DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Food and Drug Administration
Cincinnati District Office
Central Region
6751 Steger Drive
Cincinnati, OH 45237-3097
Telephone: (513) 679-2700
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WARNING LETTER

WL-CIN-14385-02
August 19 , 2002

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

Dr. John J. Ferry, Acting CEO
University Hospitals Health System
University Hospitals of Cleveland
11100 Euclid Avenue
Room – Lakeside 1011
Cleveland, OH 44106

Dear Dr. Ferry:

On July 2-3, 8-9, 11, 15, and 26 2002, an investigator from the U.S. Food and Drug Administration (FDA) conducted an inspection of your Hospital Blood Bank located at 11100 Euclid Avenue, Cleveland, OH 44106.

The investigator documented serious deviations from the Good Manufacturing Practice for blood products, Title 21, Code of Federal Regulations, Parts 606 and 640. The deviations cause the blood products processed by you facility to be adulterated under Section 501(a)(2)(B) of the Federal Food, Drug, and Cosmetic Act (the Act). The deviations included the following:

Failure to follow your firm's standard operating procedure (SOP) for performing "lookback" for a donor who had a repeatedly reactive test for Hepatitis B surface antigen [21 CFR 606.100(b)]. A repeatedly reactive test for HBsAg was found on March 30, 2002. Your SOP requires you to check the inventory for all previous units from that donor. Although the SOP does not specify a timeframe for completing this check, your staff informed our investigator that the check is supposed to be performed "immediately" after finding the repeatedly reactive unit. Your firm did not complete its check of all previous units in inventory for nearly three months, on June 25, 2002. On April 8, 2002, one unit of fresh frozen plasma from this donor was transfused.

Failure to appropriately identify blood samples of patients as required by 21 CFR 606.151(a) and your firm's SOP [21 CFR 606.100(b)]. For example, Patient [redacted] who is B+, had a sample collected and that sample was labeled with the initials for patient [redacted], who is A+. Patient [redacted] subsequently received a transfusion with the incorrect blood type.

Failure to assure that red blood cells and platelets were stored at the appropriate temperatures [21 CFR 606.160(b)(3), 640.24]. For example, the investigator documented numerous discrepancies with records for recording temperatures of red blood cells stored in the Pediatric Intensive Care Unit and with platelet incubator/rotator #2.

The failure to perform quality control testing for blood products [21 CFR 640.25(b)]. For example, quality control testing for platelet pheresis products was not conducted in May 2002.

Supplies and reagents used in the testing of blood were not used in a manner consistent with the manufacturer's instructions [21 CFR 606.65(e)]. For example, reagents used with the [redacted] platelet counter, and Nitrazine pH paper were past the expiration date .

Failure to maintain/calibrate equipment so as to assure that it will perform in the manner in which it was designed [21 CFR 606.60, 606.100]. For example, you did not calibrate the [redacted] centrifuge as required by your SOP and the operator's manual.

You have not reviewed your SOP manual on an annual basis as required by your firm's procedure [21 CFR 606.100].

Neither the above-identified deviations nor the list of inspectional observations issued at the conclusion of the inspection is intended to be an all-inclusive list of deficiencies at your hospital blood bank. It is your responsibility to ensure that your firm is in compliance with all requirements of the Act and federal regulations.

You should take prompt action to correct the current deviations. Your failure to promptly correct the deviations may result in regulatory action without further notice.

Please notify this office in writing, within 15 working days of receipt of this letter, of the specific steps you have taken to correct the noted violations and to prevent their recurrence. If corrective action cannot be completed within 15 working days, state the reason for the delay and the time within which the corrections will be completed. Please provide evidence that you have corrected the problems such as copies of finalized SOPs or new forms that are implemented to correct the problems.

Thank you for the letter dated July 19, 2002 from Roslyn Yomtovian, MD, Director, Transfusion Medicine/Blood Bank responding to the FDA-483, Inspectional Observations. This letter fails to adequately address each of the FDA-483 items. For example,

In response to FDA-483 observation #1 you stated that you will revise your SOP to include a statement on the [redacted] that the employee has checked for and quarantine any previous products from the donor. However, you have not addressed nor provided any documentation of corrective actions/retraining for the specific individual involved in this particular incident. Your response also notes that you have "met with and emphasized to staff the importance of immediate tracking of all previous products from a current donor with an abnormal test result." Please incorporate specific timeframes for tracking such products into your SOP.

With respect to your response to FDA-483 item #2, you stated that you will institute a computer change. We expect that changes to the computer system should be validated. Please provide documentation of the validation for this new change. Additionally, please explain what actions and/or retraining were taken with this particular phlebotomist.

For your response to item #3 you state that there will be a weekly QA review and documentation of deviations. The investigator documented that your personnel were noting the deviations but were not investigating/correcting them. Please explain why you believe a weekly rather than monthly QA review will solve this problem.

Finally, in response to FDA-483 item #7 concerning your firm's failure to review the SOP manual in a timely manner, you have promised to correct the deficiency by May 2003. Your response is not acceptable. You currently have procedures that have not been reviewed for up to ten years and your SOP requires that such review be performed on an annual basis. You should correct this deficiency in a more timely manner.

Your reply should be sent to the Food and Drug Administration, 6751 Steger Drive, Cincinnati, OH 45237-3097 Attn: Stephen J. Rabe, Compliance Officer. Please contact Mr. Rabe if you are still interested in scheduling a meeting to discuss this inspection.

Sincerely,

Dawn Todd-Murrell
Acting District Director
Cincinnati District Office