cc: Mr. [illegible] Mr. F. Roberts. Centers look good now!

REVLON HEALTH CARE GROUP INTEROFFICE MEMORANDUM

A0000105/1

DATE: April 27, 1983

TO: Mr. W. Biles

FROM: S. H. Mueller

SUBJECT: TRIP REPORT - PLASMA ALLIANCE REVIEWS

C.C. Mr. J. Cundall
Mr. S. T. Foster
Mr. D. Hill
Mr. R. C. Johnson
Mr. D. Miller
Dr. M. Rodell
Mr. J. Sedor
Dr. C. Swartz
Mr. W. Weathersby

On April 20 - 22, 1983, I visited five Plasma Alliance Centers in Indiana and Ohio, accompanied by Mr. J. Cundall and Mr. D. Hill. Each center was toured physically, and basic operating and documentation systems were reviewed at each. Plasma Alliance's current program for screening donors who are at high risk re AIDS was discussed with the Center Managers. Informed consent (involving senior citizen physicians) was observed at two centers. The centers we visited were West Lafayette, Indianapolis, Columbus, Akron and Cleveland.

Overview: Each of the centers we visited was clean, well-organized, and quite professional in appearance. The personnel I met were knowledgeable and aware of current regulatory issues. The centers' operations conform to current regulatory requirements. Appropriate controls are in place to assure donor safety and product quality, screen out inappropriate potential donors, prevent overly-frequent donations, and to limit overbleeding.

The Plasma Alliance organization as a whole benefits from a good working relationship between Operations and QA/QC personnel. This is evident both at Knoxville (which I visited during December 1982) and at the centers. All centers are regularly audited by Knoxville QA, and each center has a QC person on staff, who reviews center records and procedures. This combination of activities provides for continuous feedback to Knoxville management and the Center Managers, and has clearly helped PA assure a good level of operational uniformity. It is certainly worth noting that PA's FDA inspectional track record recently has been excellent.

Facilities/Equipment: The centers we visited are located either adjacent to university campuses or in near-downtown areas. All of the locations appeared to be acceptable, i.e., the neighborhoods seemed relatively stable and did not evidence adverse street activities.

continued. . . . . .

Rx-5527-8

The donors we saw were both students and neighborhood residents; donor groups were orderly in behavior. All of the centers have good lighting, are clean, and appear to be freshly painted. This serves to make a good impression on visits from regulatory agencies, contract firms (for immunization programs), as well as donors.

The centers visited range in size from 60 to 86 beds, with staffs (excluding physicians) ranging from 33 to 64 persons. The centers generally have good layouts which minimize overcrowding and facilitate proper operations; the Cleveland center would appear to be prone to some overcrowding, especially around the control desk area. The centers usually begin donor operations by 7 am daily, with personnel arriving earlier to perform calibrations and set-up work. The centers visited generally operate until early evening (6:30 to 7 pm) three days per week.

Equipment at the centers is in generally good condition. The key equipment in use includes a) dietary-type scales, to weigh units during phlebotomy, b) centrifuges, c) plasma bottle sealers, d) flash freezers, and e) storage freezers. Scale accuracy is checked twice daily using a 500 gram weight, and adjustments are made as necessary. Centrifuge temperature and RPM readings are recorded daily, and temperature gauge accuracy is checked monthly via an NBS-traceable thermometer. A new program to check centrifuge RPM accuracy has been implemented - this is done stroboscopically via small windows in the centrifuge covers (not all centrifuges have been fitted with windows at this time). Freezer temperatures are recorded continuously via chart recorders; temperature checks of freezers and flash freezers are made daily. All calibration and check records are reviewed and maintained by center QC persons. Equipment requiring repair is sent to Knoxville via one of the company-owned trucks.

One potential action item that arose concerns calibration of the dietary scales. Some records showed that relatively large, alternating, positive and negative corrections are occasionally necessary on some scales; at some point such scales are considered to be malfunctioning and are taken out of service. At present, no central guideline exists to define scale malfunction and effect removal of a scale from service - this is judgemental at each center. From examination of a scale mechanism it would appear that small corrections (approximately 1 - 5 grams) are occasionally inevitable under normal conditions of use, but that large corrections could indicate a mechanical problem requiring disassembly and repair (such as slippage of a saw-tooth drive bar which moves the scale pointer gear). It appears that some guideline or SOP concerning this is needed; this was discussed with Jim Cundall, and will be reviewed by Knoxville.

Operations/Documentation: All of the centers visited were using uniform procedures in compliance with PA policies and SOP's. New donors are photographed after presenting adequate identification, and receive a pre-donation physical exam, at which time informed consent is obtained. Repeat donors are identified via their filed photographs. In locations where other plasmapheresis operations exist nearby, centers exchange information concerning permanently-rejected donors, and also use a UV-fluorescent finger stain to detect and prevent overly-frequent multi-center donations. All donors are screened on each visit, for blood pressure, pulse, weight, temperature, hematocrit, evidence of drug

continued. . . . . .

abuse, and symptoms of hepatitis or other diseases which would affect ability to donate. Long term donors receive annual physical examinations. Blood protein is determined (by the Knoxville lab) via electrophoresis on the first visit and every four months thereafter for an active donor.

Donors are given pre-numbered blood-pack units by the control desk personnel; the numbering system identifies whether the donor is light (under 175 lbs.) or heavy, based on the screening weight. Red cells from the first unit drawn are re-infused prior to second unit withdrawal. The donor is an active participant in identifying his or her own red cells (via signature and number); additionally, each unit has a 'key' attached which must mate with a lock mechanism at the bed before cell infusion can begin.

The documentation system employed by PA is excellent, and the centers demonstrated uniform adherence. Each center maintains individual folders for each donor; the folders include the following: a) a donor identification card, which shows name, address, sex, height, age, blood group and type, employer, identification documents used, and which includes the donor's photograph; b) a plasmapheresis donor product card, which shows the screening data, bleed numbers, bleed times, amount donated, and initials for key operations; c) signed informed consent statements, for regular donations and immunization programs, if any; and d) the record of medical exams and protein electrophoresis data.

Sample donor record folders, selected at random, were reviewed at each center, and each was found to be essentially well-kept and complete. At one center, one folder for a donor who was temporarily rejected due to high blood pressure did not have BP readings on the donor product card - the data was on the donor ID card, however.

Each center was found to maintain a daily log of rejected donors, and the information correlated with donor folders. The QC person at each center is responsible for reviewing donor record folders for completeness; these records are also regularly reviewed during internal audits.

AIDS: Plasma Alliance has implemented a program to screen out high risk donors, per current FDA requirements. A fact sheet concerning AIDS has been posted in each of the screening booths. Donor product cards now include a screening question to determine whether a donor is in a high risk group. Also, each donor is being asked to sign a questionnaire verifying that they have read the AIDS fact sheet and that they do not belong to a high risk group. The signed questionnaire is being kept in the donor record folder.

Each of the Center Managers I spoke with thought that the program was working reasonably well. Each reported that some donors have voluntarily eliminated themselves from the program. The screening questionnaire has not caused any adverse donor response, and in fact, apparently has engendered some serious conversations about AIDS among donors and potential donors. Center Managers advised that in some cases they personally spoke to donors who they suspected of being in a high risk group (after the donors signed the questionnaire to the contrary), and these donors also voluntarily withdrew. I was quite impressed by the sensitive fashion in which Center Managers are approaching this task - also, their responses are indicative of the prompt manner in which the PA organization is able to implement a new program to a high degree of uniformity. I understand that screening personnel will soon be checking cervical glands for lymphadenopathy, per FDA request.

continued. . . . . .

Informed Consent: I had an opportunity to observe (with the donors' permission) informed consent at two centers (West Lafayette and Cleveland); each had their full-time physician present. Both physicians did a good job of explaining the procedures, risks, and PA controls. Both were quite responsive to donor questions, and worked fine with an observer present. It was interesting to note that both physicians had different approaches in obtaining informed consent; it would appear that there could be more variability here than in any other area of center operations. The variability is not a problem per se; however, it does require that Knoxville plan audit visits such that both full-time and part-time physicians are reviewed. Overall, I do not think that a general problem exists with informed consent - there still may be some physicians who become nervous when observed, and if so, training should alleviate any problems.

At this point, I plan to tour additional centers later on in the year (most likely the 4th quarter). Plasma Alliance personnel were quite courteous and cooperative, and I appreciate their efforts in facilitating these visits.

GRO-C

SHM/pas Stewart H. Mueller