[](http://depts.washington.edu/labweb/index.htm)

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| **University of Washington,**  **Harborview Medical Center**  **325 9th Ave. Seattle, WA, 98104**  **Transfusion Services Laboratory**  **Policies and Procedures Manual** | **Original Effective Date:**  **July 15, 2011** | **Number:**  **1703-3** |
| **Revision Effective Date:**  02/10/2023 | **Pages:**  **4** |
| **TITLE: FDA—CBER BIOLOGICAL DEVIATION REPORTING** | | |

**Purpose:**

To provide guidance on the use of the Food and Drug Administration (FDA) Biological Product Deviation Report (BPDR) and to standardize the documentation, investigation, reporting, implementation of corrective actions, and monitoring of the BPDR by the Harborview Medical Center Transfusion Service.

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| **Role** | **Responsibility/ Requirement** |
| **FDA-CBER** | * On November 7, 2000, the Food And Drug Administration (FDA) published a final rule to amend the requirements for the reporting of errors and accidents in the manufacture of blood products. The rule amended the regulation at 21 CFR 600.14, and added a requirement at 21 CFR 606.171, applicable to all manufacturers of blood and blood products. * In August 2001, the FDA published draft guidance on Biological Product Deviation Reporting for Blood and Plasma Establishments. This guidance to the Blood Industry outlines biological product deviation reporting requirements for licensed blood donor centers and unlicensed registered transfusion services. The FDA finalized the draft guidance in October 2006, same title dated August 2001. |
| **Medical Director** | * Consults with Care provider about patient care * Interacts with Care provider if reporting fatality. * Consults with Manager when there are questions about whether an event meets the reporting criteria. * Reviews reports. * Together with manager, makes decisions about corrective action. |
| **Manager** | * Acts as facility contact with FDA * Reports incidents that meet the reporting criteria. * Prepares report for Quality Review. * Implements and monitors corrective actions. * Coordinates reporting of incident to HMC quality/risk as indicated. * Performs Timely investigation of incident. Fatality investigation must be reported in 7 days, Others must be reported within 45 days of occurrence. * Development of corrective action plans both short and long term, to prevent recurrence. * Retrieval, Quarantine, and final disposition of any unsuitable products. |

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| **Criteria for Reporting** | Any deviation or event (planned or unplanned) to include post donation information associated with manufacturing of both licensed and unlicensed blood or blood products that:   * Were manufactured with a deviation from current good manufacturing practices (cGMPs) or applicable regulations or established specifications (Policies and Procedures) that may affect the safety, purity, or potency of the product AND such deviation occurred while the product was under the control of the Transfusion Service. * Were distributed at Harborview Medical Center or a facility contracted to HMC. |
| **Definitions** | * **Manufacturing:** The collection, preparation, processing, compatibility testing, or other procedures of any blood product that meets the definition of a drug and including manipulation, sampling, testing, or control procedures applied to that final product. * **Deviation:** Change in the manufacturing process that would prevent a product from meeting all cGMPs, applicable standards or regulations and facility procedures. * **Event:** Any occurrence that may affect the product and that might occur even if the facility has followed all required procedures. Examples include:   + post donation information (reportable by the collecting facility) * patient sample used for compatibility testing was collected from the wrong patient. * materials used in the collection or processing did not meet all requirements or specifications. * **Control:** Having responsibility for maintaining the continued safety, purity, and potency of a product and for complying with applicable product and establishment standards and cGMPs. |

**Reporting Procedure**

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| **Step** | **Action** | **Related Documents** |
| 1 | Document deviation or event according to Occurrence Management Policy. | QP Occurrence Management |
| 2 | Inform management according to Occurrence Reporting protocol | QP Management of Nonconforming Events |
| 3 | Initiate investigation, describing the event in detail in the QIM form and attach any documentation. |  |
| 4 | Identify products affected and perform a look-back:   * Determine disposition, quarantine if in date and notify consignee and/or recipient and/or physician in accordance with testing and look-back policies. * Document notification if performed. | Recall and Look-Back Process |
| 5 | Determine the cause of the event.   * Meet with all parties involved. * Recreate the event and check the process flow. * Ask “Why” until the cause is determined. * Review Policies and Procedures for clarity, completeness, and contradictions. * Evaluate training process | QP Process Improvement |
| 6 | Develop and implement corrective action plan—involve staff. |  |

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| **Step** | **Action** | **Related Documents** |
| 7 | **Non-Fatalities--Complete the BPDR online form. FDA Form 3486.**   * Submit through eCBER website [www.access.fda.gov](http://www.access.fda.gov) * This website is not to be used for reporting fatalities. * The Compliance Analyst and Manager have individual accounts linked to the establishment. * From the Menu bar, select My Reports * Under Unfinished BPT Reports, click Create Report * Select your establishment and click Next * Enter Facility Tracking number (mm/dd/yy-1,2,3, etc.) * Enter the date the deviation was discovered (dd/mm/yyyy). This is the date the information was received, suggesting that a deviation had occurred. * Enter the date the deviation or event occurred. * Enter the date the BPD is reported – this date is auto-populated with the current date upon creating the report. If you save for retrieval and submit later, please update this date accordingly. * Enter the type of Product: * Blood: products manufactured by blood and plasma establishments. * Non-Blood: products manufactured by a facility other than a blood establishment. (Such as vaccines, THIg, AHF) * Enter Six-digit BPD code (Appendix A). The first two digits identify a subset of the system, and the last two digits contain detailed information regarding the event. * If you cannot determine the appropriate code, enter question marks. For example: ??-??-?? or LA-??-?? * Describe the event or deviation in detail, including description of what happened and a summary of all relevant information. DO NOT include confidential information such as patient, employee, or donor names. * Describe contributing factors or the cause of the event or deviation. Indicate if a root cause cannot be determined. * Describe all short-term and long-term corrective action and follow-up plans. Corrective actions do not have to be implemented at the time of the report. * Select the code that most closely describes the deviation or event. * If you selected blood products * Enter total number of units. * Enter the total number of Lots affected. A lot includes all products manufactured from a donor identification number. * Click the button Update Product Grid to update the number of rows that will be completed in the product grid. * For each component provide the following: * Unit Number * Collection Date * Expiration Date * Blood Product Code (will populate as you begin to type) * Distribution (in house or to another facility) * Blood Disposition Codes (utilise drop down box) * Notification—Enter Y or N to designate whether consignee was notified. Enter RN if consignee notified you of the event. | FDA Unified Registration and Listing Systems (FURLS) Electronic Submission of Biological Product Deviation Report (eBPDR) Overview  Instructions for Using the eBPDR System  Appendix A |
| **Step** | **Action** | **Related Documents** |
| 8 | **Reporting Fatalities**  Section 606/170(b) of the 21 CFR requires that facilities notify the FDA, CBER, OCBQ, as soon as possible after confirming a complication of blood collection or transfusion to be fatal. The compatibility testing facility is to report recipient fatalities. The regulation also requires the reporting facility to submit a report of the investigation within 7 days after the fatality.  To report a fatality during regular business hours, call or email the fatality program contact within the Division of Inspections and Surveillance. Outside of regular business hours, you may submit your initial notification by leaving a voice message or sending an email or facsimile.   * E-mail: [fatalities2@fda.hhs.gov](mailto:fatalities2@fda.hhs.gov) * Telephone/voice-mail number: 240-402-9160 * Fax number: 301-837-6256 * Express Mail address:   U.S. Food and Drug Administration  Center for Biologics Evaluation and Research Document Control Center  10903 New Hampshire Avenue  WO71, G112  Silver Spring, MD 20993-0002  I**nitial Notification** - there is no required FDA form or format, nor is immediate notification required. FDA recommends initial notification so they can evaluate the potential public health significance**.**  Provide the following information:   * Date and time of the notification * Your name, title, telephone number, and fax number * Facility name, mailing address, and FDA Registration number * Age and Sex of the deceased * Date, time, and cause or suspected cause of death. * If an autopsy was or will be performed. * Name and address of facility where the fatality occurred if different than reporting facility. * Transfusion date(s). * Blood/blood component(s) and unit number(s) that may be implicated. * Name and address of facility(ies) providing the blood. * Brief description of events that led to the fatality – include underlying medical condition or disease and circumstances necessitating this hospitalization, reason for transfusion, how the patient initially responded to the transfusion, any medical intervention taken or response to the reaction, and time from initiating the transfusion to patient’s death.   **Notification of Fatality—within 7 days of event**  Provide the following information, including the information above, for proper evaluation of the potential public health significance of the event.:   * Discharge summary and/or death certificate * Autopsy report (if performed) * Conclusions and follow-up actions * Complete transfusion reaction report, including the manufacturer and lot number of the blood collection system and results of the clerical, serological, and visual re-checks performed. * Additional relevant documents include hematology reports; clinical chemistry reports for cardiac and/or liver enzymes, albumin, and bilirubin; viral marker tests; microbiology reports; reports of anti-HLA and/or anti-neutrophil antibody testing; tryptase levels; radiology reports; and physicians’ consults/opinions * If replacement fluid(s) was given during the transfusion, indicate which fluid(s) and the unit or lot number(s), and include any other relevant information, manufacturer’s notices, contamination warnings, or replacement fluid recalls. * If responsibility for the fatality appears to be outside the blood bank, the nurses’ and/or physicians’ notes on the patient, radiology reports, and physicians’ consults/opinions. * Results of lookback investigation, including follow-up testing on implicated donor(s) when the fatality was the result of transfusion transmitted infectious disease such as hepatitis or HIV. * Meeting minutes or report from your transfusion committee when the fatality was reviewed and discussed. If this incident was reviewed by any other hospital oversight group(s) such as risk management or quality practices, include the report or summary of their findings.   Note: In the event this information is not available at day 7, complete notification with the information you have and submit an amended report as the information comes available, | Notifying FDA of Fatalities Related to Blood Collection or Transfusion – Guidance for Industry August 2021 |

**Appendix A:**

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| **For blood products the systems include:** | **For non-blood products the systems include:** |
| DS – Donor Screening | IM – Incoming Material Specifications |
| DD – Donor Deferral | PC – Process Controls |
| BC – Blood Collection | TE – Testing |
| CP – Component Preparation | LA – Labeling |
| VT – Transfusion-Transmitted Infection Testing | PS – Product Specifications |
| RT – Routine Testing | QC – Quality Control and Distribution |
| LA – Labeling |  |
| QC – Quality Control and Distribution |  |

**References:**

AABB Standards for Blood Banks and Transfusion Services, Current Edition

Code of Federal Regulations, 21, parts 606.171 Current Edition

Notifying FDA of Fatalities Related to Blood Collection or Transfusion – Guidance for Industry Updated August 2021