RISK MANAGEMENT

Jaap Koster
AGENDA

- Introduction to Risk Management
- Basic Principles of Risk Management
- FMEA-technique
- Risk Ranking Technique
- Preliminary Risk Analysis
INTRODUCTION TO RISK MANAGEMENT
DANGER / RISK

- What is the difference between danger and risk?
- What is danger?
- What is risk?
Danger:
A real or potential situation that can lead to damage to people or organizations either directly or in the long-term. This includes the loss off or damage to a system, equipment, property or other valuable items.

Danger depends on:
- Exposure
- Effect
**Risk:**

Risk is the probability of an event occurring, multiplied by the effects of the event and the chance that a certain scenario containing the event will happen. This is in contrast to insecurity, where chances are unknown.

The event can either be positive or negative, on most occasions the word ‘risk’ is used in a negative context.

Risk can also be calculated as the exposure multiplied by the effects and probability. This ‘calculation’ is especially useful for long processes, the first definition can mostly be applied to sudden processes.
Risk = Chance \times Gravity (Seriousness) \times Possibility of Detection
ASPECTS OF RISK

- Insecurity
- Subjectivity
- Persons Involved
TYPES OF RISK

• Acceptable Risk
• Remaining Risk
• Unacceptable Risk
• Unidentified Risk
• Unknown Risk
BASIC PRINCIPLES OF RISK MANAGEMENT
REGULATIONS

ICH Q9

Risk Management Tools

Risk Communication

Risk Assessment
- Risk Identification
- Risk Analysis
- Risk Evaluation

Risk Control
- Risk Reduction
- Risk Acceptance

Output/result of Quality Risk Management Process

Risk Review
- Review Events

Initiate
• Clearly define the problem/question

  – **System to Investigate ("the case")**
  – Risk question
  – Scope
    - What part/process (logistical, production, purchasing, ...)
    - “nature” of the analysis (microbiological, parameters, attributes ?)
    - Analysis only ?
    - Performing risk reducing actions
  – Define the goal
Compile a team

- Facilitator
- Experts (SME – Subject Matter Expert)
- Knowledge / training
- Interdisciplinary
- Team size
INITIATE RISK MANAGEMENT PROCESS

• Ensure you have a **SPONSOR**
  - Time = man hours
  - FMEA’s can be time consuming and long-lasting (selecting a scope)

• Ensure you have a well-defined goal
• Select an appropriate **risk analysis technique**
  - Define the criteria
• Clearly define the method
• Compile information / documentation
• Define (intermediate) reporting with the sponsor
RISICO ANALYSIS / RISK ASSESSMENT

• Identify possible dangers/risks
• Identify how critical the risks are
  – Qualitative
  – Semi-Qualitative
  – Quantitative
• Perform **Risk Evaluation:**
  – Compare Result to the Criteria
• If needed, perform a “Sanity Check”
  – Do the reality and perception match up?
RISK CHECKING

Determine:

• If a risk is acceptable
• If the risk(s) need(s) to be reduced
• Prioritize the risks to be reduced
RISK CHECKING

- **Identify** possible risk prevention measures
  (Preventative measures)
  - Reduce the possible amount of occurrences
  - Reduce the severity of the events
  - Increase the identification possibility

- **Re-evaluate** the measures
  - Have no new risks arisen?
  - Am I reaching the right goal?

- **Implement** the risk prevention measures
RISK COMMUNICATION

• Reporting:
  – A Report records the situation at a certain moment in time (short shelf life)
  – How to revise / when to revise?
  – In what system does a report need to be recorded?
  – What is the standard lay-out?
  – According to the assignment

• Communication
  – Report to sponsor / principal
  – Inform concerned parties
"They always give us minimum-wage, part-time guys the riskiest jobs."
• Risk management is a non-interchangeable component of the QMS (Quality Management System)

• Implement Risk Management in Existing Systems:
  – Annual Product Review
  – Deviation management
  – Change control
  – Monitoring System for water, HVAC, EM
  – ........
RISK ANALYSIS TECHNIQUES

- Failure Mode Effect (Criticality) Analysis (FME(C)A)
- Fault Tree Analysis (FTA)
- Hazard Analysis and Critical Control Points (HACCP)
- Hazard Operability Analysis (HAZOP)
- Preliminary Risk Analysis (PRA)
- Preliminary Hazard Analysis (PHA)
- Risk Ranking & Filtering Method
- Intuitive (i.e. SME’s)
FMEA

• Basic Principle:
  – RPN (Risk Priority Number)
    = C (chance) x S (severity) x D (detectability)

• (Others: LxFxD)

• Ask:
  – What can go wrong?
• Gather as much detailed process information as possible concerning “the case”.
• Check if the information is correct
• Is all information that is related to the scope (i.e. Microbiological view) present?
• It all comes down to detail(s).
1. Consecutively: divide –if not done already- the process/system into steps (pay attention to the numbering)

<table>
<thead>
<tr>
<th>Process-step</th>
<th>Fault/failure</th>
<th>Cause failure</th>
<th>Existing Measures</th>
<th>P</th>
<th>S</th>
<th>D</th>
<th>RPN</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Materials are received</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Compare to order</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Creating labels (identity)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2. Assess the pit-falls and why are they existing?

<table>
<thead>
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<th>D</th>
<th>RPN</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Creating labels</td>
<td>3.1 Wrong label</td>
<td>Faulty data input</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Wrong label</td>
<td>Wrong label in machine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Wrong label</td>
<td>Old data still in the labelprinter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### FMEA

3. Welke maatregelen zijn al aanwezig

<table>
<thead>
<tr>
<th>Process-step</th>
<th>Fault/ failure</th>
<th>Cause failure</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Wrong label</td>
<td>Wrong label in machine</td>
<td>Machine Output: Error</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Wrong label</td>
<td>Old data still in the labelprinter</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Determine the chance that the situation occurs

   Numerical (real numbers)
   Semi-quantitative (1,3,5 of 1 to 10). Never Use 1,2,3!!
   Qualitative (L, M, H)

<table>
<thead>
<tr>
<th></th>
<th>It’s unlikely this fault will occur</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The fault can occur but only on few occasions</td>
</tr>
<tr>
<td>5</td>
<td>It is highly likely the fault will occur</td>
</tr>
</tbody>
</table>
4. Determine the chance of occurrence:

<table>
<thead>
<tr>
<th>Process-step</th>
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<th>Cause failure</th>
<th>Existing Measures</th>
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</thead>
<tbody>
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<td>Faulty data input</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.2 Wrong label</td>
<td>Wrong label in machine</td>
<td>Machine Output: Error</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.3 Wrong label</td>
<td>Old data still in the labelprinter</td>
<td>N/A</td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Determine the severity of the event:

- Numerical (real numbers)
- Semi-quantitative (1, 3, 5 of 1 to 10). Never Use 1, 2, 3!!
- Qualitative (L, M, H)

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>This fault can have a possible, minor influence on the process</td>
</tr>
<tr>
<td>3</td>
<td>This fault can have a mild influence on the process</td>
</tr>
<tr>
<td>5</td>
<td>This fault will have major consequences for product quality and will negatively influence the quality</td>
</tr>
<tr>
<td>Process-step</td>
<td>Fault/ failure</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>3. Creating labels</td>
<td>3.1 Wrong label</td>
</tr>
<tr>
<td></td>
<td>3.2 Wrong label</td>
</tr>
<tr>
<td></td>
<td>3.3 Wrong label</td>
</tr>
</tbody>
</table>
6. Determine the detection possibility

   Numerical (real numbers)
   Semi-quantitative (1, 3, 5 of 1 to 10). Never Use 1, 2, 3!!
   Qualitative (L, M, H)

<table>
<thead>
<tr>
<th></th>
<th>The fault can be detected in advance 100% and the process can be adjusted in time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>There is a possibility the fault can be detected and that the process can be adjusted in time</td>
</tr>
<tr>
<td>5</td>
<td>The fault will most likely not be detected / is detected too late or cannot be influenced</td>
</tr>
<tr>
<td>Process-step</td>
<td>Fault/failure</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>3. Creating labels</td>
<td>3.1 Wrong label</td>
</tr>
<tr>
<td></td>
<td>3.2 Wrong label</td>
</tr>
<tr>
<td></td>
<td>3.3 Wrong label</td>
</tr>
</tbody>
</table>
7. Calculate the RPN
8. Explain why the score has been made

<table>
<thead>
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<th>Process-step</th>
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<th>D</th>
<th>RPN</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Creating labels</td>
<td>3.1 Wrong label</td>
<td>Faulty data input</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>75</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>3.2 Wrong label</td>
<td>Wrong label in machine</td>
<td>Machine Output: Error</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>3.3 Wrong label</td>
<td>Old data still in the labelprinter</td>
<td>N/A</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>45</td>
<td>...</td>
</tr>
</tbody>
</table>
## FMEA

**RPN, Risk Priority Number**

<table>
<thead>
<tr>
<th>Risk Value</th>
<th>Risk of contamination of the product</th>
<th>Preventative measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥75</td>
<td>Very High. There is a large chance that the quality of the product is endangered with this approach</td>
<td>Direct action needs to be taken production needs to be halted</td>
</tr>
<tr>
<td>26-74</td>
<td>Medium. There is a chance that the product quality cannot remain/be ensured.</td>
<td>Preventative measures have to be taken</td>
</tr>
<tr>
<td>6-25</td>
<td>Low, the risk of adverse effects on the quality of the product is low.</td>
<td>Where possible, preventative actions need to be taken to reduce the possibility</td>
</tr>
<tr>
<td>1-5</td>
<td>Very low, the risk to the quality of the product is very low</td>
<td>No actions needed, acceptable risk</td>
</tr>
<tr>
<td>0</td>
<td>None; there is no risk to the product</td>
<td></td>
</tr>
</tbody>
</table>
Kan niet vertalen?
Julian Koster; 20/05/2015
9. Propose possible preventative measures, examine their effectiveness.

<table>
<thead>
<tr>
<th>Process step</th>
<th>Fault/failure</th>
<th>Cause failure</th>
<th>Existing Measures</th>
<th>P</th>
<th>S</th>
<th>D</th>
<th>Measure</th>
<th>P'</th>
<th>S'</th>
<th>R'</th>
<th>RPN'</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Creating labels</td>
<td>3.1 Wrong label</td>
<td>Faulty data input</td>
<td>N/A</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>Operator 2 Check</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>3.2 Wrong label</td>
<td>Wrong label in machine</td>
<td>Machine Output: Error</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>N/A</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>3.3 Wrong label</td>
<td>Old data still in the label printer</td>
<td>N/A</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>Adjustment of System</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>
If not a process, but a machine or utility:

- Define the individual components
- Number those
- Continue with the same approach as discussed above, but not process-step wise, but component wise.
FMEA

• **Advantages**
  – Structured
  – Qualitative and (semi)-quantitative
  – Provides a good tool for evaluating possible preventative measures
  – Widely adopted, well known
  – Highly applicable to a large number of situations/cases/etc.

• **Disadvantages**
  – Less suitable for creating interactions
  – Can lead to excessively large analyses, that will be hard to read/understand and maintain in the long run
  – Longevity (many man-hours)
Usage:

Wide range of suitable situations:

• Equipment
• Computerized Systems
• Production processes
• Ask:
  – What should and should not be done?
  – What has the highest priority?
1. Determine critical factors (qualifiers) related to the question

**Question: What are the critical raw-materials?**

- Originating from an animal (TSE sensitive yes/no?)
- Use of raw-material in the production process
- Quality of the raw-material
RISK RANKING METHOD

2. Determine criticality per qualifier
   - can also be done qualitatively (yes/no, L/M/H)
## RISK RANKING METHOD

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>L</th>
<th>M</th>
<th>H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Animal Origin</td>
<td>No</td>
<td>Yes, non-cow</td>
<td>Cow</td>
</tr>
<tr>
<td>Used in the process</td>
<td>Is purified</td>
<td></td>
<td>Used in final product</td>
</tr>
<tr>
<td>Quality of Raw-material</td>
<td>USP/ EP</td>
<td>Other pharmacopoeia</td>
<td>No pharmacopoeia</td>
</tr>
</tbody>
</table>
## RISK RANKING METHOD

<table>
<thead>
<tr>
<th>Qualifier</th>
<th>L</th>
<th>M</th>
<th>H</th>
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<td>Quality of Raw-material</td>
<td>USP/EP</td>
<td>Other pharmacopoeia</td>
<td>No pharmacopoeia</td>
</tr>
</tbody>
</table>
3. Determine the calculation method for the Total Value
   - Sum up or multiplying
   - Use weighted factors

4. Determine criteria of the Total Value

<table>
<thead>
<tr>
<th>Total value</th>
<th>Criticality of RAW material</th>
<th>Preventative Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Not Critical</td>
<td>No measure needed</td>
</tr>
<tr>
<td>5</td>
<td>Barely Critical</td>
<td>Risk is acceptable, measures can be taken, however this is not necessary</td>
</tr>
<tr>
<td>6-7</td>
<td>Critical</td>
<td>Raw materials need to be fully analyzed</td>
</tr>
<tr>
<td>&gt;8</td>
<td>Very Critical</td>
<td>Raw materials need to be fully analyzed and the supplier needs to be audited</td>
</tr>
</tbody>
</table>
JK3  Geen directe vertaling
Julian Koster; 20/05/2015

JK4  Kan niet vertalen, is afbeelding, bron?
Julian Koster; 20/05/2015
5. Make a list of subjects that will be ranked
   Make sure this list is complete!

<table>
<thead>
<tr>
<th>Raw-Material</th>
<th>Animal Origin?</th>
<th>Usage in Production -Process</th>
<th>Quality of Raw Material</th>
<th>Total Value</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal serum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mannitol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CaCl₂</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Determine the score per quality-parameter

<table>
<thead>
<tr>
<th>Raw-Material</th>
<th>Animal Origin?</th>
<th>Usage in Production -Process</th>
<th>Quality of Raw Material</th>
<th>Total Value</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal serum</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mannitol</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CaCl&lt;sub&gt;2&lt;/sub&gt;</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Determine acceptable criteria of the Total Value (i.e. How will you process the total value?).

This can be numerical as well:

<table>
<thead>
<tr>
<th>Total value</th>
<th>Criticality of RAW material</th>
<th>Preventative Measures</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Diapositive 51

JK5  Idem
     Julian Koster; 20/05/2015
### RISK RANKING METHOD

7. Calculate the Total Value
   Calculation: origin x usage x quality

<table>
<thead>
<tr>
<th>Raw-Material</th>
<th>Animal Origin?</th>
<th>Usage in Production -Process</th>
<th>Quality of Raw Material</th>
<th>Total Value</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal serum</td>
<td>5</td>
<td>1</td>
<td>3</td>
<td>15</td>
<td>Very critical</td>
</tr>
<tr>
<td>Mannitol</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>7</td>
<td>critical</td>
</tr>
<tr>
<td>CaCl₂</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>Not critical</td>
</tr>
</tbody>
</table>
PRELIMINARY RISK ANALYSIS
PRELIMINARY RISK ANALYSIS

- **Properties:**
  - No formalized structure
  - Multidisciplinary
  - Intuitive

- **Advantages:**
  - Can be used to identify risks quickly and soon
  - Can be used as a pre-selection for FMEA studies
  - Easy to adjust

- **Disadvantages:**
  - No formalized structure
PRELIMINARY RISK ANALYSIS

• Usage:
  – At the beginning of a new process / equipment
  – Basic risk analysis (rough selection, process / equipment for example)
  – Less significant consideration such as;
    • Deviation wrap-up
    • Change examination
ALTERNATIVE RISK ANALYSIS (NOT PROMOTED)

As an example: RA on a process

- Do mapping of process in One Unit Operations.
- Assess with a team of SME’s (Subject Matter Experts), as follows:
  - What is the possible risk of each step (comparable with FMEA question)
  - DO RPN (basically the same as with FMEA)
  - Rank en discuss
  - Propose mitigations.
IN CONCLUSION (1)

• Always determine “the case” first: the underlying process/component.
  - What component of the entire operation are we studying

• Convince yourself/others that sufficient details have been gathered concerning:
  – The underlying process/component
  – The question

• Carefully select the appropriate analysis techniques
  – 1 overall-study can include multiple
IN CONCLUSION (2)

You are not allowed to “risk assess” non-GMP’s into your system.

Examples:

1. Annex 8 (EU), clearly states that it is not allowed (some softer wording is used) to skip test (not testing every container) of Raw Material for sterile products (all containers to be tested)

   A company was defending that they didn’t need to test each container for Excipients since an RA was showing of low risk. This was not accepted and the company got a formal observation on this.

2. Every 6 months is the frequency of Media Simulations

   A company RA-ed this into 9 months, and same story as above
THANK YOU FOR YOUR ATTENTION