Post-Approval Auditing for Studies Subject to Single IRB Review

Post-Approval Auditing Working Group
of the SMART IRB Harmonization Steering Committee

April 2021

Harmonized: This document underwent a review and input process from December 2020 to April 2021 and has now been finalized.

CONTENTS

Funded by the NIH National Center for Advancing Translational Sciences through its Clinical and Translational Science Awards Program, grant number UL1TR001102-04S1.

OBJECTIVE

The Post-Approval Auditing Working Group of the SMART IRB Harmonization Steering Committee aims to identify, propose, and harmonize best practices and tools for research oversight through for-cause and not-for-cause audits of research studies being conducted under an IRB reliance agreement.

AUDIENCE

- Reviewing IRBs
- Relying Institutions
- Reliance Staff at Reviewing IRBs and Relying Institutions
- Quality Assurance/Quality Improvement (QA/QI) Staff at Reviewing IRB Institutions[1] and Relying Institutions
- Overall Principal Investigators (PIs) & Study Teams
- Site Investigators & Study Teams

1. Note: at most institutions, the quality assurance/quality improvement (QA/QI) staff are independent of the IRB itself. Therefore, whenever QA/QI staff are engaged, we refer to "Reviewing IRB Institutions" or Reviewing IRB/ Reviewing IRB Institutions.

Funded by the NIH National Center for Advancing Translational Sciences through its Clinical and Translational Science Awards Program, grant number UL1TR001102-04S1.

INTRODUCTION

Many multisite studies are reviewed and approved by a single IRB using IRB reliance agreements. In these cases, while the Relying Institution retains compliance oversight of local activities, the Reviewing IRB has the overall responsibility for the oversight of study conduct. However, there is little consistency among IRB policies or guidance as to how this oversight should be executed. Differences include consent procedures, definitions of noncompliance, expectations for reporting these events, and others. It is difficult for investigators and their study teams to keep track of the different policies and requirements when working with a variety of IRBs.

Oversight of a study under an IRB reliance agreement is challenging. Evaluating a study at a distance, even for institutions with experience serving as a Reviewing IRB, is difficult. The Reviewing IRB may have limited knowledge of the Relying Institution or its investigators and may not be able to perform an audit, either on-site or remotely. Conversely, the Relying Institution's knowledge of the approved study protocol and of the Reviewing IRB's expectations may also be limited; they rarely have access to all study documents such as amendments, progress reports, or descriptions of events that do not subsequently require reporting to a regulatory agency. Finally, resolution of potential issues may be difficult for the Reviewing IRB, as it does not have authority over investigators whom it does not employ.

There are also differing considerations for when and how not-for-cause and for-cause audits are conducted. When for-cause audits are requested, they are typically prompted by the Reviewing IRB because of specific concerns regarding the conduct of the research. Not-for-cause audits are typically initiated by the Relying Institution as part of an institution's routine post-approval monitoring program. This guidance focuses on these two scenarios, as they are the most commonly encountered. However, other situations, such as for-cause audits initiated by the Relying institution or not-for-cause audits originated by the Reviewing IRB, are possible.

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SMART IRB MASTER COMMON RECIPROCAL INSTITUTIONAL REVIEW BOARD AUTHORIZATION AGREEMENT (SMART IRB AGREEMENT)

The SMART IRB Agreement provides clear direction on the responsibilities for both the Reviewing IRB and Relying Institution in handling study compliance and audits.

Section 4.4 of the SMART IRB Agreement outlines a number of expectations with regard to compliance oversight and auditing. Participating Institutions must, "…maintain, implement or have access to a human subjects research QA/QI process function, program or service that can conduct and report to the Participating Institution the results of for-cause and not-for-cause audits of the institution and its Research Personnel's compliance with human subjects' protections and other relevant requirements." "Participating Institutions that do not have access to a QA/QI process or function must have an alternate means of monitoring the conduct of Research as appropriate to ensure compliance." "…any Participating Institutions agreeing to participate in a Ceded Review may agree between or among themselves to waive the requirement to have access to a QA/QI process, function, program or service or alternate means of monitoring with respect to the Research that is the subject of the Ceded Review."

Section 5 of the SMART IRB Agreement provides expectations for Reviewing IRBs/Reviewing IRB Institutions with regards to study oversight. Section 5.3 states the Reviewing IRB should "[m]ake available to the Relying Institution(s), when applicable and upon request, the Reviewing IRB's policies and procedures, including policies and procedures of the Reviewing IRB/Reviewing IRB Institution regarding exemption determinations." The Reviewing IRB is required to "[p]romptly notify a Relying Institution with respect to which it is conducting an audit or investigation of an allegation or matter relating to the Ceded Review, and report its findings of fact to such Relying Institution within a reasonable timeframe." Further, "… the Reviewing IRB may request the Relying Institution to conduct its own audit/investigation and report its findings of fact back to the Reviewing IRB, or the Reviewing IRB and the Relying Institution may work cooperatively to conduct an audit/investigation." "The Reviewing IRB shall inform the Relying Institution of any corrective actions in connection with the audit, investigation, or resolution of any matter under Sections 5.9 through 5.12 hereof that are required by the Reviewing IRB but shall not prevent the Relying Institution from adopting its own more stringent additional corrective actions." The Reviewing IRB will "[n]otify a Relying Institution in advance if the Reviewing IRB determines that under applicable regulation or under the terms of the Relying Institution's FWA a report is required to a regulatory agency (e.g., OHRP, FDA), sponsor, funding agency, and/or other oversight authority of any unanticipated problems involving risk to human subjects or others, serious or continuing noncompliance with applicable human subjects protection regulations or with requirements of determinations of the Reviewing IRB, and/or any suspensions or terminations of IRB approval." "Unless an alternate reporting arrangement is agreed upon, the Reviewing IRB/Reviewing IRB Institution will draft the report and will provide the involved Relying Institution(s) the opportunity (no fewer than five (5) business days, whenever possible) to review and comment on the draft report before the Reviewing IRB/Reviewing IRB Institution sends the report to external recipients.

Section 6 of the SMART IRB Agreement explains expectations for Relying Institutions with regard to oversight. The Relying Institution must ensure that its research personnel, "…accept the decisions and requirements of the Reviewing IRB. A Relying Institution or its Research Personnel may not initiate any Research or change to the Research, except where necessary to eliminate apparent immediate hazards to subjects, without first receiving prior approval from the Reviewing IRB." The Relying Institution must promptly notify the Reviewing IRB of any unanticipated problems that may involve risk to human subjects, other noncompliance, and/or restrictions or suspension of research. The Relying Institution is expected to "[c]ooperate, and require its Research Personnel to cooperate, with any audit or investigation by the Reviewing IRB/Reviewing IRB Institution of any matter under this agreement." "If the Relying Institution is asked by the Reviewing IRB/Reviewing IRB Institution to conduct its own audit/investigation, or to work cooperatively with the Reviewing IRB/Reviewing IRB Institution to conduct an audit/investigation, then the Relying Institution will do so and will report its findings of fact to the Reviewing IRB/Reviewing IRB Institution within a reasonable timeframe."

Of note, the SMART IRB Agreement, and any reliance agreement, may not be the only applicable contract that describes terms and conditions between sites. Institutions are encouraged to review additional applicable contracts with regard to this guidance document.

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COMMUNICATION

When sites enter into a reliance arrangement, communication is essential. During the initial reliance exchange of information, the Relying Institution provides its local context information (e.g., institutional policies, state and local laws) to the Reviewing IRB. At that time, it is also important for the Relying Institution to communicate its ability to provide quality assurance/quality improvement activities for ongoing studies. This should include information such as whether the Relying Institution has an internal process to review and assess research compliance on the part of its investigators, such as its own QA/QI program or an alternative arrangement and, if so, the nature of that arrangement.

Any financial considerations or resource issues should also be clarified. Having this information early in the conduct of the research will help ensure the study has appropriate QA/QI monitoring in place and the institution is ready to perform a for-cause audit in a timely manner if and when asked. This information could be shared as a part of the SMART IRB Implementation Checklist.

In addition, communication is important throughout the processes of for-cause and not-for-cause audits. Many issues may be resolved by prompt communication.

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FOR-CAUSE AUDIT

A for-cause or directed audit is an in-depth, generally onsite review of the conduct of the research or investigators that is initiated at the request of the IRB or an institutional official to obtain or verify information necessary to ensure compliance with the protocol, regulations, and/or institutional requirements. At the initiation of a for-cause audit, the Reviewing IRB must define the scope of the audit and communicate the reason, level, and urgency of concern that prompted the request. The request should be as specific as privacy and confidentiality will permit.[2] Such specificity informs the Relying Institution of the documentation the Reviewing IRB needs in order to determine the merits of the concern.

When an audit is requested and initiated, each site's responsibilities must be clear. The Reviewing IRB should communicate the expected timing of the audit and the level of urgency and required completion date. In addition, the Reviewing IRB should communicate any suggestions or requirements for methodology and/or required information to be reviewed. It is important for the Reviewing IRB to understand that the Relying Institution may have limited resources with which to conduct the audit, as the request will be unanticipated and not part of the work plan of the Relying Institution. Concessions may be made to limit the scope of the audit, or to extend the requested timeline, to accommodate requests of the Relying Institution, but the scope and timeliness of review should be appropriate to satisfy the concerns prompting the audit. It may be necessary at times for the Reviewing IRB, engaging its own QA/QI staff at the Reviewing IRB Institution, to conduct the audit remotely and/or in-person rather than rely upon the Relying Institution to perform the audit; if so, the reasons should be made clear. The Relying Institution is of course free to extend the audit scope beyond what is requested by the Reviewing IRB, permitted the timeline for audit completion remains acceptable to the Reviewing IRB.

Any corrective action plan developed by the study team and/or Relying Institution should be submitted with the audit findings for consideration by the Reviewing IRB. While the Reviewing IRB has the authority to require additional corrective actions and must be satisfied that the corrective action plan is sufficient, it should work with the Relying Institution to ensure that local context is considered with regard to the proposed corrective actions.

Purpose

The Reviewing IRB may require a for-cause audit be performed for a variety of reasons. During the course of research, events and information may be reported to the Reviewing IRB that cause concern and prompt the audit of a specific site(s), specific investigator(s), or all participating sites involved in a study or studies. The Reviewing IRB, in consultation with the Relying Institution as appropriate, will determine the best method by which to perform this audit, including whether and which specific documents (e.g., consent documents, pharmacy records or other source material) or information could be provided from the Overall PI, Relying Institution, or study team members; whether an audit is required; and the appropriate scope of the audit to investigate the concern.

It is within the Reviewing IRB's authority to require a for-cause audit, and nothing in this guidance is meant to limit that authority. However, because the Relying Institution will not have anticipated the audit and any audit will be incremental to its own work plan, a for-cause audit should reasonably be requested only for substantive reasons. Non-substantive or other routine inquires may be directed to the study team and/or evaluated through the Reviewing IRB Institution's own QA/QI processes.

A for-cause audit is warranted when a Reviewing IRB has reason to suspect serious or continuing noncompliance or an unanticipated problem involving risks to subjects or others. Examples include:

- Information in a submission indicates suspicion of possible serious or continuing noncompliance with protocol and/or with the policies of either the Relying Institution or Reviewing IRB.
- Report of an investigator or other member of the study team of possible serious or continuing noncompliance to the IRB.

2. Under certain circumstances, execution of a confidentiality or non-disclosure agreement may be necessary.

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- Report of noncompliance and/or concerns from a third party, for example, participant or sponsor complaints, requests from institutional officials, or concerns from government agencies (e.g., FDA, NIH, OHRP).
- A need to verify that the Research is being conducted in accordance with the IRB-approved protocol (e.g., protocols conducted by Investigator(s) with a history of noncompliance; questionable study performance; complex, multisite protocols where substantial portions of study are conducted off-site).

Procedures

The Reviewing IRB will send a written notice of the requested audit to the SMART IRB Institution Point of Contact (POC), with a copy to the Overall PI and Site Investigator, when appropriate. The "Sample For-Cause Audit Notification Checklist" (Appendix A) has been developed for this purpose. If the Reviewing IRB is requesting that the Relying Institution conduct the audit, it is expected that the Relying Institution POC will then forward the audit request to the appropriate QA/QI staff at their institution or to another body charged with conducting the audit. If applicable, the POC may also provide the contact information for the party conducting the audit to the Reviewing IRB to enable direct communication of the parties. The POC may also inform the director of the human research protections program, director of the IRB, or institutional official consistent with institutional policy and confidentiality requirements.

When requesting a for-cause audit, a Reviewing IRB should communicate:

- What concerns prompted the request for an audit.
- What information and source documentation should be reviewed for the Reviewing IRB to make a decision regarding non-compliance.
- Whether self-assessment by the Site Investigator/Study Team may be substituted in lieu of review by the Relying Institution's QA/QI staff (or auditing body).
- The time frame in which the audit should be conducted and communicated back to the Reviewing IRB.
- How information and documents, including relevant policies if necessary, will be communicated between the Reviewing IRB and the Relying Institution (e.g., Reviewing IRB Institution's electronic system, summary report of submissions, pdf/zip file of relevant documents).
- Confirmation as to whether the Reviewing IRB is requesting that the Relying Institution perform the audit or plans to perform the audit directly through their own institutional resources.
- How the audit observations should be communicated back to the Reviewing IRB, including whether a standardized report template should be used.

The individual(s) performing the audit should share the audit findings with the local investigator and provide an opportunity for the local investigator to comment or respond to the findings. The auditor(s) will submit a report of the audit, including local investigator responses and any proposed corrective and prevention action plans (CAPAs) to the Reviewing IRB within the expected timeframe of the request.

The "Sample Audit Checklist", (Appendix B) has been developed for the QA/QI team to complete as they perform the audit.

The "Sample Audit Report Template" (Appendix C) has been developed to help the auditing QA/QI team summarize audit report findings.

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The Reviewing IRB will review the submitted report and, if there are further questions and if necessary, request any additional information or source documentation for verification to be submitted. Upon receipt of all the information, the Reviewing IRB will provide written notification that they have completed their review of the audit submitted by the Relying Institution. This notification should be made to the Relying Institution's POC, with a copy to the Overall PI and Site Investigator(s) as appropriate, typically within 30 calendar days of receipt. Notification may be in the form of an email and should identify the protocol, reason for the audit, findings, and, if required, plans for external reporting. The Reviewing IRB will make available a summary of their review process of the audit report if requested by the Relying Institution.

If findings suggest that an additional or revised CAPA is warranted, the Reviewing IRB should request the Relying Institution to work with the investigator and study team on a draft/revised CAPA that the Reviewing IRB will then review and finalize. Further, the Relying Institution will work with the investigator and study team to implement the CAPA and report any challenges with its implementation to the Reviewing IRB. The Reviewing IRB may request follow up or further information.

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NOT-FOR-CAUSE AUDITS

Not-for-cause audits are generally conducted at the discretion of the Relying Institution as part of their on-going post-approval monitoring program. Some institutions have well-developed QA/QI programs and a system by which to select studies for these routine audits. Relying Institutions may select studies for audit in a variety of ways.

Common selection criteria for not-for-cause audits include:

- QA/QI-selected audit: The protocol meets criteria as outlined in the Relying Institution's policies and procedures for a not-for-cause audit (for example an FDA-regulated trial in which the investigator also serves as the Sponsor, clinical trial with vulnerable population, off-site research site, study being conducted under a reliance agreement). Such triggers depend on the Relying Institution's policies and may or may not be at random.
- Investigator- or Site-requested audit: An investigator may request a not-for-cause audit for education and quality improvement purposes. The Relying Institution's QA/QI program will determine the appropriateness and feasibility of the requested audit and execute the audit at its discretion.

We recommend that Relying Institutions develop a process to track those studies that have ceded IRB review to an outside institution's IRB under a reliance arrangement. When auditing reliance studies, issues and concerns may arise regarding accessing the relevant study documents and interpreting the Reviewing IRB/Reviewing IRB Institution's policies, conduct of the study according to institutional policies, and the expectations established in the reliance agreement. The Relying Institution will work with the study team and, if necessary, the Reviewing IRB, to obtain the necessary documents in order to perform the audit. Reviewing IRBs are expected to provide materials requested by the Relying Institution in a timely manner or verify that the materials provided by the investigator(s) are true and accurate. It may also be necessary for the Relying Institution to work with the Reviewing IRB on the interpretation of the Reviewing IRB's polices.

The results of not-for-cause audits are typically written and are generally provided to the investigator per the policy of the Relying Institution. Issues of suspected serious or continuing noncompliance or other potential reportable events identified by the not-for-cause audit will be communicated to the Reviewing IRB in a timely manner consistent with the SMART IRB Agreement. In the event that no reportable events, including no observations of potential serious and/or continuing noncompliance, are discovered, notification that the audit has been completed may also be provided to the Reviewing IRB, but such notification is not required.

The Site Investigator or the Relying Institution will report any findings of potential serious or continuing noncompliance or other reportable events to the Reviewing IRB. Any corrective action plans developed by the Overall PI or Site investigator and their study teams and/or Relying Institution should be submitted with the audit findings for consideration by the Reviewing IRB. The Reviewing IRB will be responsible for determining whether further investigation is necessary via a for-cause audit or other means and will determine whether the corrective action plan is sufficient and make further determination regarding required reporting of the event to external parties. In situations where additional corrective and preventative actions are required, those plans should be developed by the Reviewing IRB and sent to the Relying Institution for comment before they are finalized.

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RESPONSIBILITIES OF THE PARTICIPATING INSTITUTIONS

Reviewing IRB Responsibilities:

- Communicate to the Relying Institution, typically in writing, the concerns that prompted a for-cause audit request; this should be as clear and complete as possible, while remaining consistent with any applicable confidentiality provisions. This communication will be sent to the POC of the Relying Institution, usually with a copy to the Site Investigator at the Relying Institution and a copy to the Overall PI. A confidentiality agreement may be necessary to permit appropriate communication.
- Determine, after consultation with the Relying Institution, who will perform the for-cause audit (e.g., Relying Institution, Reviewing IRB through engaging its own QA/QI staff at the Reviewing IRB Institution, or a designated third party).
- Establish the time frame for completion and reporting results of a for-cause audit, and any reasons for urgency to the audit.
- Communicate a process for sharing study documents in a manner that is efficient and effective for the institution conducting the audit. The process could include the Reviewing IRB providing the QA/QI personnel with site-specific study documents directly or the Reviewing IRB providing access to their electronic IRB system. Only those documents relevant to the audit and to the site should be shared. The policies of the Reviewing IRB and Reviewing IRB Institution should also be made available to the Relying Institution, if requested, and the Reviewing IRB should be available to provide interpretation of those policies.
- Notify the Relying Institution upon completion of its review of the audit report.
- Review and approve of or modify the Relying Institution's proposed corrective action plan and communicate with the Relying Institution for comment before finalizing.

Relying Institution Responsibilities:

- Conduct for-cause audits as requested by the Reviewing IRB, maintaining privacy and confidentiality as necessary.
- Comply, and ensure Overall PI and Site Investigator and their study team's compliance, with audits conducted by the Reviewing IRB/Reviewing IRB Institution, maintaining privacy and confidentiality as necessary
- Obtain and provide relevant study documents and policies to the Reviewing IRB when requested.
- Provide a written report of a for-cause audit to the Reviewing IRB, with a copy to the Site Investigator and Overall PI, as appropriate.
- Communicate, or ensure the Overall PI and Site Investigator and their study team communicate, any issues of potential serious and continuing noncompliance with the Reviewing IRB for further action or investigation.
- Provide feedback to the Reviewing IRB and investigator(s) on the corrective action plan, if necessary.
- Regularly conduct not-for-cause audits as part of their post-approval monitoring program, and, at a minimum, report results of the not-for-cause audit consistent with the reportable events policies of the SMART IRB Agreement (or other applicable reliance agreement) and institutional expectations. It is anticipated that the Relying Institution will request study documents first from the Overall PI and/or Site Investigator.

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NOTES

Questions often arise during the course of a study, either from the Reviewing IRB or Relying Institution, that require consultation but do not, at least initially, rise to the level of requiring an audit. This may include the Relying Institution being notified of participant complaints or allegations against an investigator. Depending on the situation, it may be appropriate for the Relying Institution to initiate a preliminary investigation to determine whether the allegation has merit. Once the preliminary investigation has been completed, and if there is merit, that information should be communicated to the Reviewing IRB to determine what further action is necessary.

Generally, we recommend maintaining open communication between the Participating Institutions, as often clarification or simple verification of some documentation may suffice, without rising to the level of a for-cause audit. Cooperation and good intention will advance the purpose of reliance while avoiding unnecessary work and undue burden.

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SMART IRB

APPENDIX A

SAMPLE FOR-CAUSE AUDIT NOTIFICATION CHECKLIST

FOR USE BY THE REVIEWING IRB REQUESTING THE AUDIT

STUDY TITLE: _____

PRINCIPAL INVESTIGATOR: _____

PARTICIPATING SITE FOR AUDIT: _____

SITE INVESTIGATOR: _____

RELYING INSTITUTION POINT OF CONTACT: _____

SPONSOR: _____

Funding Sources *(check all that apply)*: ☐ Industry Sponsor ☐ Foundation ☐ Government/NIH ☐ Internal Funds

Type of Study: ☐ Drug/Biologic ☐ Device ☐ Tissue/Sample Repository ☐ Genetics ☐ Vaccine
☐ Questionnaire ☐ Chart Review/Database ☐ Other: _____

WHAT CONCERNS PROMPTED THE REQUEST FOR AN AUDIT?

☐ Reviewing IRB has reason to suspect serious or continuing noncompliance or unanticipated problem involving risk to subjects or others based on information received in a submission or upon report of an investigator or other member of the study team.

☐ Report of concerns from a third party (e.g., participant or sponsor complaints, institutional official request, or government agencies (e.g., FDA, NIH, OHRP).

☐ Reason to need verification that the Research is being conducted in accordance with the IRB-approved protocol [including known/suspected issues with study conduct, data integrity, etc].

Comments and additional information:

DOCUMENTS AND INFORMATION THAT THE REVIEWING IRB REQUESTS TO BE REVIEWED IN ORDER TO MAKE A DECISION REGARDING NON-COMPLIANCE? (include relevant subject selection and/or percent of records to be reviewed where applicable)

☐ Current Protocol in use by site

☐ Current Consent Documents in use by site

☐ Investigator/Study Team Training Documentation

☐ Source Documentation *(Specify)*: _____

☐ Other (e.g., Relying Institutions Policies, Study Manuals, Investigator Brochures, Notes to file, Adverse Event and Deviation logs, etc.) *(Specify)*: _____

☐ Additional information *(Specify)*:

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Time frame in which the audit should be conducted and communicated back to the Reviewing IRB.

How will information and documents, including relevant policies if necessary, be communicated between the Reviewing IRB and the Relying Institution (e.g., Reviewing IRB Institution's electronic system, summary report of submissions, pdf/zip file of relevant documents)*?

Will the Reviewing IRB or the Relying Institution be responsible for performing the audit? If a shared responsibility, specify what aspects will be audited under the direction of the Reviewing IRB and what aspects will be audited by the Relying Institution. In addition, specify if self-assessment by the Relying Site PI or Relying Site Study Team may be used to satisfy the review request.

** Secure file transfer requirements, if any, should be followed as per IRB-approved protocol and policies of Reviewing IRB and Relying Institution.*

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SMART IRB

APPENDIX B

SAMPLE AUDIT CHECKLIST

FOR USE BY INDIVIDUAL(S) CONDUCTING THE AUDIT

A. REGULATORY DOCUMENTATION

1. Is the approved protocol on file? (Original and all previously approved versions?)	☐ Yes	☐ No	
1.1 Is the IRB Approval Letter(s) on file?	☐ Yes	☐ No	
1.2 Is this an FDA regulated study? (If no, go to 1.3)	☐ Yes	☐ No	☐ N/A
1.2.1 Is there a signed FDA 1572 on file?	☐ Yes	☐ No	
1.2.2 Are all versions of the Investigator Brochure or package insert on file?	☐ Yes	☐ No	
1.2.3 Are all versions of the package insert or device manual on file?	☐ Yes	☐ No	
1.2.4 Is all correspondence to and from the FDA on file?	☐ Yes	☐ No	
1.3 CVs of PI/Co-PI and all study staff on file?	☐ Yes	☐ No	☐ N/A
1.3.1 For all CVs on file, are they current in alignment with applicable requirements?	☐ Yes	☐ No	
1.3.2 For all CVs on file, are they signed and dated, if required?	☐ Yes	☐ No	
1.3.3 Is there a staff training log?	☐ Yes	☐ No	
1.3.4 Is the staff training log complete and up-to-date?	☐ Yes	☐ No	
1.4 Is there a subject enrollment log?	☐ Yes	☐ No	
1.4.1 Is the subject enrollment log complete?	☐ Yes	☐ No	
1.5 Is/will the site (be) monitored?	☐ Yes	☐ No	
1.5.1 Who is the monitoring body? _____			
1.5.2 How often? _____			
1.5.3 Is there a monitoring log?	☐ Yes	☐ No	
1.5.4 If yes, is the monitoring log complete?	☐ Yes	☐ No	
1.6 Is there a staff signature and delegation of responsibilities log?	☐ Yes	☐ No	☐ N/A
1.6.1 Is the staff signature and delegation log complete and up-to-date?	☐ Yes	☐ No	
1.7 Is all correspondence to and from the sponsor on file?	☐ Yes	☐ No	☐ N/A
1.8 Are lab tests required?	☐ Yes	☐ No	☐ N/A
1.8.1 If yes, is a copy of normal lab values on file?	☐ Yes	☐ No	
1.8.2 Is a copy of the lab certification on file?	☐ Yes	☐ No	

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REGULATORY DOCUMENTS COMMENTS/ISSUES:

B. SUBJECT RECRUITMENT PROCEDURES

2. How are participants identified for the study?_____

2.0.1 Are there recruitment materials for this study? ☐ Yes ☐ No

2.0.2 Are all recruitment materials IRB approved? ☐ Yes ☐ No

2.0.3 Are all currently approved recruitment materials on file? ☐ Yes ☐ No

SUBJECT RECRUITMENT PROCEDURES COMMENTS/ISSUES:

C. INFORMED CONSENT PROCESS

☐ Section not applicable (consent waived)

3. Is written consent required to be obtained by the IRB approved protocol? ☐ Yes ☐ No

3.1 If yes, how many versions of the consent form are there? _____

DATE APPROVED	EXPIRATION DATE	MASTER COPY OF APPROVED CONSENT FORM ON FILE? (Y/N)

3.2 Have any eligible subjects been enrolled in this study? ☐ Yes ☐ No

(If no, skip the remaining questions in this section and D. SUBJECT SELECTION)

For the consent forms and documentation reviewed, complete the following questions:

3.3 How many subjects are/were enrolled to date? _____

3.4 How many subjects is/was the site approved to enroll? _____

3.5 How many subjects were chosen for review? _____

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3.6 Did each subject or their LAR sign his/her own consent form? ☐ Yes ☐ No

3.7 Did each subject date his/her own consent form? ☐ Yes ☐ No

3.8 Was the current approved consent document used for each subject? ☐ Yes ☐ No

3.9 Are any participants minors? *(If yes, answer the following; if no, go to 3.10)* ☐ Yes ☐ No

3.9.1 Is there evidence of assent? ☐ Yes ☐ No

3.9.2 Did the parent(s) or guardian sign and date properly? ☐ Yes ☐ No

3.10 Did the study staff sign the consent? ☐ Yes ☐ No

3.11 Did the signing study staff date the signed consent? ☐ Yes ☐ No

3.12 Did anyone not approved by the IRB to consent subjects sign as study representative? ☐ Yes ☐ No

3.12.1 If yes, who?_____

3.13 Does the signature date prior to all approved research procedures? ☐ Yes ☐ No

3.14 Did each subject receive a copy of the signed and dated consent form? ☐ Yes ☐ No

3.15 Is subject's receipt of a copy of the signed consent form documented? ☐ Yes ☐ No

3.16 If consent was revised were subject re-consented or notified as required by the IRB? ☐ Yes ☐ No

INFORMED CONSENT PROCESS COMMENTS/ISSUES:

D. SUBJECT SELECTION

☐ Section not applicable (no subjects enrolled)

4. Is there documentation of subject eligibility (note format used)? ☐ Yes ☐ No

4.1 Did all subjects meet eligibility criteria? ☐ Yes ☐ No

4.2 If no, were they excluded appropriately? ☐ Yes ☐ No

4.2.1 If no, was a protocol deviation submitted to the IRB? ☐ Yes ☐ No

SUBJECT SELECTION COMMENTS/ISSUES:

Funded by the NIH National Center for Advancing Translational Sciences through its Clinical and Translational Science Awards Program, grant number UL1TR001102-04S1.

E. IRB REPORTING AND OVERSIGHT

5. Were study procedures conducted following initial IRB approval? ☐ Yes ☐ No

5.1 Were changes to study procedures only implemented after IRB approval was received? ☐ Yes ☐ No

5.2 Were study procedures conducted during a period of expiration or suspension? ☐ Yes ☐ No

IRB REPORTING AND OVERSIGHT COMMENTS/ISSUES:

F. STUDY CONDUCT

6. Were study assessments/evaluations performed according to protocol? ☐ Yes ☐ No

6.1 Were study tests/procedures completed at the time intervals described in the protocol? ☐ Yes ☐ No

STUDY CONDUCT COMMENTS/ISSUES:

G. ADVERSE EVENTS

7. Were adverse events monitored and recorded as described in protocol and Reviewing IRB's policies and assessed by appropriately qualified and delegated individuals in a timely manner? ☐ Yes ☐ No

ADVERSE EVENTS COMMENTS/ISSUES:

H. DATA MANAGEMENT & SECURITY

8. Is source documentation and data collection accurate, complete and appropriately transcribed? ☐ Yes ☐ No

8.1 Is the data store and transmitted (if applicable) securely? ☐ Yes ☐ No ☐ N/A

8.2 Does documentation support that the DSMP is being followed and that safety/data reviews are occurring according to the approved schedule? ☐ Yes ☐ No

DATA MANAGEMENT & SECURITY COMMENTS/ISSUES:

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SUMMARY OF COMMENTS AND ADDITIONAL ISSUES:

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APPENDIX C

SAMPLE AUDIT REPORT TEMPLATE[1]

PROTOCOL TITLE: _____

PRINCIPAL INVESTIGATOR: _____
Name

_____
Department, School

FUNDING SOURCE: _____

DATE OF REVIEW: _____

AUDITORS: _____

_____

_____

DATE OF REPORT: _____

DISTRIBUTION: _____
PI Name

1. Howes, L. M., White, S. A., & Bierer, B. E. (2019). Quality Assurance and Quality Improvement Handbook for Human Research (1st ed.). Johns Hopkins University Press.

Funded by the NIH National Center for Advancing Translational Sciences through its Clinical and Translational Science Awards Program, grant number UL1TR001102-04S1.

I. INTRODUCTION: *(include brief introduction; suggested details to include: purpose of site review, who was present, etc.)*

II. STUDY SUMMARY: *(include brief summary of the study being audited)*

III. SCOPE OF REVIEW: *(include all material reviewed including regulatory documentation, consent forms, subject files, etc.)*

THE FOLLOWING DOCUMENTS WERE REVIEWED DURING THE AUDIT:

☐ Enrollment log

☐ Delegation of responsibility

☐ Staff qualifications (CV, medical/clinical licensure)

☐ Laboratory certification and normal value ranges

☐ Sponsor correspondence

☐ IRB documentation (all significant correspondence submitted to or received from the IRB, including submissions, investigator responses, notification letters, and approved consent forms)

☐ Documentation of data and safety monitoring, including log of monitoring activities, meeting agendas, minutes and reports of the data monitoring committee

☐ Participant files for the following subjects: _____

☐ Consent forms ☐ Eligibility ☐ Protocol Compliance ☐ Adverse Events

☐ Events requiring IRB reporting ☐ Other: _____

☐ Other:

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IV. REGULATORY REVIEW HISTORY:

OVERALL FINDINGS: *(include summary of observations in bulleted format with sufficient detail and outline any specific findings below)*

SPECIFIC AUDIT FINDINGS:

Regulatory Documentation:

Corrective Action: _____

Best Practice Recommendation: _____

Informed Consent:

Corrective Action: _____

Best Practice Recommendation: _____

Participant Files:

Corrective Action: _____

Best Practice Recommendation: _____

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V. CONCLUSIONS: *(summarize the site review and provide contact for questions; if response from site is required, identify timeline for response)*

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SMART IRB HARMONIZATION STEERING COMMITTEE LEADERSHIP

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