Decree Correspondence Contains Sensitive Proprietary Information
Provided Under Consent Decree Entered Under U.S. V American Red Cross
U.S.D.C., D.C. 93 CIV. 0949
102749

American Red Cross

Biomedical Services
2025 E Street, NW
Washington, DC 20006

March 14, 2012

RECEIVED
FDA BALTIMORE DISTRICT
DATE: 3/15/12
DOC. #: 2011-003.5
REVIEW BY: CH
RESPONSE REQ. BY: —

Ms. Evelyn Bonnin
District Director
Baltimore District
Food and Drug Administration
6000 Metro Drive, Suite 101
Baltimore, MD 21215

Re: Adverse Determination Letter dated January 13, 2012

Dear Ms. Bonnin:

This is a follow-up letter to the initial response letter dated February 13, 2012 associated with the concerns raised in the Food and Drug Administration (FDA) Adverse Determination Letter (ADL) dated January 13, 2012.

This letter includes the following items in response to the ADL. 1) Attachment 1 – FDA Orders – Response Status Report – this attachment provides FDA with a status report of the Red Cross' response to each FDA Order. 2) Attachment 2 – Response to 60 day Orders (Order 1, Order 5, Order 11, and Order 15).

If you have any questions regarding this submission, please contact my office at 202-303-5300.

Sincerely,

J. Chris Hrouda
Executive Vice President
Biomedical Services

cc: Karen Midthun, M.D., Director, CBER
Mary Malarkey

Attachments:
Attachment 1 – FDA Orders – Response Status Report
Attachment 2 – Response to 60 day Orders (Order 1, Order 5, Order 11, and Order 15)

Exhibits:
Exhibit 1 – Response to the October 29, 2010 Philadelphia DCSC FDA 483

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ATTACHMENT 1

FDA Orders – Response Status Report

Order 1:
Within 60 days of receipt of this letter, provide a status report of each issue noted during internal audits of the DCSC since the beginning of consolidation in May 2008 and whether each issue has been effectively corrected. Please provide a justification for any open problems created as a result of an internal audit. Explain why they were not addressed promptly when the auditors found each issue.

Status: Red Cross' response is provided in this submission, dated March 14, 2012.

Order 2:
Within 30 days of receipt of this letter, provide a list and a complete description of each functional team in the DCSC, including a complete list of all supplemental sites assisting with Philadelphia and Charlotte DCSC activities. Provide a status report of the staff hiring plan described in your 12/15/10 response to the Philadelphia DCSC FDA 483 issued on 10/29/10.

Status: Red Cross' response was provided in the February 13, 2012 submission.

Order 3:
Within 90 days of receipt of this letter, re-examine the DCSC response to the ARC BHQ audit observations related to training. Report to FDA what ARC is doing to strengthen its DCSC training program given the audit observation and the lack of a corrective action plan to address training at that point in time. Explain why obvious training deficiencies were not addressed promptly and adequately at the time of their discovery by the auditors. Also, explain ARC's methodology for evaluating the adequacy of its DCSC training program.

Status: Red Cross will provide a response within 90 days of receipt of the ADL.

Order 4:
Within 45 days of receipt of this letter, provide a thorough description of ARC's system for determining the staffing levels for the mobile collection drives and submit the written procedure that describes this system.

Status: Red Cross' response was provided in the February 27, 2012 submission.

Order 5:
Within 60 days of receipt of this letter, provide a thorough description of the DCSC's operation for answering donor eligibility calls from collection sites, including the number of staff assigned to this function. Explain the use of inexperienced DCSC personnel answering donor eligibility

calls from collections sites. Describe what controls ARC has implemented to ensure DCSC personnel provide accurate answers to donor eligibility calls.

Status: Red Cross' response is provided in this submission, dated March 14, 2012.

Order 6:
Within 45 days of receipt of this letter, establish and implement a time frame for the Medical Director' s review of DRIRs. A timely review is critical to donor safety due to the seriousness of some donor reactions. In order to ensure that the safety of the donor is not compromised, the Medical Director's review should be completed prior to allowing a donor who has experienced a donor reaction to return for additional donations.

Status: The DCSC and Medical Directors have discussed appropriate ways to address this concern. System 14, Donation Recruitment and Qualification Management, documents have been revised to ensure that a standard process for managing donor reaction evaluations is effectively implemented throughout the organization. Red Cross anticipates full implementation of the revised procedures no later than May 7, 2012.

Red Cross requested an extension for responding to this Order in the February 13, 2012 submission letter and will provide a response within 120 days of receipt of the ADL.

Order 7:
Within 45 days of receipt of this letter, communicate to all collection staff personnel and management the regulatory and procedural requirements for managing and documenting donor adverse reactions. Ensure that all collection staff is adequately trained to perform this task. Report to FDA your plan to accomplish this order.

Status: Staff members were retrained on the donor adverse reactions process and procedures with the implementation of BioArch R1; all regions (except Puerto Rico) will implement BioArch R1 by (b) (4) To supplement this training, Red Cross developed a workshop to present to all collections staff to address this concern. The workshop materials were released to the field on February 29, 2012 with a goal to complete the workshops by (b) (4)

Red Cross requested an extension for responding to this Order in the February 13, 2012 submission letter and will provide a response within 120 days of receipt of the ADL.

Order 8:
Within 60 days of receipt of this letter, develop a work around to assess whether a donor has prior names in the NDDR to ensure that unsuitable blood products are not distributed from donors who have prior names in the NDDR.

Status: Red Cross analyzed different scenarios related to the concern about donors with prior names in the NDDR and investigated how the organization's current and future software systems react when presented with these types of scenarios. Red Cross is currently developing an action plan based on the analysis.

Red Cross requested an extension for responding to this Order in the February 13, 2012 submission letter and will provide a response within 120 days of receipt of the ADL.

Order 9:
Within 60 days of receipt of this letter, perform a retrospective review of survey cards, since the time they were first issued to the date of this letter, to identify all complaints or concerns that are related to FDA regulated functions and, as required by the Decree, manage any regulated complaints/concerns as problems. Identify all regions that issue such survey cards. Additionally explain how ARC manages such complaints and concerns that are received through the internet.

Status: Red Cross has received the regional retrospective review responses and is evaluating the data.

Red Cross requested an extension for responding to this Order in the February 13, 2012 submission letter and will provide a response within 120 days of receipt of the ADL.

Order 10:
Within 30 days of receipt of this letter, provide copies of all Quality Process Reviews conducted at the DCSC since the DCSC began merging of the regional donor management operations. This material was requested numerous times during the September-October 2010 Philadelphia DCSC inspection. Provide a detailed explanation why the completed Quality Process Reviews were not provided to the FDA investigators during the inspection.

Status: Red Cross' response was provided in the February 13, 2012 submission.

Order 11:
Within 60 days of receipt of this letter, provide a status report on ARC's 12/15/10 response to the Philadelphia DCSC FDA 483 issued on 10/29/10.

Status: Red Cross' response is provided in this submission, dated March 14, 2012.

Order 12:
Within 30 days of receipt of this letter, provide a copy and complete description of the Modified Compliance Improvement Strategy (MCIS) that the DCSC was placed on in January 2011, as well as the status of the MCIS.

Status: Red Cross' response was provided in the February 13, 2012 submission.

Order 13:
Within 60 days of receipt of this letter, develop and implement an SOP to require complete documentation of all information evaluated during review of any utility report including the

soundex reports. Provide a copy of this SOP to FDA and include the effective date of its implementation.

Status: Red Cross developed an enhancement to an existing procedure to ensure a standard process for documenting the review of any utility report including the soundex report. Red Cross anticipates full implementation of the revised procedure by (b) (4)

Red Cross requested an extension for responding to this Order in the February 13, 2012 submission letter and will provide a response within 120 days of receipt of the ADL.

Order 14:
Within 30 days of receipt of this letter, provide an explanation for the use of BPD Code QC-90-01-05 [failure to adequately manage potentially non-confirming product (product not released)] when ARC's investigation into problems determined that blood products were actually distributed. FDA noted this during the review of Exception Reports E-0780785 and E-0790730.

Status: Red Cross' response was provided in the February 13, 2012 submission.

Order 15:
Within 60 days of receipt of this letter, review the contents of the quarterly and annual QA reports to ensure that such reports adequately convey to ARC' s Biomedical Services senior management that serious problems or deficiencies are developing and/or have occurred. This would enable senior management to be aware of the potential risk of the developing problems/deficiencies to public health and the impact on ARC's compliance with the law and the Decree.

Status: Red Cross' response is provided in this submission, dated March 14, 2012.

Order 16:
Within 45 days of receipt of this letter, provide a list of all facilities using the hand warmers during the blood collection process. Include details regarding: when the facilities began utilizing the hand warmers, what the purpose of their use is, and why they were in use without training and a written procedure.

Status: Red Cross' response was provided in the February 27, 2012 submission.

Order 17:
Within 45 days of receipt of this letter, evaluate the process for performing annual competency assessments and determine the reason they consistently fail to identify employees who do not perform tasks in accordance with written procedures or manufacturer' s instructions. Report to FDA what steps you plan to take to ensure the assessments are adequate.

Status: Red Cross completed a full task analysis of the process in February 2012 and anticipates an action plan based on the analysis to be completed by the end of (b) (4)

Red Cross requested an extension for responding to this Order in the February 13, 2012 submission letter and will provide a response within 90 days of receipt of the ADL.

ATTACHMENT 2

Response to Order 1

Order 1:

Within 60 days of receipt of this letter, provide a status report of each issue noted during internal audits of the DCSC since the beginning of consolidation in May 2008 and whether each issue has been effectively corrected. Please provide a justification for any open problems created as a result of an internal audit. Explain why they were not addressed promptly when the auditors found each issue.

Response:

This response provides FDA with a status report of each issue noted during the Donor and Client Support Center (DCSC) internal audits since the beginning of consolidation in May 2008, including whether each issue has been effectively corrected. Similar issues identified during more than one audit have been grouped together to avoid redundancy in this response.

This response is presented in the following format:

- **Inspected System:** Red Cross internal audits are conducted by reviewing five distinct systems including, Quality Assurance System (QAS), Donor Suitability/Eligibility System (DES), Quarantine/Inventory Management System (QIMS); Product Processing System (PPS), and Product Testing System (PTS). For this response, the issues are grouped under the corresponding system. Please note that PPS and PTS are not applicable to the DCSC.
- **Issue Description:** A brief description of the issue
- **Audit(s) Identified:** Each audit that identified the issue.
- **Status Report:** A status report on the issue

The DCSC internal audits are listed below:

1) Philadelphia DCSC Facility Audit (2008-0358) – Date: (b) (4)
2) Charlotte DCSC Facility Audit (2008-0359) – Date: (b) (4)
3) Charlotte DCSC Facility Audit (2009-0061) – Date: (b) (4)
4) Philadelphia DCSC Facility Audit (2009-0138) – Date: (b) (4)
5) Charlotte DCSC Facility Audit (2009-0353) – Date: (b) (4)
6) Philadelphia DCSC Facility Audit (2009-0410) – Date: (b) (4) (b) (4)
7) Charlotte DCSC Problem Management Special Audit (2010-0113) – Date: (b) (4) (b) (4)
8) Charlotte DCSC Special Audit (2010-0155) – Date: (b) (4)
9) Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)
10) Charlotte DCSC Facility Audit (2011-0087) – Date: (b) (4)
11) Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)
12) Philadelphia DCSC Facility Audit (2011-0423) – Date: (b) (4) (b) (4)

Quality Assurance Management System (QAS) Issues:

QAS Issue #1:
The DCSC has experienced issues in achieving full compliance with the Problem Management (PM) standard operating procedures (SOPs) specifically in meeting defined timelines, documentation of problems in Automated Problem Management System (APMS), and development of corrective actions/effectiveness checks.

Audit(s) Identified:
This issue was identified in all DCSC internal audits except for the Charlotte DCSC Special Audit (2010-0155) – (b) (4)

Status Report:

- The ADL raised a concern regarding the adequacy of Biomedical Services Headquarters (BHQ) and DCSC QA oversight of DCSC Operations and cited several examples from multiple quality audit reports that cited untimely management of problems. The Red Cross underestimated the donor management workload and number of staff resources required to manage the associated QA and PM workload. The Red Cross Quality Management team recognized staffing levels as a contributing factor to the ineffective consolidation of donor management activities and the inability to come into full compliance with the PM SOPs.

  The ADL identified issues regarding untimely management of problems and inadequate corrective actions to prevent problems from recurring in the DCSC. Since the FDA inspection ended in October 2010, the DCSC has taken significant corrective actions to improve its ability to manage problems in a timely and effective way. As noted previously in the response to FDA ADL Order 2, the DCSC has a new QA/PM management team in place and staffing levels have nearly doubled. With the inception of the Compliance Improvement Strategy (CIS) in July 2010, BHQ problem investigators were assigned to several of the CIS teams to support the DCSC problem managers and help ensure effective problem solving. The QA/PM staff members were assessed during the period of September 2009 thru August 2010; however, since many of them were relatively new at the time of the assessment, BHQ reassessed them in April – August 2011. The results of the QA/PM re-assessment revealed that the staff performance had improved. The DCSC was encouraged to continue to improve the workload balance for the PM staff, to resolve the backlog of problems, and to continue to develop the PM staff's ability to conduct effective investigations and develop appropriate corrective actions & effectiveness checks. The DCSC was aware of these issues and had already developed corrective actions, which were included in the CIS and/or the Modified Compliance Improvement Strategy (MCIS). All QA/PM staff participated in the core MCIS workshops, which included, for example, sessions on Problem Management, Managing Suspect Product, and Managing Donor Adverse Reactions.

- There has been significant improvement in the DCSC's compliance with System 10 SOPs. However, internal auditors identified additional areas for improvement related to specific problem management documentation requirements in SmartCAPA during the 2011-0405 and 2011-0423 audits. Immediate and corrective actions were taken in December 2011 and

January 2012, with additional corrective actions planned for March 2012. The corrective actions will be monitored through May 2012 to determine effectiveness.

QAS Issue #2:

The DCSC has experienced issues with ensuring documentation of training in Biomedical Integrated Training System (BiTS) Learner Management System (LMS) is completed appropriately.

Audit(s) Identified:

Charlotte DCSC Facility Audit (2009-0061) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2009-0138) – Date: (b) (4)
(b) (4)

Status Report:

The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problems have been closed. No further instances of this issue have been identified during internal quality audits.

QAS Issue #3:

The DCSC has experienced issues in achieving full compliance with the System 3, Policy and Procedure Management, SOPs.

- Procedures, process and workflows are not always developed and managed consistently with System 3.
- Procedures and workflows have gaps.
- Documentation of records and supporting documents maintained in the hard copy case files is not organized, complete and/or compliant with System 3 requirements (Job Aid 03.4.ja028, *Seven C's for Good Documentation and Review*, and Standard 03.4.std005, *Requirements for Good Documentation Practices*)
- Process for non-regulated documents needs improvement

Audit(s) Identified:

Charlotte DCSC Facility Audit (2009-0353) – Date: (b) (4)
Charlotte DCSC Special Audit (2010-0155) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)
Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

Status Report:

- The DCSC confirmed that all corrective actions associated with the specific documentation issues identified in audits 2009-0353, 2010-0155, and 2010-0434 were completed and the associated problems have been closed.
- During the 2011-0405 audit, internal auditors noted improvements in the following areas:
  - Procedures, process and workflows are developed and managed consistently with System 3.
  - Procedures and workflows do not exhibit gaps.

- Documentation of records and supporting documents maintained in the hard copy case files is organized, complete and/or compliant with System 3 requirements

However, internal auditors identified additional areas for improvement regarding management of non-regulated documents, such as memorandums, regional contact lists and DCSC emergency contact lists. The DCSC implemented corrective actions in early 2012 and will monitor them through (b) (4) for effectiveness.

OAS Issue #4:

The delivery of training is unsuccessful as evidenced by the results of training effectiveness documented on the Report of Evaluation of Training Effectiveness Results (04.4.frm018). Staff interviewed during the audit expressed concern regarding trainer knowledge/proficiency of materials being taught.

Audit(s) Identified:
Charlotte DCSC Facility Audit (2009-0353) – Date: (b) (4)

Status Report:
The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed. No further instances of this issue have been identified during internal quality audits.

OAS Issue #5:
Multiple types of records over multiple departments are incomplete, incorrect or inconsistent. This includes but is not limited to records maintained in (b) (4), Recipient Complication Files, Lookback Files, computer validation documents, Donor Complication and Injury Record (DCIRs) and records in the LMS.

Audit(s) Identified:
Charlotte DCSC Facility Audit (2009-0353) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2009-0410) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)
Charlotte DCSC Facility Audit (2011-0087) – Date: (b) (4)
Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)
** Observations related to (b) (4) were included under the DES system*

Status Report:
- The DCSC confirmed that all corrective actions associated with the specific documentation issues identified in audits 2009-0353, 2009-0410, 2010-0434 and 2011-0087 were completed and the associated problems have been closed.
- During the 2011-0405 audit, internal audits noted improvements in incomplete and incorrect documentation on records maintained in (b) (4), Recipient Complications, Lookback Files, DCIRs and records in the LMS.

  However, internal auditors identified additional areas for improvement regarding file content in autologous lookback files and DCIR files. The DCSC implemented immediate and

corrective actions in November 2011 and January 2012, and completed follow-up communication between the supervisors and staff in early 2012. The corrective actions will be monitored through (b) (4) for effectiveness.

OAS Issue #6:

Records are not managed and tracked in a manner that ensures that cases and associated records can be tracked and retrieved.

- Cases from 2009 and early 2010 were not provided for review during the audit
- Hard copy case files are not organized in a consistent manner
- Individual records are not marked with the case numbers

Audit(s) Identified:

Charlotte DCSC Special Audit (2010-0155) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)
Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

* *Observations related to records management were included under the DES system*

Status Report:

- The DCSC confirmed that all corrective actions associated with the specific records management issues identified in audits 2010-0155 and 2010-0434 were completed and the associated problems have been closed.
- The internal auditors noted significant improvement in the records management process during the 2011-0405 audit; however, four cases from 2009/2010 were unable to be located. As an immediate action, the four case files were recreated at the time of the audit and the cases are actively being processed for closure as part of the backlog case file closure activities. Prior to the internal audit in November 2011, several corrective actions were implemented as part of the CIS Plan for Records Management. The DCSC is currently monitoring corrective actions associated with the CIS Plan through November 2012 for effectiveness.

OAS Issue #7:

Commitments made to Senior Management in response to internal audit findings are not always completed and reviewed for effectiveness.

Audit(s) Identified:

Charlotte DCSC Special Audit (2010-0155) – Date: (b) (4)

Status Report:

This observation involved DCSC required corrective action commitments for case file management issues associated with a regional audit that were not entirely met. The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed. In addition, a Quality Assurance Officer was assigned to the DCSC in October 2010 to provide assistance managing and responding to internal and FDA inspections and to monitor observation responses/commitments.

OAS Issue #8:
Management and/or supervisory oversight of staff performance of compliance related tasks are not always adequate.

Audit(s) Identified:
Charlotte DCSC Facility Audit (2011-0087) – Date: (b) (4)

Status Report:
Please note that the inadequate management oversight identified in this facility audit occurred prior to the implementation of management oversight corrective actions associated with the FDA Philadelphia DCSC inspection. The specific issue cited in the audit involved a staff member that had been removed from a task to work on a special assignment; however, the staff member was confused about which tasks could no longer be performed and continued to perform a removed task. The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed.

Donor (Suitability) Eligibility (DES) Issues:

DES Issue #1:
Product retrievals are not completed in a timely manner. Several timelines are being missed and have not been detected for more than 30 days. Additionally, documentation is not being completely concurrently with information as received.

Audit(s) Identified:
Charlotte DCSC Facility Audit (2009-0061) – Date: (b) (4)

Status Report:
The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed.

DES Issue #2:
The process to ensure accurate and timely management and closure of donor files (post donation information, callback) requires improvement. Process verification (final review) of Component Status Change Records (CSCR) and Donor Status Change Records (DSCR) associated with donor files is not occurring in a reasonable time period. In some cases, products have been retrieved and the associated problems in APMS have been closed, but the forms have not received the final process verification.

Audit(s) Identified:
Philadelphia DCSC Facility Audit (2009-0138) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)
Charlotte DCSC Facility Audit (2011-0087) – Date: (b) (4)
Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

Status Report:
- The DCSC confirmed that all corrective actions associated with the management of donor files, primarily donor file process verification, identified in the audits 2009-0138, 2010-0434 2011-0087 and 2011-0405 were completed and the associated problems have been closed. Please note that the issues identified in the 2011-0405 were process verification issues that had already been identified by the DCSC prior to the internal audit.
- One of the items for which a CIS plan was developed was for a backlog of approximately 18,000 cases that were pending a final review (process verification). The DCSC management team developed a plan to complete these pending reviews and eliminate the backlog. The progress made against the plan has been reviewed at each BHQ/DCSC leadership meeting. As of March 6, 2012, there were 36 cases or approximately 0.2% of the original 18,000 in the backlog still pending review. The remaining cases are generally the most difficult to review as they include multiple subcases or are the oldest. According to the current plan, this backlog will be eliminated by the end of (b) (4) . The DCSC is currently monitoring case load and closure as part of the CIS Plan through (b) (4) for effectiveness.

DES Issue #3:
The DCSC failed to ensure accurate and timely management and closure of Donor Reaction Injury Reports (DRIR).

Audit(s) Identified:
Philadelphia DCSC Facility Audit (2009-0138) – Date: (b) (4)

Status Report:

- At the time of the 2009 internal audit, there was no procedural time requirement for completion of the medical director or final quality review. As a result of this 2009 audit and similar issues identified in regional internal audits, on June 1, 2010, Temporary Authority (TA) 10-696 against WI 14.3.178, *Final Donor Complication Review*, was implemented that defined a timeline for the final quality review for cases opened on or after June 1, 2010. This TA stated the, "final quality review must be completed within 3 months of the case being opened unless the Medical Director specifically requests additional follow-up that extends beyond this time. The Medical Director must document the request for a case to remain open on the DRIR or electronic equivalent." With the implementation of BioArch R1, this timeline requirement was incorporated into the procedure.
- The DCSC addressed the problems regarding DRIR timely management and closure as part of the CIS Plan for Donor Adverse Reactions. In addition, timeline requirements for DRIR medical director review will be discussed in the response to Order 6.

DES Issue #4:
Operations are not always responsive to ensure problems are managed in accordance with System 10 procedures.

Audit(s) Identified:
Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)

Status Report:
The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed.

DES Issue #5:
Multiple examples of completed case files, scanned, archived, and reprinted from (b) (4) were found to be missing final product dispositions from the consignee. Information was available and maintained separately in (b) (4), but not archived with the final case file.

Audit(s) Identified:
Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

Status Report:
The DCSC implemented corrective actions in January 2012 to address this issue and will monitor them through (b) (4) to determine effectiveness.

DES Issue #6:

Case files in (b) (4) associated with closed DCIRs have not been downloaded as the hard copy source document since approximately mid-May 2011. (b) (4) is not intended for use as the "source document of record" per the intended use specified in the documents provided for Biomedical Information Technology Quality and Regulatory Management (BIT/QRM) evaluation and approval as a regulated field application, as well as described in controlled documents, such as the (b) (4) As of the date of the audit, these DCIR cases do not exist as a source document of record until downloaded upon request as a hard copy file.

Audit(s) Identified:

Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

Status Report:

The DCSC implemented corrective actions in early 2012 and will monitor them through (b) (4) (b) (4) to determine effectiveness.

DES Issue #8:

Problems are not consistently logged for an issue identified during the process verification process that met the definition of a problem.

Audit(s) Identified:

Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

Status Report:

The issue identified in the audit involved one case where the Medical Director signed a form on the incorrect signature line. The staff member was uncertain as to whether or not a problem should be logged. Please note that this discrepancy occurred prior to the MCIS problem management in-services. The DCSC confirmed that all corrective actions associated with this issue were completed and the problem is in the process of being closed.

DES Issue #9:

Notification to CBER of reportable post donation information was not made within the required timeframe.

Audit(s) Identified:

Charlotte DCSC Facility Audit (2011-0405) – Date: (b) (4)

Status Report:

The internal auditor identified one example where a post donation information problem was not logged appropriately; therefore, the timeline was missed. The discrepancy was investigated and determined to be an isolated incident. The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed.

Quarantine/Inventory Management (QIMS) Issues:

QIMS Issue #1:

Manufacturer's Inserts require that (b) (4) test tubes be stored in an area with an acceptable temperature range of 4-25 degrees C. The room in which the (b) (4) test tubes are being stored is not currently monitored to ensure that the manufacturer's storage temperature requirement is within the acceptable range.

Audit(s) Identified:

Charlotte DCSC Facility Audit (2009-0061) – Date: (b) (4)
Philadelphia DCSC Facility Audit (2010-0434) – Date: (b) (4)

Status Report:

The DCSC ships the (b) (4) test tubes to donors as part of a follow-up sample collection package. At the time of the inspection, DCSC staff members were retrieving a box of test tubes from the Penn-Jersey or Carolinas region and retaining any leftover tubes in their work area. As a result of the 2009-0061 audit, the DCSC removed all boxes of test tubes from the DCSC facility and required DCSC staff members to retrieve only the necessary number of test tubes from the region as a corrective action. The Philadelphia DCSC 2010-0434 audit identified an isolated incident where the staff member failed to discard unused test tubes that were retrieved from the region. As a result, the DCSC reminded staff to only obtain from the region the exact number of tubes necessary and to immediately discard additional tubes or return them to the region. The DCSC confirmed that all corrective actions associated with these two specific issues were completed and the associated problems have been closed.

QIMS Issue #2:

A locally developed Sample Only Log that contains the whole blood number (WBN) label issued to a specific case for donor retesting lacks evidence of version control.

Audit(s) Identified:

Charlotte DCSC Facility Audit (2009-0061) – Date: (b) (4)

Status Report:

The DCSC confirmed that all corrective actions associated with this issue were completed and the associated problem has been closed.

Conclusion:

Red Cross has made significant improvement in its methods of analyzing data, identifying areas of risk, and reducing problems. Red Cross strives to identify and resolve quality and compliance related issues as quickly as possible. The majority of issues identified during the DCSC internal audits were addressed at the time of identification and corrective actions have been put in place to reduce or prevent recurrence. With the exception of the two most recent audits, 2011-0405 and 2011-0423, the Red Cross internal audits have been reviewed by senior management and closed as indicated in the following table.

DCSC Location	ARC Log Number	Inspection Completion Date	Audit Closure Date*
Philadelphia	2008-0358	(b) (4)	
Charlotte	2008-0359		
Charlotte	2009-0061		
Philadelphia	2009-0138		
Charlotte	2009-0353		
Philadelphia	2009-0410		
Charlotte	2010-0113		
Charlotte	2010-0155		
Philadelphia	2010-0434		
Charlotte	2011-0087		
Charlotte	2011-0405		
Philadelphia	2011-0423		

* In accordance with Work Instruction 02.3.007, *Completing the Audit*, the audit is closed once the facility submits in writing that all corrective actions have been implemented.

As mentioned in the previously submitted ADL Compliance Plan, a full-time internal auditor was assigned to the DCSC in January 2011 to provide an independent assessment of the DCSC facilities. The auditor is based in Charlotte, but evaluates records from both facilities and travels to Philadelphia when necessary. The auditor reviews and reports to BHQ executive leadership on the status of CIS action items and effectiveness checks for completed actions. The auditor also conducts focused reviews as directed by BHQ senior leadership or as requested by DCSC leadership.

Red Cross realizes that although there has been significant progress at the DCSC since the October 2010 inspection, there is still some additional work to complete. The facility continues to work on improvements, not only associated with individual tasks and processes, but also related to instilling a culture of quality and compliance. Red Cross seeks to ensure that the safest possible blood products are provided when needed by recipients and is fully committed to meeting all FDA standards to ensure compliance with FDA regulations and requirements.

Response to Order 5

Order 5:

Within 60 days of receipt of this letter, provide a thorough description of the DCSC's operation for answering donor eligibility calls from collection sites, including the number of staff assigned to this function. Explain the use of inexperienced DCSC personnel answering donor eligibility calls from collections sites. Describe what controls ARC has implemented to ensure DCSC personnel provide accurate answers to donor eligibility calls.

Response:

In April 2010, the DCSC implemented the Donor Eligibility Specialist (DES) team, as part of the DCSC functionalization discussed previously in the response to FDA ADL Order 2, with the following goals in mind:

- Develop specialized staff to answer donor eligibility calls from donors and field Collection sites as well as general questions from donors such as contact information for an American Red Cross Chapter or how to replace a lost donor card.
- Improve compliance by allowing specialized eligibility staff and supervisors to focus on and develop process expertise in the donor eligibility call back function
- Improve compliance by eliminating the donor eligibility call back function from the Donor Client Support Specialist (DCSS) role to allow DCSS staff to focus on case investigations.

Prior to the establishment of the DES team, the DCSS staff members responsible for answering the phone were trained on all aspects of eligibility. However, the DCSC identified that because the DCSS staff members were trained on multiple functions, they did not develop process expertise in eligibility. Therefore, in 2010, the DCSC functionalized tasks to allow the DCSS teams to focus on case investigations and established the DES team to focus on eligibility calls.

A lean engineer assessed the number of staff required to manage the call volume based on the incoming call volume statistics available from the (b) (4) phone system. Approximately (b) (4) of the incoming call volume is from Collections staff in the field or donors. The lean engineer initially identified a need for (b) (4) DES staff to handle the call volume; however, additional analysis and potential customer service concerns prompted management to increase staffing to (b) (4) staff members.

New DCSC staff members were hired for the eligibility teams based on qualifications. (b) (4) staff members were hired in April 2010, with additional staff hired in August 2010. DES team members were trained (b) (4) Training consisted of classroom instruction and evaluation of recorded calls. After staff members were released to perform the task independently, staff began taking live calls with (b) (4) education staff available to provide support. Currently, the DES team consists of (b) (4) staff members and (b) (4)

Staff members are continually assessed to ensure proper eligibility guidance is given to donors. A full-time Call Monitoring Specialist position was established and filled in August 2010. The Call Monitoring Specialist monitors a sampling of all recorded calls from the previous month, approximately (b) (4) calls per month, and provides feedback to the staff and supervisor for process

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improvement and customer service. In addition, any problems identified relating to incorrect eligibility guidance are initiated and investigated as required by System 10, Problem Management.

Response to Order 11

Order 11:

Within 60 days of receipt of this letter, provide a status report on ARC's 12/15/10 response to the Philadelphia DCSC FDA 483 issued on 10/29/10.

Response:

The December 15, 2010 Philadelphia DCSC response to the FDA 483 that was issued on October 29, 2010, contained a number of actions that were completed prior to the response submission. The Red Cross response to the FDA 483 is attached for your convenience. This response to Order 11 provides a status report related to the commitments that were not completed at the time the response was submitted.

General Response Commitments:

1) BHQ will hire an external consulting firm to perform an evaluation of the issues that occurred with the DCSC.

   Status Report:
   Pending - An extension was approved by Red Cross Biomedical Services Headquarters senior management for selection of consulting firm until March 2012. BHQ determined that a consultant review of corrective actions, after performed and evaluated for effectiveness, would be the most beneficial. Since the CIS and MCIS in-services were not completed until November 2011, BHQ postponed hiring a consulting firm until spring 2012. BHQ executive leadership met recently to define the evaluation Red Cross will ask the consulting firm to perform. In order to ensure proper oversight BHQ has done and continues to do the following: 1) BHQ executive leadership meets with DCSC leadership on a (b) (4) basis; 2) DCSC leadership reports to the system QCOC at least (b) (4) and 3) the corporate audit group that reports directly to the Board of Governors' audit committee is performing their second audit of the DCSC.

2) Red Cross will manage key initiatives using program management principles, with appropriate governance structures and oversight established at the outset, similar to those established for management of the BioArch program. This will include the establishment of a set of metrics for monitoring performance and formal readiness reviews for key stage gates using these pre-defined metrics.

   Status Report:
   Pending – The new expectations/requirements for managing key initiatives using program management principles have been incorporated into the System 9, Change Control, procedures and are scheduled for implementation on May 21, 2012. BHQ executive leadership determined that the upgrade to the documentation system, (b) (4) would be managed using this approach. A project director was hired and an executive steering committee established. The Change Management Board reviewed all active projects and determined that no other project met the newly established criteria.

3) An updated DCSC Dashboard will include additional metrics to enhance the monitoring process.

Status Report:
Completed – Red Cross updated the DCSC Dashboard as of December 20, 2010 and began publishing the (b) (4) updates on January 6, 2011.

4) Compliance Improvement Strategy (CIS) sub-plans will be developed, approved and implemented.

Status Report:
In-progress – All sub-plans were approved by January 22, 2011. Of the 198 action items from the sub plans, 197 were completed by December 2011. The target date for the final action item is (b) (4) Effectiveness monitoring is on-going with a target completion date in the (b) (4)

5) Modified Compliance Improvement Strategy (MCIS)

Status Report:
In-progress – MCIS determination was made on January 14, 2011. Planning was completed in the spring of 2011 and in-services were completed between July and September 2011. Monitoring of performance metrics began January 2012. Note: Please refer to the response to FDA ADL Order 12 for specific MCIS description/activities.

6) A task force will established to create an integrated process by which quality metrics will be analyzed collectively and escalation triggers defined for increased oversight by either the division or system level QCOC based on this evaluation.

Status Report:
Completed – January 14, 2011

7) The President, Biomedical Services, will create a department that will have ongoing responsibility to analyze quality metrics collectively to determine the state of compliance for individual facilities, processes, and Biomedical Services, overall.

Status Report:
Completed – The Compliance Department was established in January 2011 and an interim Chief Compliance Officer was in place by February 2011. The Chief Compliance Officer was in place by August 1, 2011.

8) Staffing commitments specifically outlined in the general response.

Status Report:
Completed – Please refer to the response to FDA ADL Order 2.

9) Supervisor Academy will be developed to augment the skills of the supervisors in managing staff.

Status Report:
Completed – In-services began in September 2010 and were completed in May 2011.

10) Supervisor tools will be implemented to assist supervisory staff in overseeing the work, reconciling that all work expected is received and verifying that all activities are completed.

Status Report:
Completed – Tools associated with specific observations/commitments were documented related to those specific FDA 483 observations and the final tool was implemented July 2011.

11) Problem Management (PM) Implementation –

Status Report:
Completed –

a. Staffing issues/changes are specifically addressed in the response to FDA ADL Order 2. Final staffing modifications were completed in January 2012.
b. Monitoring process (PM workload) – monitoring tools/reports were developed in December 2010 and put into routine use January 25, 2011 with additional tools implemented April 4, 2011.
c. PM staff from other regions assisted DCSC Operational staff and DCSC PM staff to improve Manual Problem Form quality and processing January 2011-March 2011.
d. Workshop emphasizing teamwork and collaboration between DCSC Operations, PM and QA staff in association with System 10, Problem Management, requirements was presented to DCSC supervisors/management in June 2011 with additional PM related in-services provided to all staff during MCIS actions between July and September 2011.

Specific Observation Commitments:

1) Management Control (Observation 1 – E-0900152; Observation 2 – E-0900174; Observation 3 – E-0900189)

Status Report:
Although a number of corrective actions have been completed, two actions are still pending. These actions are outlined above in the general response status items:

1) Hiring of external consultant
2) Management of key initiatives using program management principles.

2) Problem Management – DRIR
(Observation 4 – E-0900194; Observation 5 – E-0900205; Observation 6 – E-0900220)

Status Report:

- Observation 4 – Corrective actions have been implemented and monitoring is scheduled through (b) (4)
- Observation 5 and 6 – Corrective actions have been implemented, determined to be effective, and the associated problems have been closed.

3) Problem Management – Suspect Products
(Observation 7 – E-0900232)

Status Report:
Completed – Corrective actions have been implemented and monitoring is scheduled through (b) (4)

4) Problem Management – Confirmatory Test/DDR
(Observation 8 –E-0900242; Observation 9-E-0900255)

Status Report:
Completed – Corrective actions have been implemented and monitoring is scheduled through (b) (4)

5) Significant Corrective Action
(Observation 10 – E-0900278; Observation 11 – E-0900294; Observation 12 – E-0900307; Observation 13 – E-0900332; Observation 14 – E-0900341)

Status Report:

- Observation 10, 12, 13, and 14 – Corrective actions have been implemented and monitoring is scheduled through (b) (4)
- Observation 11 – Corrective actions have been implemented, determined to be effective and the associated problem has been closed.

6) Health History Deferrals/Problem Management
(Observation 15- E-0900351/E-0869169; Observation 16 –E-0900375)

Status Report:

- Observation 15 – Corrective actions have been implemented and monitoring is scheduled through (b) (4)
- Observation 16 – Corrective actions have been implemented and monitoring is scheduled through (b) (4)

7) Problem Management Missed Timeframes (observation 17)
(Observation 17 – E-0900447)

Status Report:
Completed – Corrective actions have been implemented and monitoring is scheduled through (b) (4)

Response to Order 15

Order 15:

Within 60 days of receipt of this letter, review the contents of the quarterly and annual QA reports to ensure that such reports adequately convey to ARC' s Biomedical Services senior management that serious problems or deficiencies are developing and/or have occurred. This would enable senior management to be aware of the potential risk of the developing problems/deficiencies to public health and the impact on ARC's compliance with the law and the Decree.

Response:

The content of the Quarterly and Annual Quality Assurance Reports is defined under Paragraphs IV.A.2.b and IV.B.18.c of the 2003 Amended Consent Decree and states the following:

> **IV.A.2.b - Quarterly Quality Assurance Report:** Commencing with the date of entry of this Order, the director of quality assurance shall, in addition to other reports required under this Order, prepare and submit quarterly quality assurance reports in writing to ARC senior management and ARC Biomedical Services senior management, pursuant to paragraph XI herein, that completely and accurately: (i) describe the steps that have been and will be taken, with specific dates for implementation of each step, to establish, implement, and continuously maintain the QA/QC program; and (ii) describe all unresolved potential system (systemic) problems, system (systemic) problems, and trends and their corrective action status; and (iii) assess whether ARC is in compliance with the law, ARC SOPs, and this order.
>
> **IV.B.18.c - Annual Quality Assurance Report:** Within one year after entry of this Order, and no less frequently than *annually* thereafter (i.e., in the fourth quarterly quality assurance report (see paragraph IV.A.2.b)), with respect to each new or unresolved problem reported to ARC, including any problem that FDA has, after entry of this Order, brought to ARC's attention in writing, ARC shall review each element of the QA/QC program and each system, process, and control used to collect, manufacture, process, pack, hold, and distribute blood and blood components that may affect the purity of such products: (i) to ensure that each of the problems has been corrected to prevent its recurrence; and (ii) to ensure continuous compliance with the law, ARC SOPs, and the provisions of this Order. ARC shall prepare written reports of these reviews and submit them to ARC senior management and ARC Biomedical Services senior management, pursuant to paragraph XI herein, and to the ARC Biomedical Services Committee, and the Audit Committee of the ARC Board of Governors, and FDA, no later than December 15 of each year.

In February 2012, Red Cross reviewed the current contents of the Quarterly and Annual Quality Assurance Reports. Although the review identified some minor areas within the reports that could be enhanced, Red Cross found that the contents contained the necessary information required by the Consent Decree and that the information adequately conveyed to senior management that serious problems or deficiencies have occurred. However, the review identified

limitations inherent to the submission timeframes of these reports that hinder them from adequately conveying to senior management the potential development of serious problems or deficiencies on a more "real-time" basis.

The Quarterly Quality Assurance Report is submitted to senior management for review prior to the end of the next quarter (for example, the report for January through March is submitted through senior management review no later than June 30). The Annual Quality Assurance Report, which contains information from October 1 through September 30, is submitted to FDA and senior management review no later than December 15. Therefore, the information in the reports is 75 to 90 days old by the time the Quality Assurance Reports are reviewed by senior management.

Although the Quality Assurance Report is limited in its capacity to adequately convey the potential development of serious problems, Red Cross has several other mechanisms designed to inform senior management of serious problems on a more "real-time" basis. The information provided to senior management using other mechanisms is often summarized in limited detail in the Quarterly and Annual Quality Assurance Reports. Examples of these mechanisms are provided below.

Compliance Office – Compliance Monitoring Analysis

The Compliance Department was established in late January 2011 by the President, Biomedical Services, to strengthen Red Cross' ability to analyze quality metrics collectively, to assess, independently and objectively, the state of compliance for facilities and processes, to identify areas of risk that might not be realized at the facility level, and to report the assessment results to Operations, Q&RA, and senior leadership.

The Compliance Department is responsible for collectively evaluating multiple sources of data to assess each facility's compliance profile over a 12 month time frame on a (b) (4) basis. A formal mechanism and integrated process for evaluating performance data, with defined triggers for increased oversight, has been established. The Compliance Template (hereafter referred to as the Template) was developed to provide an overall picture of each facility's compliance performance based on an analysis of these multiple data sources. The key and high risk metrics agreed to by the FDA and ARC Working Group have been incorporated into the Template along with FDA Inspection Results, Internal Audit Results, Quality Scorecard Results, and Employee Pursuit of Excellence data. A Template is completed for each facility and Templates for all facilities are completed, analyzed, and reviewed on a (b) (4) basis. Three sets of Templates have been generated to date, one in September 2011 (b) (4) , one in November 2011 (b) (4) and one in February 2012 (covering (b) (4)

BHQ senior management reviews the Templates and, based on the results and level of risk identified, determines which facilities require additional oversight and the oversight mechanism to use (for example, senior leadership oversight, system QCOC, or division/functional area QCOC). The Template results are then reviewed with Operations and Quality leadership and posted on a shared site for facility leadership use.

Dashboards

In recent years, Red Cross has developed the dashboard system to provide senior management and regional management with real time data for important initiatives. Using this information, management can quickly identify facilities or processes that may require additional management attention. The following is a list of current dashboards.

- **Quality Dashboard:** The Quality Dashboard was created in January 2009 and is regularly updated to include critical metrics. The Quality Dashboard is distributed (b) (4) and provides senior management with information on how well facilities are performing in critical areas.
- **Problem Management (PM) Dashboard:** The PM Dashboard was also created in early 2009 and is updated and distributed (b) (4) The PM Dashboard provides senior management with information on the state of problem management in the organization. Some of the items presented in this dashboard include: System 10, Problem Management, procedure and process initiatives; problem management metrics; compliance with System 10 guidelines; System 10 Clarify cases; SmartCAPA status and performance; system problems, trends, and high risk initiative/investigations involving System 10.
- **DCSC Dashboard:** The DCSC Dashboard was created in February 2009 and is regularly updated to include critical metrics. The DCSC Dashboard is distributed (b) (4) and provides senior management with information on DCSC performance in critical areas.
- **BioArch Release 1 (R1) Dashboard:** The R1 Dashboard was created in the spring of 2011 as regions began implementing BioArch R1. The R1 Dashboard is distributed (b) (4) . Senior management reviews this dashboard to evaluate each region's BioArch R1 implementation metrics and to ensure that there are no adverse trends that require additional management attention.
- **Employee Pursuit of Excellence (EPoE) Dashboard:** The EPoE Dashboard was created in the summer of 2011. The EPoE Dashboard is updated and distributed (b) (4) . Senior management reviews this summary (b) (4) to ensure there is appropriate field leadership engagement and that there are no adverse trends that require additional management attention.

FDA 483 Reviews

An FDA Form 483 list of observations issued to any Red Cross facility is submitted to senior management for review within five business days of receipt. Red Cross senior management must review the FDA 483 within 10 calendar days.

Internal Audit Reviews

All internal Red Cross facility audits are submitted to senior management for review within 30 days of audit conclusion. Biomedical Services senior management must review the audit report within 10 calendar days.

Management Review Meetings

Senior management participates in the following management review meetings:

Process Management Review Meeting: This meeting is designed to assess the health of the system process through an evaluation of process quality data and other information that can impact the Quality Management System for each process. Each system must be reviewed at least (b) (4) . Core systems, such as Donor Management, Collections, and Manufacturing as well as Suspect Product Review, are reviewed (b) (4) . One meeting is scheduled (b) (4) and each meeting may cover multiple systems.

Quality Management System Management Review Meeting: This meeting is designed to assess the key quality indicators and facility performance through analysis of systemic problem data or other information that can impact the Quality Management System. The recently created Compliance Monitoring Template results are also reviewed at the meeting. This meeting is scheduled (b) (4) in conjunction with the Field Operations Group, which includes all Division Vice Presidents and BHQ leadership.

Either of these meeting could also include a discussion on large implementations and their impact on the organization.

The purpose of the Management Review Meetings is to:

- Ensure senior management is informed and is given the appropriate information to make decisions related to resources, responsibility and authority, budgets, and whether to proceed with or stop an activity.
- Determine the suitability and effectiveness of the Quality Management System based upon the established quality goals and objectives, quality policy (direction of the organization with respect to quality), and compliance policy.
- Ensure information related to quality problems or product is disseminated to those directly responsible for ensuring the quality of such product or the prevention of problems and identify responsibilities in the organization for resolution.
- Assess the health of system processes during the Process Management Review Meeting through an evaluation of process quality data and other information that can impact the Quality Management System.
- Assess the health of facilities' performance and their state of compliance during the Quality Management System Management Review Meeting through analysis of multiple sources of data. BHQ executive leadership reviews the analysis prior to the meeting and determines whether additional oversight, such as the system-level Quality and Compliance Oversight Committee (QCOC) or Executive Leadership Review, is required.

Problem Management Report Reviews

Certain types of problem management reports are submitted to senior management for review on a regular basis. The reports include: Analysis & Investigation (A&I) Report, Corrective Action

Monitoring (CAM) Report, Corrective Action Plans for National Supply & Equipment Problem and Deficiencies (NSEPD), Corrective Action Plans for System Problems, and Corrective Action Plans for Systemic Trends. Biomedical Services senior management must review these reports within (b) (4) calendar days of submission.

Quality and Compliance Oversight Committee (QCOC)

The System QCOC meets at least (b) (4) and focuses on updates to compliance data and on updates from each facility under QCOC oversight. As of January 5, 2012, QCOC membership was changed to include the senior leadership of Operations, QA, and Compliance. The QCOC is now co-chaired by the Senior Vice President (SVP), Quality & Regulatory Affairs (Q&RA), and the Vice President (VP) & Chief Compliance Officer (CCO), Biomedical Services. The Compliance Department is now responsible for analyzing the metrics and other data and presenting identified areas of risk to the QCOC. These changes ensure that Biomedical Services leadership is well-informed, without the filter of management from the facility, and can provide the oversight and support necessary to achieve improvements in compliance.

In conclusion, based on these established methods for monitoring process and facility performance, the Red Cross respectfully requests that the FDA allow Red Cross to replace the quarterly Quality Assurance Report with the oversight mechanisms defined above. These mechanisms provide real-time, interactive opportunities to review, discuss, and take action, as necessary, to improve Red Cross systems and performance. Red Cross would continue to develop the Annual Quality Assurance Report and submit it to the FDA by December 15 annually. The Red Cross appreciates the FDA's consideration of this request.