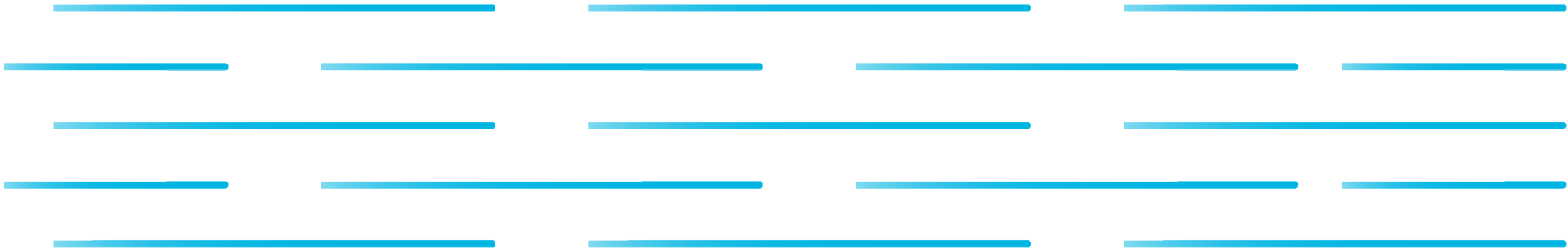




Quality by design (QbD) in process development

DCVMN 10 March 2017



Product quality cannot be ensured by inspections, it has to be designed into the product by a robust production process

What is QbD?

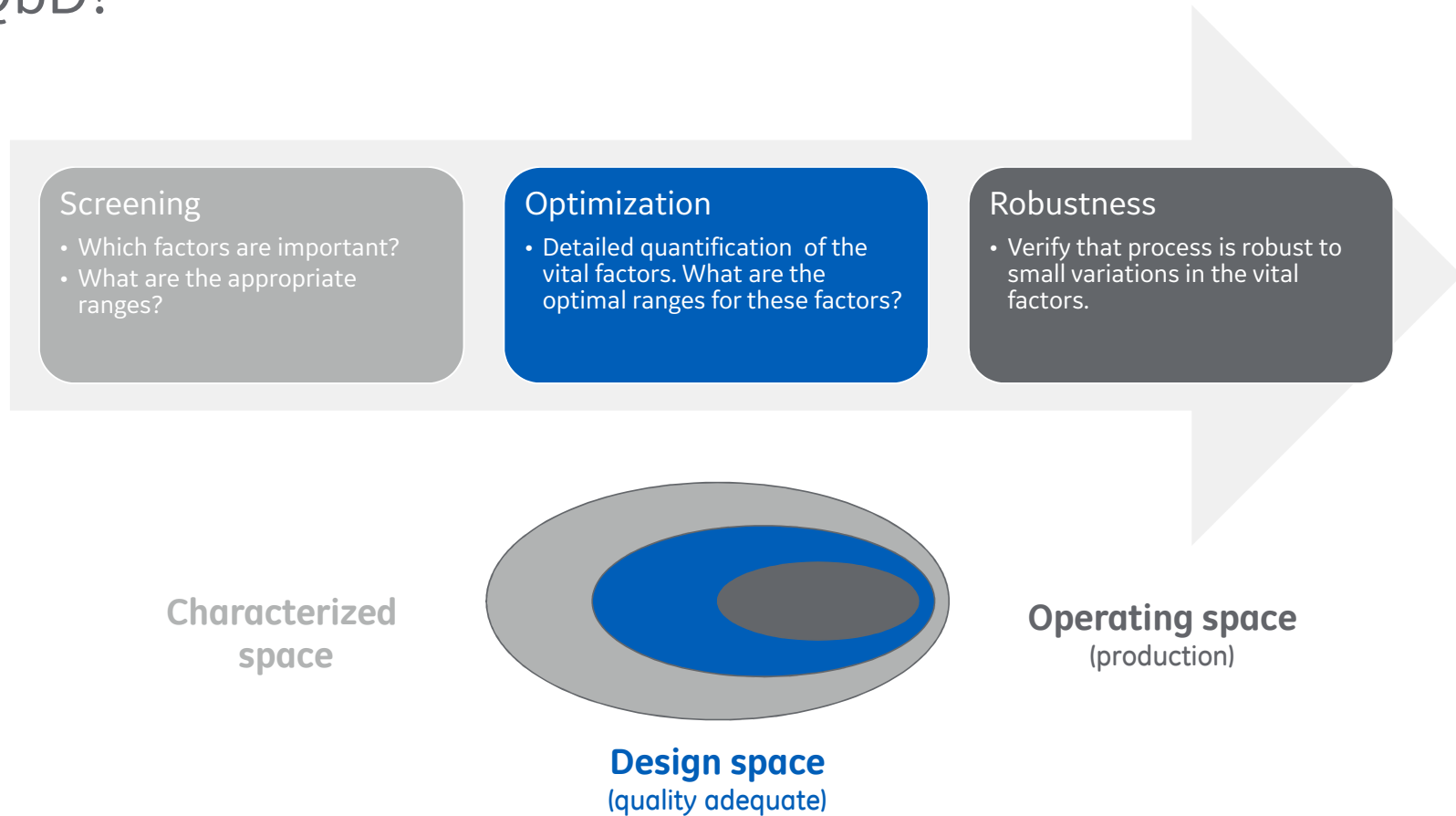
Four key steps defining process design space



- Process mapping
 - Process flow, fishbone diagrams
 - Which factors could potentially affect our process?
- Risk analysis
 - Failure Mode and Effects Analysis (FMEA)
 - Which parameters should be investigated in detail?
- Design of experiments (DoE)
 - Screening extended space in many parameters
 - Detailed quantification of cause and effect relationships
- Execution and analysis, definition of design space



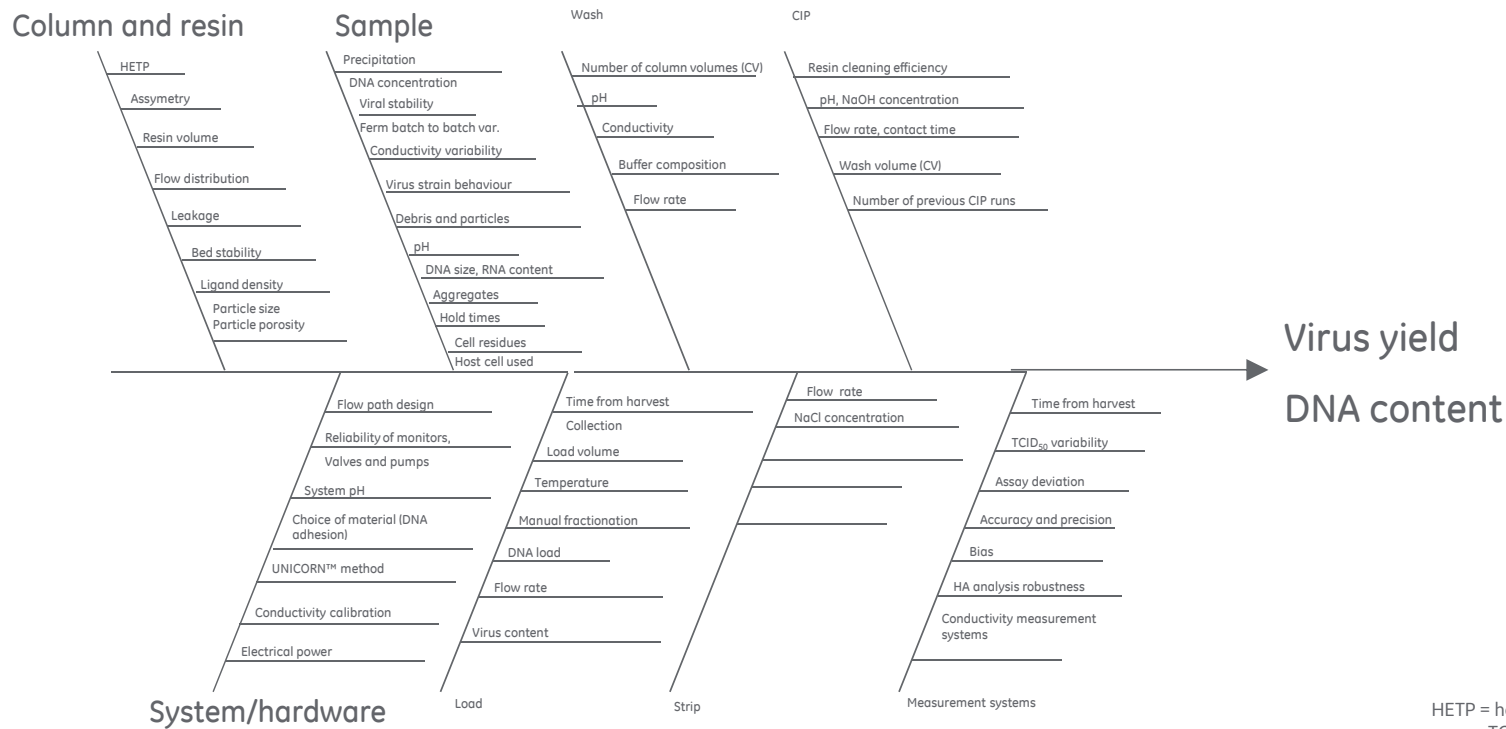
Why QbD?



Risk analysis

Example of fishbone analysis

DNA removal using an anion-exchange chromatography column for cell-based influenza purification



CIP = cleaning in place

HA = hemagglutinin

HETP = height equivalent to the theoretical plate

TCID₅₀ = 50% tissue culture infective dose



FMEA: failure modes and effects analysis

Risk analysis and mitigation

1. What might go wrong?
2. How severe are the consequences?
3. What is the likelihood the failure will occur?
4. Can we detect the failure?

S = Severity of each failure (1-10)
O = Likelihood of occurrence (1-10)
D = Likelihood of detection (1-10)
RPN = Risk priority number = $S \times O \times D$
Define what each level represent

To be performed in cross-functional teams (operators, R&D, QA/QC, management, etc.)



DoE essentials

What is DoE?

DoE is a systematic way of changing process **inputs** and analyzing the resulting process **outputs** in order to quantify the **cause and effect** relationship between them while using a **minimum number of runs**.

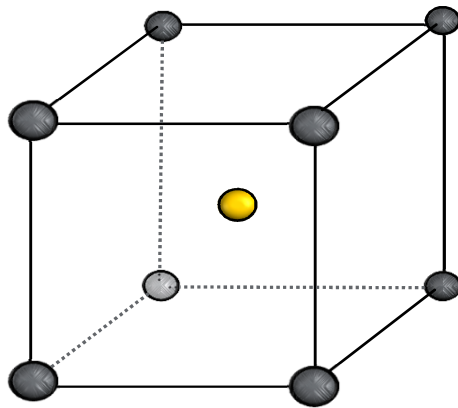


Keywords for DoE

Factors

A parameter (variable) that is thought to affect the result

Can usually be controlled



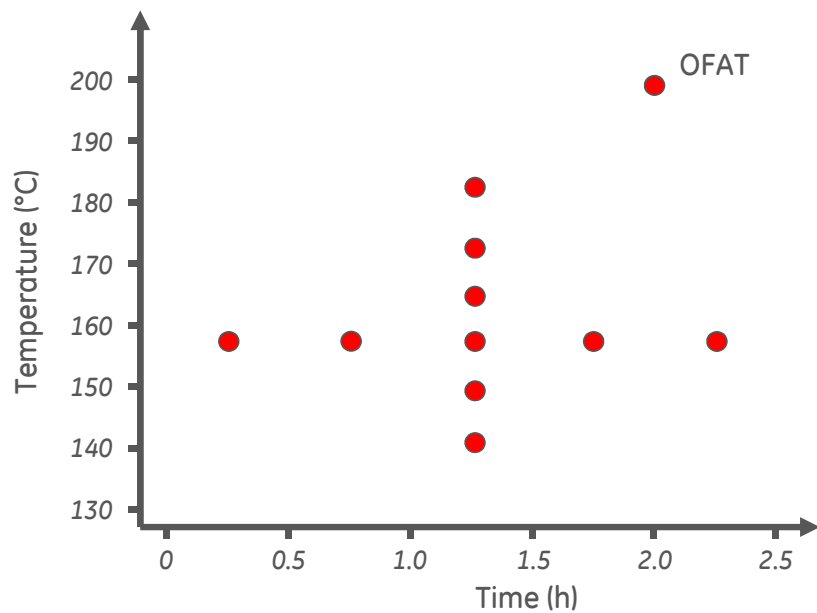
Responses

One or more measured variables describing the outcome of the experiment

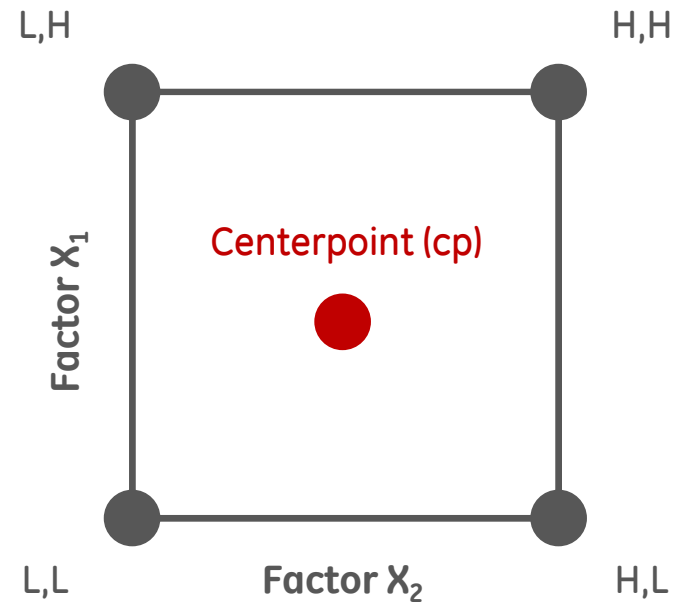


General design constructions with two factors

One factor at the time (OFAT)

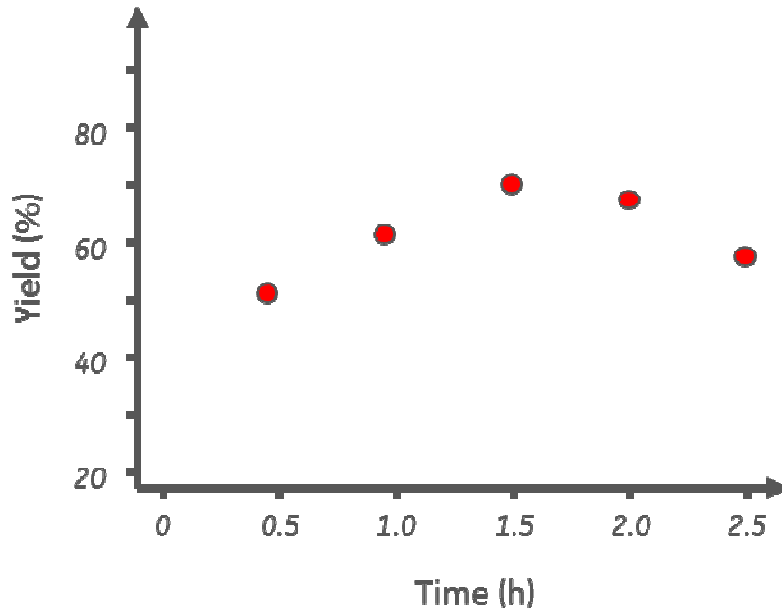


DoE

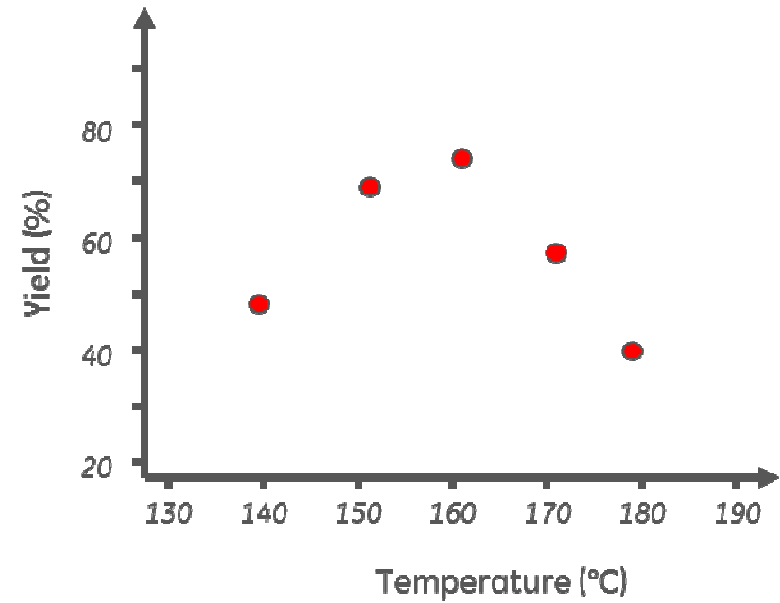


OFAT: the classical/intuitive approach

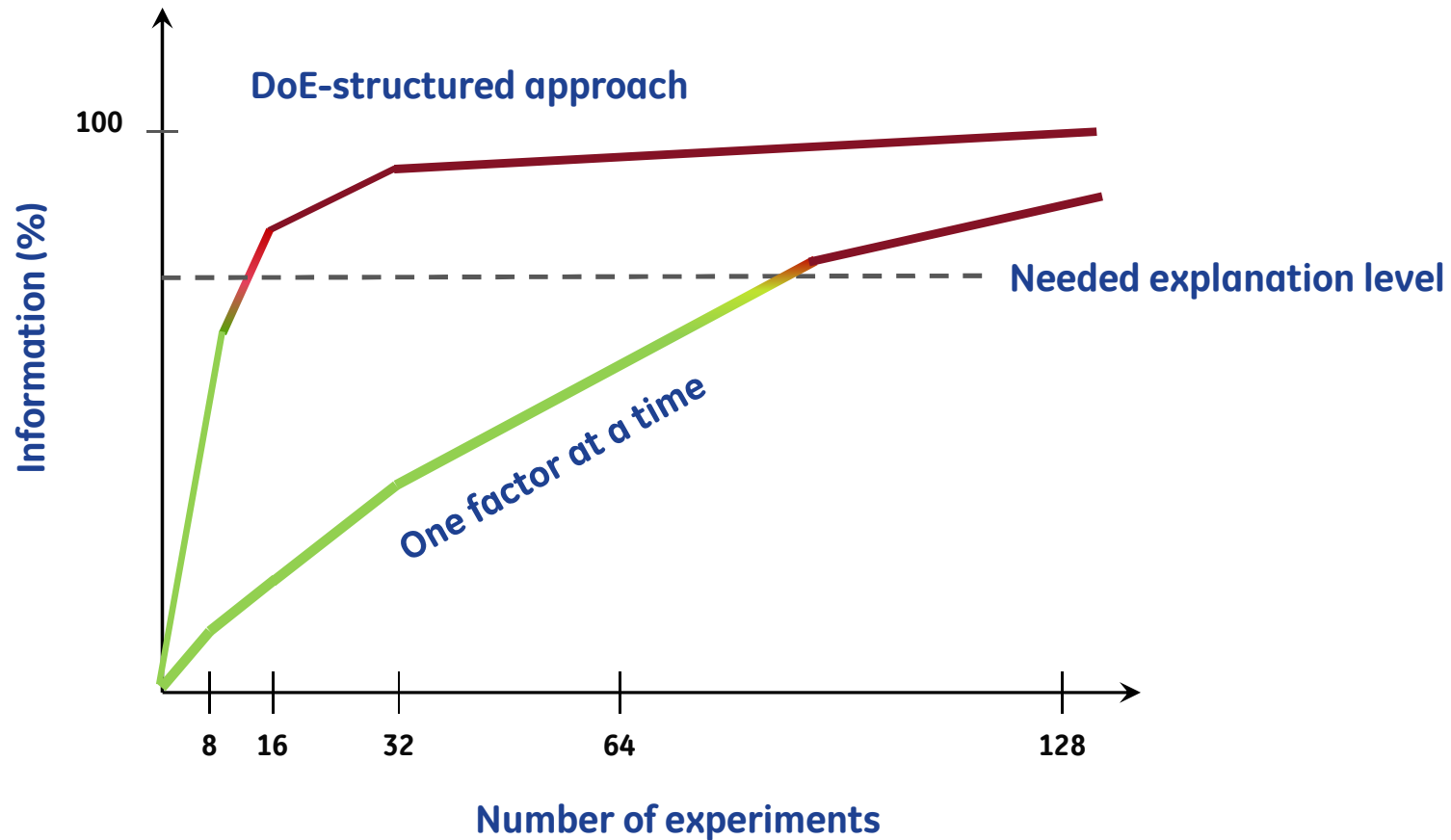
Time (h)



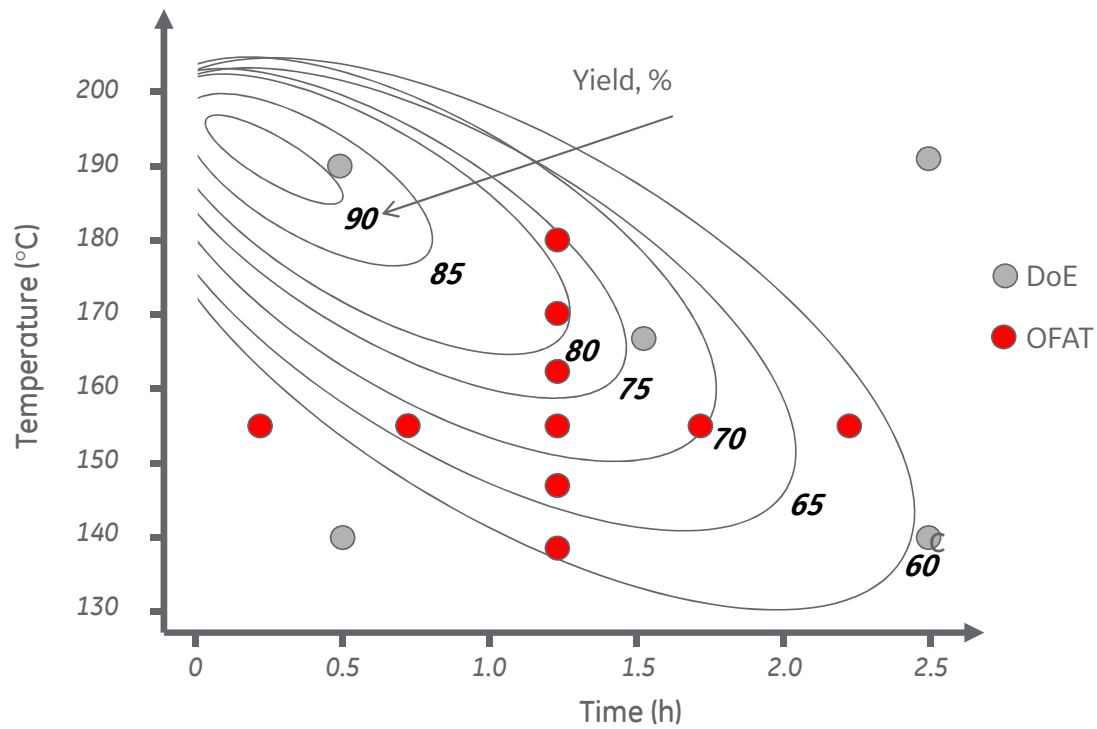
Temperature (°C)



DoE results in more information with less experiments



Interactions between factors can be discovered with DoE



Analysis for vaccines

Examples of analytical methods for vaccines

Single radial immunodiffusion (SRID)

Hemagglutinin (HA) agglutination assay

Enzyme-linked immunosorbent assay (ELISA)

SDS-PAGE/Western blot

qPCR

Plaque assays

TCID₅₀

Challenges with analytical methods for QbD and DoE

Sensitivity, detection range

Method variation (precision, accuracy)

Hands on time

Cost

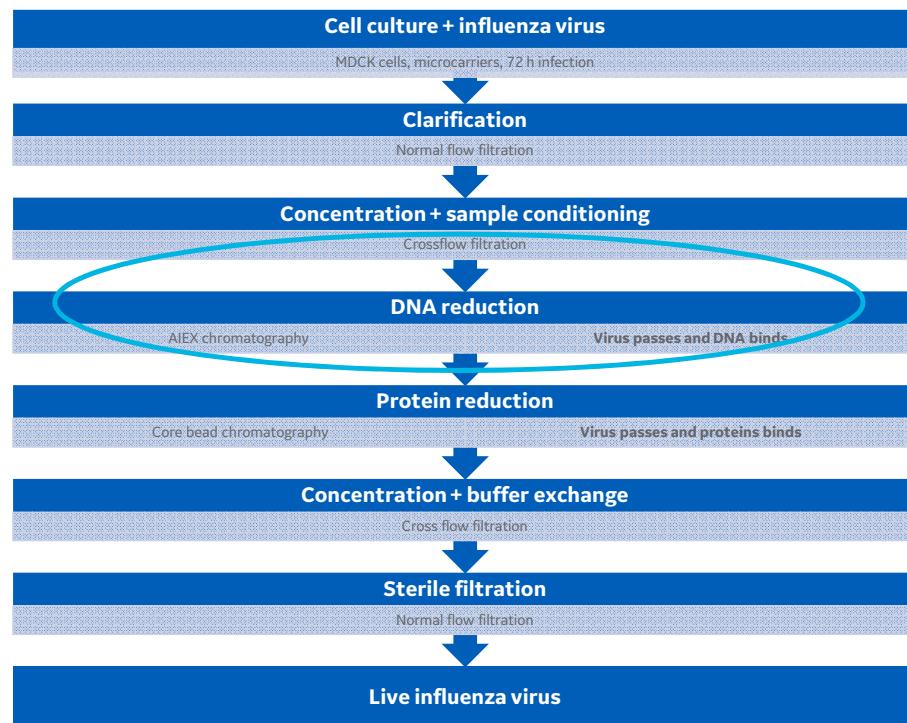
Robustness

TCID₅₀ = 50% tissue culture infective dose



DoE case study:
DNA reduction in vaccine
processing

DNA removal in vaccine process



- Process mapping and FMEA showed that loss of product and inefficient DNA removal have highest impact on product quality.
- Host cell DNA is a critical impurity.
- DoE setup with pH and conductivity as factors, and antigen yield and DNA removal as responses.

AEX = anion exchange chromatography



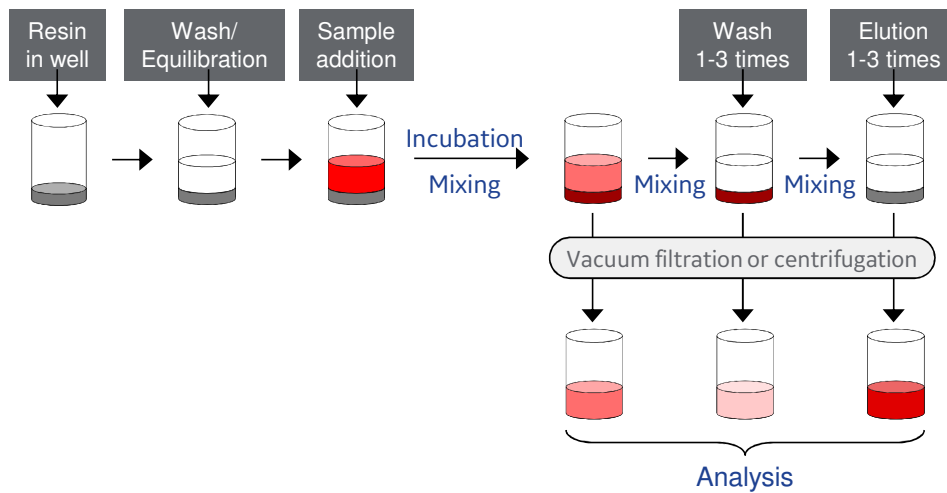
DoE: experimental parameters



Factors	DoE range
pH (equil., load, wash)	7.0–9.0
NaCl (equil., load, wash)	300–800 mM
Responses (supernatant)	
MDCK cell DNA (qPCR)	
Influenza HA analysis	



DoE: experimental set-up



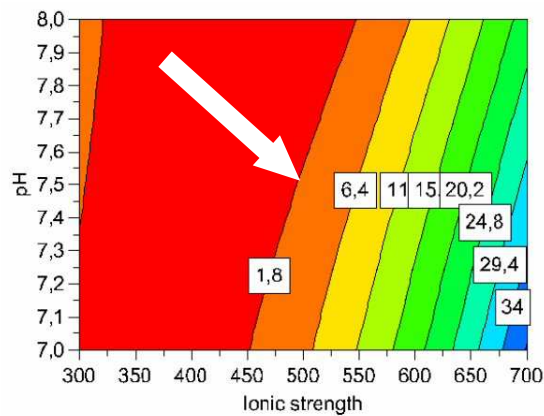
Material

Sample	A/Solomon Island/3/2006 (H1N1) A/Wisconsin/67/2005 (H3N2) B/Malaysia/2506/2004 (B)
Sample conditioning	PD-10 Desalting columns
Format	Prepacked 96-well plates
Capto™ Q resin	50 µL/well
Sample load	400 µL/well
Incubation	10 min/shaker
Supernatant collection (flowthrough)	Centrifugation, 500 × g

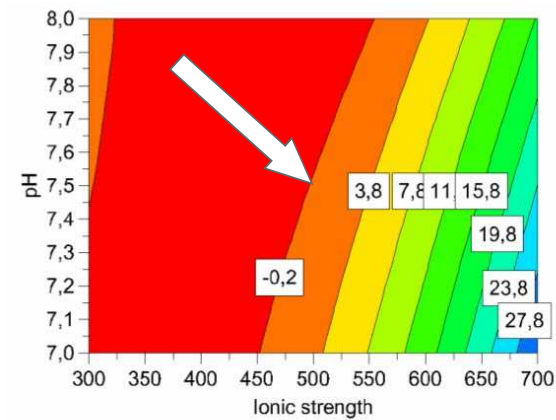


DoE reveals optimal DNA reduction

A/Solomon Islands/3/2006 (H1N1)



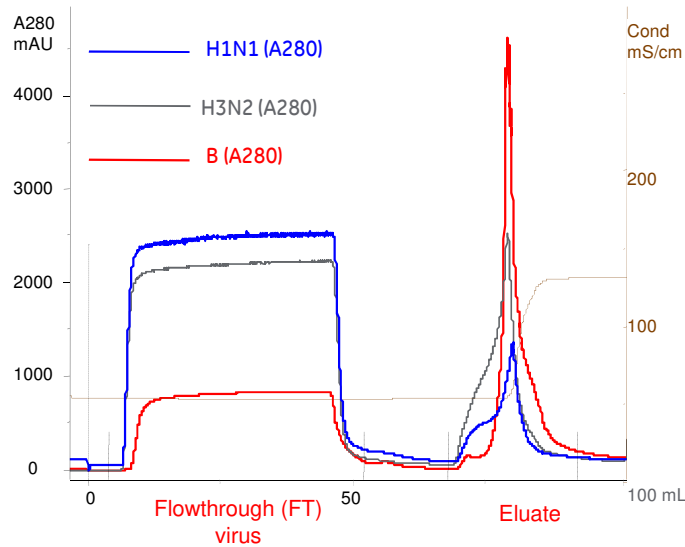
A/Wisconsin/67/2005 (H3N2)



- The level of gDNA (%) in the flowthrough is shown in the boxes.
- Conditions were chosen to achieve efficient DNA reduction (red region) and keep the influenza virus in a non-binding mode.



Chromatography—confirmation of DoE



Column: XK16/20
 Volume: 20 mL Capto™ Q resin
 Flow rate: 2.0 mL/min (60 cm/h)

Equil. buffer: 20 mM Tris, 0.5 M NaCl, pH 7.5
 Elution buffer: 20 mM Tris, 1.5 M NaCl, pH 7.5
 CIP: 1 M NaOH

Sample load: 40 mL (2 CV)
 FT volume: 1.12-fold sample volume

Sample	HA yield (%)	gDNA (ng/mL) before	gDNA (ng/mL) after	DNA log reduction
A/Solomon Island/3/2006 (H1N1)	> 85	2010	17	2.1
A/Wisconsin/67/2005 (H3N2)	> 85	11 300	16	2.9
B/Malaysia/2506/2004 (B)	> 85	96 800	16	3.8

CIP = cleaning in place



Summary: benefits of QbD and DoE

QbD

Systematic approach to identify potential sources of process variability and parameters likely to have greatest impact on product quality.

DoE

Systematically vary several experimental parameters simultaneously to obtain sufficient information with minimum number of experiments.

Analytical methods are crucial for a successful DoE



Introduction to QbD exercice

What is QbD?

Four key steps defining process design space



- Process mapping
 - Process flow, fishbone diagrams
 - Which factors could potentially affect our process?
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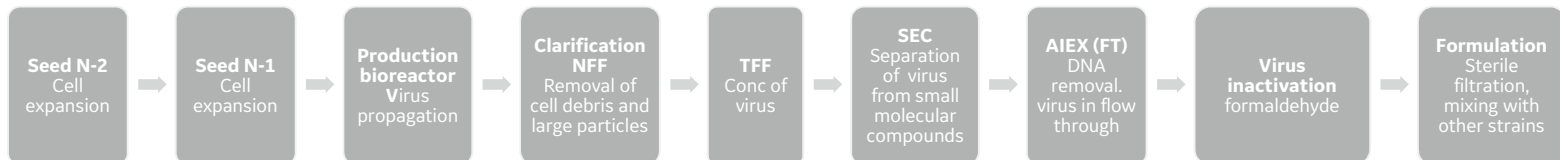
Process mapping

- Which factors could potentially affect our process?
- Tools: High level process maps
Fishbone diagrams



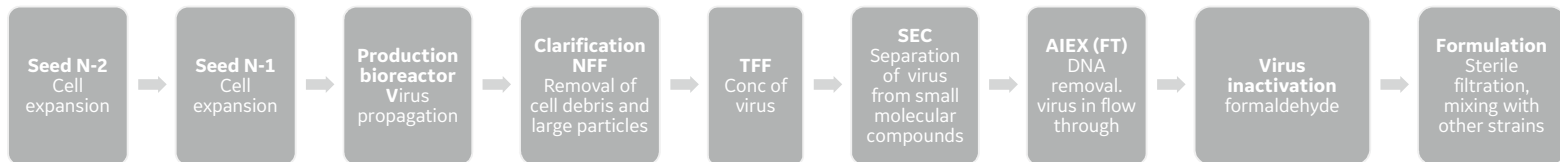
Process mapping

- Which factors could potentially affect our process?
- Tools: High level process maps
Fishbone diagrams



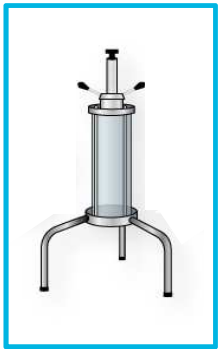
Process mapping

- Which factors could potentially affect our process?
- Tools: High level process maps
Fishbone diagrams



Process mapping

- Which factors could potentially affect our process?
- Tools: High level process maps
Fishbone diagrams

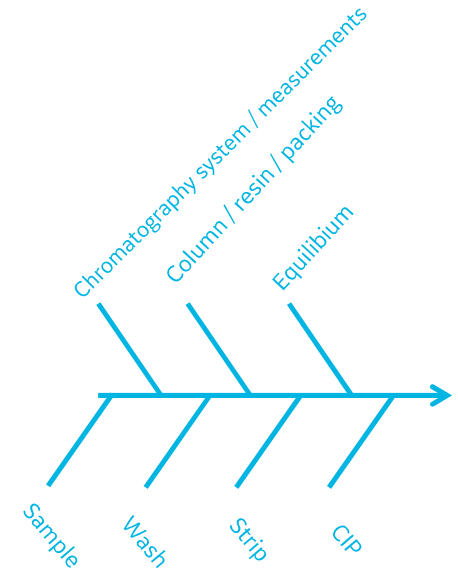


Break down



- Chromatography system / measurements
- Column / resin / packing
- Running conditions:
 - Equilibrium
 - Sample
 - Wash
 - Strip
 - CIP

Fishbone analysis



FMEA – Failure Modes and Effects Analysis

Risk analysis and mitigation - To be performed in cross-functional teams

1. What might go wrong?
2. How severe are the consequences?
3. What is the likelihood the failure will occur?
4. Can we detect the failure?

S - Severity of each failure (1-10)
O - Likelihood of occurrence (1-10)
D - Likelihood of detection (1-10)
RPN - Risk Priority Number = $S \times O \times D$
Define what each level represent



The components of an FMEA

Item / Process Step	Potential Failure Mode(s)	Potential Effect(s) of Failure	Severity	Potential Mechanism(s) of Failure	Level	Severity	Occurrence	Detection
					9-10	Possible harm/injury to patient or operator	Every batch/run	Will probably not be detected by existing systems
Eq. pH	Below limit	Loss of product	5	Buffer blending	7-8	Loss of several batches, damage to equipment	once in 2-10 batches	Detection at batch release or at periodical control after batch completion
					5-6	Batch involved probably lost/needs to be discarded	twice yearly, ~once every 10 batches	Detection at batch release/equivalent
					3-4	Small consequences: Additional batch testing, re-work...	Once yearly/ once in every 50 batches	Will be detected at-line before next unit operation by existing systems
					1-2	No or negligible consequences	Verylow/Practically no occurrence	Immediate, obvious detection

Identify each failure mode.

Identify each potential consequence(s) (local, next and end) of that failure.

Severity - On a scale of 1-10, rate the Severity of the end effect. See Severity sheet for full definition.

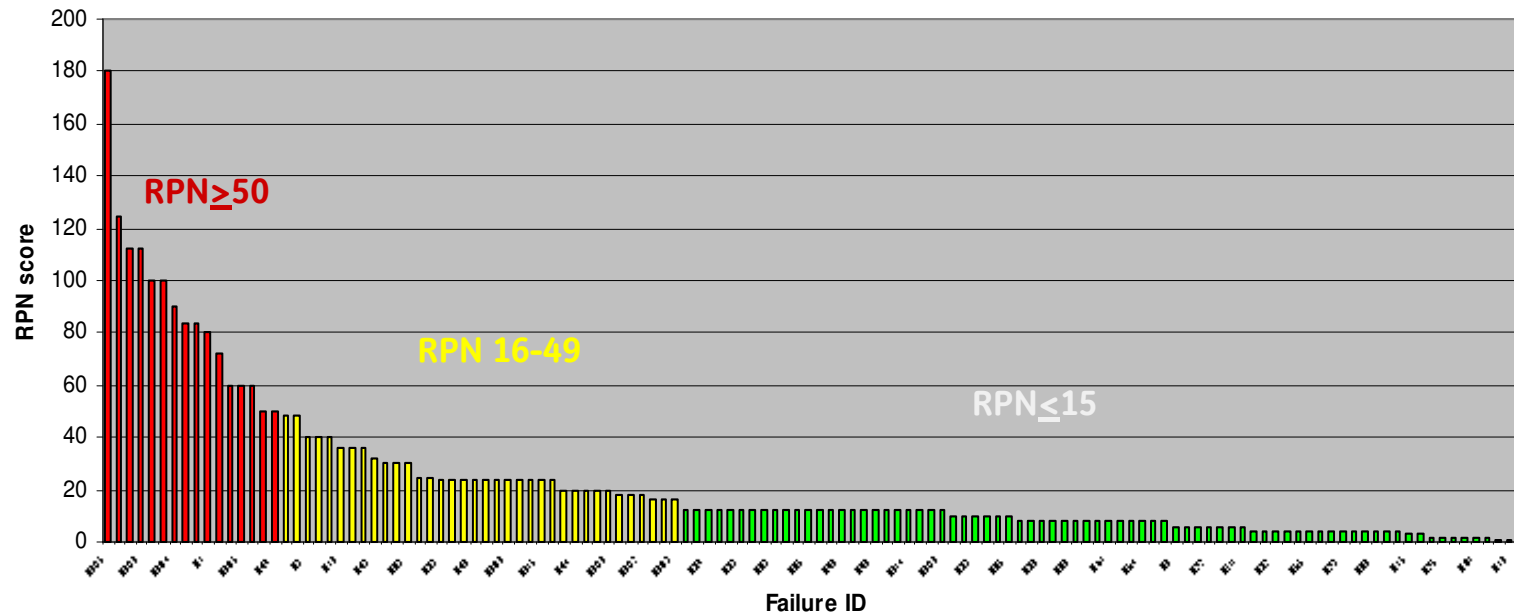
Identify the potential failure mechanism(s).

Occurrence - the likelihood of the failure occurring (that the current controls will detect the failure). See Occurrence sheet for full definition.



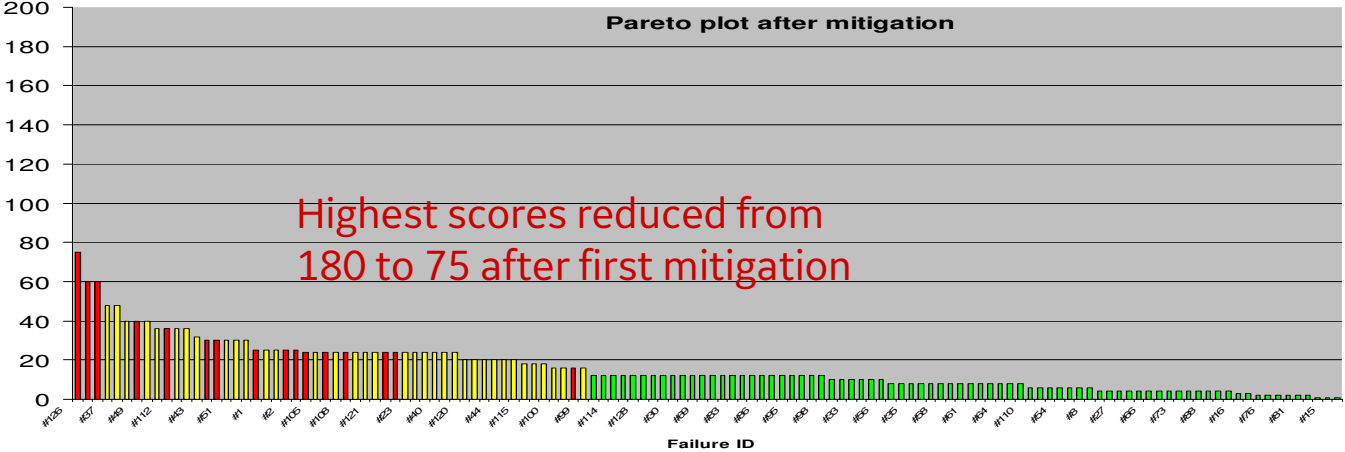
Pareto plot of RPN scores

Pareto plot, FMEA Capto Q VFW



FMEA score card for top 10 RPN's

Item / Process Step	Potential Failure Mode(s)	Potential Effect(s) of Failure	S	Potential Mechanism(s) of Failure	O	Current Process Controls	D	RPN	Recommended Action(s)	Action Results				
										Actions Taken	New S	New O	New D	New RPN
Analysis assay	failure	loss of batch	6	operator error	5	internal std run, operator	6	180	Consistent re-analysis for OOS results	Yes	3	5	5	75
Sample DNA level	too high	DNA in product	5	Unstream process var	5	DNA assay	5	125	Picogreen screening of sample pre-run	Yes	4	5	3	60



Group exercise:
Fishbone analysis and FMEA on
buffer preparation

Practical exercise: Risk analysis for buffer preparations

Contamination

Wrong pH

Wrong conductivity

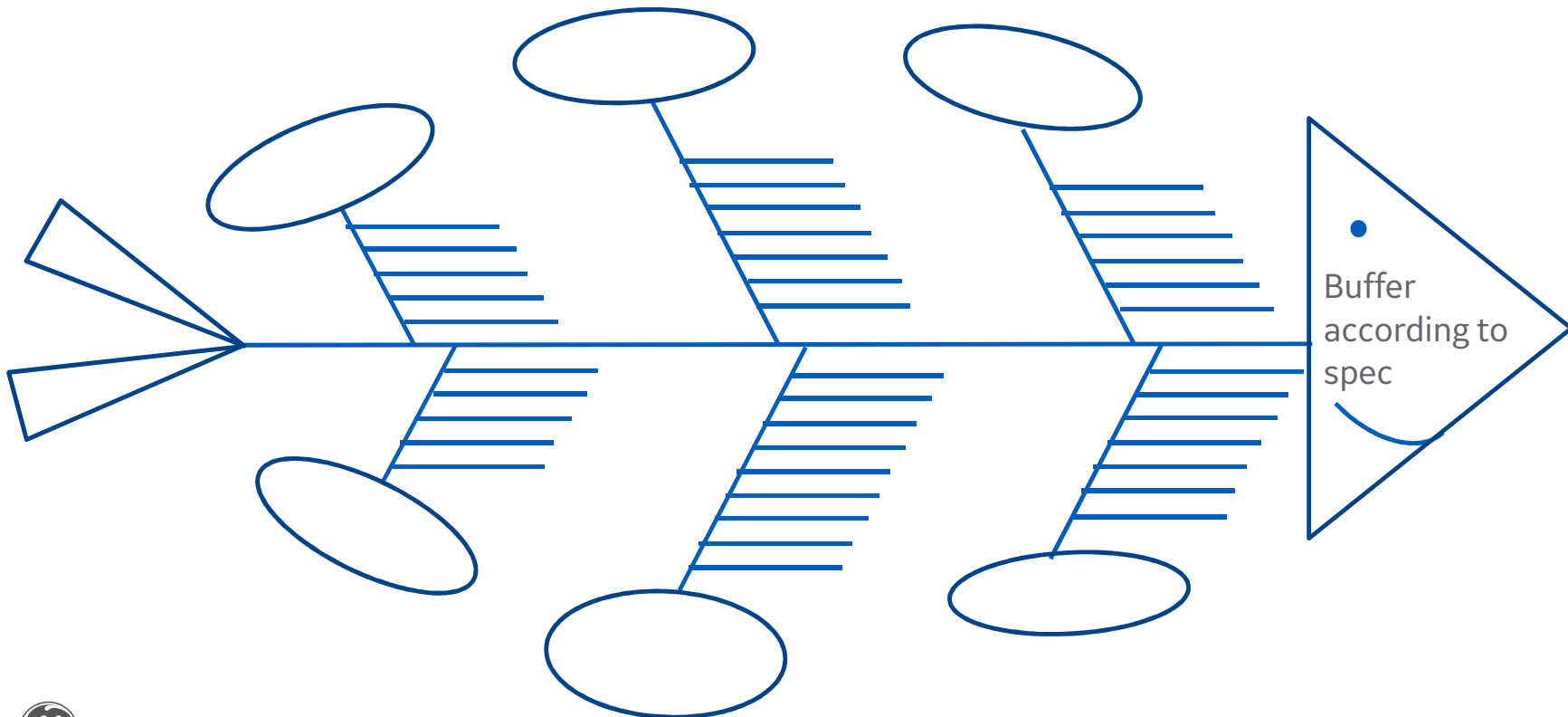
Wrong water quality

Other?



Fishbone analysis: Buffer preparation

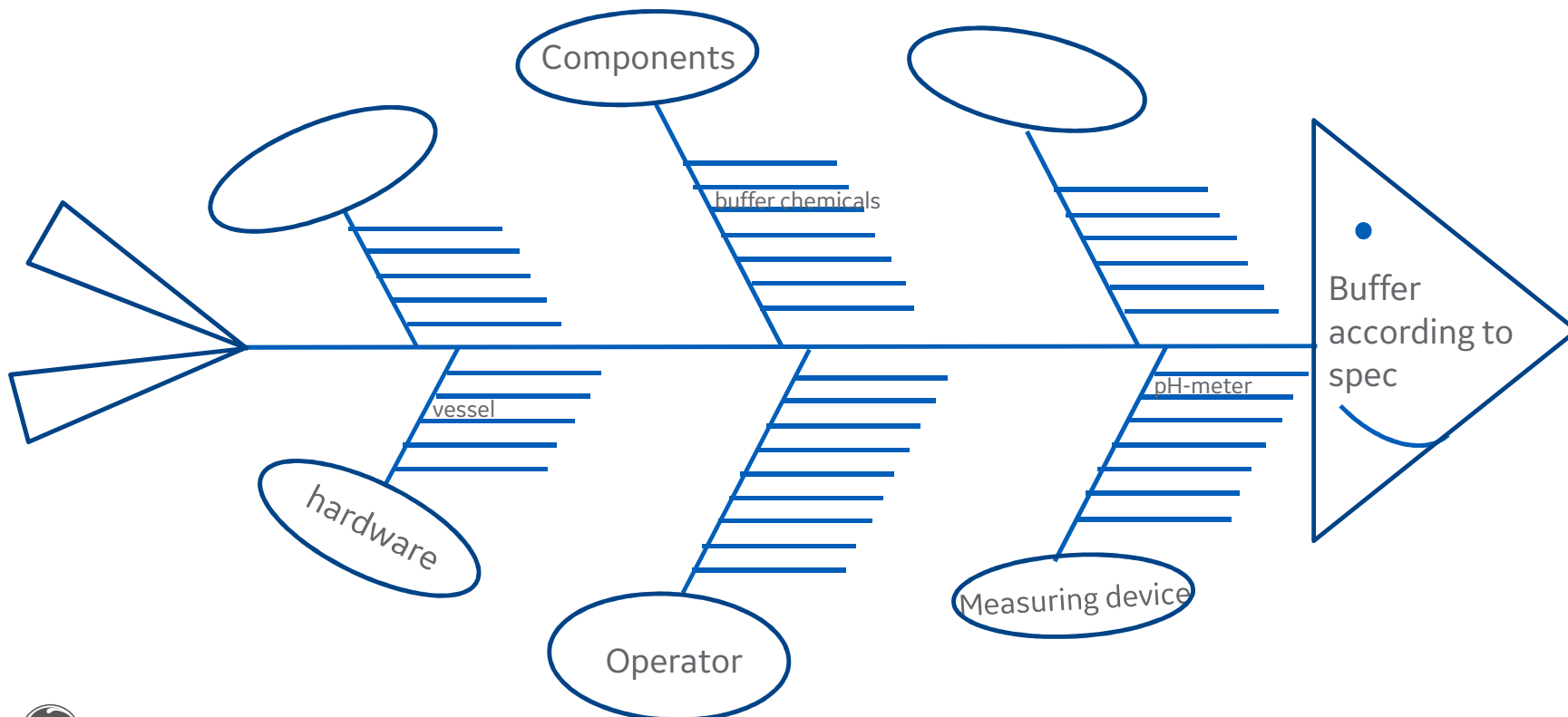
What could possibly go wrong?



Fishbone analysis: Buffer preparation



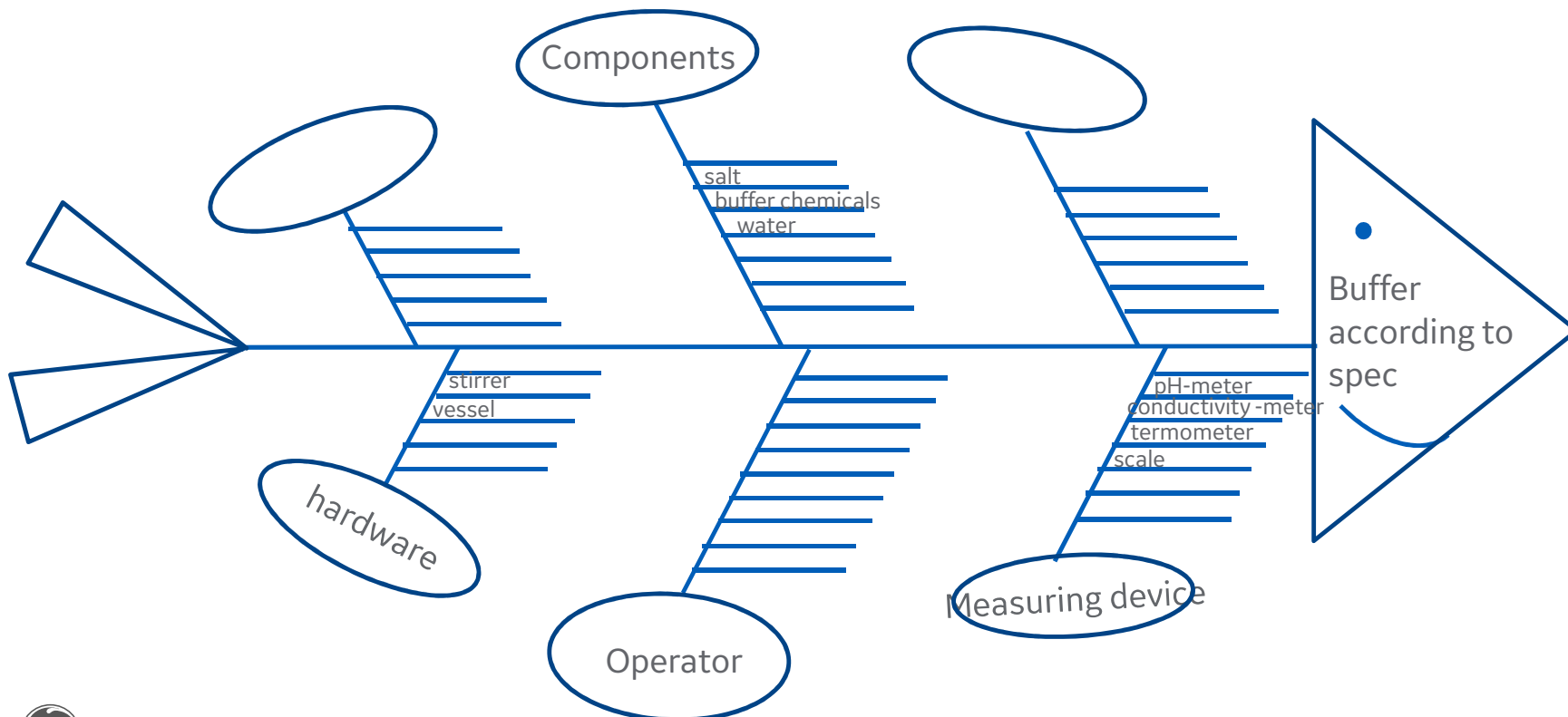
What could possibly go wrong?



Fishbone analysis: Buffer preparation

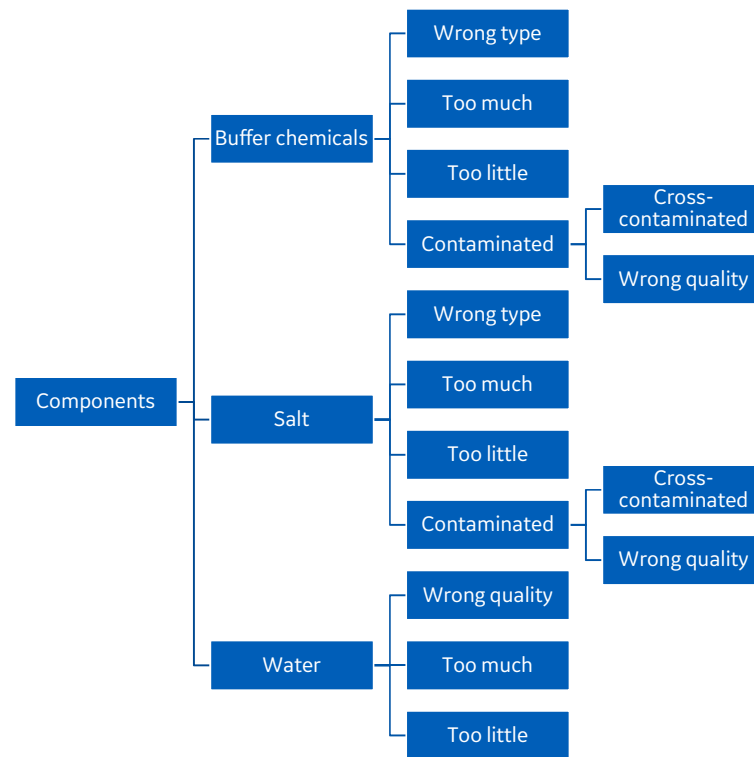


What could possibly go wrong?



Breakdown of failure modes for components in buffer preparation

Example



Ranking - Severity

Effect	Severity of Effect	Ranking
Hazardous without warning	Possible harm/injury to patient or operator	10
Hazardous with warning	Possible harm/injury to patient or operator	9
Very High	Loss of several batches, damage to equipment	8
High	Loss of several batches, damage to equipment	7
Moderate	Batch involved probably lost/needs to be discarded	6
Low	Batch involved probably lost/needs to be discarded	5
Very Low	Small consequences: Additional batch testing, re-work...	4
Minor	Small consequences: Additional batch testing, re-work...	3
Very Minor	No or negligible consequences	2
None	No or negligible consequences	1

Severity is an assessment of the seriousness of the effects (next, local and end) as felt by the customer.



Ranking - Occurrence

Probability of Process Failure	Failure Rates* (failures per batch)	Ranking
Very High: Failure is almost inevitable	> 1 in 2	10
	1 in 5	9
High: Repeated failures	1 in 10	8
	1 in 10	7
Moderate: Occasional failures	1 in 20	6
	1 in 20	5
	1 in 100	4
Low: Relatively few failures	1 in 100	3
	1 in 1 000	2
Remote: Failure is unlikely	< 1 in 1 000	1

Occurrence is the likelihood that the failure mechanism and subsequent failure mode will occur (based on historical data on similar processes or past experience knowledge).



Ranking - Detection

Detection	Likelihood of Detection	Likelihood of Detection	Ranking
Absolute Uncertainty	Will probably not be detected by existing systems	< 1%	10
Very Remote	Will probably not be detected by existing systems	1% - 5%	9
Remote	Detection at batch release or at periodical control after batch completion	5% - 15%	8
Very Low	Detection at batch release or at periodical control after batch completion.	15% - 30%	7
Low	Detection at batch release/equivalent	30% - 50%	6
Moderate	Detection at batch release/equivalent	50% - 75%	5
Moderately High	Will be detected at-line before next unit operation by existing systems	75% - 85%	4
High	Will be detected at-line before next unit operation by existing systems	85% - 93%	3
Very High	Immediate, obvious detection	93% - 99%	2
Almost Certain	Immediate, obvious detection	>99 %	1

Detection is the likelihood that the control will detect the failure.



FMEA

Practical example

Item/ process step	Potential Failure Mode(s)	Potential Effect(s) of Failure	Severity	Potential Mechanism (s) of Failure	Occurance	Current process control	Detection	RPN (S x O x D)
Component / Chemical	Contaminat ion	Chemicals	6	Contaminated hardware	3	pH / cond	3	54
Component / Chemical	Contaminat ion	Bioburden	6	Contaminated hardware	3	Bioburden testing	6	108
Component / Chemical	Contaminat ion	Bioburden	6	Contaminated chemical	5	Bioburden testing	6	180



Practical exercise

Fill in the table in groups

Contamination

Wrong pH

Wrong conductivity

Wrong water quality

Other?



FMEA



Practical example

Item/ process step	Potential Failure Mode(s)	Potential Effect(s) of Failure	Severity	Potential Mechanism (s) of Failure	Occurance	Current process control	Detection	RPN (S x O x D)
Component / Chemical	Contaminat ion	Chemicals	6	Contaminated hardware	3	pH / cond	3	54
Component / Chemical	Contaminat ion	Bioburden	6	Contaminated hardware	3	Bioburden testing	6	108
Component / Chemical	Contaminat ion	Bioburden	6	Contaminated chemical	5	Bioburden testing	6	180



FMEA



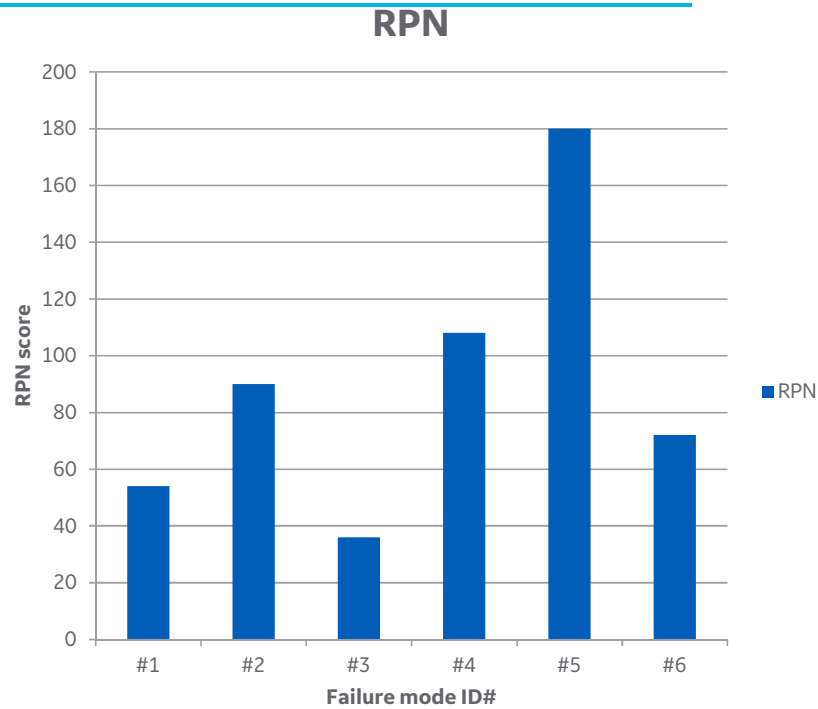
Practical example

Failure mode ID #	Item/ process step	Potential Failure Mode(s)	Potential Effect(s) of Failure	Severity	Potential Mechanism (s) of Failure	Occurance	Current process control	Detection	RPN (S x O x D)
1	Component / Chemical	Contamination	chemicals	6	contaminated hardware	3	pH / cond	3	54
2	Component / Chemical	contamination	chemicals	6	contaminated buffer component	5	pH / cond	3	90
3	Component / Chemical	contamination	chemicals	6	contaminated buffer component	2	pH / cond	3	36
4	Component / Chemical	contamination	bioburden	6	contaminated hardware	3	bioburden testing	6	108
5	Component / Chemical	contamination	bioburden	6	contaminated buffer component	5	bioburden testing	6	180
6	Component / Chemical	contamination	bioburden	6	contaminated buffer component	2	bioburden testing	6	72



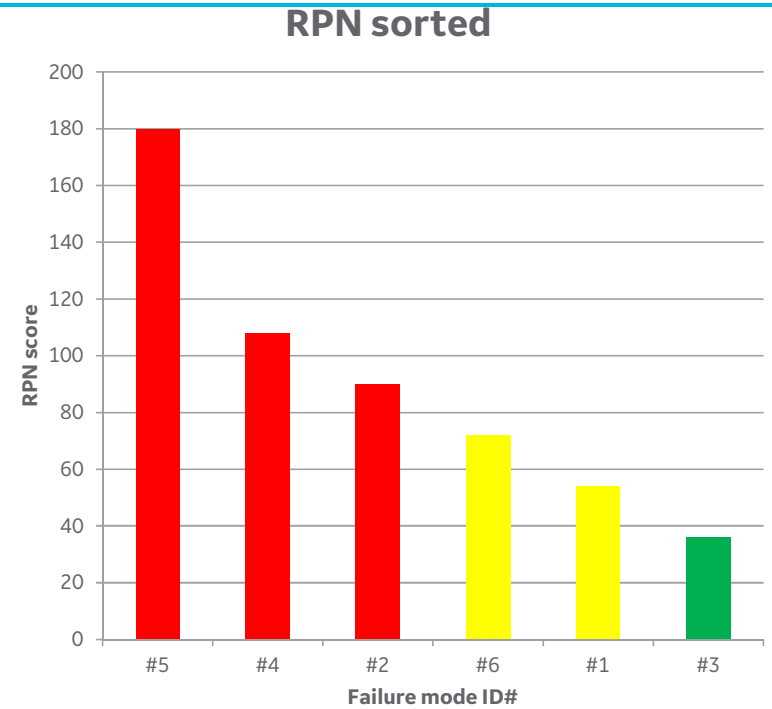
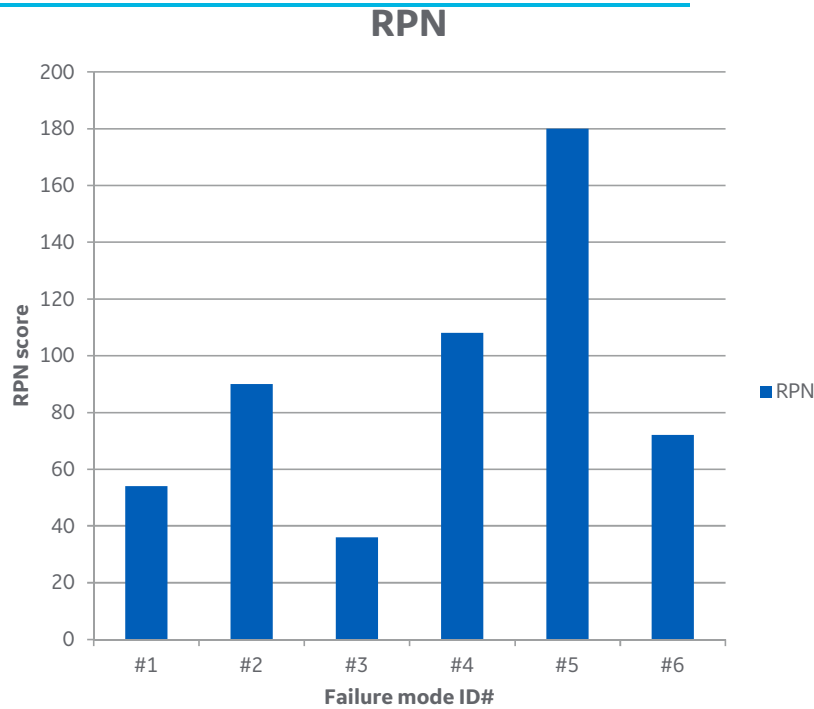
Pareto plot - Failure mode ID vs RPN

RPN



Pareto plot - Failure mode ID vs RPN

RPN



FMEA risk mitigation

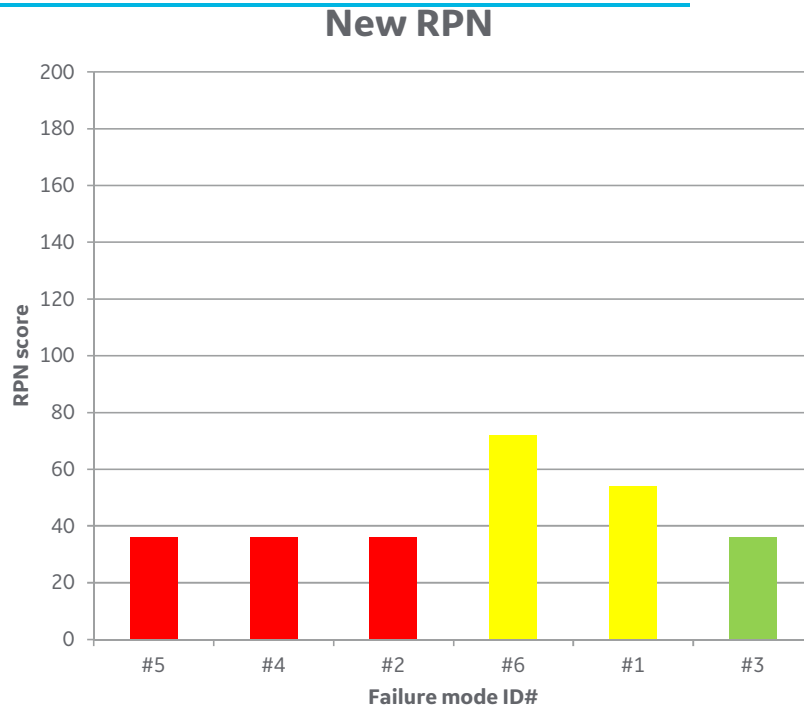
RPN > 80

Failure mode ID#	Item/ process step	Potential Failure Mode(s)	Potential Effect(s) of Failure	Severity	Potential Mechanism (s) of Failure	Occurance	Current process control	Detection	RPN (S x O x D)	Action(s)	New Severity	New Occurance	New Detection	New RPN
5	Component / Chemical	contamination	bioburden	6	contaminated buffer component	5	bioburden testing	6	180	Sterile filtration	6	1	6	36
4	Component / Chemical	contamination	bioburden	6	contaminated hardware	3	bioburden testing	6	108	Sterile filtration	6	1	6	36
2	Component / Chemical	contamination	chemicals	6	contaminated buffer component	5	pH / cond	3	90	Clear SOP	6	2	6	72



Pareto plot after risk mitigation

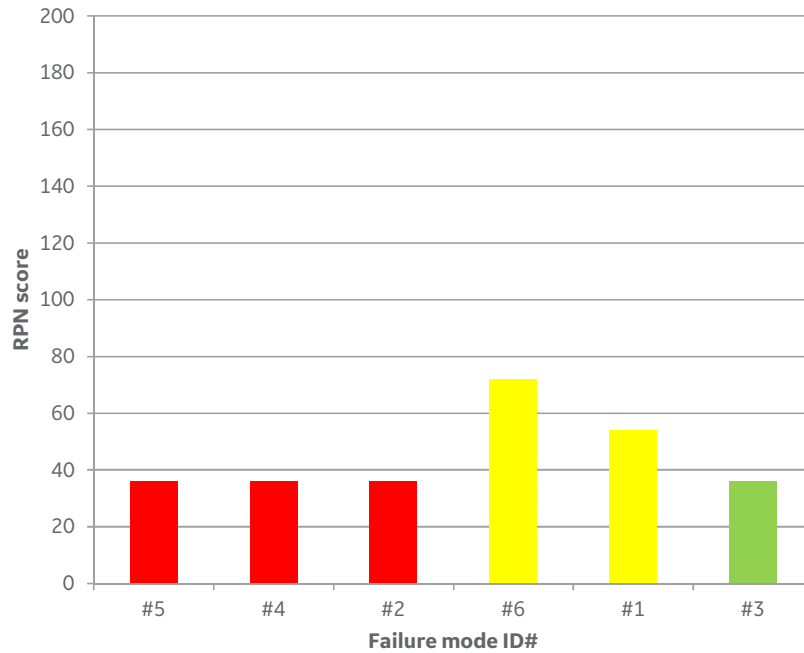
RPN



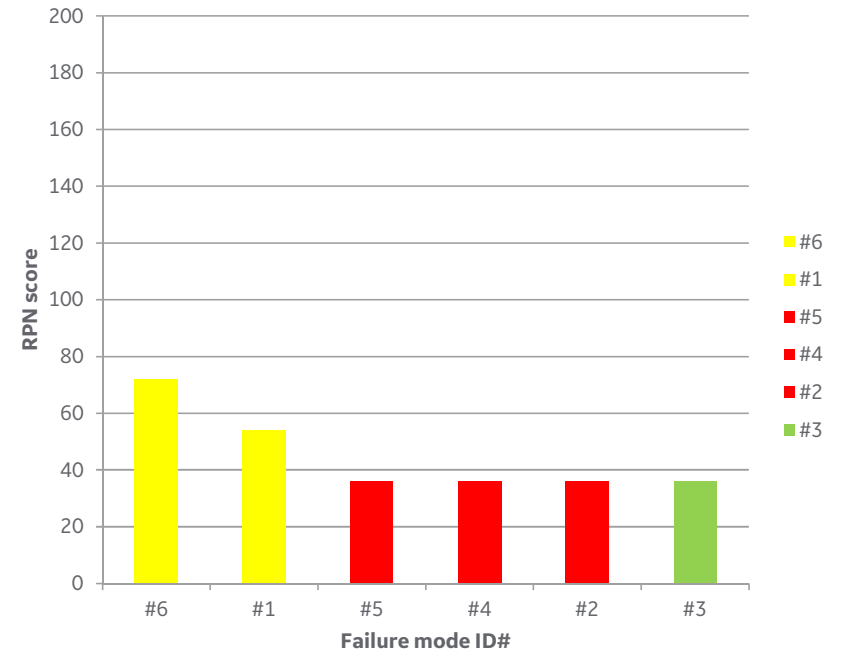
Pareto plot after risk mitigation

RPN

New RPN



New RPN sorted



Investigation on highest risks after mitigation

Examples

Experimental work

DoE

Training

New equipment

Facility upgrade

Business management



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