for absence
13:05 – 13:20	Approval of Minutes of previous meeting held 06 February 2018. Matters arising from minutes: • Item 3 – Perfusion of organs for transplantation – MHRA to liaise with HTA on traceability requirements, and send list of collated questions to NHSBT • Item 4.1 – Collaborative working – MHRA to further explore links between MHRA and UKAS • Item 4.4 – Online blood forum for stakeholders: Review and future use –MHRA to consider potential input to forum or other communications from patient groups • Item 4.6 – Process for committee members to submit agenda items for BCC – MHRA to implement a mechanism for reporting agenda items and communicate this to committee members.
13:20 – 13:30	EU Exit update
13:30 – 14:15	Agenda items submitted by committee members • Proposal to hold workshops • Proposals to encourage participation of all members: 5 minute agenda slots, or 1-2 slides presubmitted if not attending • Proposal for the blood forum to send a weekly newsletter to all subscribers and to have a documents repository • Handling of whistleblower information

Agenda

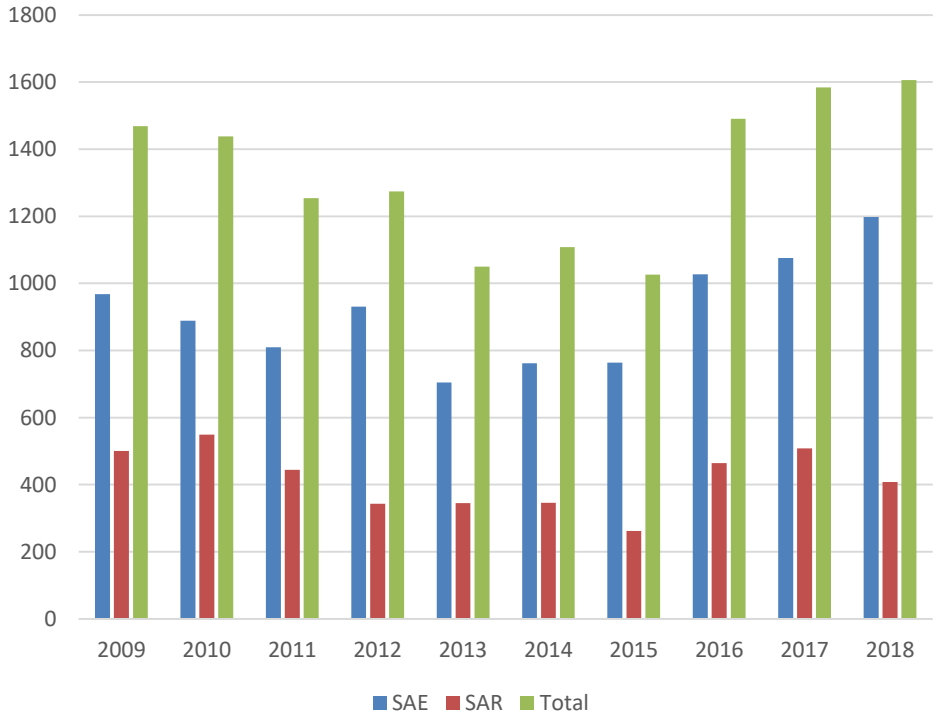
14:15 – 14:30	SABRE Update
14:30 – 15:15	BCR process update • 2018/19 BCR process review • 2018/19 inspection trends • 2019/20 BCR process forward look
15:15 – 15:30	Regulatory Update, to include: • Review of the EUBD and EUTCD which is due to report end 2018 • Joint action on regulatory controls for new blood components and new tissue components • VISTART programme (including CESIP) and expert subgroup on inspections
15.30 – 16.00	AOB
16:00	Meeting Close

Blood Consultative Committee Meeting

SABRE Update

Medicines & Healthcare products Regulatory Agency

Reporting Activity 2018

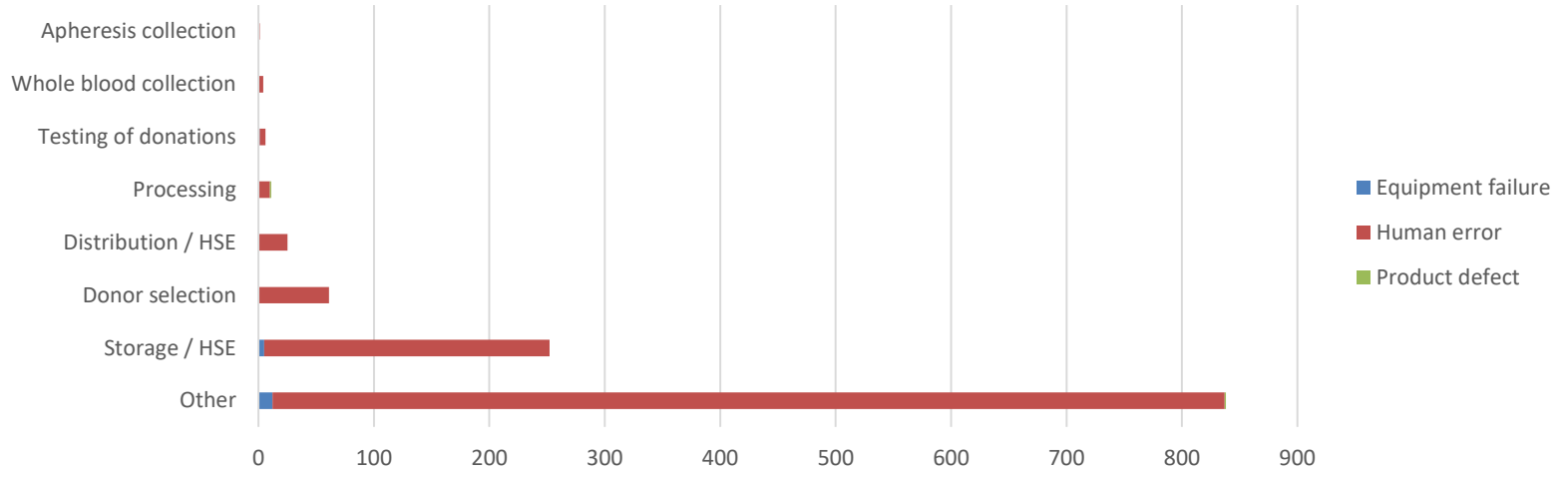


Slight increase in total number of report

SAR reports have decreased, but SAE reports increase

Over half of the increase in SAEs is due to one hospital reporting based on strict adherence to zero tolerance policies

SAEs by Deviation 2018



The proportion of reports in each category remains broadly similar to previous years although there are some changes to the sub-categories reported

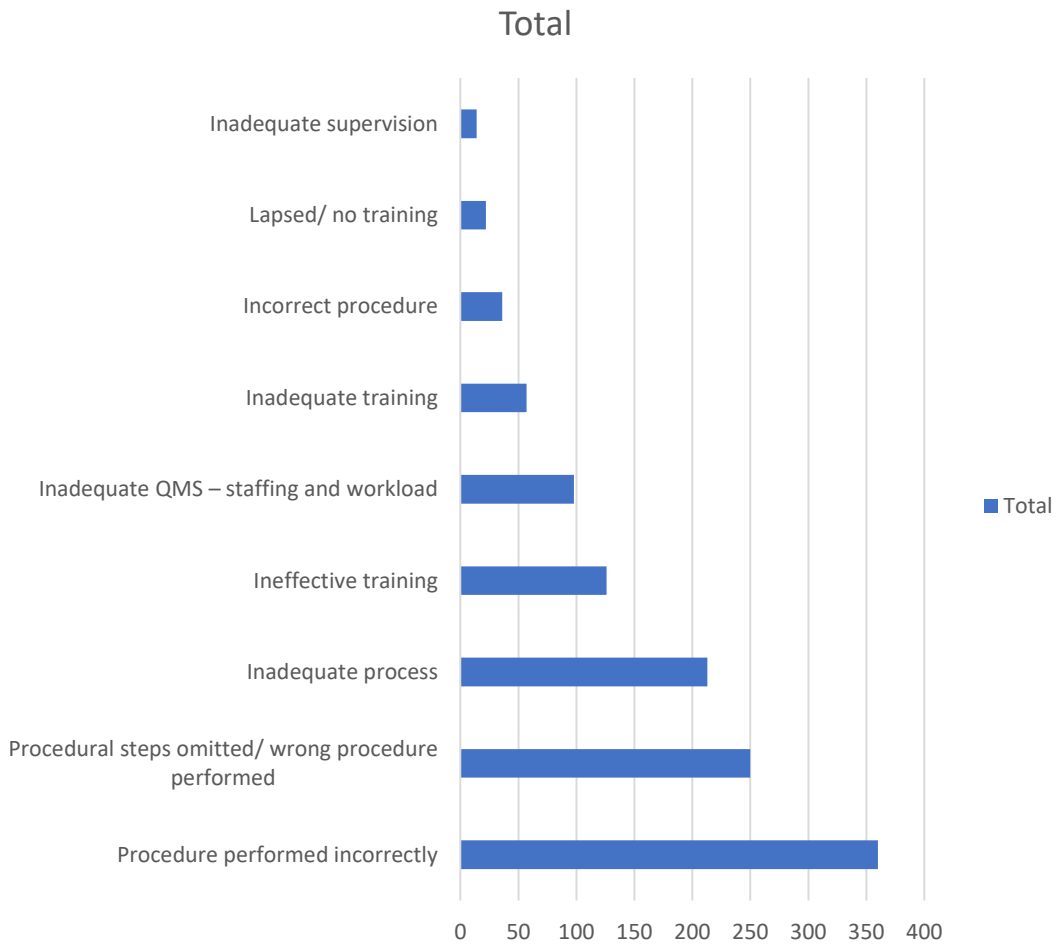
“Human Error” is still the highest single SAE deviation

Other reports sub categories 2018

- Increase in numbers of reports not just due to single hospital (CCE and SPE)
- Increase in IBCI (?processes controlling blood required for transplant patients)

Other sub-category	2018 (+/- 2017)	2017 position
Incorrect blood component issued (IBCI)	212 (+37)	1
Sample processing error (SPE)	185 (+62)	2
Component labelling error (CLE)	131 (+17)	3
Component collection error (CCE)	114 (+20)	5
Pre-transfusion testing error (PTTE)	93 (-11)	4
Data entry error (DEE)	73 (+2)	6
Component available for transfusion past de-reservation (CATPD)	6 (+1)	9=
Failed recall (FR)	6 (-12)	7
Unspecified (UNSPEC)	5 (-4)	8
Expired component available for transfusion (ECAT)	5 (0)	9=
Incorrect blood component ordered (IBCO)	4 (-1)	9=
Handling damage (HD)	2 (0)	12
Incorrect blood component accepted (IBCA)	1 (0)	13
Total	837 (+111)	x

Human factors



- Little change in spread of reports
- Highest proportion of reports still linked to slips and lapses
- Still concerns of the quality of SABRE reports/ investigations not thoroughly investigating RCs linked to the design of the process/ QMS and incorrectly assigning responsibility to staff error

Human factors

- Reporters must continue to investigate thoroughly to identify all root causes and contributory factors (GPG requirement and frequent inspection finding)
- Detailed CAPA needs to be produced to address human factors involved
- Work needs to be done to make processes more robust and SOPs written that are detailed enough for staff to know exactly what to do, even when tasks don’t go to plan

- MHRA will continue identify staffing and workload issues and inspectors often raise this at inspection
- MHRA will continue to support the industry in addressing it

Future activity

- **SABRE upgrade deferred pending resolution of other IT projects**

Blood Consultative Committee Meeting

Blood Compliance Report (BCR) Process Update

Medicines & Healthcare products Regulatory Agency

Topics for discussion

2017/18 Preparation and Changes

2017/18 BCR Assessment - Common Issues and Outcome

2018/19 Further changes and Improvement

2018/19 Inspection Outcome

2018/19 Inspection Common Deficiency Finding Examples

2017/18 Preparation and Changes

Preparation:

- Revised BCR questions
- Revised HBB Guidance Notes and text on webpage
- Placed announcement on Blood Forum
- Notified BB Managers via emails
- Revised new Admin Work Instructions and training presentations on BCR assessment process

2017/18 Preparation and Changes

HBB BCR:

Change in Q 7.4

Does the site have on-going staffing issues that are impacting on the laboratory workload, training, or QMS tasks? If so please indicate the level of understaffing as a decimal fraction (i.e. if 20% understaffing, enter 0.20). If not please enter “0” (zero)

2017/18 Preparation and Changes

HBB BCR:

Change in H10

Are records of incident investigations formally reviewed before final closure to confirm that the recorded details are clear and fully explain the incident, root cause identified, risk impact assessment performed, actions taken and conclusions?

2017/18 BCR Assessment - Common Issues and Outcome

Issues in 17/18 submissions

- Late submission of HBB BCRs or Declaration forms (risk score of 5 is added for late submission)
- Early submission of Blood Facility Declaration (before 01 April 2018)
- Missing Facility Declaration Forms (111 of 808 BF submitted)
  - Facility managers must fill in the blood facility declaration form

Reminder for HBBs

Section R				Distribution of blood components	
1				Do you supply blood components or services to off site locations or other organisations (e.g. community hospitals, hospices and satellite units)?	
	If response to R1 was 'Yes', please provide details of all other organisations to which you supply blood components or services (e.g. community hospitals, hospices and satellite units). If the organisation supplied is classified as facility (see guidance notes), please advise each of these to submit a facility declaration form.				

Blood Facilities

A hospital ward, hospice or care home etc which receives blood from a hospital blood bank for transfusion purposes (but does not perform compatibility tests on site) is defined as a ‘Facility’.

Blood Facilities are required to complete the Blood Facility Declaration Form.

Blood Facilities

Facilities may perform three key tasks which are covered by the scope of a blood compliance report (BCR). These are:

- The control of monitoring, maintenance and calibration of any controlled temperature storage equipment on site
- Reporting of serious adverse events and reactions to SABRE
- Maintenance of traceability records

A ‘Facility’ should have a Service Level Agreement (or similar document) in place if the supplying Hospital Blood Bank is responsible for these functions.

Blood Facilities

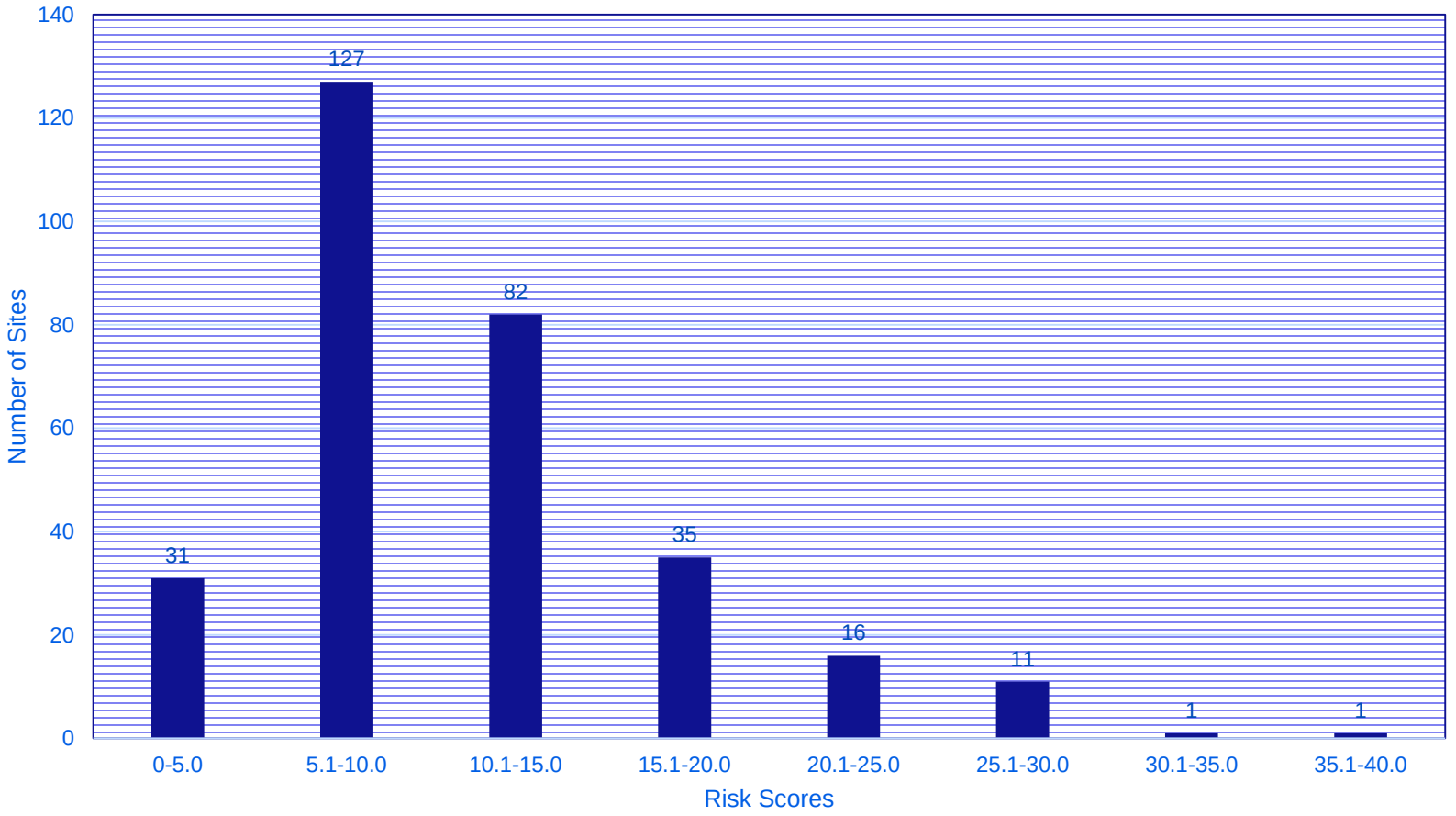
Letter will be sent to Blood Facilities that did not submit the declaration form in 2018:

- Request for 2018 declaration form
- Remind the requirements for submitting Blood Facility declaration form

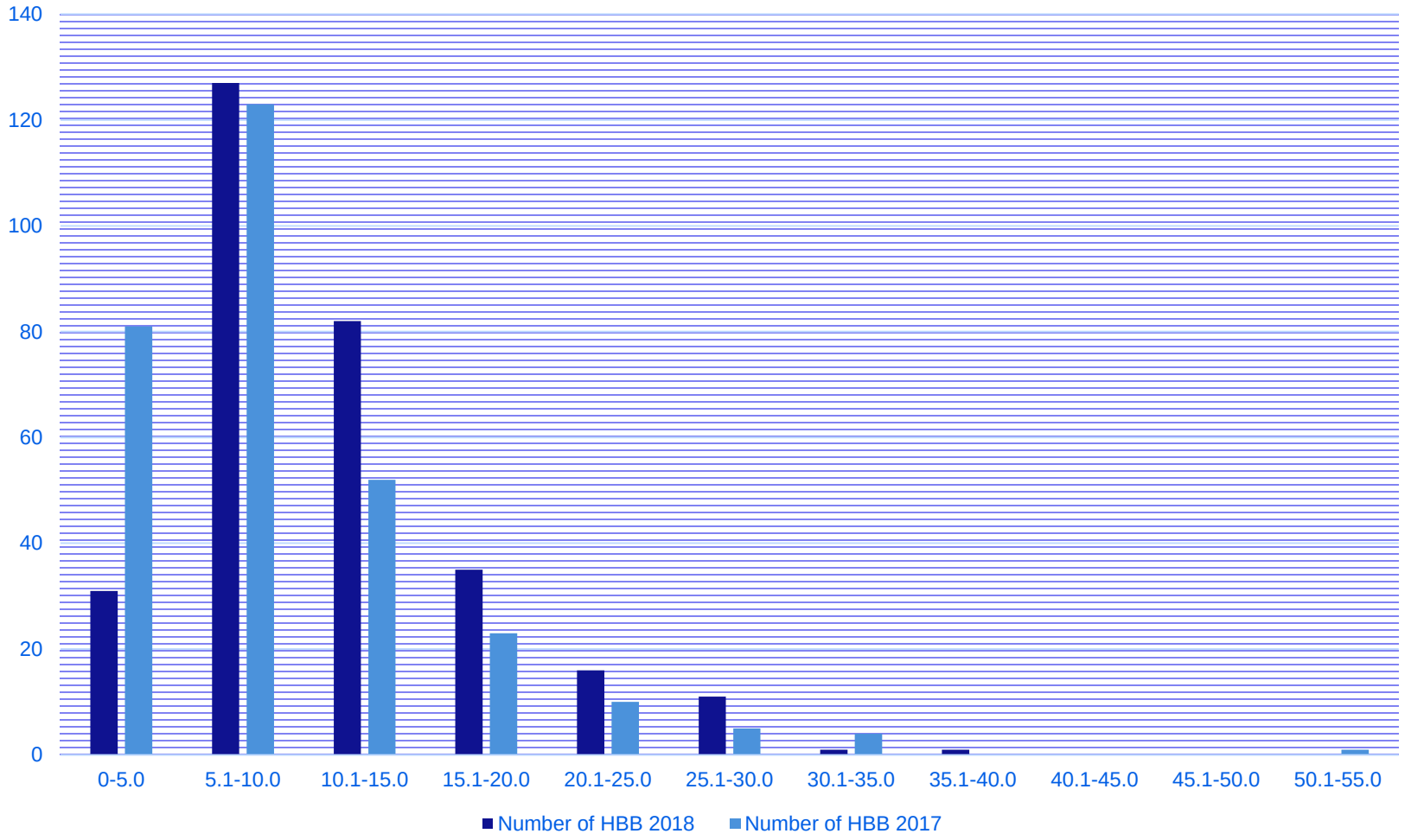
BCR Assessment Outcome

HBB BCR received	304
Late submission (after 30 April 2018)	19
No. of high risk site	28
BAT referral required	89
Range of risk score	2 to 37.5
Site required inspection	31 (including 4 control sites)
No. of inspection to date	19 sites

Range of risk score 2018



Range of risk score 2018 vs 2017



2018/19
Further changes and Improvement

Changes and Improvement

Changes in submissions

Separate mail box for submissions:

Hospital blood banks: bcr@mhra.gov.uk

Email subject heading: Full hospital name – BCR 2019

Completed BCR

Declaration form

Supporting information

Facilities: bcrbf@mhra.gov.uk

Email subject heading: Full facility name – BCR 2019

Blood Facility Declaration

Changes and Improvement

- Revise HBB Declaration Form to include the purchase order number for invoicing

- Revise BCR to set up restriction ensuring answers are completed in correct format

Changes and Improvement

- Revise Guidance Note
  - colour / bold text to highlight deadline and areas that require special attention
  - Add additional information, updates and comments in Section T and Section U
  - Provide clarification on H5.2

2018/19 Inspection Outcome

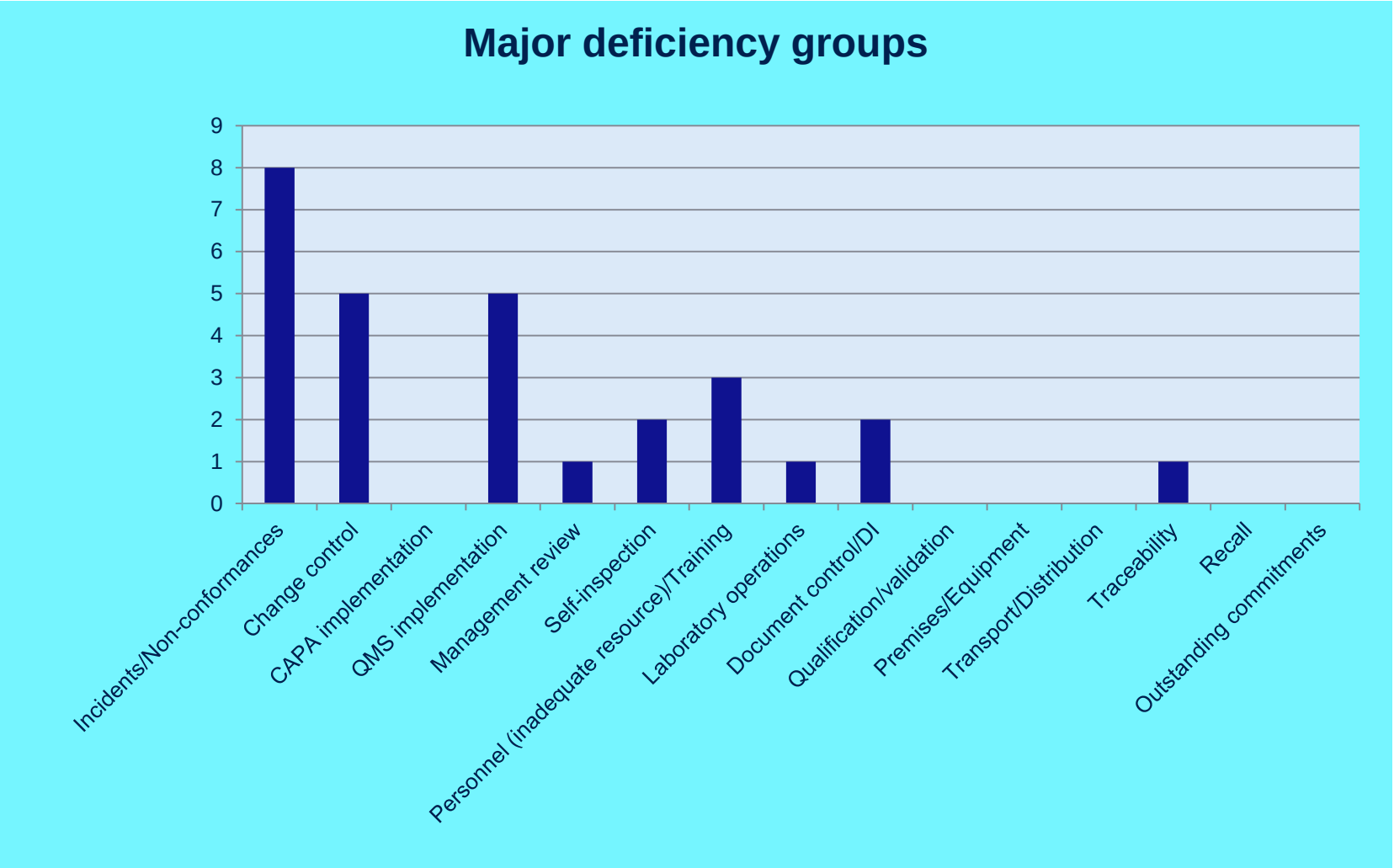
2018/19 Inspection Outcome

Number of inspection	19
Critical Deficiency	0
Major Deficiency	28
Other Deficiency	55
IAG referral	0 (1 in IAG follow-up)
CMT referral	3 (4 in CMT follow-up)

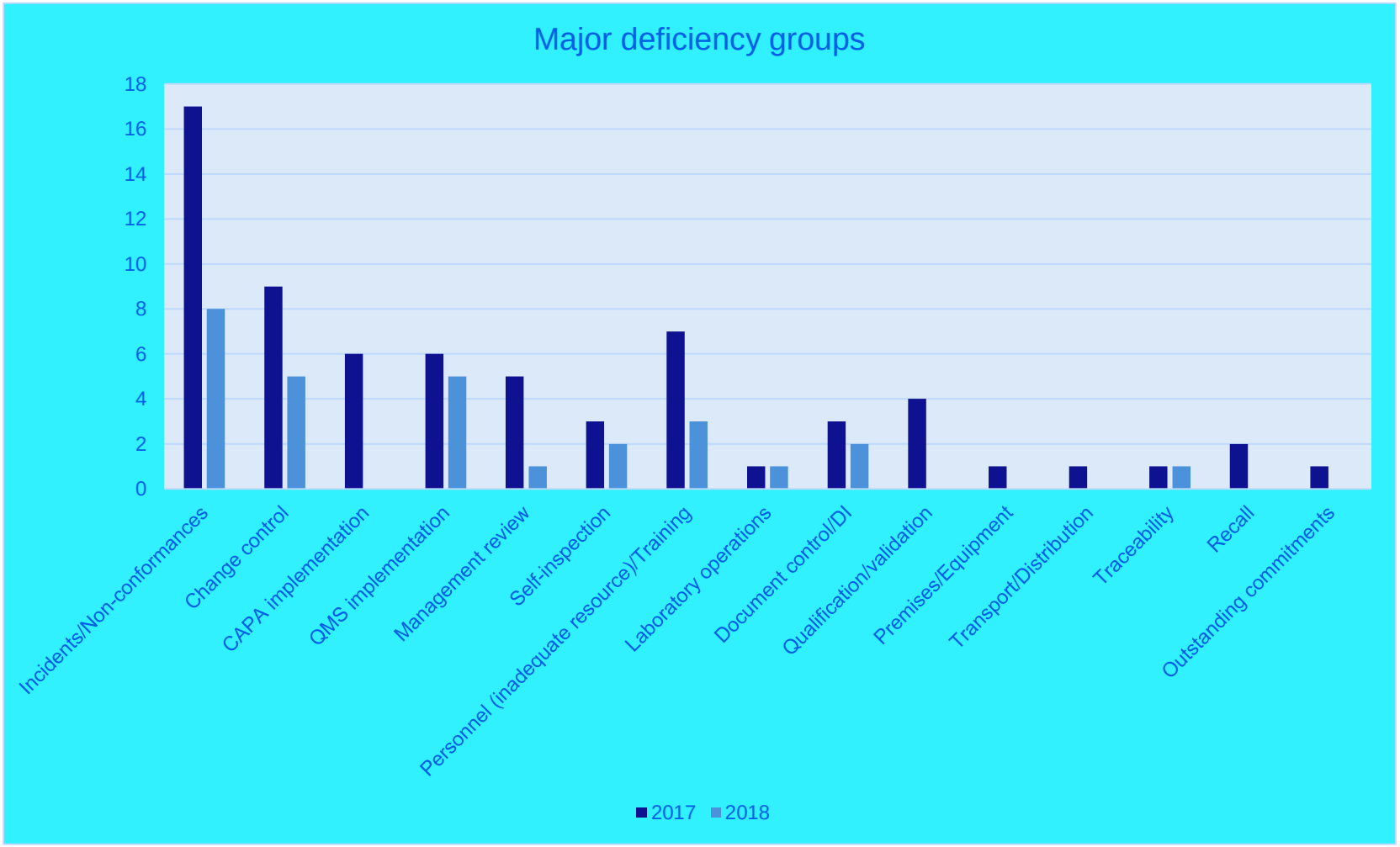
Good Practice Guidelines

The Good Practice Guidelines (GPGs) jointly developed by the Commission and the European Directorate for the Quality of Medicines and Healthcare of the Council of Europe and published by the Council of Europe are contained in the 18th Edition of the Council of Europe Guide to the Preparation, Use and Quality Assurance of Blood Components. In addition they can be found through the following link https://www.edqm.eu/sites/default/files/goodpracticeguidelines-19th_edition_guide_preparation_use_qa_blood_compon ents-december2016.pdf on the webpage for the Blood Transfusion Guide https://www.edqm.eu/en/blood-transfusion-guides-1608.html .

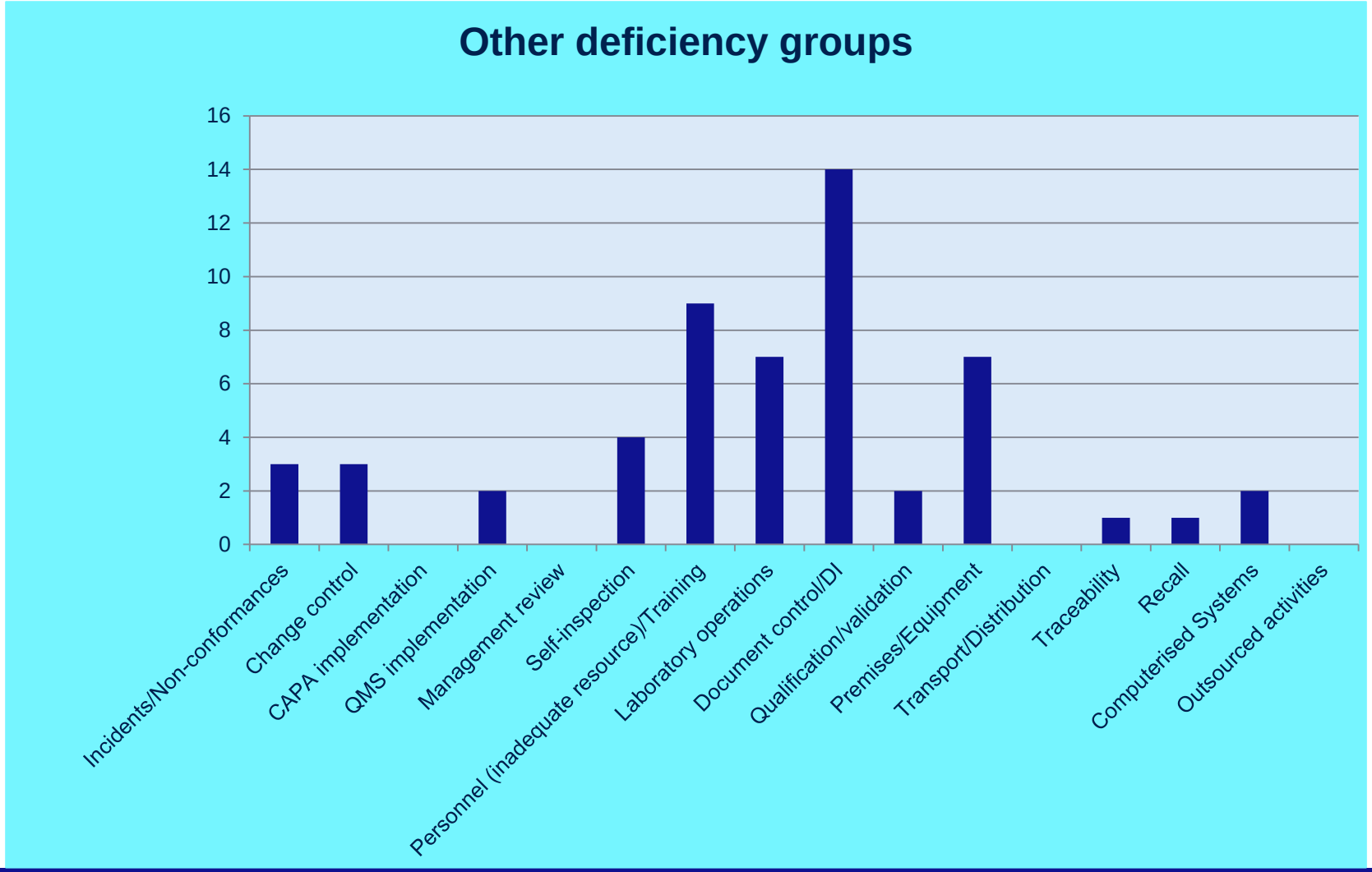
2018/19 Inspection Outcome



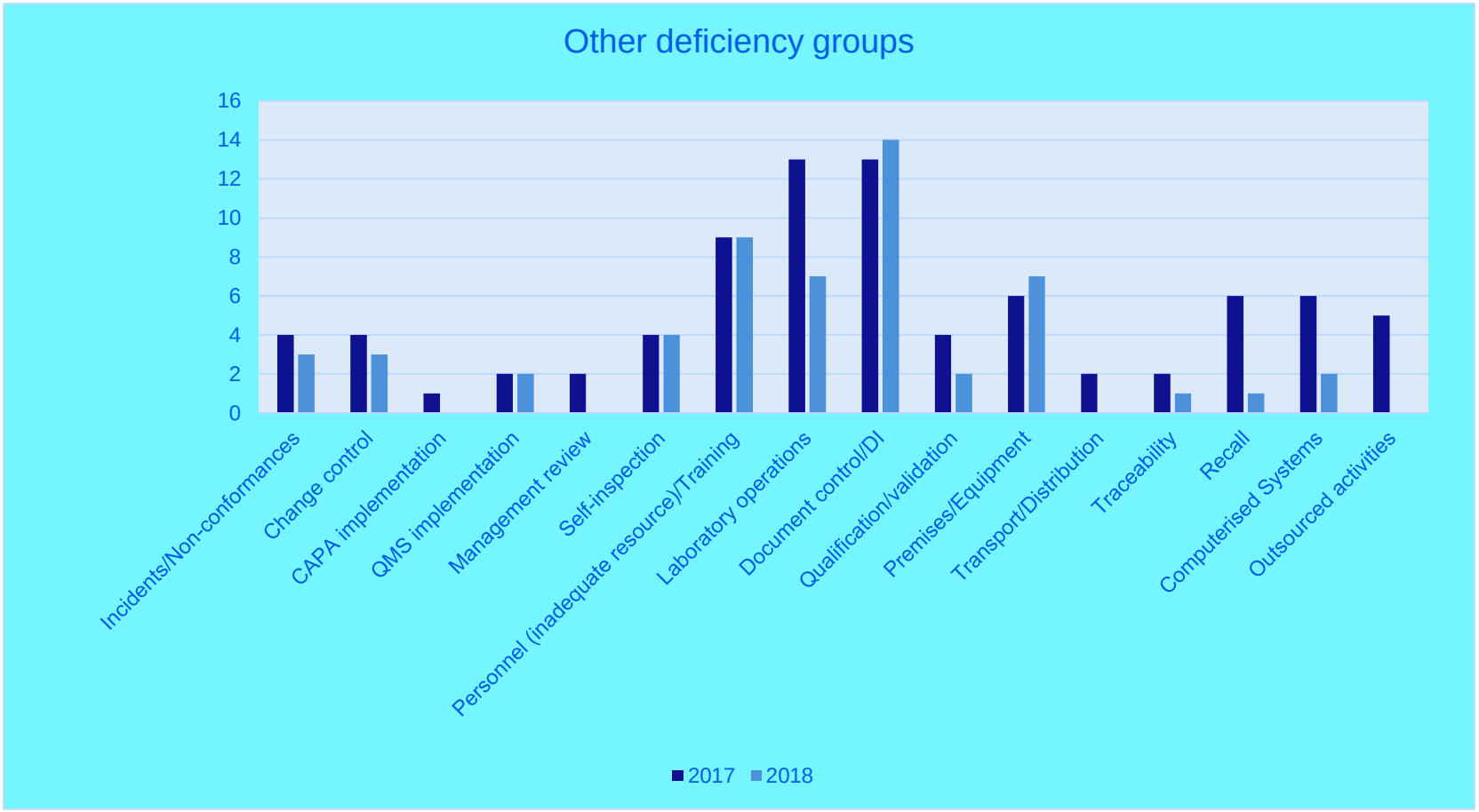
Inspection Outcome 2017 v 2018



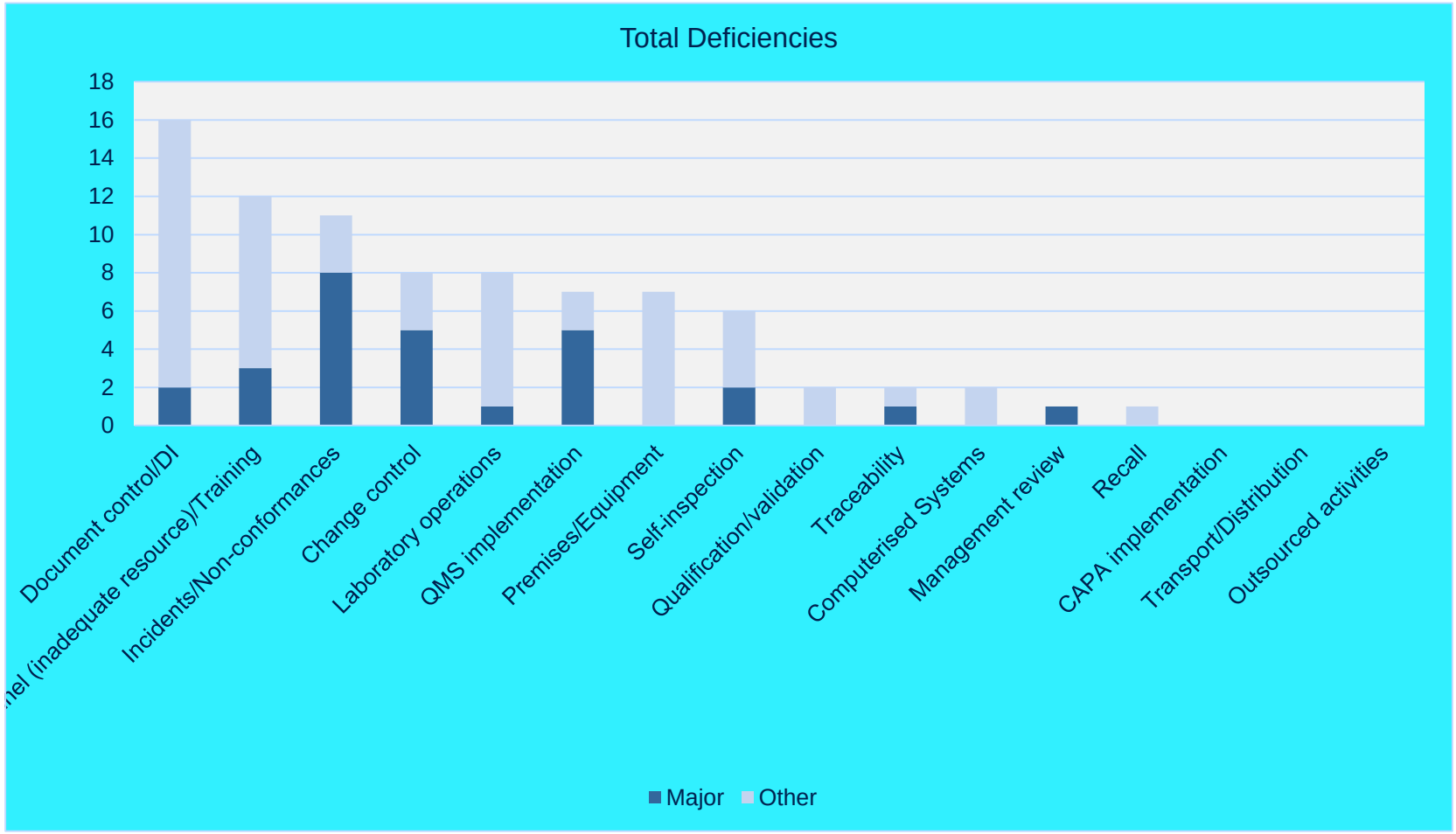
2018/19 Inspection Outcome



Inspection Outcome 2017 v 2018



2018/19 Inspection Outcome



Most common deficiencies in last 2 years

Rank	2017	2018
1	Incidents / Non-conformances	Documentation / Data Integrity
2	Personnel (resource) / Training	Personnel (resource) / Training
3	Documentation / Data Integrity	Incidents / Non-conformances
4	Laboratory Operations	Change Control
5	Change Control	Laboratory Operations

Inspection Outcome Trends

- General decrease in overall number of deficiencies in 2018/19 cycle.
- Most common deficiencies still associated with non-conformances, personnel / training and documentation / data integrity.
- Decrease may be related to the number of CMT follow-up inspections.
- The move to 7 day notice inspections may have improved inspection readiness

2018/19 Inspection Common Deficiency Finding Examples

GPG 5. Documentation

5.4. Good documentation practices

5.4.4. Any alteration made to the entry on a document should be signed and dated; the alteration should permit reading of the original information. Where appropriate, the reason for the alteration should be recorded.

Examples:

- Several records were observed which indicated poor documentation practice with obliterations, unqualified deletions, and pencil usage observed.
- Poor documentation practice such as overwriting, deletions and blanks.
- Several documents were reviewed where poor documentation practice was observed in respect to overwriting and uncontrolled deletions.
- The checklist used to record daily, weekly and monthly maintenance tasks on the analysers had several omissions for weekly tasks

GPG 4. Equipment and materials

4.2. Data processing systems

4.2.4. There must be a hierarchy of permitted user access to enter, amend, read or print data. Methods of preventing unauthorised entry must be in place, such as personal identity codes or passwords that are changed regularly.

4.2.5. All necessary measures must be taken to ensure protection of data. These measures must ensure that safeguards against unauthorised additions, deletions or modifications of data and transfer of information are in place to resolve data discrepancies, and to prevent unauthorised disclosure of such information.

Examples:

- The system used for traceability data entry failed to ensure that the person entering data was adequately identified.
- Access codes to fridges were not secure in that they were available in SOPs.
- There was no automated logout of personnel to prevent actions being completed by others under the incorrect identification and profile.
- The Q-Pulse eQMS did not have an audit trail installed.

4.3. Qualification and validation

4.3.1.2 The principles of qualification and validation are applicable to the collection, preparation, testing, distribution and issuance of blood components. It is a requirement of Good Practice that blood establishments and hospital blood banks control the critical aspects of their operations through the life cycle of the blood components and the associated processes. Any planned changes to the facilities, equipment, utilities and processes should be formally documented and the impact on the quality on blood components should be validated.

<u>Examples:</u>

- No change control was raised for the introduction of the XX Analysers which were observed to be in use.
- Change controls were not raised in a timely manner in instances of new equipment purchase i.e. at the time the equipment purchase was initially proposed.
- Several change controls were in draft despite some of these changes being enacted.

4.3. Qualification and validation

4.3.3.7. Results which fail to meet the pre-defined acceptance criteria should be recorded as a deviation and be fully investigated according to local procedures. Any implications for the validation should be discussed in the report.

4.3.3.9. A formal release for the next stage in the qualification and validation process should be authorised by the relevant responsible personnel either as part of the validation report approval or as a separate summary document

Examples:

- Omissions within the validation package did not result in deviations being raised. This was exemplified by but not restricted to IQ environmental conditions, IQ staff list population, IQ software and firmware, a failure to capture all 8 common ABO/D groups in the OQ and “pass” being recorded with no documented results.
- The PQ was signed off on XXX with comments regarding issues which had not been resolved. No deviations were raised for these non-conformances and no resolution was visible within the records presented.
- There was no assessment or authorisation of the change prior to its implementation.
- The analysers were introduced into routine use on XXX however there was no positive confirmation that the validation was accepted and could be brought into routine use.

GPG 2. Personnel and Organisation

2.2. The organisation should have an adequate number of personnel with the necessary qualifications and experience.

2.7 All personnel must receive initial and continued training appropriate to their specific tasks. Training records must be maintained. Training programmes must be in place and must include Good Practice (Directive/2005/62/EC/Annex 2.3).

Examples:

- There were no defined actions to be taken when resources fell to a level which did not allow all activities to be maintained.
- The management failed to demonstrate their responsibilities to ensure staff receive appropriate initial and continued training appropriate to their specific tasks.
- Several deviations raised reflect low personnel numbers as the root cause of the issue.
- The system for competency assessment for out of hours working failed to ensure that such personnel were competent in the application of core quality management systems such as deviations and recalls.
- Training records for established personnel were incomplete.

GPG 9. Non-conformance and recall 9.1. Deviations

9.1.6. Deviations from established procedures should be avoided as much as possible and should be documented and explained. Any errors, accidents or significant deviations that may affect the quality or safety of blood and blood components should be fully recorded and investigated in order to identify systematic problems that require corrective action. Appropriate corrective and preventive actions should be defined and implemented.

Examples:

- There was inadequate detail recorded within deviation records to fully understand the deviation, investigation, root cause, application of CAPA and post implementation review.
- This was covered in the BCR in question H10:

  Are records of incident investigations formally reviewed before final closure to confirm that the recorded details are clear and fully explain the incident, root cause identified, risk impact assessment performed, actions taken and conclusions?

All 9 HBBs that had this as a deficiency answered yes to this question.

9.4. Deviation management and corrective and preventive actions

9.4.5. Investigations should include a review of previous reports or any other relevant information for any indication of specific or recurring problems requiring attention and possibly further regulatory action.

Examples:

- There was no review of previous events for similar issues to determine if there was a trend and previously applied CAPA was effective.
- The incident reporting process did not require a review of previous incidents as part of a deviation investigation to identify if a one off or a recurring issue
- No event history was required to consider trends.

9.4. Deviation management and corrective and preventive actions

9.4.7. The decisions that are made during and following investigations should reflect the level of risk that is presented by the deviation as well as the seriousness of any non-compliance with respect to the requirements of the blood component specifications or GP. Such decisions should be timely to ensure that patient safety is maintained, in a way that is commensurate with the level of risk that is presented by those issues.

Examples:

- The number of extensions to close out dates observed for non-conformances was considered excessive, in addition a vast number of the non-conformance close out date extensions had no justification.
- There was a lack of formal control with respect to the closure of NCR's within the prescribed target dates and whilst a system for formal extension following review and authorisation was available within the procedure, this was not utilised.

Laboratory Operations – Analyser QC

4.1.8. Procedures must be available for each type of equipment that detail the action to be taken if malfunctions or failures occur.

5.4.2. Records should be made or completed at the time each action is taken and in such a way that all significant activities concerning the donation, collection, processing, testing and distribution of blood and blood components are traceable.

11.2.2. Results of quality-control testing must be evaluated continuously and steps taken to correct defective procedures or equipment.

Examples:

- Several QC failure types (wrong liquid level (WLL); Fibrinogen; Few Cells) were not classified as failures and were accepted despite the failed assessment. This approach failed to ensure that the failure cause was appropriately determined, and a true QC pass was applied, which devalued the QC test, required to validate the test method.
- There was no log of QC failures as required by the procedure.
- Despite a requirement to record the reason for IQC failures on the analyser, this was not consistently followed with several examples observed of failures with no explanation being provided.