GUI-0061: Risk classification of observations made during blood establishment inspections

January 31, 2022

Health Canada Santé Canada

Canada

Health Canada Santé Canada

Date issued:	31 January 2022
Date implemented:	31 January 2022
Replaces:	GUI-0061: Risk classification of observations made during blood establishment inspections (v7)

Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health. Health Canada is committed to improving the lives of all of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

Également disponible en français sous le titre: GUI-0061: Classification, en fonction du risque, des observations notées lors des inspections d'établissements de sang.

To obtain additional information, please contact:

Health Canada
Address Locator 0900C2
Ottawa, ON K1A 0K9
Tel.: 613-957-2991
Toll free: 1-866-225-0709
Fax: 613-941-5366
TTY: 1-800-465-7735
Email: hc.publications-publications.sc@canada.ca

Publication date: January 2022.

Cat.: H14-387/2022E-PDF
ISBN: 978-0-660-41517-8
Pub.: 210503

Disclaimer

This document does not constitute legislation. In the event of any inconsistency or conflict between the legislation and this document, the legislation takes precedence. This document is an administrative document that is intended to facilitate compliance by the regulated party with the legislation and the applicable administrative policies.

Table of contents

The following legend shows the alerts used in this document and the way they are intended to be used.

Key or cautionary information.

Supplementary information like quotes and legal references.

1. Purpose

Establishments performing activities relating to blood for transfusion or plasma for further manufacture must comply with the *Food and Drugs Act* (the Act) and the *Blood Regulations*. Examples of these activities include:

- processing
    - donor suitability assessment
    - collection
    - testing
    - blood component preparation
- labelling
- storage
- distribution
- transformation
- importation

The *Blood Regulations* also contain requirements for quality management, record keeping, and error/accident and adverse reaction investigation and reporting.

Health Canada inspects blood establishments for compliance with the Act and the Regulations. This guide:

- provides examples of inspection ratings and observations

- helps classify observations made during inspections of blood establishments
- describes how overall compliance ratings are assigned to an inspection, including the situations that may result in a non-compliance rating
- promotes consistency in individual observations and in overall inspection ratings

This guide is also used by Health Canada inspectors to assess observations or other information noted by foreign regulatory partners when they conduct paper review assessments of evidence to demonstrate compliance with the *Blood Regulations* for foreign buildings. For more information on evidence for foreign buildings, see the *Guidance document: Blood Regulations*.

You should read this document along with:

- the *Food and Drugs Act*
- the *Blood Regulations*
- the relevant sections of the National Standard, *CAN/CSA-Z902 Blood and blood components* (CSA Blood Standard) as referenced in the *Blood Regulations*
- *Guidance Document: Blood Regulations*
- *Inspection Approach for Blood Establishments (POL-0039)*

A primary responsibility of a Health Canada regulated party is to understand its obligations under the Act and to comply with these requirements. Regulated parties who fail to comply will be subject to compliance and enforcement actions. Health Canada's *Compliance and enforcement policy framework* and the *Compliance and enforcement policy for health products (POL-0001)* can be referenced on the Health Canada website.

2. Scope

This guide applies to all Health Canada inspections of establishments regulated under the *Blood Regulations*.

The *Blood Regulations* apply to human blood that is collected either for transfusion or for use in the manufacture of a drug for human use. Under the *Blood Regulations*, "blood" includes whole blood and blood components.

Manufacturing of drug products using blood or blood components (blood products and blood derivatives) is outside the scope of the *Blood Regulations* and is regulated under the *Food and Drug Regulations*.

3. Assigning risk to an observation

Health Canada inspectors may inspect any party that conducts regulated activities under the *Blood Regulations*. Health Canada inspections are part of a national compliance and enforcement program.

Health Canada's authority to inspect blood establishments comes from sections 22(1) and 23 of the Act.

During an inspection, an inspector notes deficiencies from the applicable requirements of the Act or *Blood Regulations*. These deficiencies may appear as observations on the inspection *Exit Notice* provided to the blood establishment.

The possible risk ratings for observations are:

- Critical observation (Risk 1) -
    - Describes a situation that directly affects the safety of blood and is likely to result in a risk to human health and safety.

      or
    - Describes a situation that involves fraud, misrepresentation or falsification of records or data.
- Major observation (Risk 2) - Describes a situation that may affect the safety of blood and could result in a risk to human health and safety.
- Minor observation (Risk 3) - Describes a situation that is neither critical nor major, but is a deficiency from the applicable requirements in the Act or the *Blood Regulations*.

Inspectors consider the following criteria when classifying an observation:

- potential or immediate risk to human health and safety
- nature of the deficiency
- severity of the harm or potential harm
- number of times the deficiency has occurred
- number of activities or processes impacted
- whether the same deficiency was noted during a previous inspection
- context of the situation

See Appendix A for a list of sample observations Health Canada considers critical (Risk 1), major (Risk 2) and minor (Risk 3).

4. Issuing the Exit Notice

After an inspection, Health Canada issues an *Exit Notice* to the establishment. In this document, if the inspector notes deficiencies from the applicable requirements of the Act or *Blood Regulations*, the inspector lists each observation, their corresponding risk ratings and applicable section(s) of the *Blood Regulations*.

The *Exit Notice* also communicates to the establishment an overall rating of **compliant (C)** or **non-compliant (NC)**. This rating is based on the establishment's level of control of the regulated activities conducted and risk level of the observations.

Establishments must investigate the cause of all observations recorded on the *Exit Notice* and implement corrective and preventive actions within an appropriate timeframe.

5. Compliant and non-compliant inspection ratings

The possible overall inspection ratings are **compliant (C)** or **non-compliant (NC)**.

Compliant (C): At the time of the inspection, the establishment demonstrated that the activities it conducts are in compliance with the Act and the *Blood Regulations*.

A compliant rating does not mean there were no observations or that corrective actions are not required. The overall inspection rating is based on the risk involved, and takes into account the nature and extent of the deficiencies.

Generally, a compliant rating is assigned in the following situations:

- no observations are made
- only minor observations are made
- some major observations are made, but the establishment demonstrated that it is in control of its regulated activities

Non-compliant (NC): At the time of the inspection, the establishment did not demonstrate that the activities it conducts are in compliance with the Act and the *Blood Regulations*.

Situations that may result in a non-compliant rating include:

- a critical observation (Risk 1) is identified
- any attempt by the regulated party to deceive, misrepresent or falsify records or data
- major observations have shown a systemic problem or that the establishment is not in control of its regulated activities
- corrective measures were not implemented for critical or major observations made in previous inspections (e.g. repeat observations)

When a critical observation is noted, Health Canada will require that the establishment take immediate action to mitigate risk(s) to health. Health Canada will direct the establishment to provide an action plan identifying corrective measures to be taken and

time required for implementation. Health Canada will inform the establishment that this may result in a non-compliant rating.

A non-compliant rating can have serious consequences for an establishment that may include the suspension and/or cancellation of an establishment licence and/or registration, as applicable. Health Canada's *Compliance and enforcement policy for health products (POL-0001)* outlines the measures that can be taken when a regulated party fails to comply with regulatory requirements.

In the event that the regulated party wants to dispute the results of the inspection or the final rating, the dispute process is outlined the letter accompanying the *Exit Notice*.

Appendix A – Sample observations with risk ratings

Although the following examples of observations have been assigned a specific risk rating, similar observations could be classified as higher or lower in risk depending on the nature, extent and reoccurrence of the deficiency. These examples are not intended to limit the discretion of an inspector in determining compliance with the Act and *Blood Regulations*, and in practice, each case will be assessed based on the specific facts at hand. For example, observations that are repeated from previous inspections might be assigned a higher risk.

This is not an exhaustive list of observations that may be cited during an inspection.

Section of the *Blood Regulations*

Section 4: Prohibition

Critical

- The establishment distributed autologous blood processed by an unregistered establishment.
- The establishment distributed blood that was transformed by an unregistered establishment.
- The establishment imported, distributed or transfused blood that was not processed by an establishment in accordance with an authorization and determined safe for distribution under subsection 73(1).
- The establishment distributed blood that was under quarantine.

Sections 5 to 16: Authorizations

Critical

- The establishment processed or imported allogeneic blood without an authorization.

Major

- The establishment did not file an annual report with Health Canada describing changes made in the year that could compromise human safety or the safety of blood.
- The establishment did not file an amendment application with Health Canada before making a significant change to an authorized process.

Sections 17 to 29: Establishment Licences

Critical:

- The establishment performed transmissible disease testing for a pre-assessed donor without an establishment licence.
- The establishment processed or imported blood without an establishment licence.

Major

- The establishment did not file an amendment application with Health Canada prior to making a change to their licensed activities.

Minor

- The establishment did not notify Health Canada in writing within 30 days of ceasing a licensed activity.

Sections 30 to 37: Registration

Critical

- The establishment collected autologous blood without a registration.

- The establishment transformed blood without a registration.
- The establishment had a pre-assessed donor program without a registration.

Minor

- The establishment did not notify Health Canada of changes to their registration information in writing within the required time frame.

Sections 38 to 44: Donor Suitability Assessment

Critical

- Allogeneic blood was mistakenly collected due to the assignment of an incorrect deferral code.
- A deferral code was not applied for Human Immunodeficiency Virus (HIV) or Hepatitis C Virus (HCV) and allogeneic blood was collected.
- A donor was not deferred and allogeneic blood was collected after they answered "yes" to a high-risk question, such as "Have you had sex with anyone who has Acquired Immune Deficiency Syndrome (AIDS) or has tested positive for HIV or AIDS?"

Major

- An incorrect deferral code was assigned in which the deferral time frame was shorter than required.
- Documentation for a donor's travel history was inadequate, however blood was collected. For example, the documentation did not include the location and/or duration so malaria risk could not be determined.
- A donor's medication history was not adequately documented.
- For allogeneic collections, the establishment did not obtain sufficient information to determine the presence of risk factors for diseases transmissible by blood. For example, an assessment of the skin at the venipuncture site for the presence or absence of skin lesions was not included.

Minor

- A donor's medication history of daily acetylsalicylic acid (ASA) was not documented. However, the blood was not processed to make platelets.

- Documentation for a donor's travel history was inadequate and a donor deferral code was not applied. Blood was not collected.
- The hematocrit or hemoglobin was not documented.

Sections 45 to 51: Collection

Critical

- The establishment did not collect allogeneic blood in accordance with its authorization.
- Aseptic techniques were not followed during phlebotomy.
- The establishment did not link the donation code for each unit of blood collected to the donor identification code in its records.
- Containers or collection equipment in use were not licensed under the *Medical Devices Regulations*.
- The establishment reused blood containers.

Major

- For autologous donations, the establishment did not adjust the volume of blood collected and amount of anticoagulant used according to the donor's weight.
- Collection procedures did not require the assessment of containers for defects or damage prior to use.
- The establishment did not record container lot numbers and link them to the donation codes.

Minor

- For autologous collections, the establishment did not comply with the criteria set out in section 12.2.1 of the CSA Blood Standard. For example, the establishment did not assess the skin at the venipuncture site.

Sections 52 to 56: Testing

Critical

- The establishment did not test allogeneic blood in accordance with an authorization.

- Transmissible disease testing was not performed according to the manufacturer's instructions.
- The establishment did not quarantine any units of allogeneic blood collected from a donor whose blood tested repeat reactive for a transmissible disease agent or marker.
- The establishment did not notify every establishment to which it distributed blood from a donor that tested repeat reactive for a transmissible disease agent or marker.

Major

- The establishment did not use medical devices licensed in accordance with the *Medical Devices Regulations* when testing autologous blood.
- The establishment did not have documents demonstrating that the physician of an autologous donor was notified of a positive test result for a transmissible disease.
- An autologous donor's blood was not tested for transmissible diseases when the autologous blood collection was performed more than 42 days after the previous autologous donation.

Sections 57 to 58: Blood Component Preparation

Critical

- The establishment did not prepare allogeneic blood components in accordance with its authorization.
- Processing methods used to prepare autologous donations did not maintain the sterility of the blood.

Major

- Red blood cells, not in a nutrient solution, were frozen after 7 days without rejuvenation.
- The establishment did not prepare autologous blood components according to their procedures.

Sections 59 to 68: Labelling

Critical

- The ABO group and Rh factor were incorrectly labelled.

Major

- Required information did not appear on the label of aliquoted blood for transfusion.
- The statement “For Autologous Use Only” did not appear on the label of autologous blood.

Minor

- The registration number and the approximate volume of the whole blood collected did not appear on the autologous blood label.
- The name of the establishment that collected blood was not on the label.
- The establishment did not verify the information it added to the label.

Sections 69 to 72: Storage

Critical

- No actions were taken following a significant temperature deviation in the released plasma storage freezer and product was distributed.
- The establishment did not maintain distributed blood under appropriate environmental conditions.

Major

- The establishment did not have records to demonstrate that storage equipment was consistently monitored. However, there were no temperature excursions that activated the alarms.
- The establishment did not segregate autologous blood from allogeneic blood.

Sections 73 to 76: Distribution

Critical

- Allogeneic blood was distributed prior to determining its safety.
- Distributed blood was not tested for a required infectious disease marker.

Major

- The legibility of the label and integrity of the blood container were not examined prior to distribution.
- Shipping containers used to transport blood were validated to transport over a specified period. However, blood transport times routinely exceeded this time period without any safety assessment of the blood.

Minor

- Shipping containers used to transport frozen blood components were not qualified for their intended use; however, the establishment was able to demonstrate that the safety of blood was not impacted.

Sections 77 to 80: Transformation

Critical

- The expiration date of the pooled components, prepared using a closed system, exceeded the expiration of the oldest component in the pool.
- A unit of pooled platelets, prepared using an open system, was labelled with an expiry greater than 4 hours after preparation.

Major

- The dose delivery of the irradiator was not verified and documented as required by the irradiator manufacturer; therefore, it could not be confirmed if blood was exposed to the required dose.
- The establishment could not verify that every irradiated blood component received the required dosage of irradiation.

Minor

- The label for the washed red blood cells did not include the licence number of the collecting establishment.
- The label for pooled red blood cells with thawed plasma did not include the number of units and the ABO type of the plasma used in the pool.
- Components requiring irradiation were labelled as irradiated products prior to performing the irradiation.
- The total volume of the pooled cryoprecipitate on the label did not represent the actual volume of the units of cryoprecipitate and saline contained in the pooled unit.

Sections 81 to 85: Exceptional Distribution

Critical

- The establishment did not have documentation to demonstrate blood without all required test results was distributed using exceptional distribution.
- Blood released under exceptional distribution was stored and then transfused into a recipient who was not the intended recipient.

Major

- The labelling for blood distributed under exceptional distribution did not indicate that the required testing was incomplete.

Minor

- The notice of exceptional distribution did not include the name of the establishment and the signature of the medical director.

Sections 86 to 91: Pre-assessed Donor Programs

Critical

- The establishment did not have documentation to demonstrate there was no alternative source of blood available for a recipient of pre-assessed donor blood.
- A pre-assessed donor did not have donor suitability assessment and testing performed every 3 months.

Major

- The establishment did not have documentation to demonstrate that the latest ABO group and Rh factor results were compared to the last available results for a pre-assessed donor.
- The label for blood collected from a pre-assessed donor was incomplete.

Section 92: Importation in Urgent Circumstances

Critical

- The establishment imported allogeneic blood in an urgent circumstance without meeting the requirements.

Sections 93 to 94: Quality Management System

Critical

- The establishment did not have a system for recalling distributed blood when high-risk behaviour in a donor was identified or could not be ruled out.
- The disposition of a recalled unit of blood could not be determined.
- The testing laboratory did not have systems and controls in place for the proper qualification, operation, calibration and maintenance of equipment, standards, solutions, and record keeping to assure that the results generated are accurate, precise and reliable.

Major

- The licensed or registered establishment did not have an adequate Quality Management System in place.
- Internal audits were conducted by individuals who have direct responsibility for the audited activities.
- The establishment did not have a process for managing deviations from operating procedures during component preparation.
- The establishment's process for retrieving distribution records did not permit the prompt recall of blood.
- The establishment did not perform any quality control testing for washed red blood cells.

Minor

- The internal audit did not assess transformation activities.
- The current system for error/accident investigation and reporting does not include all requirements of sections 103 to 108 of the *Blood Regulations*.
- Excel spreadsheets containing calculation formulas, used when performing transformation activities, were not validated.

Sections 95 to 97: Operating Procedures

Critical

- The establishment did not have a documented procedure or process for performing donor suitability assessment.

Major

- The establishment did not have a documented procedure for reporting suspected errors and accidents to all relevant establishments, as required.
- Operating procedures were not readily available at all locations where related activities were conducted.
- The establishment did not have a documented procedure to ensure that blood was correctly labelled.
- The establishment did not have a documented procedure for a registered activity (e.g. washing red blood cells).
- The establishment did not have documented evidence to show that the procedure used for washing red blood cells would consistently remove almost all of the plasma, as required by clause 7.5.3.1 of the CSA Blood Standard.

Minor

- The procedure for performing blood collection did not require a review of the donation record prior to the collection.
- Operating procedures did not include some required steps performed during component preparation.
- Contrary to the operating procedure, the date and time of irradiation was documented on the label prior to performing the irradiation.

- Operating procedures were not always kept up to date.
- While observing whole blood collection, some steps in the operating procedure were not followed.
- Protein electrophoresis testing was not performed on an apheresis donor who was donating more than 4 months after their last donation.

Section 98: Personnel

Critical

- The individual conducting donor suitability assessment was not qualified by their education, training or experience.

Major

- The establishment did not have documentation to demonstrate training and competency evaluations were performed for relevant staff with regards to certain procedures.

Minor

- Training records were not updated to reflect changes to procedures and/or training requirements.
- It could not be confirmed whether staff were trained on updated versions of procedures prior to their implementation.
- Training records were incomplete for some staff members. For example, version numbers of procedures were not indicated in training records.

Section 99: Facilities

Critical

- Unauthorized personnel had access to blood testing laboratories or component preparation areas.
- The warehouse storage area was noted to have rodent and insect infestations.

Major

- Donor screening was not conducted in privacy.

Minor

- Access to the storage area of critical supplies was not always controlled.
- Clinic site evaluation inspections (permanent and mobile) were not conducted at the required frequency.
- Monthly facility cleaning was not always being conducted.

Section 100: Equipment

Critical

- There was no maintenance or calibration of any critical equipment.
- Critical equipment was used despite evidence of a malfunction.
- Testing equipment or computerized blood system was used without validation for its intended purpose.

Major

- Routine calibrations or preventive maintenance were not performed on critical equipment.
- Critical equipment did not always operate within its specifications.
- Critical equipment was not revalidated after it was relocated.

Minor

- Sections of the preventive maintenance form pertaining to cleaning of equipment were not completed.
- The annual preventive maintenance was overdue.
- It could not be confirmed that a piece of equipment was not used while placed out of service.

Section 101: Storage Equipment

Critical

- The refrigerator used to store blood did not maintain the appropriate temperature as per section 69 of the *Blood Regulations*.

Major

- The establishment did not have sufficient documentation to demonstrate the single temperature probe was positioned based on the worst case location.
- The establishment did not have documentation to demonstrate the blood storage refrigerator had been qualified.

Minor

- The high and low temperature alarm activation set points for the walk-in blood storage refrigerator did not allow sufficient time for staff members to take appropriate actions to maintain the blood components at their required storage temperature of 1-6°C.

Section 102: Supplies

Major

- The establishment did not have documentation to demonstrate any of their critical supplies had been qualified.
- The establishment did not have documentation to show that open boxes of irradiation labels did not exceed the storage requirements specified in the product insert.
- The expiry dates of critical supplies were not strictly observed.

Minor

- The establishment did not have documentation to demonstrate a critical supply had been qualified.

Sections 103 to 116: Error, Accident and Adverse Reaction Investigation and Reporting

Critical

- The establishment did not investigate an unexpected or serious adverse reaction attributable to an activity it carried out.

- The establishment did not investigate an error or accident attributable to an activity they performed which had a reasonable probability of resulting in a serious adverse reaction.
- The establishment did not immediately quarantine all implicated blood following receipt of an error or accident notice and implicated blood was distributed and/or transfused.

Major

- The establishment did not submit an error and accident report to Health Canada following the transfusion of a unit of blood when the storage conditions of the unit were unknown for three days.
- The establishment conducting an investigation into a serious or unexpected adverse reaction did not report to Health Canada within 15 days after it learned of the adverse reaction.
- The establishment did not immediately quarantine all implicated blood following receipt of an error or accident notice and implicated blood was not distributed.

Minor

- The establishment did not prepare an annual report summarizing all of the errors and accident investigations that were conducted in the last 12 months.
- The establishment did not prepare an annual report summarizing all final adverse reaction reports filed in the year.

Sections 117 to 123: Records

Critical

- Distribution records for allogeneic blood did not enable the traceability of blood.

Major

- The establishment stored records in a location that was not secured against the entry of unauthorized persons.
- Records were discarded before the minimum retention period as required by the *Blood Regulations*. For example, disposition records for allogeneic blood were discarded after 10 years, rather than the required 50 years.

- The donation code was inconsistently documented in the establishment's records.

Minor

- The shipping records contained some documentation errors.
- There was no supervisor sign-off for daily equipment cleaning records.
- Incorrect instrument serial numbers were referenced in laboratory records.
- Daily temperature monitoring results were not always documented.
- Preventative maintenance records for equipment were not always accurate or complete.
- Scanned records were missing some information.

Appendix B – Glossary

Terms

These definitions explain how terms are used in this document. If there is a conflict with a definition in the *Food and Drugs Act or Blood Regulations*, the definition in the Act or *Blood Regulations* prevails.

Exit Notice: A report listing the observations and/or violations of the *Food and Drugs Act* and Regulations found during an inspection.

Inspection: Monitoring and assessment against the applicable requirements of the *Food and Drugs Act* and its associated regulations. Inspections are routinely conducted based on risk to assess compliance.

Observation: A deficiency in compliance with the Act or the *Blood Regulations* noted during the inspection of an establishment and that is documented in the inspection report (*Exit Notice*). An observation is classified according to the level of risk associated with the deficiency.

Appendix C – References

Laws and Regulations

Food and Drugs Act
http://laws-lois.justice.gc.ca/eng/acts/f-27/

Blood Regulations
http://laws-lois.justice.gc.ca/eng/regulations/SOR-2013-178/page-1.html

Medical Devices Regulations
http://laws-lois.justice.gc.ca/eng/regulations/SOR-98-282/

CAN/CSA-Z902 – Blood and Blood Components
https://store.csagroup.org/ccrz__ProductDetails?viewState=DetailView&cartID=&sku=2702081&isCSRFlow=true&portalUser=&store=&cclcl=en_US

Guidance documents and policies

Compliance and enforcement policy for health products (POL-0001)
https://www.canada.ca/en/health-canada/services/drugs-health-products/compliance-enforcement/good-manufacturing-practices/policies-standards/compliance-enforcement-policy-0001.html

Compliance and enforcement policy framework
https://www.canada.ca/en/health-canada/corporate/mandate/regulatory-role/what-health-canada-does-as-regulator/compliance-enforcement-framework.html

Guidance Document: Blood Regulations
https://www.canada.ca/en/health-canada/services/drugs-health-products/biologics-radiopharmaceuticals-genetic-therapies/applications-submissions/guidance-documents/blood-regulations/guidance-document-blood-regulations-1.html

Inspection strategy for blood establishments (POL-0039)
https://www.canada.ca/en/health-canada/services/drugs-health-products/compliance-enforcement/information-health-product/blood-donor/inspection-strategy-blood-establishments-0039-summary.html