**QA/QC Study Summary Report**

**Study:** Pfizer C4591001 – COVID Vaccine Study
**Date(s) of review:** 10/25/2020 – 11/19/2020

**Regulatory/Complion Review:**

The eRegulatory software was introduced and used in place of the original regulatory binder received from the sponsor. I would recommend based on the findings on this report that the regulatory staff create a standard as to where documents will be filed for all studies. I recently spoke to Kathryn Weems and was informed that we can discuss placement of tabs in the Complion system to enhance and provide more user-friendly access to staff. This task would foster organization and standard filing instructions for those who use the system. I also recommend that all crucial documents be maintained in the current folder and all older documents in archive to alleviate any discrepancy with staff in regards to version control. The chart below mimicks the tabs in Complion and demonstrates the need to provide correction, recommendation and enhanced use of the tabs provided in the system. See attached report.

**Unblinded Investigational Product Review:**

An extensive review of the Investigational Product could not be accomplished due to time restraints. However, I was able to pull 30 charts and perform a quality review based on information in the unblinded binder. The overall findings are minimal, but keep in mind that this review only reflects approximately 10% of charts. One deviation was noted. I have attached the report for your review. **I would suggest to unblinded staff to label each volume. I placed stickers on as an example. I would also suggest that since the source is created by date, that the site be consistent in labeling the date tabs in all the volumes. At present, there are tabs that someone placed all over the binders to separate dates and it appear very unorganized.** Due to time restraints, I did not have time to do a full review of the IP receipt binder. I did see one document that did not include an IMPALA confirmation. **I would suggest that staff review the receipt binder thoroughly to ensure all IMPALA confirmations are present.**

**Subject Chart Reviews: (refer to Master QA Spreadsheet)**

Based on the overall quality reviews for the Pfizer C4591001 I would like to provide specific items that would possibly draw attention and may present an issue to regulatory authorities:

**Issue #1:** **Investigator Oversight:** There is poor investigator oversight. The PI is not signing off on source in a timely manner. The dates of signatures in source are illegible on many entries. The PI is not consistent in using the full 2020 year when entering dates into the source. Sub-I's could be utilized much better if source was not created to designate only a PI to sign off. **Suggested would be Investigator Responsibility training with PI and Sub-I's to express importance of oversight and responsibilities in research. Ensure a PI or Sub-I is available on site Monday thru Friday to address AE's, see patients and provide oversight to the study.**

**Issue #2:** **Adverse Events:** The PI is not signing off timely on the adverse events in some instances. It would appear that the CRC's are not contacting the PI or Sub-I in a timely manner when events are reported.

**Issue #3:** **Source Documentation:** Many staff are not writing clear notes at study visits. When subject reports AE's/con meds, boxes may be checked yes, but only logs are updated. Very minimal documentation is present. Staff are using abbreviations in date fields and when documenting in progress notes. This is not following ALCOA standards for documentation. There are many writeovers in source transcribed by both subjects and staff. There are many versions of the source documents. I located a note to file explaining that why there are many versions but the reason is not due to amendments in the protocol. It appears to be more in regards to formatting. There are also several versions of the ICF checklist. There are multiple forms and documents with no version control. Patient information sheets are not being reviewed by staff at the screening visit. It was found on many occasions withing the medical history that CRC's are not using medical terminology to enter indications. **Suggested are to utilize very experienced staff who could create comprehensive source documents with very little room for error to avoid multiple versions being created. CRC documentation training and medical terminology resources would also enhance their knowledge of good documentation practices.**

**Issue #4:** **Informed Consent:** There are several versions of the ICF checklist with no version control. Some were incorporated in source and some are specific ICF checklist documents. There are many ICF's that were not QC'd by staff at the time of consent. There are also errors which include writeovers or instances where subject signatures do not match that on their ID's. It seems clear that CRC's may not be instructing the subjects on documentation practice for research or writing their full name and appropriate date in the fields required. **See suggestions for Issue #3**

**Issue #5:** **Visit Schedule:** It was noted on many source documents that they remained at the site for a very long length of time for a single study visit. Unable to determine the reasoning which may include poor scheduling of subjects or lack of staff to accommodate the visit schedule. There were also several out of window deviations as well. **Scheduling subjects in cohorts would be helpful in ensuring that the IP was not wasted or visits were not delayed, all the while ensuring enough staff are available to accommodate those cohorts.**

**Issue #6:** **Assessments/Procedures:** The timing of assessments and procedures did not appear to be followed for many subjects. There were many subjects where the time from ICF to IVRS was either the same exact time or either a great delay before other assessments were done. There was a specific coordinator who would write down the ICF time and sitting time for vitals as the same exact time. However, IVRS was not registered until after that time and would not have a subject ID prior to beginning assessments. The initial timing of events is not in order.

Coordinators are also entering the same time, if not a couple minutes from the time of blood draw to the nasal swab. **Documentation should follow real time events and not appear that both procedures are occurring at the same time. Again, educating CRC's in regards to importance of timing of events and reasoning for that importance, would be helpful.**

**Issue #7:** **eDiary and Reporting:** There is a source question with regards to the ediary review which states it was printed and reviewed with staff. Most ediaries are present who record day 1-7. However, many of those ediary reports are missing entries and at times the documentation is not clear as to why. For those participating in the subset, the same question is present in source and the ediary is not printed until Visit 3. I would have expected to see the ediary at each visit behind the source for review and this was not done.

**Issue #8:** Unblinded CRC's are not adhering to the needle size guidance for subject's weight. As per the IP manual, subjects are to receive needle sizes based upon their weight. However, unblinded staff are writing notes directly onto the source indicating that the subject's arm is the appropriate size for a smaller needle. The IP manual does not refer to a subject's arm size and this has afforded several deviations. **Suggest for staff to follow protocol guidance only**

**Summary:**
It is my suggestion that the site revisit some of the note to file's that are created that would draw unnecessary attention to site errors in our operations. There are some note to files that could have been replaced by simply changing the source. It would be highly recommended to allow very seasoned staff to create source documents. This would cut down on multiple versions and the many meetings to discuss the versions and simplify the process. Staff training is very much needed in many areas. The more staff training to address the major issues would be helpful. It would also be helpful to create and adhere to CAPA plans for process improvement prior to an audit. Although there may be findings, the FDA respects that the site take responsibility and document the issues and address the steps for improvement. Operationally, it would help to create thorough work practices for training purposes. This would not only provide more clear and step by step instructions for executing processes, but would also allow management the documentation for acknowledgement of the training for staff accountability purposes. It is my hope that this exhaustive report assists in identifying issues and prompts training and assists in operational improvement.

Sincerely,

QA/QC Team, Fort Worth