

EXPECTATIONS FOR A SUCCESSFUL REGULATORY AUDIT

PURPOSE OF AUDIT

- ◆ To verify compliance with federal regulations for the protection of human research subjects through the review of the following:
 - IRB documentation
 - Consent form content
 - Delegation of Task Logs
 - Signed informed consent documents

AUDIT PREPARATION

- ◆ Well organized and tabbed records are easier to review and ensures all documentation can be located
- ◆ Allows the site to be proactive in fixing errors and implementing corrective action plans
- ◆ Maintenance of records in electronic format is acceptable

IRB REVIEW – LOCAL IRB

Regulatory Binder Contents

- ◆ Annual progress reports
- ◆ Documentation of IRB actions
- ◆ All versions of IRB-approved consent forms or comprehensive list of all approved versions
- ◆ IRB acknowledgement of internal Serious Adverse Events (SAEs), if applicable
- ◆ IRB acknowledgement of safety reports (distributed by sponsor), if applicable
- ◆ Reports of serious non-compliance
- ◆ Correspondence
- ◆ SOPs if applicable to audit process (e.g., submission of external safety reports)

Verification of the following:

- ◆ Initial approval and continuing annual reviews within 365 days
- ◆ Approval of protocol modifications (amendments, revisions, action letters, etc.) and associated consent forms, if applicable, within 90 days of distribution
- ◆ Detailed documentation that provides date of meeting, item approved, protocol/consent versions, etc.
- ◆ Submission of external safety reports reportable per OHRP policy within 90 days (10% verified at audit)
- ◆ Submission of internal Serious Adverse Events per local SOP

Additional information and recommendations

- ◆ Routinely monitor bi-monthly CTSU distributions to ensure timely processing of protocol updates.
- ◆ Create a system for tracking submission of external safety reports to the local IRB, if applicable
- ◆ Alternatively, you are encouraged to work with your IRB to implement alternate procedures for handling external safety reports in accordance with FDA and OHRP guidance
- ◆ Monitor the List of Applicable Protocols for S9808-Long Term Follow-up Protocol and List of Protocols with No Required Follow-up available on the CRA Workbench
- ◆ Verify IRB approval of long-term follow-up protocols against your list of patients on long term follow-up (refer to the CRA Workbench for a list of patients in follow-up at your site)
- ◆ IRB oversight of a study must continue until the protocol has been added to the List of Protocols with No Required Follow-up (available on the CRA Workbench)
- ◆ Per the revised Common Rule effective 1/21/19, some studies may be exempt from continuing review; however, the IRB must continue to monitor the study until it meets the criteria to be closed permanently.

IRB REVIEW – CIRB

Regulatory Binder Contents

- ◆ Initial ***CIRB Approval of the Study-Specific Worksheet About Local Context*** giving approval to conduct the study
- ◆ Updated versions of the ***Study-Specific Worksheet***
- ◆ Documentation of date of local activation or implementation of protocol updates/consent versions
- ◆ Documentation of submission of reportable internal SAEs

Verification of the following:

- ◆ Documentation of CIRB approval of the ***Study-Specific Worksheet*** prior to accrual
- ◆ Implementation of ICF incorporating approved boilerplate language prior to accrual
- ◆ Documentation of date of local activation or implementation of protocol updates/consent versions within 30 days of distribution by the CTSU bi-monthly broadcast email
- ◆ Submission of reportable internal SAEs to the CIRB

Additional information and recommendations

- ◆ If a study transfers from the local IRB to the CIRB, consent forms that include approved boilerplate language must be implemented before consenting new patients
- ◆ If the ***Study-Specific Worksheet*** is updated, local consent forms must be updated to include the new boilerplate language at the time of the next revision or prior to consenting new patients.
- ◆ Routinely monitor bi-monthly CTSU distributions to ensure timely processing of protocol updates.
- ◆ Monitor the List of Applicable Protocols for S9808-Long Term Follow-up Protocol and List of Protocols with No Required Follow-up available on the CRA Workbench

CONSENT FORM CONTENT REVIEW

Verification of the Following:

- ◆ Contains all essential elements required by federal regulations
- ◆ Compared to the model consent to ensure intent of the content is the same
- ◆ Deletions or substantive modifications to the risks or alternatives sections approved by SWOG/CTSU
- ◆ For CIRB studies, the only changes allowed to the model ICF are the incorporation of the CIRB-approved boilerplate language (local context)
- ◆ Updated by protocol modifications within the required timeframes
- ◆ Optional research questions identical to the model

Additional information

- ◆ Implement a secondary review process to ensure consent forms are complete after modifications are made (e.g., information not inadvertently deleted during copy and paste)
- ◆ When the informed consent document is revised, there must be a system that identifies the revised consent document to preclude the use of the older version (i.e., version date, date approved) and to facilitate the audit process

DELATION OF TASK LOG (DTL)

Verification of the following:

- ◆ Maintenance of a paper Site Authority Log for all key research personnel (SWOG Site Authority Log available on QA page of SWOG website). A single log for all NCI sponsored studies is acceptable. Local versions of the form are also acceptable.
- ◆ Electronic Delegation of Task Log (DTL) on CTSU website maintained for potential FDA registration studies (S1400/LungMAP, S1404, S1418, S1605, S1806, S1914) and select investigational studies

REVIEW OF SIGNED CONSENT FORMS IN THE PATIENT CHARTS

Verification of the Following:

- ◆ Patient signed the most current approved version of the consent form. For sites using the local IRB, updated consents should be implemented within 5 working days of local IRB approval.
- ◆ Consent signed and dated by the patient prior to registration
- ◆ Contains all required signatures. Investigator signature, if applicable, may be obtained within 7 days of patient consent.
- ◆ Patient responses to optional research questions reported correctly at time of registration
- ◆ Patient informed of new findings (updated risks, etc.) in a timely manner (per sponsor requirements)
- ◆ HIPAA authorization signed that allows release of PHI to SWOG or CTSU representative for the life of the study

General Recommendations

- ◆ Implement a system to ensure the use of the most current version of the consent when consenting new patients
- ◆ The patient should date his/her own signature. Errors must be corrected using proper editing techniques (i.e., no scratch outs, line through error and initial the correction)
- ◆ Document the consent process in the research record including any unusual circumstances (e.g., consent signed by patient at home so date of staff signature [witness, person obtaining consent, etc.] is different from date of patient signature)
- ◆ If there is a substantial delay from the time the patient signs consent and is enrolled in a study (> 30 days), it is recommended that the information contained in the consent form be reviewed with the subject prior to initiating any research procedures with the subject and the discussion documented in the research record. The patient must be re-consented and/or verbally informed prior to registration if there have been any significant updates to the consent (new study design, added risk, etc.). Reconsent is not required if there are no changes or only minor changes to the consent.
- ◆ When significant new findings develop during the course of the research that may relate to a subject's willingness to continue participation (e.g., Action Letters), this information must be provided to subjects. There is no requirement to wait for IRB review and approval of such information before it is provided to already enrolled subjects. New risk information must be communicated promptly (as directed by the SWOG/sponsoring group cover memo). Anytime there is a discrepancy between instructions provided by the NCI, CIRB or sponsoring group, the most stringent instructions must be followed. ***In the absence of specific instructions to notify patients, the expectation is that at a minimum, the patient be verbally informed at the next visit.*** Please contact the SWOG QA Department if additional clarification is needed.
- ◆ Implement procedures for informing research staff about changes that require patients to be informed of new findings and/or re-consented including the timeframe for informing patients
- ◆ If the patient is informed verbally of new findings, this action **MUST** be documented in the research record.
- ◆ If the patient changes his/her responses to optional research questions at any time after initial consent, the updated responses must be reported to the sponsor. The changes must be documented in the research record but the original consent form should not be modified.
- ◆ IRBs should have a policy in place to address the consent of non-English speaking patients using either a translated consent form or translated short form

For questions, contact the SWOG Quality Assurance Department at qamail@swog.org.