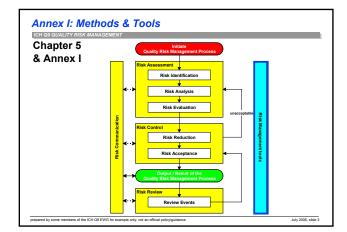
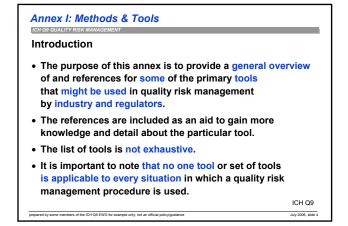
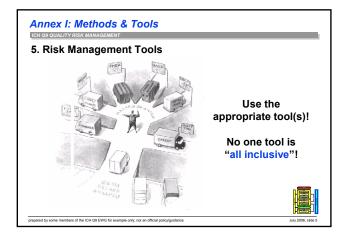
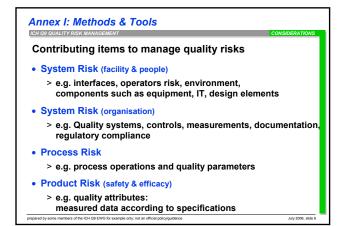


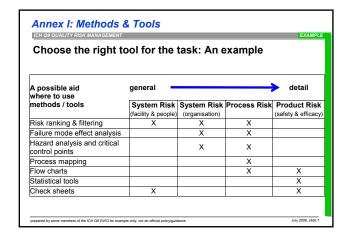
Annex I: Methods & Tools [CHOS QUALITY RISK MANAGEMENT] Purpose of this part • To guide through Risk Management Methods and Tools • Give an aid by providing key principles on the theory of the tools • Give some examples and methods of use

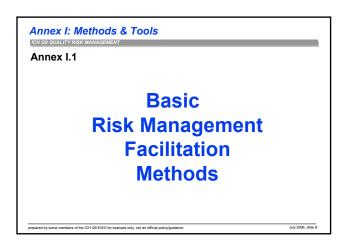


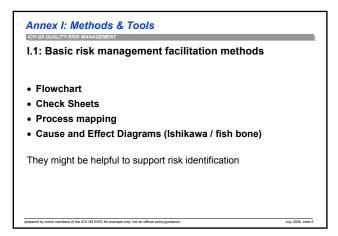


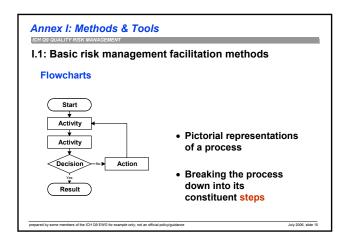


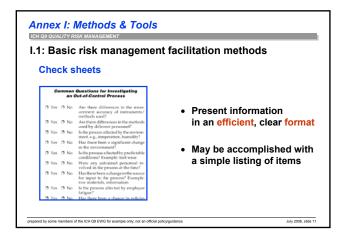


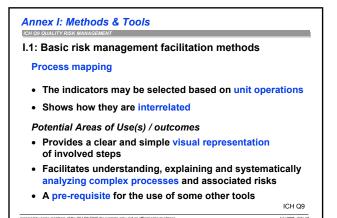


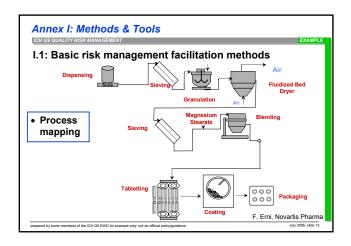


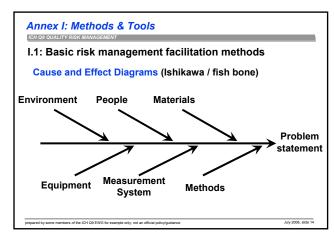












Annex I: Methods & Tools

[CHOO CUMLITY RISK MANAGEMENT]

I.1: Basic risk management facilitation methods

Cause and Effect Diagrams (Ishikawa / fish bone)

• To associate multiple possible causes with a single effect

• Constructed to identify and organize possible causes for it

• Primary branch: represents the effect

• Major branch: corresponds to a major cause

• Minor branch: correspond to more detailed causal factors

Annex I: Methods & Tools

ICHOS CUALITY RISK MANAGEMENT

I.1: Basic risk management facilitation methods

Cause and Effect Diagrams (Ishikawa / fish bone)

How to perform?

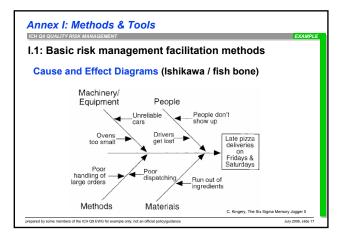
• Define and agree a precise problem statement (put as "head" of fish bone) Think "What could be its causes?" for each node

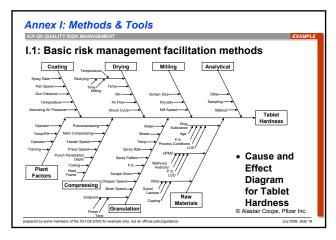
• Add it to the "fish bone" diagram

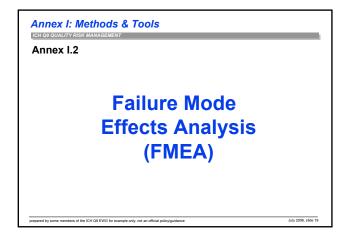
• For each line pursue back to its root cause

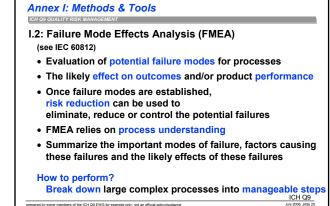
• Consider splitting up overcrowded sections "bones"

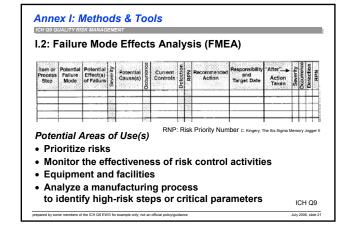
• Consider which potential root causes and the need for further investigation on them

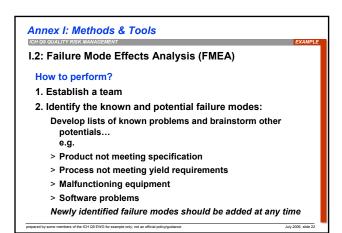


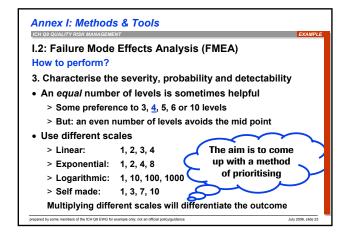


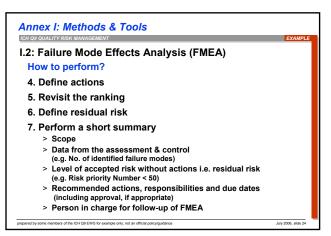


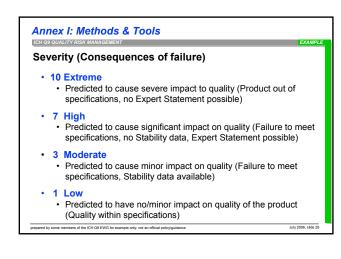


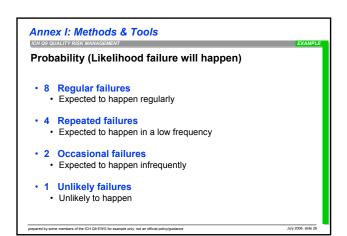


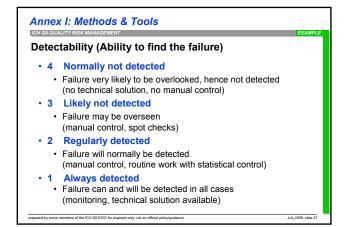


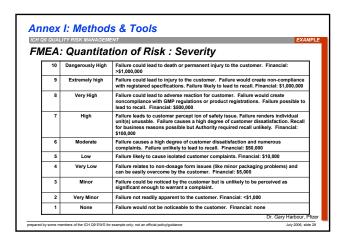


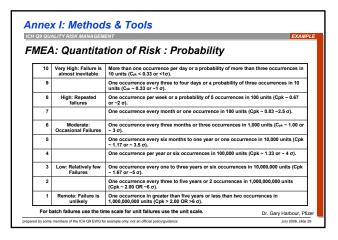


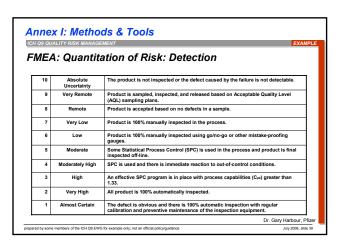




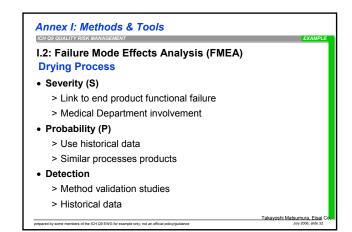


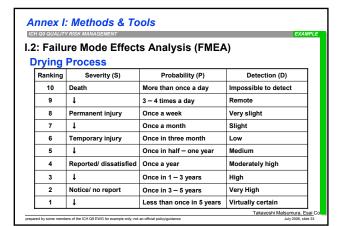


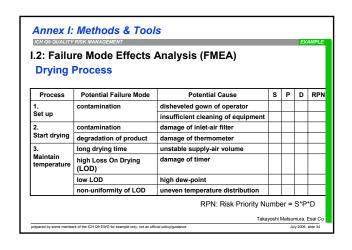


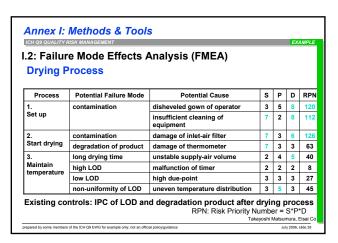


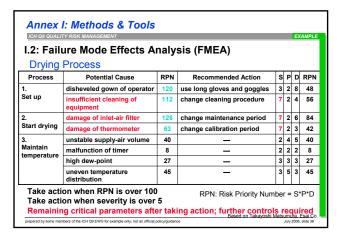
	ALITY RISK MANAGEMENT		EXAM		
Severity / Probability / Detection (SPD)					
Ranking	Severity (S)	Probability (P)	Detection (D)		
1	Negligible effect on final product performance as designed.	Never happened and is unlikely to occur.	Can always detect failure before it reaches customer		
3	Reasonable expectation that the patient/ user will experience inconvenience e.g. can't open container.		High confidence will detect both random and systemic errors >99%		
4	Reasonable expectation that the patient' user will experience temporary discomfort not requiring medical intervention e.g. pain on injection, brief fever	Low volume production: Never occurred but likely to or Seen once on a similar product, High volume production: Problem occurred once in 2 years	Confident systemic errors will be detected. > 95% Little chance of random error detection <95%		
6	Reasonable expectation that the fault will cause patient/user non- permanent medical condition requiring medical intervention e.g., infection requiring antibiotics.	Low volume production: Occurred once in 5 years High volume production: Occurred more than once per year			
8	Reasonable expectation that the fault will cause patient/user permanent injury e.g. paralysis, coma.	Problem occurs occasionally more than 3 times per year	No confidence that a random or remote error will be detected e.g.,. < 95%		
10	Reasonable expectation that the fault will cause patient/user death.	Occurs frequently >1% of batches/vials/events	Virtually impossible to detect failure before it reaches customer		

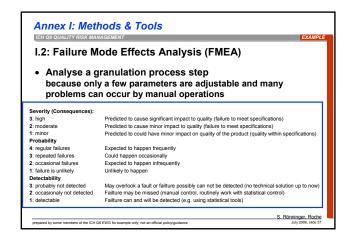


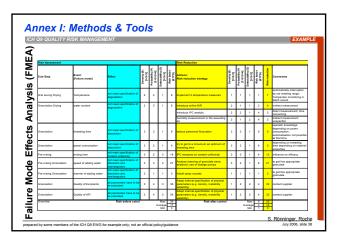


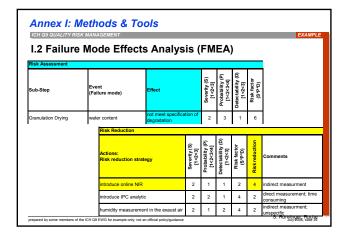


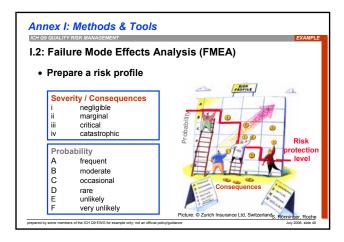


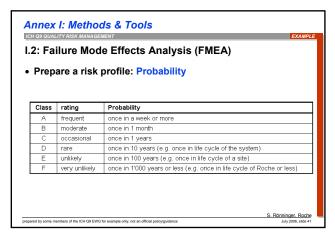


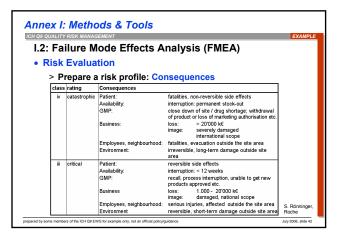


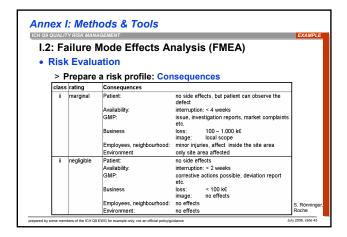


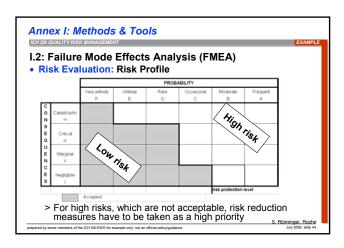


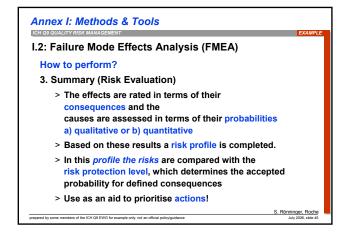


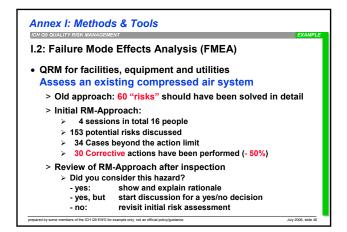


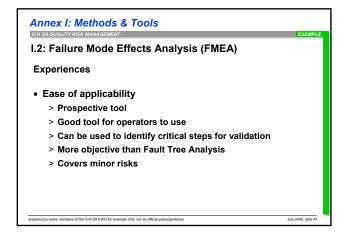


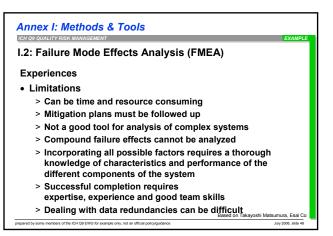


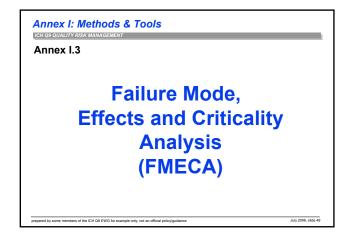






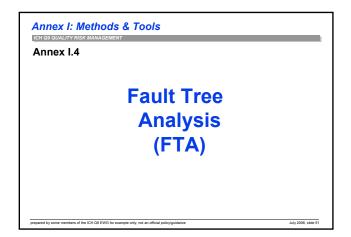


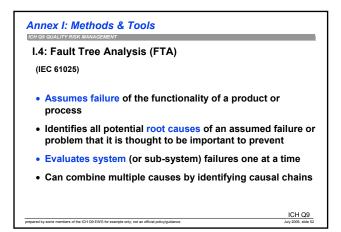


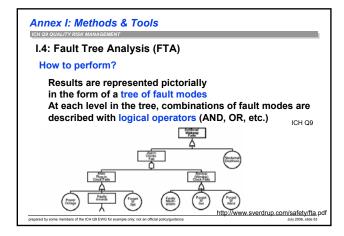


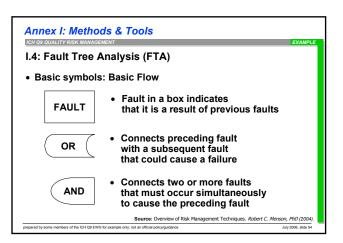
I.3: Failure Mode, Effects and Criticality Analysis (FMECA) (IEC 60812) • Extended to incorporate an investigation of the degree of severity of the consequences, their respective probabilities of occurrence and their detectability • The product or process specifications should be established • Identify places where additional preventive actions may be necessary to minimize risks Potential Areas of Use(s) • Utilized on failures and risks associated with manufacturing processes

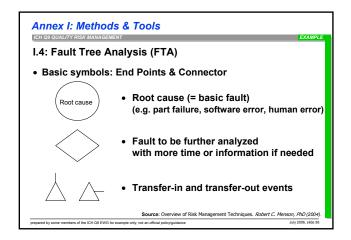
Annex I: Methods & Tools

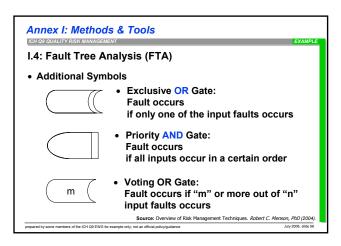












Annex I: Methods & Tools

I.4: Fault Tree Analysis (FTA)

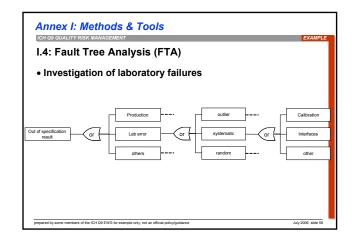
Potential Areas of Use(s)

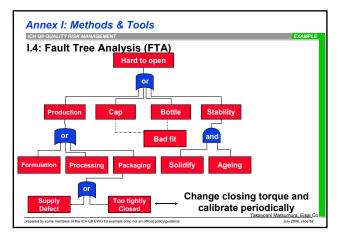
• Establish the pathway to the root cause of the failure

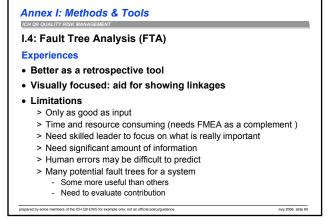
• While investigating complaints or deviations to fully understand their root cause

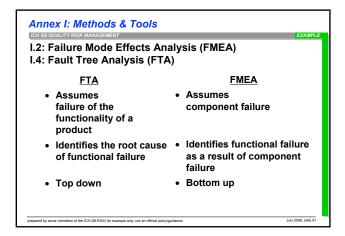
• Ensure that intended improvements will fully resolve the issue and not lead to other issues

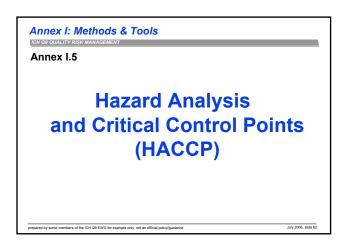
• Evaluating how multiple factors affect a given issue











Annex I: Methods & Tools

I.5: Hazard Analysis and Critical Control Points (HACCP)

"A systematic, proactive, and preventive method for assuring product quality, reliability, and safety"

WHO: http://www.who.int/medicines/library/qsm/trs908/trs908-7.pdf
Application of Hazard Analysis and Critical Control Point (HACCP) methodology to pharmaceuticals, WHO Technical Report Series No 908, Annex 7, WHO, Geneva, 2003

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1.5: Hazard Analysis and Critical Control Points (HACCP)

How to perform?

1. Conduct hazard analysis: identify preventive measures for each step of the process

2. Determine critical control points (CCP's)

3. Establish target levels and critical limit(s)

4. Establish system to monitor the CCP's

5. Establish corrective actions to be taken, if CCP is out of control

6. Establish verification procedures, that HACCP works effectively

7. Establish documentation of all procedures and keep records

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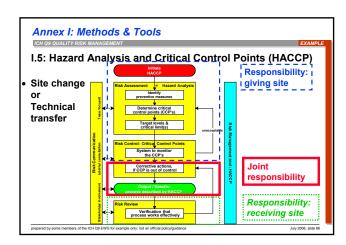
I.5: Hazard Analysis and Critical Control Points (HACCP)

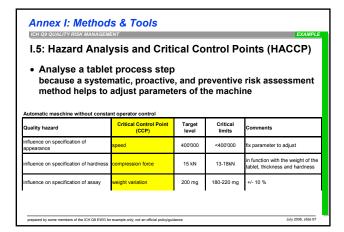
Potential Areas of Use(s)

• To identify and manage risks associated with physical, chemical and biological hazards (including microbiological contamination)

• Useful when process understanding is sufficiently comprehensive to support identification of critical control points (critical parameters / variables)

• Facilitates monitoring of critical points in the manufacturing process





.5: Hazard Analy	ysis and Cr	itical Control Poin	ts (HACCP)
Comments	System to monitor CCP	Possible corrective actions, if CCP is out of control	Keeping records
fix parameter to adjust	by equipment (autoimmunisation)	< content uniformity out of range	online Batch Record
in function with the weight of the tablet, thickness and hardness	by equipment (autoimmunisation)	automatic ejection of tablet	online Batch Record
+/- 10 %	IPC on weight	rejection (100% mass control)	analytical data in Batch Record
	compression force	automatic ejection of tablet	online Batch Record
release limit for stability must be	stability studies	critical limit: min 50 N	stability studies
optimisation during production	IPC of appearance	adjust machine parameters	online Batch Record

Annex I: Methods & Tools

I.5: Hazard Analysis and Critical Control Points (HACCP)

Experiences

- Benefit
 - > Teamwork in cross functional groups
 - > Use very similar principles in Qualification & Validation
 - > Critical control points (CCPs) are similar to critical process parameters
- · Limitations of the model
 - > Has to be combined with another tool (e.g. FMEA, statistical tools)
 - > Not good for complex processes
 - > Assumes you know the processes
 - > Most CCPs should be addressed for risk control activities
 - > May need to use other models for quantifying risk

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Annex I: Methods & Tools ICH Q9 QUALITY RISK MANAGEMENT

Annex I.6

Hazard Operability Analysis (HAZOP)

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Annex I: Methods & Tools

H Q9 QUALITY RISK MANAGEMENT

I.6: Hazard Operability Analysis (HAZOP)

IEC 61882)

- A theory that assumes that risk events are caused by deviations from the design or operating intentions
- Identify potential deviations from normal use

How to perform?

A systematic brainstorming technique for identifying hazards using so-called "guide-words" applied to relevant parameters:

> No, More, Other Than, None

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H Q9 QUALITY RISK MANAGEMENT

I.6: Hazard Operability Analysis (HAZOP)

Concept

- Focus team discussions by applying "deviations" to specific nodes
- Deviations are generated by applying Guidewords to process parameters
- Examine the process by discussing causes of each deviation
 - > Identify consequences
 - > Evaluate risk and safeguards
 - > Make recommendations, if necessary
- . Include all parts of the process

Source: Hazard and Operability Studies in Solid Dosage Manufacture. Nail L. Maxson. (2004)
spared by some members of the ICH Q9 EWG for example only; not an official policylguidance

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CH Q9 QUALITY RISK MANAGEMENT

I.6: Hazard Operability Analysis (HAZOP)

Potential Areas of Use(s)

- . Manufacturing processes
- . Equipment and facilities
- Evaluating process safety hazards
- . Primarily as starter of a HACCP
- Operator error ("use error")

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I.6: Hazard Operability Analysis (HAZOP)

Guidewords	Explanation	Remarks
NO, NOT, NONE	The total absence of the function	No part of the function is active, but also nothing else happens
MORE LESS	Quantitative increase or Quantitative decrease	This applies to quantities & properties such as flow, temperature, and also for functions such as heating and reacting.
AS WELL AS	Qualitative increase or Qualitative decrease	All desired functions & operations are achieved Additionally, something else happens. Only a few functions are achieved, some not.
REVERSE	E The logical reverse of the desired function be applied to materials, e.g., poison instead of antidote, or D- instead of L- optical isomer.	
OTHER Total exchange		The original function is not performed. Something totally different happens.

Annex I: Methods & Tools I.6: Hazard Operability Analysis (HAZOP) Deviation Causes Consequences Safeguards Recommend Feed material #1 Steam heating Diverse high temp. Test interlock High temperature in blender control reaches interlock on on quarterly basis decomposition temperature malfunction blender Blender vented Add steam Violent reaction with heating contro to monthly PM toxic gas generation Equipment damage prepared by some members of the ICH Q9 EWG for example only; not an official polici

Annex I: Methods & Tools ICH Q9 QUALITY RISK MANAGEMENT 1.6: Hazard Operability An

I.6: Hazard Operability Analysis (HAZOP)

Experiences

- . Ease of applicability of the model?
 - > Simplifies decision making
 - > Allows uniformity of analysis across sites
 - > Process steps guided ("guide words", if available)
- . Limitations of the model
 - > Applies to specific situations only
 - > May need to use other models for quantifying risk
 - > Not a structured approach
 - > Not designed for quantifiable risk assessment
 - > Complex output

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I.7: Preliminary Hazard Analysis (PHA)

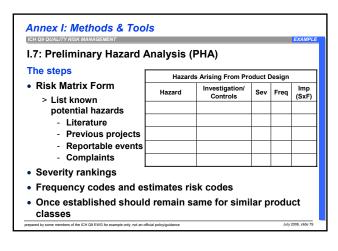
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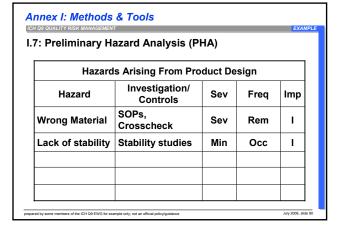
- Analysis based on applying prior experience or knowledge of a hazard or failure to identify future hazards, hazardous situations and events that can cause harm
- In estimating their probability of occurrence for a given activity, facility, product or system

How to perform?

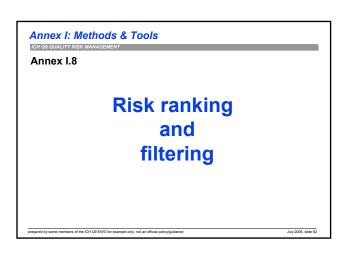
- Identification of the possibilities that the risk event happens
- Qualitative evaluation of the extent of possible injury or damage to health that could result
- · Identification of possible remedial measures

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Annex I: Methods & Tools

I.8: Risk ranking and filtering

Compare and prioritize risks

How to perform?

• Requires evaluation of multiple diverse quantitative and qualitative factors for each risk

• Involves breaking down a basic risk question into as many components as needed to capture factors involved in the risk

• These factors are combined into a single relative risk score that can then be compared, prioritized and ranked

Annex I: Methods & Tools

[CHOS COLLEGE ANNAGEMENT]

I.8: Risk ranking and filtering

Potential Areas of Use(s)

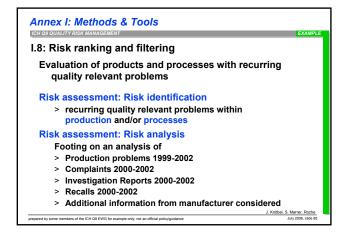
• To prioritize manufacturing sites for inspection/audit by regulators or industry

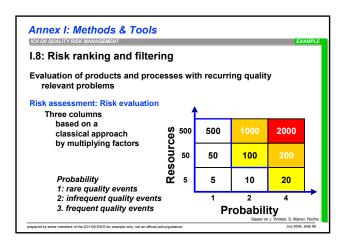
• Helpful in situations in which the portfolio of risks and the underlying consequences to be managed are diverse and difficult to compare using a single tool

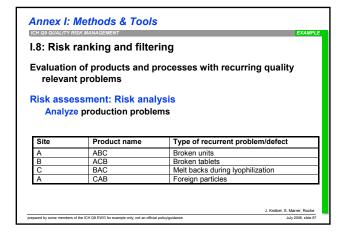
• Useful when management needs to evaluate both

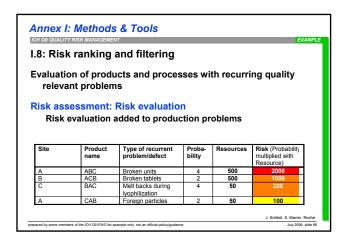
quantitatively and qualitatively assessed risks within the

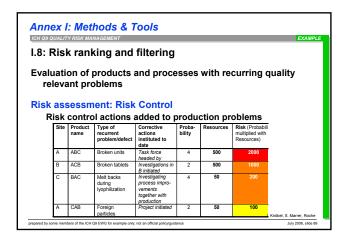
same organizational framework

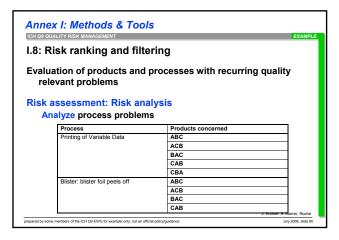


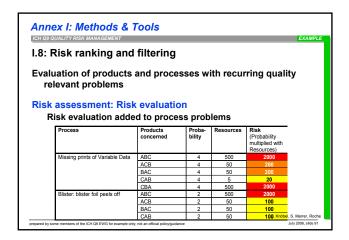


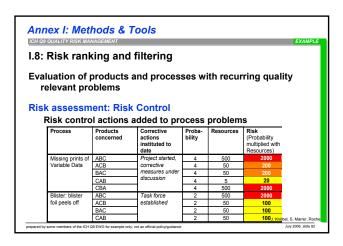


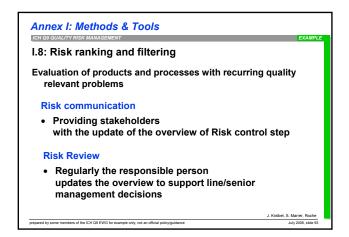


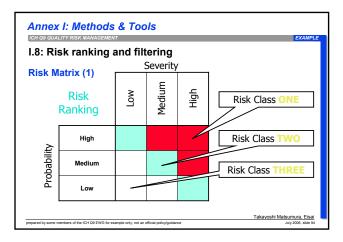


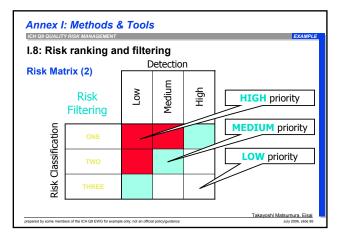


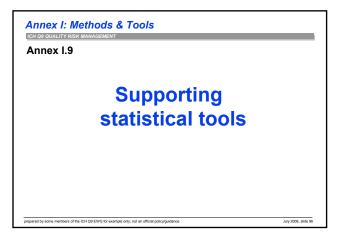


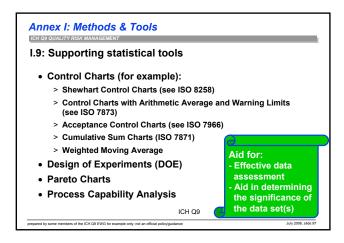


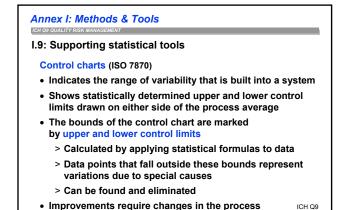




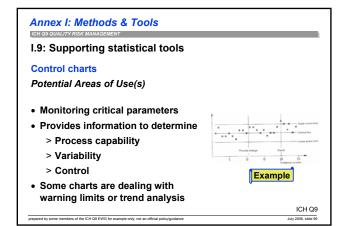


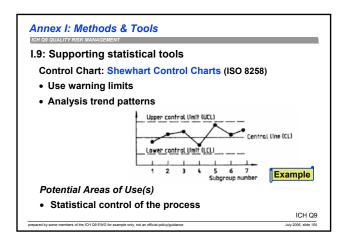


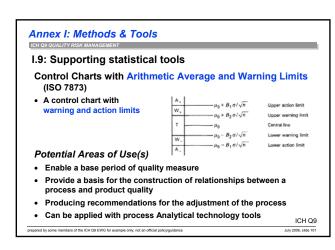


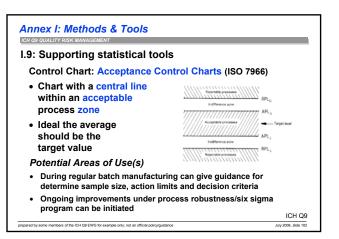


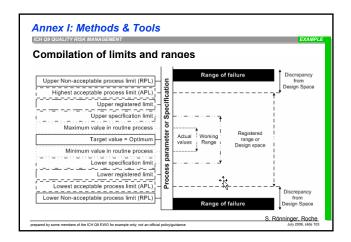
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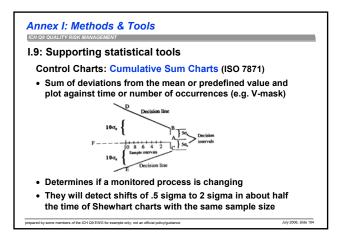


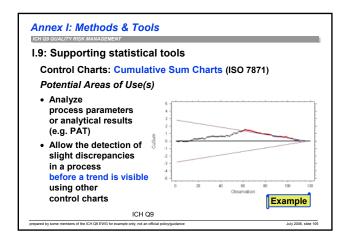


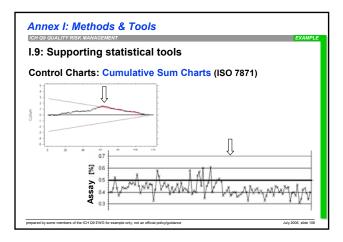


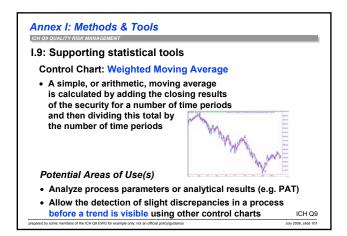


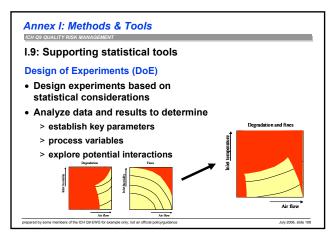












Annex I: Methods & Tools 1.9: Supporting statistical tools Design of Experiments (DOE) Potential Areas of Use(s) Research and development area Retrospective evaluation of established parameters (Proven Acceptable Ranges Systematically choosing certain combinations of

 Systematically choosing certain combinations of variables it is possible to separate their individual effects

 A special variant: focus on optimizing design parameters to minimize variation BEFORE optimizing design to hit mean target values for output parameters

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Annex I: Methods & Tools

ICH 09 CUALITY RISK MANAGEMENT

I.9: Supporting statistical tools

Design of Experiments (DOE) in a submission

• Type of experimental design used e.g. full/ fractional factorial

• Justification of the selection of factors and responses

• As an appendix

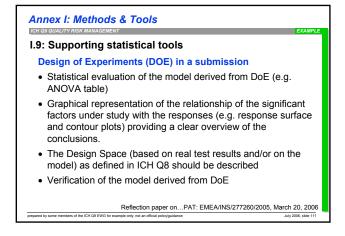
> Number and levels of factors under study

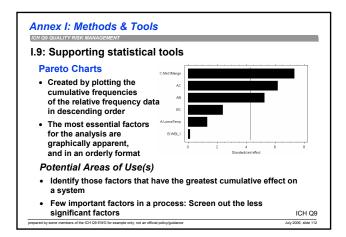
> The experimental matrix with the values of the responses for each combination of factors

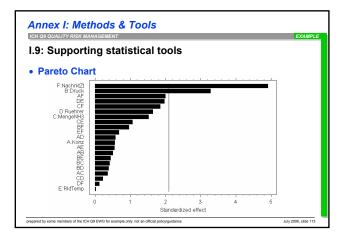
• Graphical representation

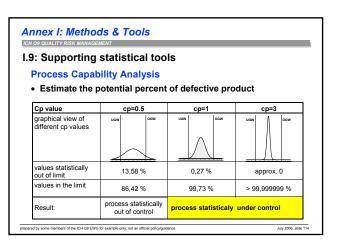
> Coefficient plot of the relative significance of the factors under study and interactions between them

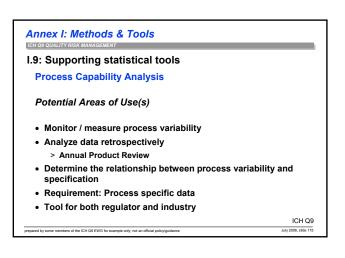
Reflection paper on...PAT: EMEA/INS/277260/2005, March 20, 2006

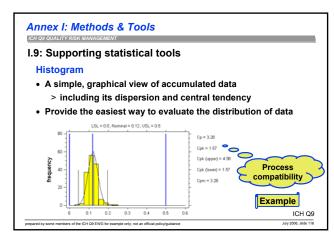


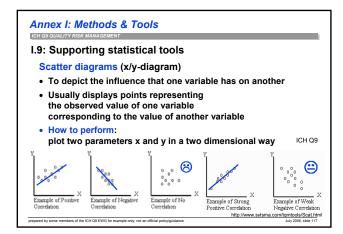


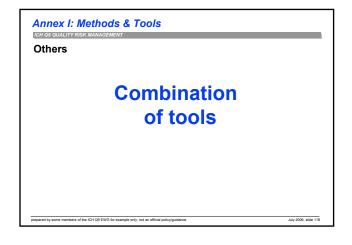




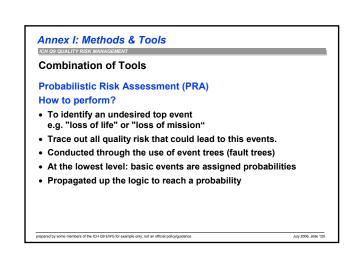


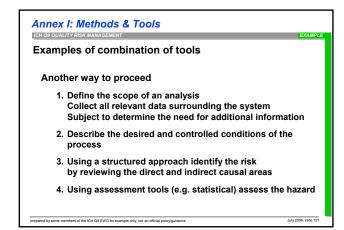


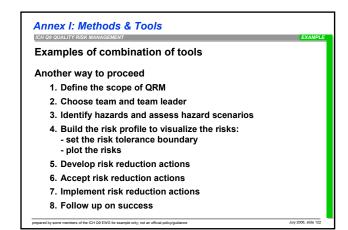


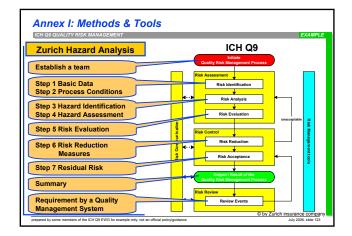


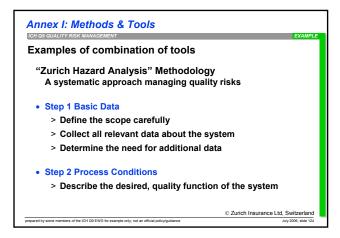
Annex I: Methods & Tools Combination of Tools Probabilistic Risk Assessment (PRA) Integrating various reliability modelling tools such as Fault Tree, Event Tree Block Diagram, FMEA to numerically quantify risks Determine what quality risk scenarios can occur, what is the likelihood and the consequences given they occur. Estimates of the parameters used to determine the frequencies and probabilities of the various events It involves the development of models that delineate the response of systems and operators to accident initiating events. http://www.relexsoftware.com/resources/riskassess.asp

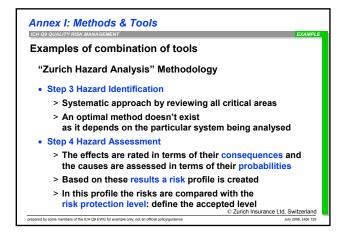


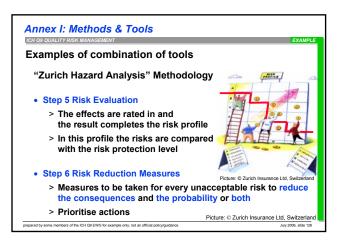


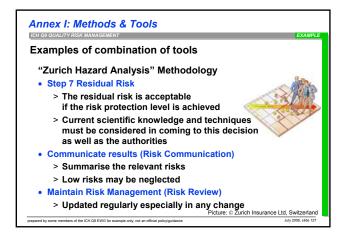


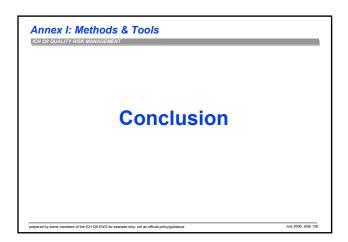


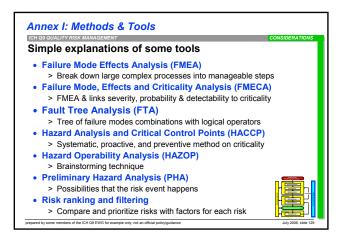


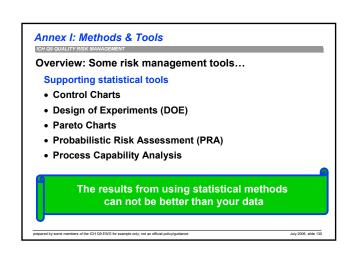




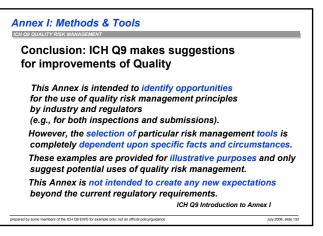




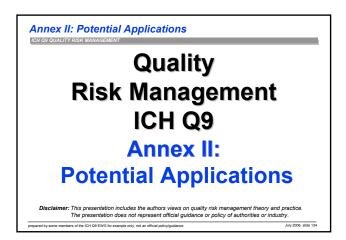




Annex I: Methods & Tools ICHOR QUALITY RISK MANAGEMENT Conclusion on Methods and Tools • Provides a general overview of and references for some of the primary tools • Might be used in QRM by industry and competent authorities • This is not an exhaustive list • No one tool or set of tools is applicable to every situation in which a QRM procedure is used







Annex II: Potential Applications

Purpose of this part

- To guide through
 Potential Applications for Quality Risk Management
- Provision of some concrete, non exhaustive examples

spared by some members of the ICH Q9 EWG for example only; not an official policylguidance

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Annex II: Potential Applications

Introduction

- This Annex is intended to identify potential uses of quality risk management principles and tools by industry and regulators.
- However, the selection of particular risk management tools is completely dependent upon specific facts and circumstances.
- These examples are provided for illustrative purposes and only suggest potential uses of quality risk management.
- This Annex is not intended to create any new expectations beyond the current regulatory requirements.

prepared by some members of the ICH Q9 EWG for example only; not an official policy/guidance

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Annex II: Potential Applications

Potential Applications for Quality Risk Management

Quality Risk Management as Part of...

- II.1 Integrated Quality Management
- II.2 Regulatory Operations
- II.3 Development
- II.4 Facilities, Equipment and Utilities
- II.5 Materials Management
- II.6 Production
- II.7 Laboratory Control and Stability Studies
- I.8 Packaging and Labelling

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Annex II: Potential Applications

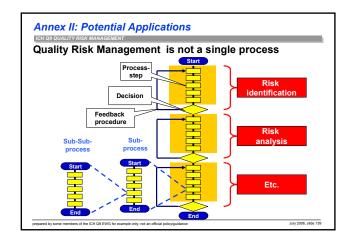
Quality risk management

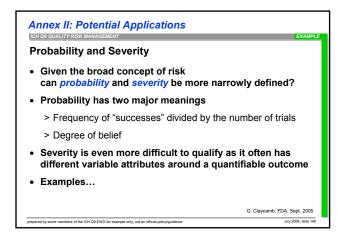
Communication
facilitates trust
and understanding

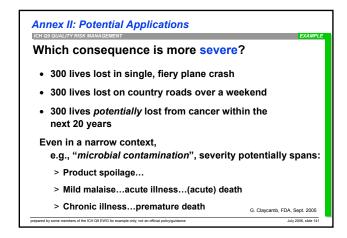
Regulators
operation
- Reviews
- Inspections
- Submissions
- Manufacturing

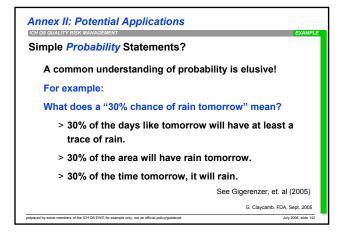
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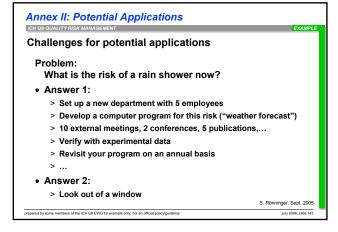
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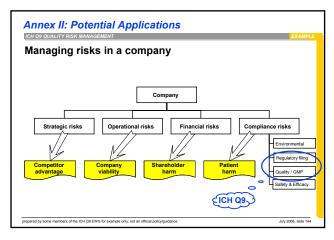


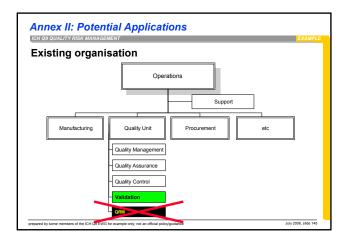


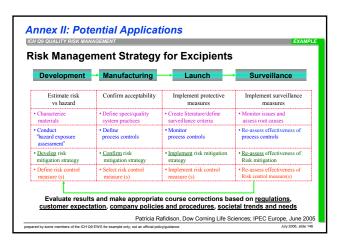














Annex II: Potential Applications

[CH 09 QUALITY RISK MANAGEMENT

Quality risk management as part of...

II.1: Integrated quality management

> Documentation

> Training and education

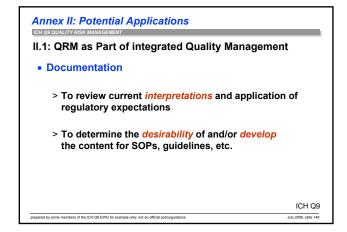
> Quality defects

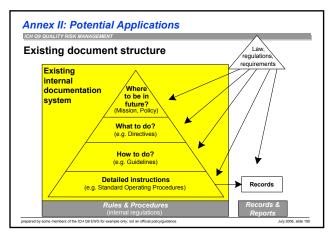
> Auditing / Inspection

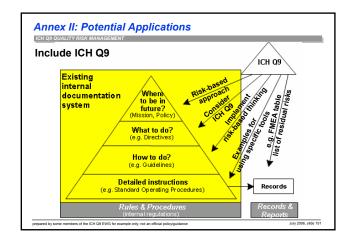
> Periodic review

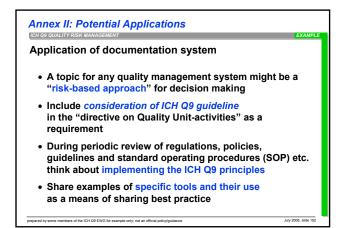
> Change management / change control

> Continual improvement

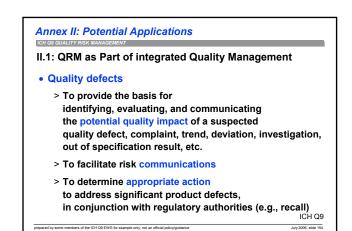


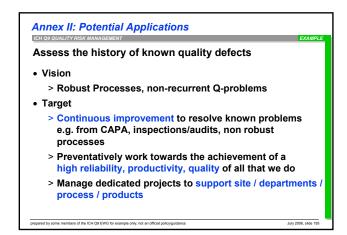


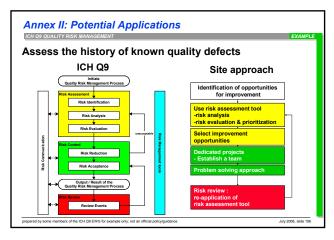


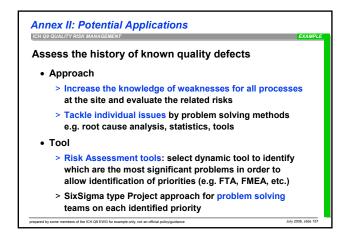


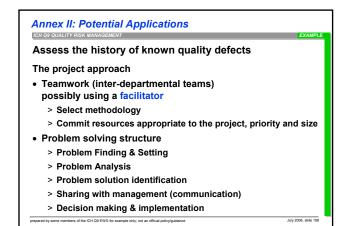
Annex II: Potential Applications THE CONTRIBER MANAGEMENT II.1: QRM as Part of integrated Quality Management • Training and education • To determine the appropriateness of initial and/or ongoing training sessions • Based on education, experience and working habits • A periodic assessment of previous training (effectiveness) • To identify the training, experience, qualifications and physical abilities • To perform an operation reliably and with no adverse impact on the quality of the product ICH Q9 page 100 CH QUE THE CONTRIBER OF THE PRODUCT IN CO



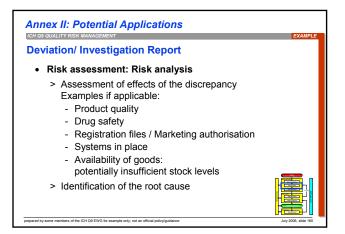


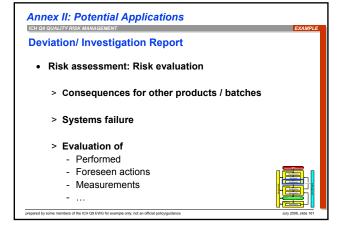


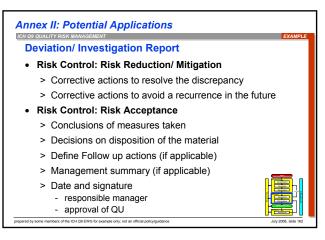


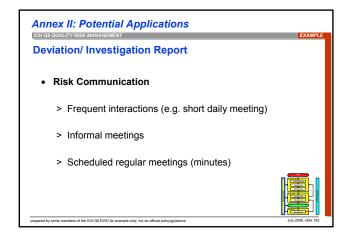


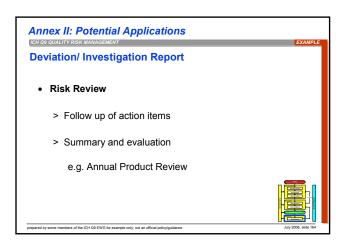


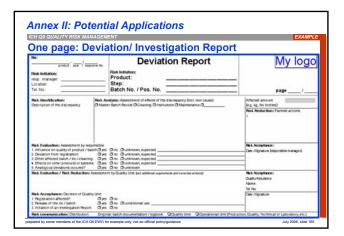


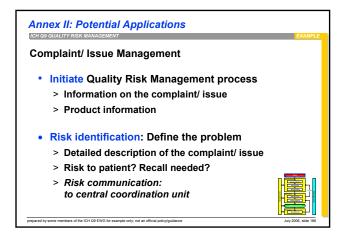


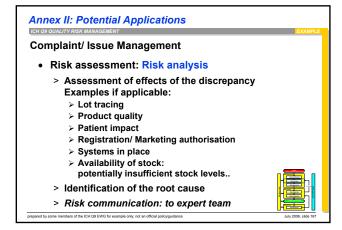


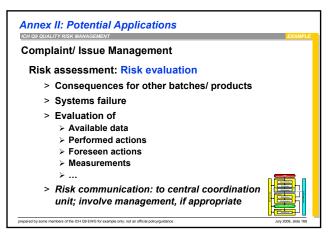


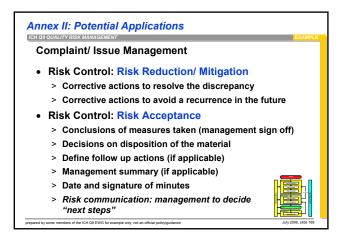


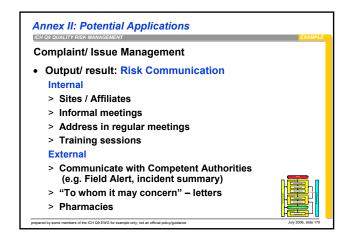


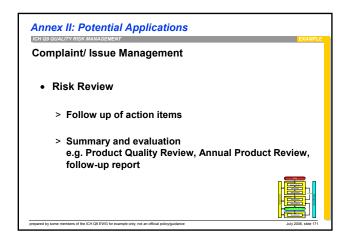


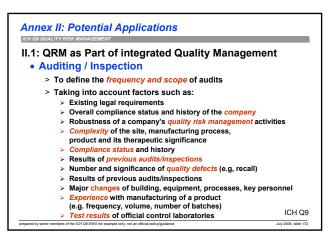


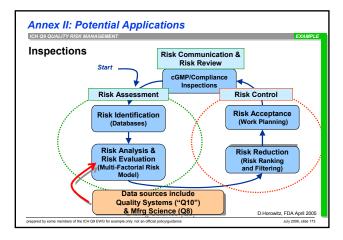




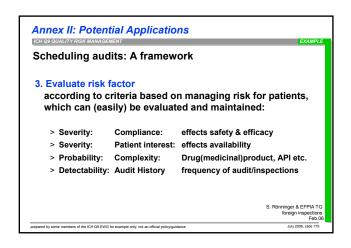


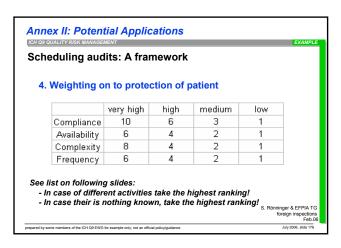


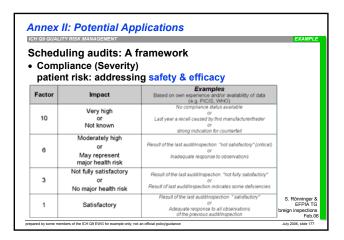


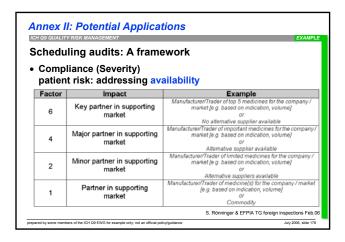


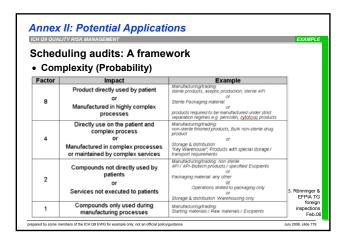


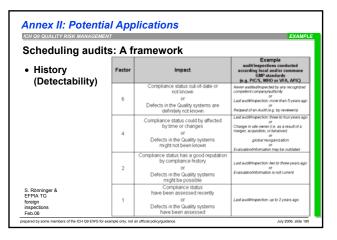


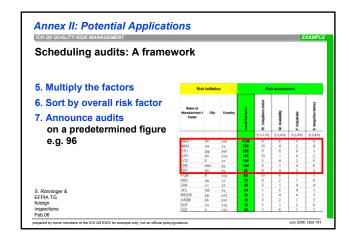


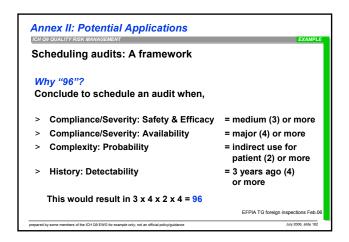


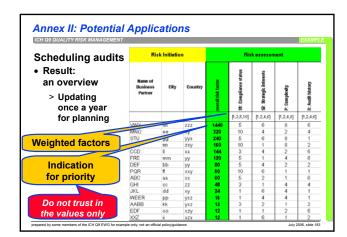


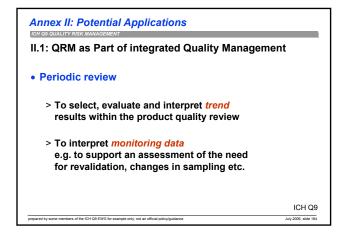


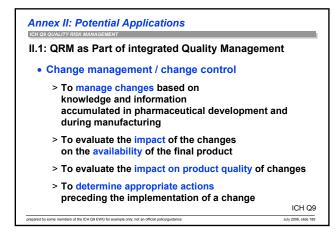


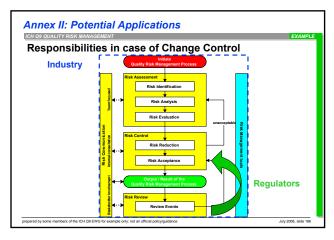


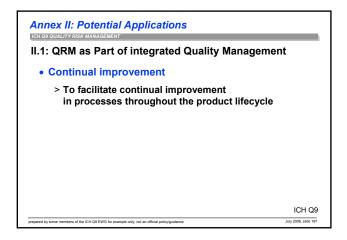


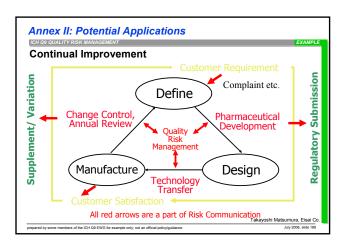


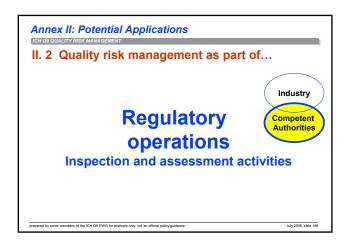


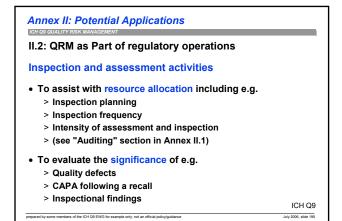


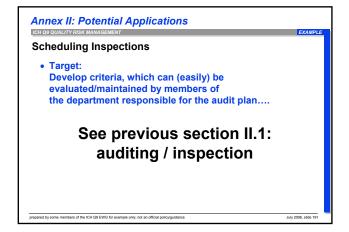












Annex II: Potential Applications

II.2: QRM as Part of regulatory operations

Inspection and assessment activities

• To determine the appropriateness and type of post-inspection regulatory follow-up

• To evaluate information submitted by industry including pharmaceutical development information

• To evaluate impact of proposed variations or changes

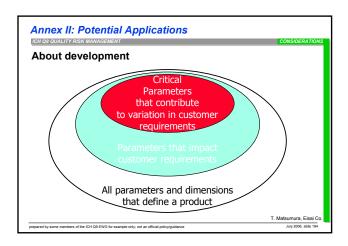
• To identify risks which should be communicated

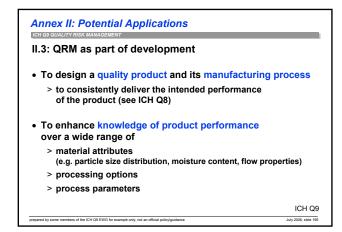
> between inspectors and assessors

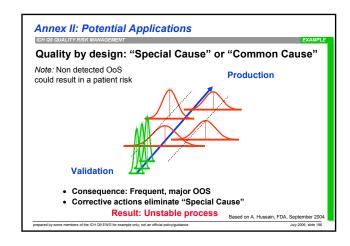
• To facilitate better understanding

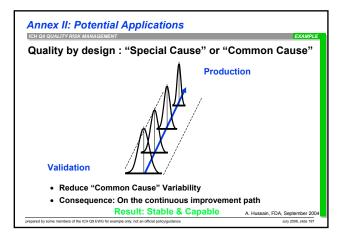
> how risks can be or are controlled (CHQ9) (e.g., parametric release, Process Analytical Technology (PAT)

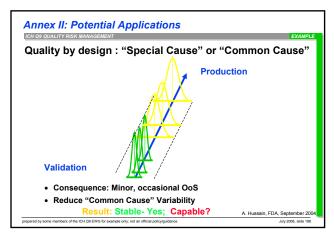


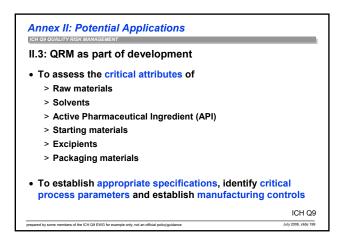


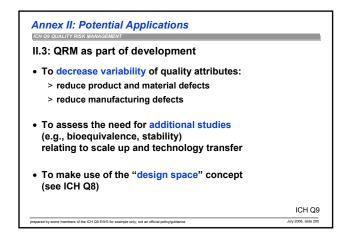


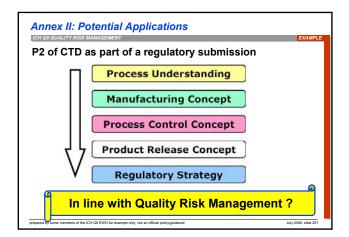


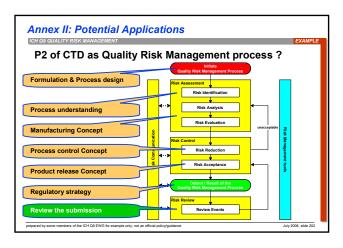


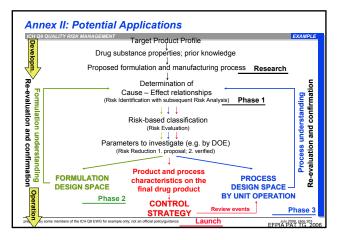


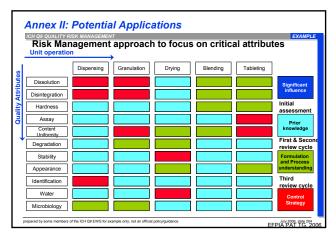


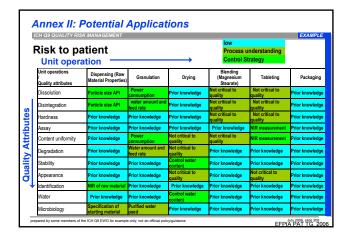


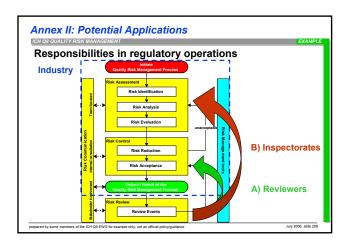


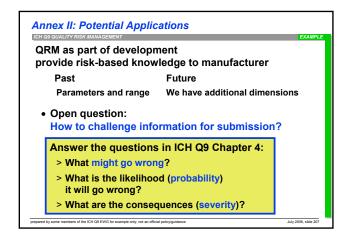


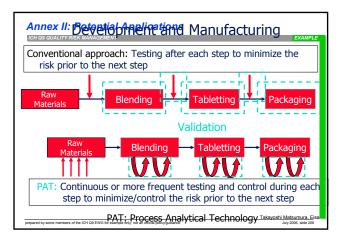




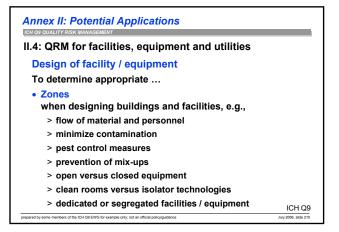


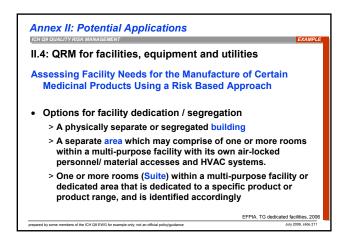


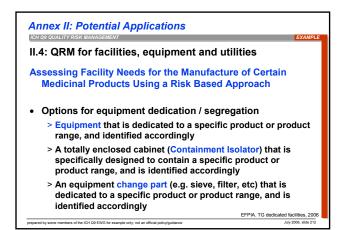


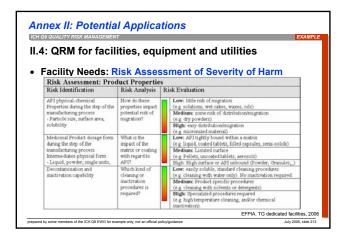


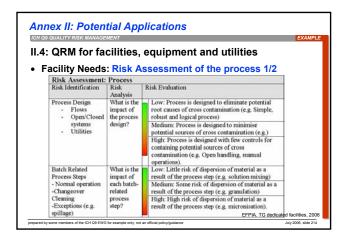


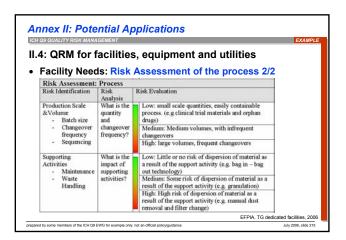


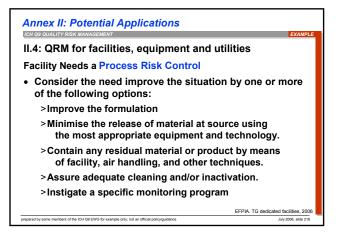


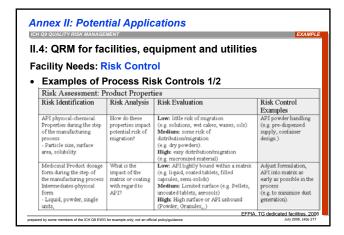


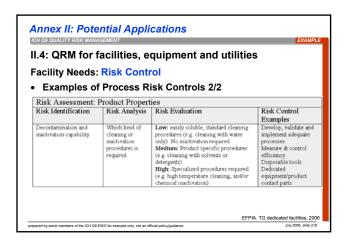


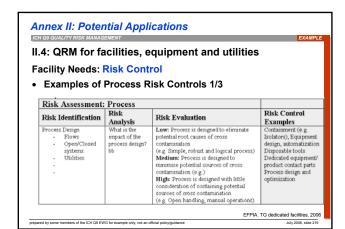


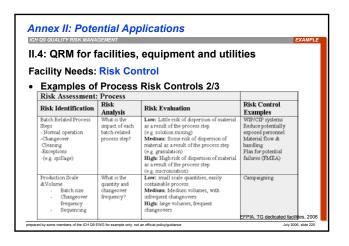


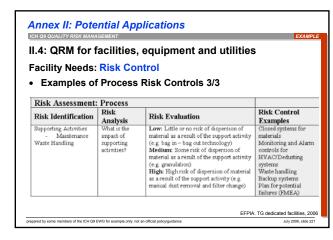


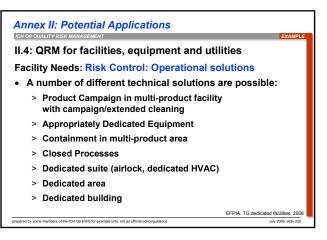


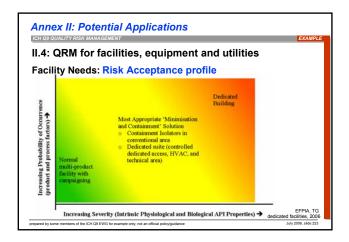


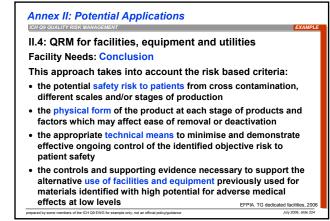


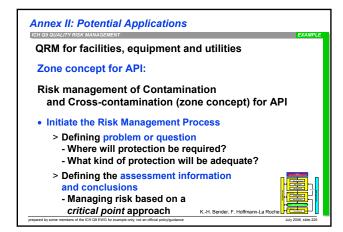


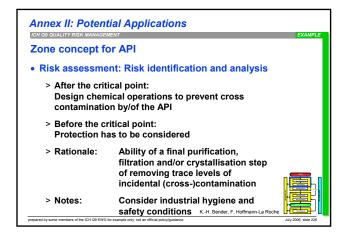


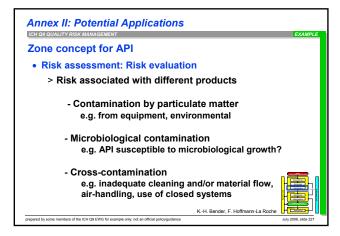


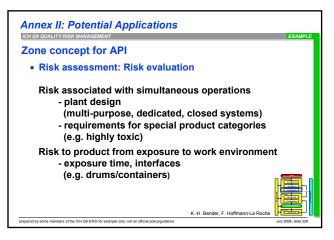


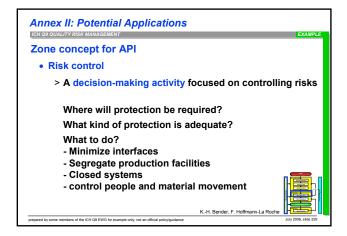


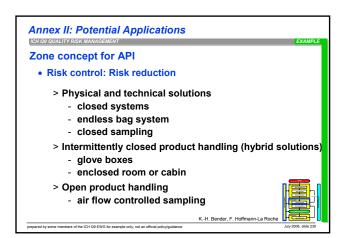


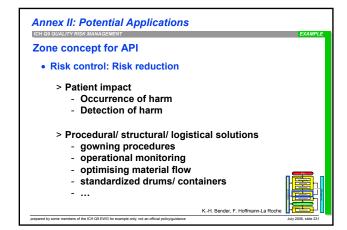


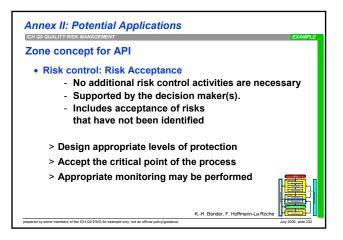


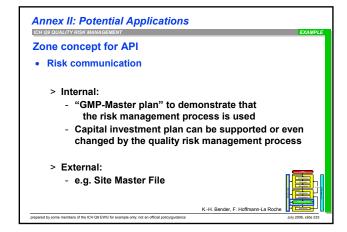


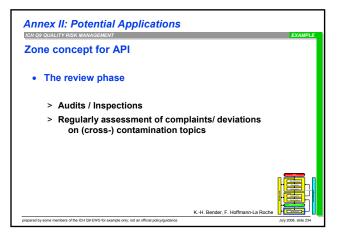


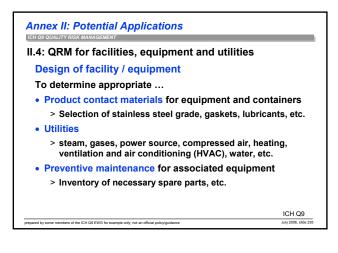


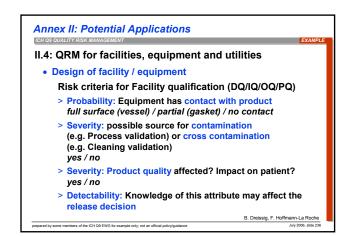


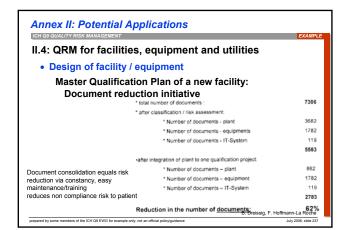


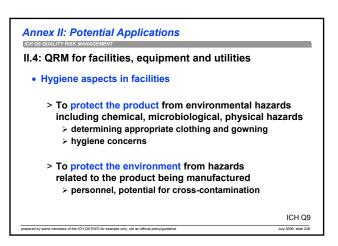


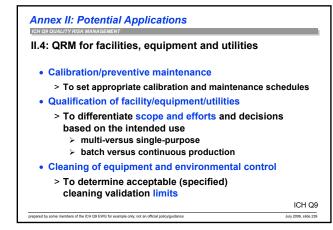


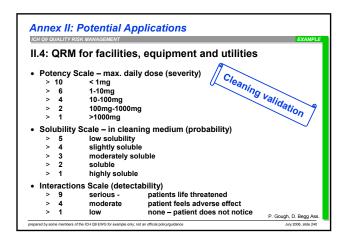


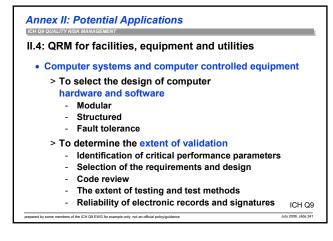


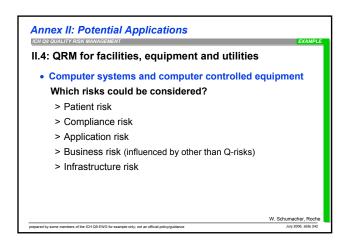


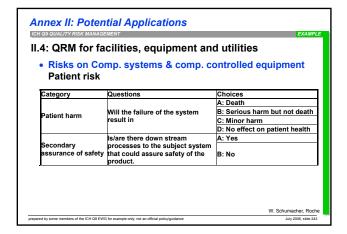


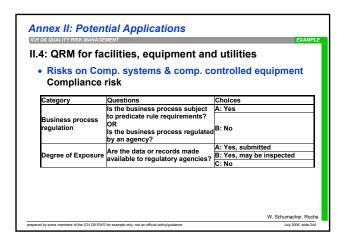


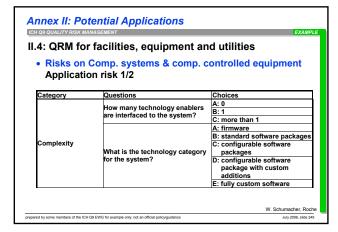


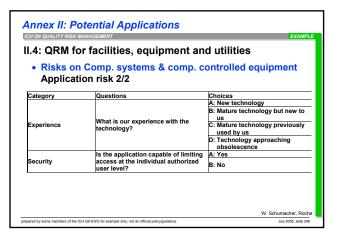


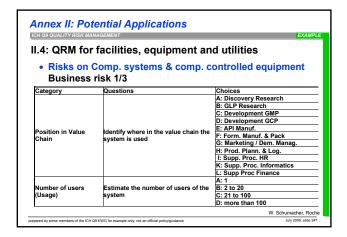


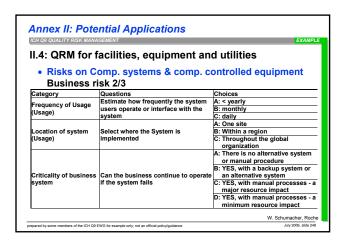


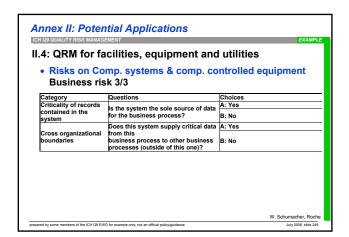


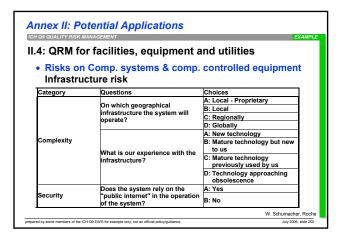




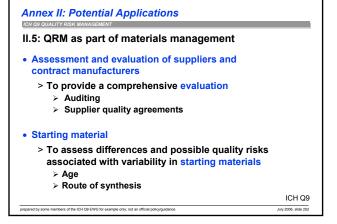


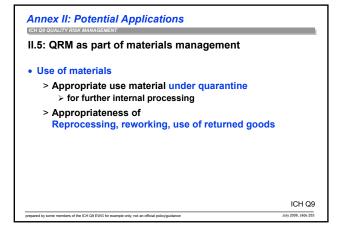


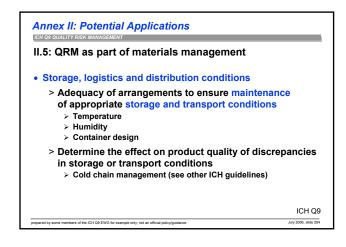


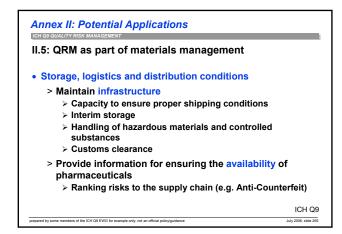


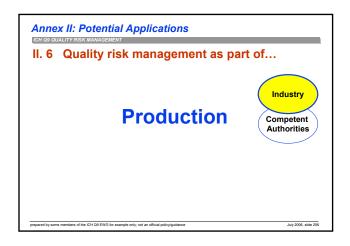


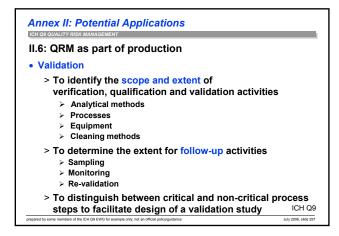


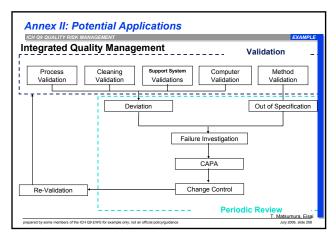


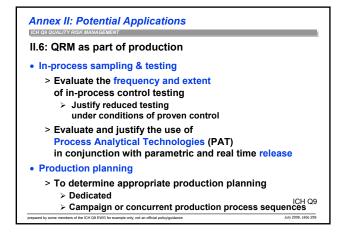




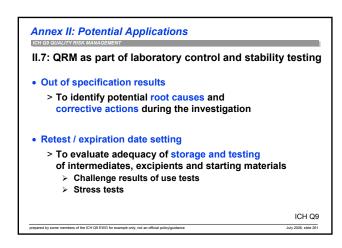


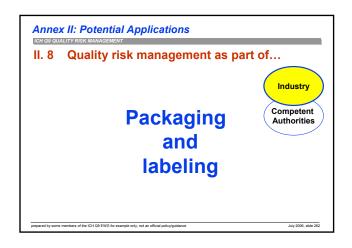


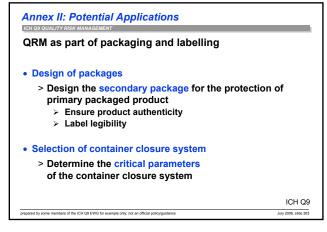


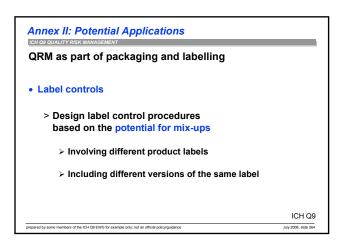












Annex II: Potential Applications

Quality risk management as part of...

Conclusion

prepared by some members of the ICH Q9 EWG for example only; not an official policy/quidance

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Annex II: Potential Applications

Using ICH Q9 will...

- Facilitate
 - > Communication and transparency
 - > More informed, scientifically based decision making
 - > Patient focused actions on quality risks
 - > Realistic and appropriate solutions
 - > Use of existing solutions (Share best practice/prior knowledge)
- Manage critical to quality aspects
 - > Through systems, organisations, processes & products
 - > Maintain responsibility & accountability for QRM
- Focus activity towards patient protection

It should never be used as a "hobby horse" / preconceived idea

prepared by some members of the ICH Q9 EWG for example only; not an official policylguidance

Annex II: Potential Applications

Opportunity for the Industry & Competent Authorities

- Using the same guideline apply QRM to industry (Development & Manufacture) and regulators (Reviewer & Inspectorate)
- Provides for establishing a defined program for what we already do every day in our jobs
- Supports science-based decision making
- Optimisation of resources
- Prevention from overly restrictive and unnecessary requirements
- Facilitates communication and transparency

prepared by some members of the ICH Q0 EWG for example only; not an official policy/guidance

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Annex II: Potential Applications

Challenges for Industry & Competent Authorities

- Interpreting and adopting the concepts of quality risk management into specific areas
 - > Embed this behavior into quality aspects of business, technology and regulation
 - > Adopt in existing structures, organizations and Quality System
 - > Balance the documented use of "informal" and "formal" quality risk management

prepared by some members of the ICH Q9 EWG for example only; not an official policy/guidance

July 2006, slide 2

Integration of QRM
into existing systems
and regulatory processes
will require a
development of trust over time