

Risk assessment of pharmaceutical preparations control process by FMECA methodology



Feasibility study

Control

Request for

control

Léa Savio¹, Lucile Durroux¹, Laurent de Brito¹, Yassine Bouattour², Valérie Sautou², Philip Chennell²

¹CHU Clermont-Ferrand, Pôle Pharmacie, 63000 Clermont-Ferrand, France. ²Université Clermont Auvergne, CHU Clermont-Ferrand, CNRS, SIGMA Clermont-Ferrand, ICCF, 63000 Clermont-Ferrand, France.

Context and Objectives

The main activity of the control laboratory affiliated to our university hospital is to transmit information to its customers regarding compliance with the specifications of a batch of pharmaceutical preparation.

Objectives:

- to identify failure modes
- → to assess their potential impact on the process
- → to take appropriate corrective actions

Material and Method

June January **Applying FMECA method** 2021 2021 (Failure Mode, Effects and Criticality Analysis)

- Multidisciplinary team
- For each identified failure mode, assessment of the impact on: the information/preparations/the laboratory/the customers
- Severity was rated on a scale constructed by the team (example of the laboratory below)

Severity	Impact on the laboratory	Severity	Impact on the laboratory
2	No impact Image (loss of business, discredit, opportunity)	3	Production (loss of time,
			disorganization, equipment issues)
		4	Safety, security, environment

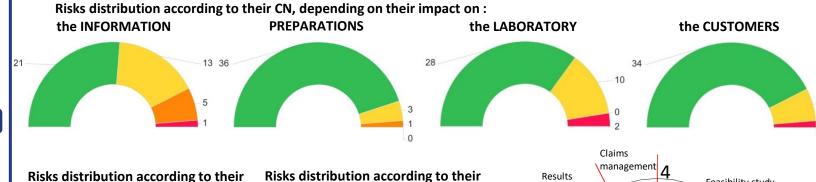
Sum of the relative severities of the different impacts = **Total severity**

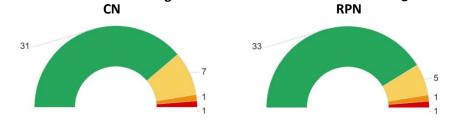
Critical Number (CN) = Occurrence x Total Severity

Risk Priority Number (RPN) = CN x Detection

Results

→ 40 failure modes identified: mainly concerned control (42.5%), feasibility study (20%) and pharmaceutical validation (12.5%) steps





- 1 critical risk, 1 major, 7 (5)* moderate and 31 (33)* low
 - * after taking detection into account
- > Control request step appears to be the most at risk
 - Small difference between CN and RPN, explained by weak means of control, leaving a large field for improvement

Means of control evaluation, according to realisation reliability, supervision, formalisation and relevance of the existing means of control

validation

transmission

Conclusion

Further development of quality culture - Highlight of the elements most affected by the failure through the separation of impacts into 4 categories and subjectivity limitation - Weakness of the means of control identification - Priorities for action and targeted corrective actions definition