DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION

DISTRICT OFFICE ADDRESS AND PHONE NUMBER	DATE(S) OF INSPECTION
Kansas City District Office 8050 Marshall Drive Suite 205 Lenexa, KS 66214 913-495-5100 Industry Information: www.fda.gov/oc/industry	2/19-27/2013
	FEI NUMBER 3003244004

NAME AND TITLE OF INDIVIDUAL TO WHOM REPORT IS ISSUED

TO: Denis D. Wormington, R.Ph. Director of Pharmacy

FIRM NAME	STREET ADDRESS
Central Admixture Pharmacy Services, Inc.	1512 N. Topping Ave
CITY, STATE AND ZIP CODE	TYPE OF ESTABLISHMENT INSPECTED
Kansas City, Missouri 64120	Producer of Sterile Drug Products

THIS DOCUMENT LISTS OBSERVATIONS MADE BY THE FDA REPRESENTATIVE(S) DURING THE INSPECTION OF YOUR FACILITY. THEY ARE INSPECTIONAL OBSERVATIONS; AND DO NOT REPRESENT A FINAL AGENCY DETERMINATION REGARDING YOUR COMPLIANCE. IF YOU HAVE AN OBJECTION REGARDING AN OBSERVATION, OR HAVE IMPLEMENTED, OR PLAN TO IMPLEMENT CORRECTIVE ACTION IN RESPONSE TO AN OBSERVATION, YOU MAY DISCUSS THE OBJECTION OR ACTION WITH THE FDA REPRESENTATIVE(S) DURING THE INSPECTION OR SUBMIT THIS INFORMATION TO FDA AT THE ADDRESS ABOVE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT FDA AT THE PHONE NUMBER AND ADDRESS ABOVE.

DURING AN INSPECTION OF YOUR FIRM (I (WE) OBSERVED:

1. Laboratory controls do not include the establishment of scientifically sound and appropriate sampling plans and test procedures designed to assure that drug products conform to appropriate standards of identity, strength, quality and purity. Specifically,

Your firm has not established testing procedures to perform sterility or endotoxin testing on each batch or lot of drug product manufactured at your facility to obtain results prior to releasing and distributing drug products. Testing is performed (b) (4) depending on the drug product. Test samples are sent to an outside laboratory and product is distributed prior to receiving passing results.

2. Procedures designed to prevent microbiological contamination of drug products purporting to be sterile are not fully established and/or followed. Specifically,

Your firm does not have adequate procedures and controls in place to mitigate the ingress of contaminants into the ISO 5 hoods where aseptic compounding of finished drug products take place. The products affected are Oxytocin, Adenocaine (Adenosine, Lidocaine), Lipid Syringes, Total Parenteral Nutrition (TPN) for adults and neonates, Cardioplegic Solution (amino acid enriched solutions of various formulations, which can contain dextrose 5%, KCl, phosphates, NaCl, etc), Continuous Renal Replacement Therapy, and Diltiazem. Specifically;

a) On 2/19 and 2/20/2013 personnel were seen with exposed skin around the neck and face entering into the hood breaching the laminar air space. "GOWNING REQUIREMENTS" SOP-CAPS-4000171 Effective 2012-10-05 step 9.11. states: Keep head out of the ISO Class 5 work space during compounding."

Personnel do not don sterile hoods, goggles, hair nets or face masks to protect sensitive pharmaceuticals which are preservative free.

b) Your SOP "GOWNING REQUIREMENTS" SOP-CAPS-4000171 Effective 2012-10-05 is silent to sterile

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	Tara L. Breckenridge Shirley J Berryman	Tara L Breckenridge, Investigator Shirley J Berryman, Investigator	2/28/2013

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sleeve and glove practices with regard to specific sanitization practices and consistency. Personnel are not consistent in how they sanitize and (b)(4) their hands upon exit and entry back into the hoods. On 2/19 and 2/20/2013 some personnel were seen applying very short burst/quick sprays of (b)(4) onto their hands without rubbing and spreading the (b)(4) evenly, while other personnel were seen liberally applying (b)(4) and thoroughly rubbing, spreading the (b)(4) to saturation. Your procedure does not describe in additional detail intervals where gloves and sterile sleeves must be changed out, except upon (b)(4) [redacted]. Personnel only change out their sterile gloves and sleeves as they determine may be necessary. On 2/19-20/2013 personnel were observed working up to 2+ hours without determining additional sterile glove changes may be necessary after numerous (b)(4) sanitization which could degrade the quality of the glove over extended periods of time. During observation employees were seen only wearing (b)(4) of gloves.

c) Plastic holders are not cleaned and sanitized on a frequent enough basis. Within some of the ISO 5 laminar flow hoods plastic holding containers attached with suction cups are positioned against one of the side walls. These containers were viewed holding pens, unsterile labels, sterile luer lock caps for syringes, which were opened, and other sterile or unsterile supplies or components. The plastic holders are not removed on a daily basis and cleaned. This could compromise asepsis of the ISO 5 zone and pose a risk to product sterility.

After market (b)(4) type hood guards, which are not part of the hood's original design, are affixed to limit personnel breaching the laminar air space. These guards are not removed on a daily basis to facilitate cleaning. There are gaps and spray residue visible on these guards which could compromise asepsis of the ISO 5 zone and pose a risk to product sterility. The (b) (4) [redacted], used to attach the guard to the hood does not appear to be easily cleanable. It was confirmed, gaps between the surface of the hood and barrier/ guard is only only cleaned approximately (b) (4) [redacted]

d) Electronic computerized scan equipment which cannot be fully cleaned or immersed for sanitization is kept within the ISO 5 hood where compounding occurs. The inability to fully clean the equipment could impact asepsis of the ISO 5 hood.

e) On 2/19 and 2/20/2013 in the room where oxytocin is compounded, the hoods were observed filled with (b) [redacted] bags of diluent base solution. The firm has not assessed the impact of the full hood with regard to unidirectional

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airflow. Smoke studies which were performed, are deficient in assuring there is no degrade in air flow. The smoke did not reach fully to the back of the hood where the bags were stacked to demonstrate airflow integrity was maintained.

3. Aseptic processing areas are deficient regarding the system for monitoring environmental conditions. Specifically,

Environmental monitoring of personnel via finger touch and sleeve touch plates was observed on 2/20/2013. Personnel sanitized their hands with [redacted], performed one manipulation pushing a syringe of oxytocin into a bag of diluent base solution, and then that technician was immediately sampled as the subject of finger touch and sleeve plates. This process negated the potential for bioburden recovery, which would be representative of the work environment and personnel practices.

4. Batch production and control records do not include the specific identification of each batch of component or in-process material used for each batch of drug product produced. Specifically,

Your firm does not track or document direct product contact component lot numbers in any of the batch record documentation. This includes items such as IV bags, sterile tubing, syringes, etc. Your firm does not have the ability to trace and recall any products which may be a part of a component recall or which is otherwise determined to be compromised.

The lot numbers for container bags are not documented. CAPS™ Solution Report does not include a lot numbers for the EVA Container bags used in the TPN compounding process. For example: CAPS RX. 19-372367-0-1 only shows the use of "Selected bag x41 EVA Container 3000mL" and CAPS RX. 19-330819-0-1 shows the use of "Selected bag x42 EVA Container 4000mL".

5. Written records of investigations into unexplained discrepancies do not always include the conclusions and follow-up. Specifically;

a) The investigations for five complaints of leaking bags of TPN received in 2012 are inadequate. TPN leaking bag complaints were reported on the following dates: 1/3/2012, 1/8/2012, 4/10/2012, 10/11/2012, and 10/31/2012.

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The lot number of the bags is not documented in order to conduct an adequate investigation. It was not documented in the investigation that the manufacturer of the IV bag component was contacted to report the leaking bag(s). In all cases the leaking bag was not returned but destroyed by the hospital and the location of the leak is not available. The root cause documented is "mishandling of the TSP bag by the personnel at the customer site" and one was "mishandling of the package by [(b) (4)]".

b) Despite the return of 16 bags of Oxytocin from a batch of [(b) (4)] bags compounded on 6/20/2012 for the customer, you failed to perform any testing of the returned product. The Oxytocin was returned by the customer because they reported they did not get the expected result. SOP-CAPS-4000217, Customer Inquiry/Complaint Handling and Reporting, 4.5.7. states "Testing and / or analysis to confirm Product Complaint or clarify problem." And under A. Testing should include analysis of returned sample product as appropriate and includes Lack of Therapeutic Effect. The 16 bags of Oxytocin were returned and destroyed on 7/2/2012.

6. Aseptic processing areas are deficient regarding systems for maintaining any equipment used to control the aseptic conditions. Specifically,

ISO 5 Laminar Flow Hood number 10 was observed to not be maintained in good repair. There was an approximate 8+ inch crack on the left side wall. Inner side walls of hoods were viewed to have spray residue which was dried onto the hoods within the ISO 5 space and not thoroughly cleaned.

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